Training of Health Auxiliaries in the West Indies

DR. K. L. STANDARD AND DR. O. ENNEVER

INTRODUCTION

Expectations are outstripping our socioeconomic resources in the Americas. Through communication and education more and more people are becoming aware of their needs and making demands for better health care. Though the deficiencies are greatest in rural areas in the developing countries, they also exist in urban areas, even in some of the developed countries. The need for auxiliaries of all kinds to work with the health team has been increasingly emphasized.

In the English-speaking Caribbean the limited activities to date for the development of auxiliary health personnel have meant that the knowledge and skills of specially trained personnel have not been employed to the best possible advantage. Despite limited resources, health manpower is being underutilized while a pool of potentially useful persons, who with relatively simple training could perform effectively, has remained untapped.

In October 1967 thought was first given to the possibility of training residents of the Hermitage and August Town communities who had been giving voluntary service in clinics there. The idea was to help them to function more effectively. Other interested persons who were deemed to be suitable candidates for training were also included. Thus began the first experimental training program for community health aides in Jamaica under the auspices of the Department of Social and Preventive Medicine, University of the West Indies. This project, together with the experiences that followed, are described in the present paper.

1Department of Social and Preventive Medicine, School of Medicine, University of the West Indies, Jamaica.
The overall purpose was to train local residents in a village to work as auxiliaries in a health team under the direction and supervision of established health professionals—public health nurses, public health inspectors, district midwives, social workers, or community development workers. It was hoped that the training would provide the aides with the right sort of motivation to carry forward their work in the communities and enable them to identify the problems that should be brought to the notice of trained personnel.

Elements of the Program

The persons selected to participate in the Community Health Aide Training Program were those who it was believed could command the respect of the citizens, who were not otherwise employed, and who appeared to have an interest in our health program and in the community. No special attention was given to formal educational qualifications at this stage. Priority was given to those persons who belonged to and had made some active contribution to voluntary organizations such as the parent-teachers' associations, clinic committees, and youth and church groups. The first part of the program was a four-week orientation, during which an ongoing assessment was aimed at final selection of the persons to undergo the more intensive course. Eleven persons, including a young man, were chosen for the Community Health Aide Training Program.

Before and during the training program many discussions were held with senior administrative personnel from both the nursing and social work professions in Jamaica. It was stressed to them that these new workers would only lighten the burden of the established professional groups and would not be in competition with any of them.

Functions and Duties of the Aide

It was envisaged that the community health aide would:

- Assist the trained nurse in some of the duties which by virtue of tradition she has been called upon to perform but which can be carried out as well by less skilled persons, thereby releasing the trained nurse to use her knowledge and skills in a wider and more productive manner; and
• Recognize the significance of important signs and symptoms of illness—for example, rising temperature or increasing pulse rate—and report or refer the situation to the appropriate authority.

Specifically, the aide would have the following duties:

• In the clinic act as receptionist, chaperone, take temperatures, test urine, weigh and measure children and adults, do simple dressings, collect and record certain routine information, etc.

• In the field, follow up on broken appointments, especially in child health, antenatal, and family planning clinics; also, visit homes and assist with basic home care of the ill and aged by giving bed baths, taking care of pressure areas, taking temperatures, and assisting in preparation and demonstration of diets for infants, young children, and invalids.

Part I (First Four Weeks)

Content. Lectures and seminars were given on personal hygiene, basic nursing procedures, aspects of public health, human relationships, the structure and resources of the community, basic English, and the role of the community health aide. In addition, a field project was undertaken to discover reasons for nonattendance of children at school in a few selected areas. Related practical work was also done.

Evaluation. Residents were involved in helping to choose the candidates originally. This was a good idea and probably contributed to quicker acceptance of the aides by members of the community during the field project.

As early as the first week it became clear that some of the candidates were definitely not suited for the training. Because of the poor standard of English, sessions on basic English were introduced. However, it was realized that this problem could not be tackled successfully in such a short course, so the subject was not included in Part II, but the aides were encouraged to continue with lessons on their own.

Selection. An ongoing assessment of the candidates continued throughout the preliminary four weeks. They were judged on the basis of their performance in the classroom, in the clinic, and in field situations. The selection committee looked for not only aptitude but also ability to maintain good personal relationships.

Candidates were graded on a five-point scale—very good (5), good (4), fair (3), moderate (2), poor (1)—for each of the following 10 qualities: alertness, interest, initiative, flexibility, punctuality, ability to express ideas, potential for learning, awareness of needs of others, personal appearance, and general approach to others.
The selection committee met during the final week and recommended that eight of the original 11 candidates continue with Part II of the course. One candidate had had to drop out during Part I because of ill health; two others were considered to be unsuited for this type of work on the basis of the criteria applied.

**Part II**

Designed as a continuation of the first four weeks, Part II extended over a three-month period from January to April 1968. In each week there were 12 hours of theory, 20 hours of practical work in the clinic and the field, and study periods. The introduction to human relations was continued because the quality of service rendered depends to such a great extent on good personal relationships. This area of study was strengthened by seminars on working with groups in the community setting. Use was made of role-playing with a view to acquiring increased insight into emotional reactions which create problems. By way of practical demonstration of the understanding gained in the course, the trainees were given the task of arranging and conducting a public meeting on family planning. This exercise helped to impress upon them the role they can play in health education programs.

Sessions were held once each week for the purpose of review, clarification, and correlation of the material covered.

**Suggestions for Follow-through.** At the end of the period the aides for the most part were still somewhat diffident and unsure of their ability to carry out certain procedures on their own. It was felt that this problem might be overcome through further practice under continued in-service training.

It was suggested the trainees might well profit from at least a two-week period of hospital care for sick children as part of their course, it being felt that if the aide convinced a mother of her competence in looking after a sick child this would increase her willingness to cooperate.

Since the community health aide is expected to assume a leading role in the community, the ability merely to read and write is not enough. The aide should be capable of grasping new ideas or interpretations in regard to health and illness and explaining them intelligently.

**Employment, Continuing Education, and Objective Assessment**

Even though it was stressed from the outset that there was no
commitment to provide paid jobs upon completion of training, the program made every effort to place the course's graduates. All eight of them have been employed, although not necessarily in their own communities. They have worked for varying periods in the Department of Social and Preventive Medicine, in the University Health Service, in the Department of Physiotherapy, in the field on research projects directed by the Departments of Microbiology and of Social and Preventive Medicine, and in family planning clinics.

Hospital Experience

During the first half of 1970 the aides rotated among various departments in the hospital for six weeks in order to gain experience. The areas in which they worked included the pediatric service, all the wards, the out-patient service, the child welfare and sickle-cell clinics, the physiotherapy services, the Department of Social and Preventive Medicine, the casualty service, the family planning clinic, and an obstetric ward.

THE ELDERSLIE PROJECT: ANOTHER TRAINING COURSE FOR
COMMUNITY HEALTH AIDES IN A RURAL DISTRICT–MINISTRY
OF HEALTH INVOLVEMENT

As a result of the foregoing program, many saw the need for the experiment to be repeated in a remote rural community. Accordingly, in 1969 a joint project was undertaken by the Jamaican Ministry of Health and Environmental Control, Cornell University Medical College, and the UWI Department of Social and Preventive Medicine. The place chosen was Elderslie, which is located in an isolated mountainous district about 30 miles to the north of Black River and extends over an area about 27 miles square. It is the main township in the western parish of St. Elizabeth and has a population of about 6,000. The roads are poor and water supply is often inadequate. The educational level is not very high and many adults are illiterate.

The Elderslie Health Center is relatively isolated from other health facilities in the parish. The nearest government health centers in St. Elizabeth are the ones at Ginger Hill, which is about 20 miles away by road although only about six miles in a direct line from Elderslie, and at Balaclava, 19 miles away by road or about 11 miles in a direct line.

Working together, the health staff and the citizens of the district chose 12 candidates for training. These persons were then interviewed
by a committee, and six (four women and two men) were finally selected for the program, to run from January to March 1970. The course was similar to the previous one (Hermitage and August Town). A manual had been prepared using the lectures and demonstrations from the first course. Again the training was full-time. In charge of the program was a public health nurse who was assigned exclusively to the project by the Medical Officer (Health) for the parish. The training team comprised other public health nurses and inspectors of the parish, assisted by senior medical students from Cornell University who were studying an elective course in community medicine. These medical students also helped to augment the existing clinical medical service staff.

In Elderslie the population under five years of age numbers about 1,000. This age group accounts for approximately half of all deaths in the district. Malnutrition is a primary or associated cause in more than two-thirds of these deaths (1). Gastroenteritis, respiratory infections, and malnutrition are the chief health problems in young children.

A young child nutrition program, aimed at reducing morbidity and mortality from malnutrition, was designed in Elderslie with community health aides as the primary providers of health care. The aides' tasks have been: to take anthropometric measurements, to give health education instruction with particular reference to nutrition, to distribute powdered skim milk, to follow up malnourished children with at least monthly measurement, reassessment, and home visits.

During the first year of the study 1,150 children were examined by the community health aides. Clinic services were decentralized, so that mothers and children attended not only the Elderslie health center but also four other outstation clinics which were established in remote villages within the overall Elderslie district. Regular attendance was encouraged particularly for newborns, malnourished children, and those who had missed previous clinic visits. The aides weighed the children and kept appropriate records on graph sheets using the Gómez classification.

In Jamaica the cost of in-patient hospital care for seven children for one month has been estimated at approximately J$2,500 (US$2,272). This amount would pay the salaries of enough community health aides to take care of all the 1,000-odd preschoolers living in the district (1).

The community health aide project in Elderslie has shown that residents in rural communities can be trained locally and economically and can provide a certain degree of primary care toward meeting the basic health needs of a community.
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The Jamaican Ministry of Health and Environmental Control has accepted this category of worker, and corresponding provision is being made for salaries within the regular health budget.

THE ST. JAMES-HANOVER AND KINGSTON PROJECTS

In October 1972 the Ministry of Health and Environmental Control decided to train community health aides in the parishes of St. James and Hanover. Nearly 300 aides were graduated from an eight-week training program in December and placed on the field in January 1973. Following this, another training program, this time for 75 aides, was carried out in Kingston and these graduates are also working in their communities.

CONTINUING EDUCATION

The Department of Social and Preventive Medicine has maintained a continuing interest in the educational development of the first group of community health aides trained. Special in-service training programs have been arranged from time to time.

The concept of using auxiliaries in the health services has been accepted in many parts of the world in both developed and developing countries. Examples of their utilization in the United States of America, in Canada, and in Europe (the latter with special reference to Dutch "maternity aides") have been reported (2).

Wise and colleagues (3) described the Montefiore Hospital Neighborhood Medical Care Demonstration carried out in July 1966. The program demonstrates how a neighborhood resident trained for six months and supervised by public health nurses can perform many of the duties traditionally assigned to public health nurses and social workers.

CONCLUDING REMARKS

Fendall (4) states that "the proper training and utilization of the auxiliary permits the fullest advantage to be taken of the knowledge and skills of scarce high-level manpower and enables the professional to obtain a full measure of job satisfaction."

The expensively trained health professionals should be wisely used in any country. To delegate suitable duties and responsibilities to specially
trained auxiliaries is in no way a detrimental dilution or a lowering of standards of medical care, whether these auxiliaries be in the hospital, in the special services of the allied health professions (e.g., laboratory technology), or in the community (e.g., attached to health center dispensaries or clinics or assigned to make home visits).

Training schemes should be planned with imagination according to the needs of the community. The auxiliaries must be able to speak the local language and communicate easily with the local residents. Although a minimum of basic education is necessary, academic achievement and potential should be given less importance than other fundamental qualities. The character of the individual is of paramount importance. Efforts should be made to recruit persons who are hard-working, diligent, reliable, and conscientious. Persons with initiative and foresight are an asset.

It is important that there be adequate supervision and guidance by more experienced and senior persons on the health team. Provision must be made for in-service training of all types of auxiliaries. It must also be remembered that the auxiliaries should function only within their capabilities and should not be expected to perform tasks or carry out duties for which they have not been trained. Therefore, a very important part of the training is to outline carefully a description of the job to be done.

Training should include both the theoretical classroom work and the practical work of executing given tasks and demonstrating certain procedures. Experienced and senior auxiliaries may assist in various ways in a training program. The training syllabuses will be determined to a large extent by the job description. The jobs to be done will, in turn, depend on the needs of the health services.

If the health services are to reach the entire population, bringing the benefits of preventive and curative medicine at both the individual and community level, then we have no choice but to improve upon the old traditional patterns of health care delivery. A staff capable of providing a basic minimum of services, especially in remote areas, must somehow be developed. This cannot be achieved in very many of our communities without the enlistment of health auxiliaries.

In conclusion, it is important to repeat that the auxiliaries must be constantly supervised. They must also be able to reach the remotest districts. Universities and other traditional institutions for the training of health professionals have an important role to play in helping to bring about significant changes in the prevailing health care patterns. They must be committed to this goal and be continuously involved in
creating the right atmosphere for the development of attitudes that are sensitive to the needs of the communities. And they must have the necessary knowledge and skills to help in the solution of problems.

SUMMARY

An experimental program for the training of community health aides was undertaken in Jamaica in late 1967 under the auspices of the Department of Social and Preventive Medicine, University of the West Indies. It envisioned the preparation of local residents to work in a health team under the direction and supervision of health professionals—public health nurses, public health inspectors, district midwives, social workers, or community development workers.

The first course drew its candidates from among residents of Hermitage and August Town. The 11 persons selected for the program started with four weeks of lectures and seminars on personal hygiene, basic nursing procedures, aspects of public health, human relationships, the structure and resources of the community, basic English, and the role of the community health aide. During this period they were being very carefully screened. Those who did well and could continue (eight of them) went on to three months of more intensive training in most of these same areas. Theory was combined with extensive practice in the clinic and the field.

As a result of the first course, preparations for a second one were begun in 1969 in a remote rural community, Elderslie—this time with assistance also from the Ministry of Health and Environmental Control. In 1972, on the basis of the success of these experimental courses, nearly 300 aides were trained in an eight-week program in St. James-Hanover and another 75 in a similar course in Kingston.

REFERENCES

ADIESTRAMIENTO DE AUXILIARES DE SALUD EN LAS INDIAS OCCIDENTALES (Resumen)

A fines de 1967 se llevó a cabo en Jamaica un programa experimental para la capacitación de auxiliares de salud comunitaria bajo los auspicios del Departamento de Medicina Preventiva y Social de la Universidad de las Indias Occidentales. Su propósito fue la preparación de residentes locales para trabajar en un equipo de salud bajo la dirección y supervisión de personal profesional de salud—enfermeras de salud pública, inspectores de salud pública, parteras de distrito, trabajadores sociales o trabajadores de desarrollo comunal.

En el primer curso los participantes fueron seleccionados entre los residentes de Hermitage y August Town. Las 11 personas escogidas comenzaron el programa con cuatro semanas de conferencias y seminarios sobre higiene personal, procedimientos básicos de enfermería, aspectos de salud pública, relaciones humanas, estructura y recursos de la comunidad, inglés básico, y el papel del auxiliar de salud comunitario.

Durante ese tiempo fueron supervisados cuidadosamente. Aquellos que se desenvolvieron satisfactoriamente y que continuarían el programa (ocho de ellos) prosiguieron por tres meses más un adiestramiento más intenso en la mayoría de las mismas materias. La teoría se combinó con extensas prácticas en la clínica y en el campo.

Como resultado del primer curso, en 1969 se iniciaron los preparativos para el segundo curso en una comunidad rural remota—Elderslie—esta vez también con el apoyo del Ministerio de Salud y Control del Ambiente.

En 1972, a base del éxito de estos cursos experimentales, unos 300 auxiliares fueron capacitados en un programa de ocho semanas en St. James-Hanover y otros 75 en un curso similar en Kingston.

O TREINAMENTO DE AUXILIARES DE SAÚDE NAS INDIAS OCIDENTAIS (Resumo)

Sob os auspícios do Departamento de Medicina Social e Preventiva da Universidade das Indias Ocidentais iniciou-se em fins de 1972, na Jamaica, um programa experimental de treinamento de auxiliares de saúde comunitária. O programa visava a preparação de moradores de localidades como integrantes de equipes de saúde dirigidas e supervisionadas por profissionais da saúde—enfermeiras de saúde pública, inspetores de saúde pública, parteiras distritais, assistentes sociais e assistentes de desenvolvimento comunitário.

O primeiro curso reuniu os candidatos que se qualificaram entre os moradores de Hermitage e August Town. As 11 pessoas selecionadas para o programa participaram de um período inicial de quatro semanas de aulas e seminários sobre higiene pessoal, métodos básicos de enfermagem, aspectos de saúde pública, relações humanas, estrutura e recursos da comunidade, inglês básico e o papel do auxiliar de saúde comunitária. Durante esse período, os candidatos foram submetidos a rigorosa triagem. Os classificados e em condições de continuar o curso (oito participantes) completaram mais três meses de treinamento intensificado que abrangeu a maior parte dessas especializações. Combinou-se a teoria com a prática extensiva clínica e de campo.
Em decorrência do primeiro curso iniciaram-se os preparativos para o segundo, ministrado na remota comunidade rural de Elderslie—desta vez com a assistência adicional do Ministério da Saúde e Controle Ambiental.

Em 1972, com base no êxito desses cursos experimentais, cerca de 300 auxiliares receberam treinamento através de um programa de oito semanas realizado em St. James-Hanover, e outros 75 completaram um curso semelhante em Kingston.

LA FORMATION D’AUXILIAIRES DE SANTE DANS LES ANTILLES (Résumé)

C’est à la fin de 1967 que, sous les auspices du Département de la médecine préventive et sociale de l’Université des Antilles, a été entrepris en Jamaique un programme expérimental de formation d’auxiliaires de santé pour les collectivités. L’objet de ce programme était de préparer des résidents locaux à travailler dans une équipe de santé sous la direction et la supervision de professionnels: infirmières de santé publique, inspecteurs de santé publique, sages-femmes de district, travailleurs sociaux ou travailleurs pour le développement des collectivités.

Au premier cours se portèrent candidat des résidents d’Hermitage et d’August Town. Les onze personnes sélectionnées commencèrent par suivre quatre semaines de cours et de séminaires sur l’hygiène personnelle, les soins infirmiers de base, les aspects de la santé publique, les relations humaines, la structure et les ressources des collectivités, la langue anglaise de base et la rôle de l’auxiliaire de santé. Pendant cette période, elles furent soumises à un contrôle approfondi. Celles qui se montrèrent à la hauteur de leur tâche (huit) furent admises à un cours de formation intensive de trois mois dans la plupart des domaines précités. Théorie et pratique s’épousaient tant en matière clinique que sur le terrain.

A l’issue du premier cours, les intéressés entreprirent en 1969 la préparation d’un second à Elderslie, collectivité rurale éloignée, avec la collaboration du Ministère de la santé et de la qualité de la vie.

En 1972, à la lumière du succès remporté par ces cours de nature expérimentale, près de 300 auxiliaires furent formés dans le cadre d’un programme de huit semaines organisé à St. James-Hanover, et 75 autres dans celui d’un programme similaire à Kingston.