Listening to Community Health Workers: How Ethnographic Research Can Inform Positive Relationships Among Community Health Workers, Health Institutions, and Communities

Many actors in global health are concerned with improving community health worker (CHW) policy and practice to achieve universal health care. Ethnographic research can play an important role in providing information critical to the formation of effective CHW programs, by elucidating the life histories that shape CHWs' desires for alleviation of their own and others' economic and health challenges, and by addressing the working relationships that exist among CHWs, intended beneficiaries, and health officials.

We briefly discuss ethnographic research with 3 groups of CHWs: volunteers involved in HIV/AIDS care and treatment support in Ethiopia and Mozambique and Lady Health Workers in Pakistan.

We call for a broader application of ethnographic research to inform working relationships among CHWs, communities, and health institutions. (*Am J Public Health.* 2014;104:e5–e9. doi: 10.2105/AJPH.2014.301907)

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PARTICULARLY AFTER THE Alma Ata Declaration of 1978,[1] many countries institutionalized community health worker (CHW) programs as a strategy to extend primary health care to impoverished populations, and to address the relationship among poverty, inequality, and community health.[2–4] Currently, many actors in the field of global health are reaffirming the importance of CHWs in achieving universal health care. For instance, 2011 saw the Frontline Health Workers Coalition and the One Million Community Health Worker Campaign emerge in the United States through partnerships among universities, philanthropic foundations, international nongovernmental organizations (NGOs), and multinational pharmaceutical companies. Major global health institutions have identified massive shortages of CHWs, and have called for innovative and evidence-based policies that improve recruitment, retention, and performance of community health workforces.[5–9]

Across contexts, CHW programs vary considerably in terms of job descriptions, remuneration, and structural relationships to intended beneficiaries and to governmental, nongovernmental, and donor organizations. Complex political and economic challenges also surround CHW policy and practice in many contexts. Our work as ethnographers in 3 CHW contexts—Ethiopia, Pakistan, and Mozambique—suggests that positive working relationships among CHWs, the institutions that deploy them, and communities are crucial, yet are rarely treated as an explicit goal.

On the basis of our findings in these diverse contexts, we identified 3 underresearched areas of ethnographic inquiry that, if given sufficient attention, can greatly inform such relationships. The first is CHWs' life courses, and how they have shaped CHWs' desires for alleviation of their own and others' economic and health challenges. The second is the quality of existing relationships between CHWs and intended beneficiaries, particularly those who are poorer and more marginalized. And the third is the ways in which policymakers, donors, and CHWs themselves negotiate and compromise on CHW policy decisions. These areas of inquiry may be more crucial in contexts where CHWs are regarded more as labor resources deployed by health institutions and less as partners with a seat at the table of policy development, but will still be important in places where CHWs are more active in the process of policy change.

We elaborate on our ethnographic research involving participant observation and interviews with CHWs and policymakers and implementers in Ethiopia, Pakistan, and Mozambique. In Ethiopia, research focused on volunteer CHWs specializing in HIV/AIDS care and treatment support in the capital city, Addis Ababa, between 2006 and 2009. In Mozambique, research focused on volunteer CHWs working within HIV/AIDS treatment programs in the town of Chimoio between 2003 and 2010. Although both of these urban contexts are characterized by high rates of unemployment, chronic malnutrition, HIV infection, and inequality, people—including CHWs—in these contexts have different historical experiences of, for instance, colonialism, war, structural adjustment, and the role of religious institutions in health care.[10] In Pakistan, research focused on Lady Health Workers (LHWs) employed by the health department, between 2008 and 2011. These CHWs provide a variety of health services to their neighbors, from family planning education to tuberculosis treatment support, in a severely underresourced and sometimes corrupt health system that lags behind those of other countries in the region.[11–13]

HOW AND WHY PEOPLE BECOME COMMUNITY HEALTH WORKERS

Recent ethnographic studies show that CHWs have many motivations, including hopes for better job opportunities and patron–client relationships, and desires to reduce others' suffering and live up to values of sacrifice and service.[14–19] However, studies rarely examine how CHWs' motivations are related to their life histories. Use of in-depth interviews to

elicit life histories[20] from CHWs yields important insights. First, structural violence has shaped many CHWs' lives as well as the health systems and epidemics that draw them in. Second, CHWs' past and present hardships give rise to desires for improvement in the economic and health statuses of their communities. And third, CHWs desire to improve the lives of others partly because of the values they have internalized through relationships with family, friends, and religious community members. Overall, ethnographic attention to CHWs' life histories elucidates how their multiple, coexisting motivations are embedded in their relationships with others, and clarifies how important good jobs and positive relationships are to CHWs, their families, and impoverished communities in general. The insights generated by such work can inform the design and implementation of context-specific incentive schemes.

For instance, when conflict in Mozambique escalated in the late 1970s, many families fled to Zimbabwe. While she was a refugee, a Mozambican woman joined an association of displaced people who aimed to build solidarity and understand each other's cultural differences. When she returned to Mozambique, she joined a local AIDS-care NGO whose mission to provide care for diverse peoples reminded her of the refugee association in Zimbabwe. "That was a great experience and I thought it would be great to have it again."[10] Having separated from her husband, she was also the primary source of support for her children, pursuing multiple informal economic opportunities.

In Addis Ababa, many volunteer CHWs came from families that had endured war in the 1970s and 1980s and grinding poverty in the 1990s and 2000s. One 33-year-old man joined a local AIDS-care NGO as a volunteer CHW while still living with his mother and father, a retired soldier. He had worked at a string of menial jobs to support his parents, but found these jobs meaningless. A 26-year-old Ethiopian woman became a volunteer CHW in the same organization after having worked as a domestic servant in Saudi Arabia and Kuwait, a difficult job she endured to support her mother and father, also a retired soldier. She recounted her initial interest to become a CHW as a case of "spiritual envy." She heard about CHWs doing "good things for others" and thought, "What if I do something like them?" Unmarried and living with their parents, both of these individuals were frustrated with the lack of good jobs in Addis Ababa that would allow them to support rather than depend on others.[21]

War often contributes to local epidemics, weakens health care systems, and shapes individual lives.[22,23] Political–economic changes in the early 1990s in many sub-Saharan African countries put an end to some violent conflicts but led to cuts in health expenditures, "outsourcing" of government services to NGOs, and reduction in the availability of public-sector jobs. In Pakistan, by contrast, the longstanding threat of war with India, along with recent political instability, have led the government to direct funds to defense rather than health, and have disrupted the lives of many families. Women in multiple countries, furthermore, face limited employment opportunities as well as widespread biases that caregiving is "women's work."[24,25] These diverse structural processes help explain why people in Pakistan, Ethiopia, and Mozambique end up serving as underpaid CHWs, and why women predominate in CHW roles around the world.

To build productive partnerships, health institutions and donors that recruit and deploy CHWs need to know where individuals within these ranks are coming from and where they want to go, morally, socially, and economically. Paying attention to the life histories of CHWs is also an important part of recognizing that CHWs are actors who could play a bigger role in policy change and implementation.

IMPROVING HEALTH AND ADDRESSING DISCRIMINATION

Community health workers are increasingly recognized for their success in preventing unhealthy behaviors, improving treatment adherence, and lowering rates of morbidity and mortality.[26] Unlike doctors and nurses who may distance themselves from their patients' day-to-day struggles and social dramas, CHWs ideally maintain a greater level of intimacy with patients and treat them as relative equals.[27,28]

There is no guarantee that CHWs will relate to intended beneficiaries with mutual respect and intimacy, however.[29] In Addis Ababa, idioms of fellowship reinforced by family, NGOs, government, and religious institutions help to motivate CHWs to treat patients of various backgrounds as fellow humans deserving of care. Here, CHWs describe their close relationships as meaningful and positive aspects of their own identities. They do not, however, establish close relationships with all patients. Some CHWs distinguish between "good patients" who greet them nicely, openly discuss their problems, and "care for themselves" on the one hand, and patients who "do not have good behavior" and "do not listen to what we tell them" on the other. Some CHWs in this context recognize and attempt to curb these tendencies to distance and discriminate. One CHW claimed she countered such talk among other CHWs by telling them, "it could be because of your approach. You have to give good love for the patient in the first place." Another CHW was reluctant to blame "difficult" patients, explaining, "They are thinking a lot about their problems and their disease. So you should avoid your negative perception of these patients, and try to be kind."

Although CHWs who deal primarily with HIV/AIDS have unique experiences, various forms of status inequalities and discrimination occur more broadly.[30] In Pakistan, many LHWs are reluctant to visit minority populations. One LHW living in a Punjabi-majority area discussed her feelings about serving Pathans, a minority ethnic group in that part of the country: "I'm scared of Pathans. . . . [Their] children are dirty, too. [They have] bare feet [and are] in a horrible state. There are some places I just don't want to go." Still, other LHWs in the area were supportive and open to visiting Pathans. "Those people are so cooperative!" one explained.

Across contexts, then, acceptance and discrimination coexist. Community health workers should be expected not only to reduce morbidity and mortality but also to confront the "illness of discrimination."[31] Policymakers cannot, however, simply mandate that CHWs build close relationships with potentially stigmatized and economically marginalized patients. Bringing about positive change in this area will require

diligent ethnographic description, analysis, and interpretation of what is actually occurring in CHWs' engagements with intended beneficiaries, and how practices are experienced and explained by those involved.[27] This work can inform constructive dialogue among policymakers, CHWs, and intended beneficiaries about how to root out various forms of discrimination and inequality and build strong relationships.

LABOR RELATIONS AND POLICY COMPROMISE

Proactively improving CHW labor relations is an important yet often overlooked goal in debates over CHW program effectiveness.[8] A more proactive approach to CHW labor relations requires recognition that policy decisions about CHW jobs often reflect goals of not only improving public health, but also reducing poverty and empowering women; that CHW policy decisions are often based on compromises among national and transnational policymakers and donors who have heterogeneous interests, values, and traditions; and that it is very likely that CHWs across the world will seek to become more active participants in shaping policy. Ethnographic research examining complex negotiations among stakeholders in CHW policies can greatly inform efforts to improve working relationships and policy outcomes.

For instance, Ethiopia's Health Extension Program, the centerpiece of Ethiopia's nationwide effort to achieve universal health care, involved the creation of roughly 34 000 Health Extension Worker jobs for women. According to Ethiopia's then–minister of health, the "key to success" of the Health Extension Program was "engaging health extension workers as full-time salaried civil servants" and thereby "moving away from volunteerism."[32] Some public health officials and donors have argued that CHWs should have a "volunteer spirit," meaning that they should be less interested in monetary compensation and more committed to serving others.[14,15,33–35] The Ethiopian minister's comments suggest that by creating full-time salaried jobs for unemployed people, particularly women, ministry officials were rejecting this logic and taking steps not only toward universal primary health care, but also toward poverty reduction and women's empowerment. This is more in line with the World Health Organization's recommendation that CHWs receive "adequate wages" and that such wages "may contribute to broader human development and poverty reduction strategies,"[9(p36)] which has been affirmed by other leaders in global health.[6,36,37]

Yet examination of policy documents and ethnographic research reveals that from the beginning of the program, Health Extension Workers relied heavily on volunteer CHWs and, more recently, volunteers in the Women's Development Army.[38–42] From one perspective, the creation of the Health Extension Program and then the Women's Development Army reflects a budgetary compromise. The government's efforts to create salaried Health Extension Worker jobs, notable internationally for its scale, still faced budget constraints, and so plenty of the labor needed by the program still falls in the unpaid or "volunteer" category, on the shoulders of impoverished women and men. From another perspective, the Women's Development Army reflects the government's philosophy that every household, and particularly women, should be "empowered" to understand health and hygiene and to engage in behaviors deemed desirable and healthy by the government.

The Ethiopian case illustrates that ethnographic research attuned to local politics, history, and relationships with international donors can and should be used to reveal the multiple values, goals, and compromises that often shape CHW policy decisions. We also need to study what role CHWs play in these compromises. In Ethiopia and Mozambique, CHWs do not have any collective voice. In contrast, CHWs in places as various as Massachusetts,[43] Pakistan,[11] Nepal,[15] and South Africa[44] have organized, developed leadership, and protested or pursued legislation to improve work conditions. What lessons can we draw from such organized efforts? The case of LHWs in Pakistan is instructive.

Many LHWs say that they are frustrated by lack of opportunities for job advancement. Those with money for education and political connections might become supervisors, but further advancement, they say, is nearly impossible. "That's it," one supervisor said. "You get this far and the brakes engage." The LHWs are also frustrated by low pay. One supervisor pointed out that LHW responsibilities had multiplied in recent years and that their payment was in arrears. "They haven't been paid in six months," he said, "but still when we call them and say, 'come to the stop smoking march,' or whatever it is this week, they have to get a rickshaw and show up."

A LHW labor movement that organized public strikes across the country gained traction in 2010, when the movement led to a Supreme Court decision that LHWs must be paid the national minimum wage (about US $100 per month) for their work. Nearly all LHWs and their low-level supervisors supported the Supreme Court decision. Despite the Court's ruling, however, LHWs' wages were not immediately raised, leading to more strikes. Lack of maternity leave and pensions were also highlighted during the protests.[45–48] One LHW who participated in overnight sit-ins in Karachi said,

> Sure, I was a little scared. I'd heard firing often happens in those situations . . . but looking at the women who were there breastfeeding their babies—if they could come, then so could I.

It was only in response to outrage over the killings of several LHWs by militants in December 2012 that the national government agreed to "regularize" LHWs—that is, to extend to them the same job security and benefits that other government employees enjoy.[49]

The Pakistan LHW labor movement further demonstrates that CHW policy changes involve compromise and negotiation, not just top-down technocratic testing of innovations on CHWs. Even in places where CHWs are generally unheard in the policy process, CHW organization and activism can emerge as CHWs desire to become more active and respected participants in shaping policy. Depending on the context, such desires may be based on CHWs' awareness of the intense social and emotional work they put in,[10] their sense of inequity in comparison with salaried elites in government or NGOs,[19] or their desires to experience progress from past and present situations involving poverty and conflict.

Because of the importance of CHW program goals, proactively improving relations between CHWs and the institutions that rely on their labor may be worthwhile. Ethnographic work that attends to the varied interests and values of policymakers, donors, and CHWs—and how they negotiate and compromise—can inform health partnerships based on mutual understanding and a shared role in improving policy and practice.

SUMMARY AND IMPLICATIONS

The goal to improve CHW policy and practice—in multiple political contexts around the world—requires treating CHWs like global health actors and not as resources to be better exploited through technical quick fixes.[36,50] Our ethnographic inquiries collectively indicate the importance of understanding the life histories behind people's decisions to become CHWs, the ways that CHWs build relationships with community members and confront discrimination, and the ways in which policymakers, donors, and CHWs build solid working relationships despite their heterogeneous and potentially conflicting interests, values, and traditions.

We argue that investing ethnographic attention—with its unique focus on the evolving social realities of "target populations" and of the actors on whom the burden of community health program implementation lies[50]—can generate valuable returns, helping to inform healthy working relationships among communities, CHWs, and health institutions. ■

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This article was accepted January 18, 2014.

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Acknowledgments

K. Maes was supported by the National Science Foundation (Cultural Anthropology Dissertation Improvement Grant 0752966), Emory University's AIDS International Training and Research Program (NIH/FIC D43 TW01042), and Brown University's Population Studies and Training Center (NICHD T32 HD 733824). S. Closser was supported by the National Science Foundation (Cultural Anthropology Dissertation Improvement Grant 0613159), a Wenner-Gren Foundation Dissertation Fieldwork Grant, and UNICEF. I. Kalofonos was supported by a Fulbright-Hayes Doctoral Dissertation Research Award, the UC Berkeley Rocca Research Award, and a UCSF School of Medicine International Program Grant.

We are grateful to all in Ethiopia, Pakistan, and Mozambique who shared their experiences with us. We also extend thanks to the organizations and individuals who supported this work.

Human Participant Protection

The research reported here was conducted with the approval of the institutional review boards of Emory University; Addis Ababa University Faculty of Medicine; ALERT Hospital (Addis Ababa, Ethiopia), Middlebury College; University of California, San Francisco; and the Mozambique Ministry of Health.

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