

B7 | THE REVIVAL OF COMMUNITY HEALTH WORKERS IN NATIONAL HEALTH SYSTEMS

Introduction

The generic designation of ‘community health worker’ (CHW) is used to refer to a variety of types of community workers, with different modes and areas of activity, with a scope of practice that may extend to comprehensive actions or be limited to specific interventions depending on the context. Nonetheless, the special relationship CHWs share simultaneously with both the community and the health system, regardless of setting or location, can be considered their defining characteristic (Lavor et al. 2004). A common feature of the numerous and diverse experiences with CHWs is their role in both improving access to healthcare of the most vulnerable populations and involving community members in this role (Walt 1990). Equally, the use of CHWs is recognized as an important strategy for health systems’ development (Haines et al. 2007; Lehmann and Sanders 2007).

One of the most inspiring early experiences of CHWs was that of bare-foot doctors, introduced as a national policy in China in 1968. This and other community-based experiences that were being developed around the world attracted the attention of the World Health Organization (Brown et al. 2006). Experiences such as that of the Chimaltenango development project in Guatemala, the comprehensive rural health project in Jamkhed, India, the community development approach to raising health standards in Solo, Central Java, Indonesia, among others, were documented by the WHO as examples in the global effort to strengthen health systems and ensure positive health outcomes for the rural majority (Newell 1975). These experiences contributed to the adoption of a primary healthcare (PHC) perspective that included CHWs as a core component.

In 1978, the outcome document of the International Conference on Primary Health Care in Alma-Ata, the Alma-Ata Declaration, highlighted the role of a properly trained CHW in responding to community health needs (WHO 1978). In 1989, the WHO defined CHWs as follows:

CHW’s should be members of the community 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 as a part of its organisation; and have a shorter training than professional workers. (WHO Study Group 1989)



Image B7.1 CHW: lackey or liberator? CHWs as social mobilizers (Indranil Mukhopadhyay)

The 1980s saw great interest and investment in CHWs but this declined in the 1990s as national programmes often experienced difficulties that had been less visible in NGO-driven initiatives and a few selected countries. Changes in priorities and funding availability were major factors, but the collapse was aggravated by conceptual and implementation problems of several large programmes, such as ‘unrealistic expectations, poor initial planning, problems of sustainability, and the difficulties of maintaining quality’ (Gilson et al. 1989).

The demands of the HIV/AIDS pandemic, especially in sub-Saharan Africa, and the crisis in human resources for health (see Chapter B9) have contributed to the revival of CHW programmes, which are currently being implemented in many low- and middle-income countries (LMICs). The initial conceptualization of CHWs took place in the context of the then dominant ‘basic needs’ approach to development, and of struggles of communities for political power and transformative change. Examples include Village Health Workers in Tanzania and Zimbabwe (in the wake of the decolonization struggle in Zimbabwe and the Ujamaa movement in Tanzania), which both focused on self-reliance, rural development and the eradication of poverty and societal inequities.

These contexts fuelled a vigorous debate regarding the potential dual role of CHWs: provision of basic healthcare (preventive and curative) to communities, and their social mobilizing role. This dichotomy was encapsulated in David Werner’s seminal paper that posed the CHW as lackey (of the health system) or liberator (of the community’s potential) (Werner 1981). The idea that community health workers can catalyse the active involvement of community members in transforming the circumstances in which they live, and that members of the community can themselves be transformed in this process, was a key element in conceiving community health workers as transformative agents. The early literature emphasized the role of the CHWs as not only (and possibly not even primarily) a healthcare provider, but also as an advocate for the community and an agent of social change.

However, more recent experiences, initially in HIV programmes, but now



Image B7.2 CHW: lackey or liberator? CHWs as extensions of health services (Indranil Mukhopadhyay)

generalized to many national initiatives, emphasize the healthcare provision activities of CHWs, characterizing the process that defines their role as one of ‘task shifting’. Task shifting is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. This implies that CHWs act solely as extensions of health services, with a restricted set of tasks delegated by ‘superior’ health workers.

This concentration on service ‘delivery’ has focused attention on several important technical aspects and the need for integration of community-level healthcare with the health system. Key technical factors that have received attention are adequate and appropriate training, supportive supervision and professional development opportunities. Past experience has spurred experimentation with different forms of financing and new communication technologies have spawned a number of interesting initiatives that use mobile phone technology (see Chapter B10) in support for and monitoring of CHW performance.

However, key questions remain for government CHW programmes, including the issue of their dual accountability (to the community and to the health system), and the accompanying conundrum of ensuring their secure employment and safe working conditions. Through four case studies, from four parts of the world, we discuss some of the issues outlined above in current programmes and conclude with reflections for the reconceptualization of the ‘community health worker’ in the current context.

Programa de Agentes Comunitários de Saúde in Brazil

The CHW programme in Brazil is rooted in a comprehensive PHC strategy (Lehmann and Sanders 2007; WHO 2008; Bhutta et al. 2010). The Brazilian Community Health Worker Programme (*Programa de Agentes Comunitários de Saúde*, PACS) was created in 1991 by the Brazilian Ministry of Health. It was motivated by the positive results achieved in an earlier state-wide programme, involving ‘community health agents’, in the north-eastern state of Ceará. The Ceará programme was introduced after the drought of 1987. The programme was designed to address a broad range of health-related functions, such as prenatal care, vaccinations, health screening, breastfeeding promotion and oral rehydration (McGuire 2001).

In 1994, the Family Health Programme (PSF) was established and is the core component of Brazil’s primary healthcare initiative. CHWs under the PACS became part of a health team created by the PSF, comprising at least a physician and a nurse, as well as nurse technicians and dentists. The team is responsible for the primary care of the population living in a geographically defined area. This ensures that CHWs are not working in an isolated fashion, but are supported by a health team, adequately remunerated and formally part of the health system.

A Unified Health System (*Sistema Único de Saúde*, SUS) was established in Brazil in 1990 (see Chapter B4). The inclusion of the PACS in a national health system based on universality, equity and social participation enabled it to expand geographically and extend the reach of the activities of CHWs.

Currently, there are over 32,000 Family Health Teams and 248,000 CHWs working across Brazil, covering 121 million people (DAB 2012) (each CHW, thus, covers about 500–750 people). Each team works with up to twelve CHWs, who build and strengthen links between the health team and the community. CHWs monitor the health conditions in the community and monitor high-risk patients, contribute to preventive public health interventions, provide health education, and maintain records. CHWs must be residents of the area and should have at least primary school education.

CHWs in the Brazilian system are full-time salaried workers and since 2002 have been legally recognized as health professionals affiliated with the SUS. Thus, technically, the CHWs are not ‘volunteers’ supported by the community. However, issues of community engagement are addressed in the SUS through an extensive and decentralized system of health councils (with statutory powers in determining budgets and monitoring performance) that have strong community ownership and participation (Cornwall and Shankland 2008; see also Chapter B4). However, successful community engagement depends on both an institutionalized system and the level of mobilization of the community (Lehmann and Sanders 2007).

South Africa: still seeking a clear role for CHWs

South Africa has a long history of CHWs, going back as far as the 1940s. During the 1980s, while South Africa was still under the system of apartheid, CHWs in many NGO programmes became agents of social change and played a role in the liberation struggle for democracy and social justice. After liberation in 1994, the new government introduced a health system that was professional-driven, in which CHWs did not have a significant role. The influence of international trends in the 1990s, which promoted ‘vertical’ disease control programmes (e.g. HIV/AIDS control programmes), contributed to CHWs being deployed as ‘single-purpose’ workers. The concept of CHWs, thus, became far removed from the earlier concept of CHWs as community mobilizers and agents of change (Van Ginneken et al. 2010).

In an apparent policy shift, a Community Health Workers Policy Framework was adopted in 2004 (NDoH 2004). Unfortunately, the 2004 framework continued to promote fragmented vertical programmes, in lieu of comprehensive community health initiatives (Van Ginneken et al. 2010). As dictated by the policy, civil society organizations employ and coordinate ‘community care givers’ (CCGs), who could be ‘multi-purpose’ or ‘single-purpose’ workers. As a bulk of the CHWs focus on care (e.g. TB Direct Observed Treatment workers, HIV adherence counsellors, home-based care givers, etc.), they are referred to as ‘community care givers’. In 2009, over 1,600 NGOs had a contractual relationship with the government under this programme, which accounted for around 65,000 CCGs, mainly involved in HIV/TB-related work (Lloyd et al. 2010).

CCGs, mainly women from poor communities, were often paid very low stipends – ranging from ZAR 500 (less than US\$50) to ZAR 2,500 (more than US\$200) per month. Many organizations employing CCGs complained of irregular and inadequate payments, while the poor remuneration that CCGs received had serious impacts on health service delivery. The programme lacks coherence because a number of organizations act as implementing agencies. While statutory structures exist for community participation (clinic committees, etc.), these are usually dysfunctional, owing in part to limited financial and technical support. As a consequence of the number of deficiencies in the programme, CCGs remain peripheral to the public health system (ibid.).

In 2009, the South African government proposed the implementation of a publicly funded National Health Insurance (NHI) scheme (ANC 2009). The NHI proposes the establishment of at least one PHC outreach team in each municipal ward. These teams are to be composed of professional nurses and environmental health and health promotion practitioners as well as CHWs, and the main function of these teams will be to promote good health; CHWs are expected to play a crucial role at the community level (Matsoso and Fryatt 2013). However, CHWs are not allowed to undertake any significant curative role, unlike in an increasing number of African countries, where CHWs now

manage cases of childhood diarrhoea, pneumonia and malaria. In addition, the ratio of CHWs to population of approximately 1:1500 is less than half that of Brazil and a fraction of that in countries such as Rwanda and Thailand. Sufficient numbers of health workers and professionals, and an appropriate skills mix of personnel, remain a key challenge for the implementation of a NHI scheme that will improve healthcare for all in South Africa (Lloyd et al. 2010).

India's 'ASHA' programme

In 2005, the government of India's Ministry of Health and Family Welfare (MoHFW) launched the National Rural Health Mission (NRHM) as a flagship health programme, with the aim of improving healthcare delivery in rural areas. Under this, new mechanisms for healthcare delivery were proposed, including a large-scale community health worker component – namely, the Accredited Social Health Activist (ASHA) Scheme.¹ In 2013, there were more than 860,000 ASHAs active in the country (MoHFW 2013), each covering up to 1,000 people in the eighteen high-focus states envisaged by the scheme (NHSRC 2011).

ASHAs are envisaged as health activists from and based in their community. Guidelines for the scheme mandate involvement of the community in the selection of ASHAs (MoHFW 2005). Evaluations of the scheme indicate that in states where these guidelines were followed, ASHAs performed better in carrying out their defined tasks (NHSRC 2011).



Image B7.3 Indian CHWs (ASHA workers) at a convention for secure employment conditions, in Ranchi, India (Amit Sengupta)

ASHAs are required to facilitate access to health services, mobilize communities to realize healthcare access, entitlements and rights, provide community-level care for priority health conditions, make referrals and accompany people to health facilities when needed (MoHFW 2005). Experience with the scheme, as regards performance, is varied. An evaluation of the ASHA programme found that: (a) the role of ASHAs as facilitators in linking community members to public health services has successfully developed; (b) their role as a service provider is developing; and (c) their role as community mobilizers and activists is still very limited (NHSRC 2011).

The ASHA programme's design incorporates several key elements of the 'Mitandin programme', a decade-old initiative to provide health support at the village level through community health volunteers in the newly created Indian state of Chhattisgarh.² The genesis of the Mitandin programme was marked by collaboration between the state government and civil society organizations, based on the civil society proposition of promoting community action in health mainly through the activity of a village health worker, belonging to and selected by the local population (PHFI 2012). The ASHA scheme, however, does not incorporate a similar level of engagement with civil society groups and community-based organizations, and poor community participation and ownership have been a major shortcoming of the ASHA programme.

Except in a couple of states, the ASHAs have no fixed salary, but receive performance-based incentives for activities related to priority health programmes (such as institutional deliveries, Pulse Polio Day, immunization days, etc.). A large majority of ASHAs have demanded a regular salary, status and corresponding employee rights (Bajpai and Dholakia 2011). The government has continued to resist demands that ASHAs be treated as regular workers, on the ground that this would negatively impact on the community. However, as the responsibility of disbursement of incentives is given to the healthcare system, ASHAs are generally perceived anyway as part of the healthcare system, and not as community representatives (*ibid.*). As most ASHAs are from indigent backgrounds and are dependent on the programme for their livelihood, their actions centre on activities with monetary incentives rather than the critical activities without allocated incentives, such as community mobilization (Joshi and George 2012).

Other key issues have been those of training, monitoring and supervision, and institutional support. The MoHFW has developed a seven-round training plan for ASHAs, which includes a twenty-three-day induction training, added to which is skill training for home-based newborn care of similar length, with dedicated training personnel and structures. However, states are ultimately responsible for implementing and revising the training curriculum. Though training is undertaken in all states, rates of training completion are uneven across states. Tellingly, activism and leadership were missing in the training until the fifth ASHA training module was introduced (NHSRC 2011).

The annual allocation for the ASHA programme in 2013 was close to INR 20,000 (around US\$330) per ASHA per annum (MoHFW 2013). While this allocation is seen as inadequate, the actual spending by the states has been found to be even lower (NHSRC 2011). Capacity and motivation of ASHA workers are uneven and low in many areas (Bajpai and Dholakia 2011; Joshi and George 2012), indicative of inadequate support provided through training and continuing education.

Finally, while supervision and constant mentoring support have been identified as critical components of the ASHA programme, there are major gaps in these areas (NHSRC 2011; Bajpai and Dholakia 2011). Further, poor institutional support and the rigid hierarchical structure of the health system continue to be challenges (Scott and Shanker 2010).

However, while ASHAs were meant to be the first contact with the health sector, in practice they have become the only contact with the health system for many poor people in difficult areas of India, as a result of the inadequate public health infrastructure, poor outreach of health systems and higher costs to access the next levels of public or private healthcare facilities. This underscores the importance of ensuring overall development of the entire health system, to optimize the potential of CHW programmes.

Behvarz in Iran: linchpin of primary healthcare

The Iranian healthcare delivery system expanded quickly after the Iranian Revolution in 1979. The ensuing reforms aimed at ensuring the right of all citizens to enjoy the highest attainable level of health and access to healthcare (Article 29 of the Constitution of the Islamic Republic of Iran) (IHRDC 1979). In practice, this resulted in a strong focus on a public healthcare system financed from the public budget and delivered through a strong public primary-care delivery system.³

A particular feature of the healthcare reforms was the introduction of a national CHW programme, based on pilot projects that had begun decades earlier (Amini et al. 1983; Ronaghy et al. 1983). Iranian CHWs, called *behvarz* – derived from *beh* (good) and *varz* (skill) in the Farsi language – are permanent employees and they receive specialized training on the health needs of rural populations. Primary-care facilities in rural areas are called ‘health houses’, and the *behvarz* function from these facilities. Each health house is designed to cover a population of about 1,500. There are now over 17,000 health houses in Iran, covering most of Iran’s 65,000 villages, with almost 31,000 *behvarz* working in these facilities. All health houses have at least one female *behvarz* and almost two-thirds of the *behvarz* are female (each health house has at least one female *behvarz*) (Javanparast, Heidari and Baum 2011). Today, in Iran, almost all rural people have easy access to basic healthcare via a trained and community-friendly *behvarz*.

The responsibility of recruiting the *behvarz* lies with a committee consisting

of representatives of the *behvarz* training centre and local rural councils. A *behvarz* should preferably be a native of the village where the health house is situated. The *behvarz* training centres (BTCs) provide pre-service as well as in-service training. *Behvarz* need to have completed the secondary level of schooling, and they undergo a two-year training course (including clinical placement in rural areas during training). The content of training is reviewed regularly and adjusted according to changing patterns of illness and population needs (ibid.). The training covers a broad range of topics from healthcare services to communication skills and social determinants of health (Javanparast et al. 2012).

The inclusion of topics on social determinants of health, inter-sectoral collaboration and community engagement in the curriculum and job profile of the *behvarz* demonstrates a welcome move towards a comprehensive approach to primary healthcare. However, given that the *behvarz* are engaged in multiple tasks aimed at providing basic healthcare, they have little time to adequately serve as agents for community development and change. The workload of the *behvarz* (which has increased over time) needs further review. Further, the amount of time the *behvarz* spend in meeting the ‘cultural expectations’ of local communities is not sufficiently appreciated (Javanparast, Baum and Sanders 2011).

Studies indicate significant improvements in a range of health indicators in Iran (Movahedi et al. 2008; Mehryar et al. 2005). Dramatic improvements in some indicators such as infant, maternal and neonatal mortality rate, population growth, immunization and child malnutrition have been attributed (at least in part) to the performance of the *behvarz* (Asadi-Lari et al. 2004).

Conclusion

The case studies range from well-established programmes integrated into robust and well-resourced health systems (Brazil and Iran) to more recent initiatives with several weaknesses (South Africa and India). CHWs in Brazil and Iran are salaried employees of the health services, while in India they are paid for performance, which appears to distort their practice in favour of certain ‘incentivized’ activities. South Africa has a ‘mixed’ system, with CCGs paid stipends by NGOs and newer government-employed CHWs receiving salaries, resulting in significant unhappiness on the part of CCGs. Community participation is institutionalized in both Brazil and Iran, although its extent and depth are unclear and likely to be variable in different settings, while in India and South Africa community participation is weak, reflecting not only the relative newness of these initiatives, but also the genesis of the former programmes during periods of widespread political and social mobilization in these countries.

These programmes do, however, demonstrate a number of commonalities: they all exhibit a relatively weak focus on and arrangements for inter-sectoral



Image B7.4 CHW delegates at a People's Health Assembly, 2012 (Louis Reynolds)

action on social and environmental determinants of health. Within the perspective of comprehensive PHC, national health systems should bring healthcare as close as possible to where people live and work. CHWs constitute the first and most important element of this process. However, CHWs are much more than ‘task-shifting’ agents, i.e. cheaper providers of primary-level care directly located in the community. As they are themselves members of the community, they have the potential to bridge the perspective of the health team and that of the community. In doing so, they can contribute to shaping healthcare to the expectations and reality of the community the health team serves.

In addition, in order for the CHW to claim a place in the community, the relationship between the CHW and the community has to be a two-way process. The community should, ideally, be involved in the selection of CHWs, and in decisions on what they are taught and the tasks they are given, and CHWs should be accountable to the community, which guides their work.

The role of a CHW has to be understood to go beyond basic healthcare, or essential healthcare, and extend to what can be described as community development (Lehmann and Sanders 2007). By community development, we understand a process by which social conditions improve and good conditions are available for and accessible to all community members (*ibid.*). In this conception, the CHW’s role is to contribute to a just distribution of health resources and, ultimately, power. The narrowing of their role in currently dominant health discourse to that of agents to whom tasks should be shifted reflects a broader depoliticization of health (and development) policy, one consonant with the hegemonic paradigm which sees healthcare as a commodity to be ‘delivered’ as cost-efficiently as possible. This emphasis, which is the core feature of a technocratic and ‘selective’ PHC, neglects the important

‘demand’ side of an organized population and its potential to serve both as an active contributor to health service coverage and quality, and also as a key factor in securing government responsiveness in addressing the social determinants of health.

In summary, then, community health workers’ role is to:

- 1 Ensure improved coverage of first-contact care. This entails providing essential healthcare, including basic treatment of acute conditions, as well as facilitating referral to primary-level facilities (clinics and health centres), and receiving back referrals for continuing care.
- 2 Take action on all dimensions of health comprehensively, including addressing the broader social and environmental determinants through advocacy and social mobilization.
- 3 Engage communities and their structures in dialogue and action concerning their health situation and its causes, including issues of social, economic and political inequity.

Clearly, the capacity of CHWs to undertake these related actions will depend both on such key technical factors as their training, support and working conditions and also, fundamentally, on the local and national political context – in short, the extent to which participatory democracy operates and power is shared.

Notes

- 1 The term ‘ASHA’ in Hindi translates to ‘hope’ in English.
- 2 See www.shsrc.org/mitanin-programme.htm.
- 3 The private health sector, through private hospitals and clinics, mainly focuses on secondary and tertiary care and on urban areas.

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