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Becoming and remaining community health workers: Perspectives from Ethiopia and Mozambique

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ABSTRACT

Many global health practitioners are currently reaffirming the importance of recruiting and retaining effective community health workers (CHWs) in order to achieve major public health goals. This raises policy-relevant questions about why people become and remain CHWs. This paper addresses these questions, drawing on ethnographic work in Addis Ababa, the capital of Ethiopia, between 2006 and 2009, and in Chimoio, a provincial town in central Mozambique, between 2003 and 2010. Participant observation and in-depth interviews were used to understand the life histories that lead people to become CHWs, their relationships with intended beneficiaries after becoming CHWs, and their social and economic aspirations. People in Ethiopia and Mozambique have faced similar political and economic challenges in the last few decades, involving war, structural adjustment, and food price inflation. Results suggest that these challenges, as well as the socio-moral values that people come to uphold through the example of parents and religious communities, influence why and how men and women become CHWs. Relationships with intended beneficiaries strongly influence why people remain CHWs, and why some may come to experience frustration and distress. There are complex reasons why CHWs come to seek greater compensation, including desires to escape poverty and to materially support families and other community members, a sense of deservingness given the emotional and social work involved in maintaining relationships with beneficiaries, and inequity vis-à-vis higher-salaried elites. Ethnographic work is needed to engage CHWs in the policy process, help shape new standards for CHW programs based on rooting out social and economic inequities, and develop appropriate solutions to complex CHW policy problems.

Introduction

Currently, many actors in the field of global health are reaffirming the crucial importance of community health workers (CHWs)—lay workers trained to provide primary health care and promote healthy behaviors for their own communities—in achieving public health goals in the context of poverty and weak health systems. For instance, 2011 saw the emergence of the Frontline Health Workers Coalition, a coalition not of workers themselves, but of international organizations seeking to make better use of them. Though there is considerable debate over the value and activities that should be assigned to CHWs, major global health-development institutions proclaim "No Health Without Health Workers," identify massive global shortages of CHWs, and call for innovative and evidence-based policies that improve recruitment and retention of community health workforces (Bhutta, Lassi, Pariyo, & Huicho, 2010; Watt, Brikci, Brearley, & Rawe, 2011; WHO, 2006).

In the 1970s, the importance of community health workers was originally affirmed by the World Health Organization. After the Alma Ata Declaration of 1978, many countries in sub-Saharan Africa began to institutionalize CHW programs as a strategy to extend primary health care to impoverished rural and urban populations and to address the relationship between poverty, inequality and community health (Cueto, 2004; Newell, 1975; Standing & Chowdhury 2008). For example, Mozambique's newly independent government instituted a cadre of community health workers known as *Agentes Polivalentes Elementares* (APEs), and Ethiopia's military government called for a new cadre of Community Health Agents (CHAs). APEs have remained active to the present in Mozambique (Simon et al., 2009), while CHAs in Ethiopia were largely neglected and eventually abandoned (Kloos, 1998). In the last few years, Mozambique has sought to re-invest in its APEs (Simon et al., 2009). And in 2003, the Ethiopian Ministry of Health

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created a new community health worker cadre of salaried, full-time Health Extension Workers (HEWs) (Donnelly, 2011).

With renewed interest in CHWs, public and private health agencies have recently begun to partner with economists to carry out randomized controlled trials to build an evidence base for recruitment and mixed incentivization schemes that positively impact community health worker performance (for example, see http://www.povertyactionlab.org/evaluation/recruiting-and-motivating-community-health-workers-zambia). This approach may be helpful to policy makers, and increased attention to CHWs—rather than to specific diseases—is a welcome step toward a more humanistic approach to health policy making (Biehl, 2011). However, the recruitment, retention and performance of CHWs may involve complex social and political processes linking CHWs' life histories, values and desires, and relationships with beneficiaries and the institutions that recruit them, and randomized controlled trials and other evaluations of interventions are usually not designed to adequately assess these processes (Christopher, Le May, Lewin, & Ross, 2011).

Ethnographic work can address these processes and provide policy makers with a more holistic understanding of how and why people become and remain CHWs. In recent years a few ethnographic studies have examined the motivations and social relationships of community health workers. These studies suggest that CHWs have many motivations including desires for better compensation and other job opportunities, new knowledge, patron–client relationships, and more pro-social motivations such as reducing suffering and living up to civic and religious values of sacrifice and service (Akintola, 2011; Kaler & Watkins, 2001; Kironde & Klaasen, 2002; Rödlach, 2009; Swidler & Watkins, 2009). The policy implications of CHWs' desires for better compensation are unclear, as fair compensation is a contentious issue for stakeholders interested in improving community health workforces. Leading global health bodies have recently affirmed that CHWs deserve fair wages to secure their livelihoods and ensure their commitments and effectiveness in serving public health institutions (Watt et al., 2011; WHO, 2008). The international NGO Partners in Health has demonstrated that CHWs have an economic right to receive fair monetary compensation, and that providing fair compensation contributes to the goal of improving population health and social solidarity (Farmer, 2010; Public Broadcasting Service, 2009). But public health institutions and donors use several economic and moral arguments to justify the minimal compensation of CHWs and volunteers (Glenton et al., 2010; Maes, Kohrt, & Closser, 2010). For instance, some argue that CHWs, even those that receive a salary, should have a "volunteer spirit," meaning that they should be less interested in monetary compensation and more committed to serving others (Maes, 2012; Kalofonos, 2008; WHO, 2002). Meanwhile, CHWs in places as various as Massachusetts (Mason et al., 2010), Pakistan (Closser, 2010), Nepal (Glenton et al., 2010), and South Africa (Kuppan, 2005) have organized, developed leadership, and protested or pursued legislation to attain better work conditions.

We aim here to build on recent ethnographic studies of CHWs by more closely examining the life histories that lead people to become CHWs, the ways that relationships with intended beneficiaries influence CHWs' commitments, and the multiple reasons why many CHWs may desire better compensation for their contributions to community health. A better understanding of these processes can potentially inform positive policy changes to CHW programs in which stakeholders, including CHWs themselves, envision innovative policies that address goals of livelihood security and fulfillment for CHWs, improved work performance and population well-being, and greater solidarity between CHWs, health professionals and bureaucrats, and the communities they serve. We present narratives from CHWs in two study sites—Addis Ababa, Ethiopia and Chimoio, Mozambique—and contextualize these narratives within the political and economic histories of these sites. We show that processes by which people become and remain CHWs are rooted in past and present experiences of poverty and inequality. Comparing results from two different sites reveals that CHWs, communities, and health officials in different contexts face similar problems, yet underlines the importance of socio-political and cultural differences for community health workforce policy making.

We report on volunteer CHWs who have been crucial to HIV/AIDS treatment programs in sub-Saharan Africa, ensuring accessible and successful antiretroviral therapies for millions of new patients (Akintola, 2008; Iliffe, 2006; Simon et al., 2009). As lay persons, they provide drug adherence support and counseling. They also mediate patients' access to clinical care and social support, and collect data on their activities so that public health institutions can monitor their progress toward AIDS treatment and prevention goals.

In the mid-1990s, HIV-positive people in Ethiopia and Mozambique could generally access treatment only for opportunistic infections. Antiretroviral therapies were only available for those who could pay high prices. At this time, NGOs in both sites began implementing home-based care, defined by the WHO as "care including physical, psychosocial, palliative, and spiritual activities" aimed at helping family caregivers and the ill "to maintain their independence and achieve their best quality of life" (Iliffe, 2006; WHO, 2002: 8). As HIV became a priority of donors and international activists in the early 2000s, rapid testing centers opened in Mozambique and Ethiopia, and antiretroviral therapies began to be introduced. Clinical operations were carried out within these countries' public health systems. Home-based care was the responsibility of local NGOs, which received funding and support from foreign NGOs and donors. Combination antiretroviral drugs became more widely available after 2004 as the prices of first-line antiretrovirals plummeted and global donors—particularly PEPFAR, the U.S. President's Emergency Plan for AIDS Relief—began to prioritize HIV/AIDS treatment. Volunteers, organized by already-existing local NGOs and community institutions, were asked by funders and administrators to recruit patients for HIV testing and treatment and support their drug adherence while continuing to provide home-based care. In Ethiopia and Mozambique, then, the roles of these volunteer CHWs in antiretroviral drug roll-out look similar, due to similar health system weaknesses and to norms of HIV/AIDS home-based care, financing, drug prescription, and monitoring that are common throughout sub-Saharan Africa.

Organized by NGOs and focused on HIV/AIDS, these volunteer CHWs have operated somewhat independently from the more generalist, government-organized CHWs that exist in Mozambique and Ethiopia. In both locations, however, there are efforts underway to integrate the work of HIV/AIDS-focused and generalist CHWs through partnerships between health-development NGOs and government (Simon et al., 2009). While it is problematic to apply our findings to other cadres of CHWs, and comparative ethnographic research is needed, the CHW narratives reported here offer lessons for policy makers and practitioners involved in CHW programs beyond our study settings. Specifically, our research suggests that policy making should better address CHWs' (1) life histories, including the pro-social role models and hardships they have encountered; (2) relationships with intended beneficiaries, given that these relationships are the basis for achieving basic global public health goals and are important determinants of CHWs' own well-being; and (3) aspirations for socioeconomic progress and policy innovations.