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Community health workers – optimizing the benefits of their unique position between communities and the health sector

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Introduction

Good morning to you all. I feel honored to be invited to speak at this symposium on the contribution of community health workers in attainment of the sustainable development goals. The 2030 agenda for sustainable development reassures a focus on universal health coverage and access to quality health care. It is clear that in many societies, community health workers directly contribute towards attaining the SDGs. Their role in ensuring healthy lives and promoting well-being for all is widely recognized. Although sometimes less visible, community health workers also contribute towards *other* goals, such as achieving gender equality and empowering of communities, including women and girls.

Over the past years, community health workers have received considerable attention of policy makers, practitioners and researchers. The realization that community health workers are needed to achieve universal health coverage is there, in many corners of the world. We know that since Alma Ata, community health worker programmes have been on the rise *and* in decline. The recent renewed and strategic interest in the role of community health workers stresses the importance of learning from the past (*and* the present). What works and in which context? Which elements of community health worker programmes make them work, which issues can result in inefficiency or ineffectiveness? Despite the fact that community health workers have so many different positions and roles within health systems; and are working in different contexts, even *within* countries, I do see cross-cutting issues that should be taken in consideration when we aim to optimize community health workers' performance and increase programme effectiveness.

Hard- and software and their influence on community health worker performance

The unique intermediary position of community health workers – between communities and the health sector – has a profound influence on their *performance*. On the one hand, community health workers are well positioned to increase access of communities to health services; and facilitate interactions between communities and the health sector. On the other hand, their intermediary position can result in a double burden with regard to accountability and expectations.

Community health workers have an interface role in health systems, and health systems are complex, social institutions. In these complex systems, performance is very much influenced by the ideas, interests, relationships, power, norms and values of all people that make up the system. This is what is called the systems "software". Performance can be seen as a transactional social process. Every health worker is part of social interactions and environments, which, together with available resources, related to systems "hardware", shape their performance. I argue that the intermediary position makes the influence of software on performance even more profound in the case of

community health workers. They need to understand and deal with interests from both communities and the health sector. They are part of both, and they cannot “hide” for the other at one of both sides.

An example

Let me introduce you to Damitao Asharn, a health surveillance assistant with whom I worked between 2009 and 2011 in Mwanza, Malawi. Asharn was one of the best performing community health workers. While many villages were facing health challenges in this poor and rural district, the villages that Asharn was responsible for were doing better compared to others on several health indicators: there were more pit latrines at the household level, and more women were delivering in the health facility instead of at home. What made, besides his personal dedication, the difference with the rest of the district?

Health surveillance assistants are not selected with involvement of communities: they are recruited at central level. Therefore, Asharn was not from the community he served, but made sure he lived in the village. He established trusting relationships with the head teacher, traditional leader and village elders. He made sure he was present and participating in community activities, such as molding bricks for the church. People came to know him. He organized the village health committee, consisting of ten volunteers, chosen by the community. Together, they mapped the village; a situation assessment was done. Asharn linked with the district health office, obtaining small funds for realizing local pit latrines built by the community. District officials heard about this success and visited the area. This boosted a feeling of recognition of the volunteers in the village, resulting in active participation during child health days and other campaigns. The idea of an inter-household competition on hygiene was born within one of the monthly village health committee meetings. A local team of volunteers, led by Asharn, prepared small prices for winning households and set criteria for assessment. An awarding ceremony was held, with active participation of the village headman. The initiative spread to other parts of the district, and small scale awarding ceremonies turned out to be well attended health education events *(as you can see from this picture)*.

What is standing out in this example? That *relationships* are the glue that supports community health workers in their interface role. The strength of community health workers’ relationships influences their motivation and performance, which affects the access to and the quality of the services they provide.

Trusting relationships

While we need to keep on improving the hardware elements of community health worker programmes, such as the availability of supervision structures and training, it is equally important to look at *how* these structures could be set up, so that they trigger mechanisms that generate trusting relationships. Trusting relationships – between community health workers and community members *(here we see the interaction between community health workers and a community member at the household level),* but also between community health workers and professionals in the health system, such as supervisors. Programme design can influence software elements, such as relationships, trust and power, which are *essential* for optimal performance.

Evidence from the REACHOUT consortium, which has been studying community health worker programmes in six countries, identified several mechanisms related to trusting relationships.

Let's first focus on the mechanisms that we identified regarding relationships between *community health workers and communities*, which were leading to better performance:

- For both community health workers and community members, feelings of connectedness, familiarity, serving the same goals, and free discussion lead to trusting relationships and better performance.
- For community members, the perception that community health workers serve in the community's interest enhances recognition and respect; and notions of credibility (for example through visible supervision or expanded curative tasks of community health workers) lead to trusting relationships and better performance.
- For community health workers themselves, feelings of self-fulfilment lead to trusting relationships with their communities and better performance.

Between *community health workers and their supervisors and other health professionals*, trusting relationships also relate to feelings of connectedness and serving the same goals. When community health workers believe that they are supported by health sector staff, relationships tend to be stronger. When health professionals value the role of community health workers and believe that their work assists them, relationships appear to get strengthened and performance improves.

What does this mean, what can we do to improve community health worker programming?

How can we trigger those mechanisms that facilitate trusting relationships? We know, from various examples in the international literature, that it helps when the programme design ensures that community health workers are recruited from the place that they work in, with the involvement of communities in decision making. The involvement of volunteers as an official element of the programme, as well as the involvement of traditional leaders, is also proven to facilitate trusting relationships between different actors, especially in contexts where community participation and volunteerism are generally valued in society. An example is the Ethiopian health extension programme, where the government made the health development army explicitly part of the programme. This mix of volunteers and paid community health workers is seen, more often, in other countries as well, but implications on trusting relationships and performance still need further research.

Trusting relationships could also be enhanced if curative tasks are shifted to community health workers: it gives them credibility. However, all actors in the health system should agree *and* be clear about which tasks are supposed to be conducted by community health workers (and which not), to avoid expectations that cannot be met. In addition, when inadequate training and supplies hinder community health workers from conducting their new tasks, credibility can come into danger, and relationships could deteriorate.

In contexts where gender roles in health care are separated, having female community health workers is important. However, we know examples of female community health workers in Afghanistan being constrained in conducting certain tasks, as male involvement is no option in a

society where females cannot speak to males outside their own households. In this way, programme design could hinder the ability to establish relationships and negatively influence performance. Other countries therefore chose for a mix of female and male community health workers. It shows that we need to think critically about gender in the deployment *and* valuing of health workers.

Furthermore, relationships can be strengthened through joint trainings of community health workers and health professionals. It can increase team work, and clarify roles and expectations. Visible supervision of community health workers can not only improve quality of their services, but can also enhance recognition of the community health worker in his or her community. There is a need for improved, *supportive* supervision, rather than administrative or fault-finding supervision.

When training supervisors, there should be a focus on technical skills, people management and the implications of community health workers' intermediate position for relationship building with communities. As supervision is a form of human interaction, strategies that reduce social distance between supervisor and supervisee (such as team building events) could improve relationships and performance.

Learning from things that do not go well yet: listening to the voices of community health workers

In the same district in Malawi which I referred to earlier, I came across situations of mistrust between volunteers, health surveillance assistants and supervisors. This mistrust was a result of perceptions of dishonesty towards the "upper level" about financial incentives that were expected to come, but were felt to be not distributed properly. This situation was caused by multiple programmes that worked separately from each other, each with their own incentive structure. It shows that programme design, in this case the way incentives are handled, can – quite easily – knock down existing, but fragile, trusting relationships. Community health workers can end up being "caught" between different forces.

Too often, in the past *and* in the present, community health workers have to juggle between the health sector and the community. They are in a continuous balancing act to meet the interests of their surroundings. They work in a complex environment, where power relations and societal values and norms influence their ability to act. We need to hear from them what helps in the balancing act, how to optimize the benefits of their unique position.

Over the past weeks, Healthcare Information For All hosted an online discussion on community health workers. Accredited social health activists (ASHAs) in India reacted, through a What's App group, on the question what are the triggers of stress in their lives. Also for them, issues regarding being denied incentives that they are entitled to result in problematic relationships with both health professionals and their own families. Their undefined position in the health system make some of them feel vulnerable. One ASHA said: *"Neither does the health services system hold our hand, nor do they leave our hand".* And a village health team member from Uganda stated: *"We would like it very much if officials from the ministry of health visit us and listen to our concerns as some problems cannot be solved by our coordinators."*

By listening to the voices of community health workers, we would be able to understand communities better as well. Community health workers are not only part of the health workforce supporting the achievement of – often – disease related targets. They also have the potential to facilitate relationships between different actors in the health system, and act as social change agents by raising the voices of communities. In other words, community health workers play an important role in bonding, bridging and linking – the pillars of social capital.

Some people argue that this function of community health workers has been unjustly pushed away from the forefront. Indeed, often, the task composition, but also the way in which performance is measured, focus a lot on reaching the targets set on health indicators. With the arguments that I am presenting in this speech, I want to stress that these targets, of course related to the sustainable development goals, cannot be reached without acknowledging the importance of the software elements within health systems. Community health workers can act as agents of social change, when they feel empowered and supported. They need to be trained in soft skills such as communication, problem-solving, and assuring confidentiality at community level.

We need to look beyond human resource management interventions to improve community health worker retention and productivity, and incorporate lessons learned from community health workers' realities as intermediaries within health systems, embedded in specific social, political and economic contexts. Only with these insights from community health workers themselves; policy makers, practitioners and researchers can draw conclusions on what can be done, together with community health workers, to improve trusting relationships and address power between all actors involved.

If we have an eye for both the hardware and software, I believe community health workers would gain the support they need, to be able to make substantial contributions to achieving the sustainable development goals.