

## **Community Health Worker Voice, Power, and Citizens' Right to Health**

### **Meeting brief for “think-in” to develop a research agenda**

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*This brief is intended to provide background to participants of the meeting on Community Health Worker Voice, Power, and Citizen’s Right to Health. The guiding questions for the meeting are as follows: What factors promote or undermine community health workers as accountability agents? (and) Can these factors be intentionally fostered or suppressed to impel health system accountability? The text below provides a basic overview on community health workers and accountability, as well as a non-exhaustive discussion of some of the kinds of issues that will likely arise during the meeting.*

#### **Community health workers**

The term ‘community health worker’ (CHW) has been used to describe various cadres of community health aides with varying levels of training, providing a variety of different health services. In general, however, this umbrella term encompasses workers who: are members of the communities where they work; are (at least in part) selected by the communities they serve; and are required to represent and/or deliver health services (WHO, 2007). CHWs are also commonly envisioned as being answerable to the community for their activities (WHO, 2007), however the extent to which this is achieved is unclear. CHWs often perform a linking function between communities and the health system, and are frequently put forward as a remedy for lack of health system capacity, including challenges associated with health service coverage and with low community engagement in the health system.

CHW programs have a long history, dating back to the 1930s with China’s ‘Farmer Scholars.’ The 1960s/70s saw a flurry of CHW programs in various countries, followed by efforts at national-scale government programs in the 1970s/80s. A number of factors encountered in the 1980s/90s—including a global recession, the debt crisis in many developing countries, donors’ structural adjustment policies, and the loss of momentum in the primary health care movement (which had firmly endorsed the use of CHWs)—resulted in waning financial and political support for CHW programs, which were ultimately reduced or discontinued (Perry, Crigler, & Hodgins, 2014a). Renewed interest in CHWs since the 2000s has led to a proliferation of new and revived programs, with increasing focus and reliance on CHWs as a mechanism for expanding communities’ access to basic health services. Many of these programs have produced robust evidence that CHWs can improve population health outcomes (Bhutta, Lassi, Pariyo, & Huicho, 2010; Gilmore & McAuliffe, 2013; Perry et al., 2017; Perry, Zulliger, & Rogers, 2014b), inspiring confidence that CHWs may be a valuable asset in realizing universal health coverage.

#### **Accountability**

‘Accountability’ is also a term with numerous definitions, but can be thought of as “the continuing concern for checks and oversight, for surveillance and institutional constraints on the exercise of power” (Schedler, 1999). Whatever the definition, there is general consensus that accountability has two key features: answerability—whereby actors are obligated to provide information and justification regarding policy and practice; and enforceability—that sanctions must exist for failure to comport with (or rewards for realization of) policy

(Brinkerhoff, 2004; Schedler, 1999). Accountability mechanisms that allow one branch of the state to oversee another are known as checks and balances (commonly called horizontal accountability). The role of citizen voice and action in holding state actors accountable is often called vertical accountability (O'Donnell, 1998). Examples of the former include legal review by the judiciary of actions taken by other government branches, or audit and anti-corruption investigative bodies; examples of the latter include citizens voting for elected officials, or advocacy by civil society groups. Vertical accountability can also be seen as 'downward accountability,' or accountability from the health system to the communities they serve, in contrast to the 'upward accountability' relations of frontline service providers to policy implementers, who in turn ostensibly report to policymakers. Diagonal accountability refers to combinations of vertical and horizontal oversight, wherein citizens participate in state accountability structures (Fox, 2015).

Beyond conceptualizing accountability as horizontal, vertical, or diagonal, one can also consider different subtypes of accountability. Political accountability focuses on the actions of politicians. Administrative accountability covers the appropriateness of bureaucratic activities. Financial accountability monitors how public monies are allocated and spent. Legal accountability reviews adherence to laws (Schedler, 1999).

Other theorists are circumspect of these more taxonomic approaches to accountability, arguing that accountability can also be understood as an 'emergent property' of a system, characterized by a multiplicity of accountable relationships supported by political commitment and professional norms that favor accountability (Freedman & Schaaf, 2013; O'Connell, 2005). The notion of 'accountability ecosystems' brings together multiple accountability approaches and actors—and the need for synergy between them (Halloran, 2015). To address the multiple links in the chain of service delivery decision-making, the vertical integration of civil society monitoring and advocacy can identify both key bottlenecks and opportunities for change (Fox & Acheron, 2016).

Social accountability refers to non-electoral mechanisms through which civil society aims to control state power (Smulovitz & Peruzzotti, 2000). It is "an evolving umbrella category that includes: citizen monitoring and oversight of public and/or private sector performance, user-centered public information access/dissemination systems, public complaint and grievance redress mechanisms, as well as citizen participation in actual resource allocation decision-making, such as participatory budgeting" (Fox, 2015). Because of their links with and between communities and the health system, CHWs may be well-placed to act as agents of vertical accountability. Depending on their position and power in the health system, they may also be able to advance horizontal accountability by interacting with other governmental agencies, or diagonal accountability through their engagement with village health committees and other entities that engage both governments and citizens.

### **CHWs as accountability agents**

Although CHWs have broad and often varying job descriptions, across many contexts they have an explicit mandate to be agents of downward accountability. In other settings, they have an implicit downward accountability function, such as representing community concerns to the local health facility or educating the community about their rights and entitlements. At the same time, CHWs may experience significant upward accountability pressures. As employees of governments that are trying to meet ambitious health service coverage goals, CHWs may feel much greater obligation to meeting and documenting service provision goals than to providing respectful, quality service to their communities, or to representing community needs and priorities to the health system. Indeed, at times these obligations can undercut downward accountability, resulting in CHWs providing perfunctory, poor quality, or coercive care.

Even though governmental CHW programs may include an implicit or explicit expectation that CHWs foster health system accountability to the community (and vice-versa), this area has been little studied or discussed in policy fora outside of a few studies in India (Saprii, Richards, Kokho, & Theobald, 2015; Scott & Shanker, 2010). The proposition that there may exist inherent tensions between downward and upward accountability in the CHW role (de Koning et al., 2014) has also received little research attention. This tension may go beyond “doing what is best for the community” or “doing what your boss wants.” In some cases, CHWs may be a cog in a complex system of political patronage (Chauls, 1982; Mumtaz, Salway, Waseem, & Umer, 2003; Raven et al., 2015; Sanders, 1990; Saprii et al., 2015). These functions may coexist, with CHWs balancing multiple demands from their communities, the government, and those holding political power.

There is an abundance of literature on CHW programs, some of which can shed light on the conditions under which CHWs may be able to effectively serve as agents of accountability. Some of the relevant literature is summarized below.

#### *CHWs can be a bridge between the health system and the community*

CHWs are unique in having a formal mandate to interact with both communities and health facilities. The resulting ‘bridge’ formed between community members and the formal health system is often simply used to deliver health services to community members who would otherwise not have access, thereby employing CHWs primarily as ‘another pair of hands’ for service delivery (Walt, 1990). But this bridge also provides a platform through which CHWs can function as ‘cultural brokers’ (McKenna, Fernbacher, Furness, & Hannon, 2015), facilitating dialogue on health matters between the health system and the community. Finally, CHWs can serve as ‘agents of social change’ (Lehmann, Friedman, & Sanders, 2004) or ‘liberators’ (Werner, 1981), advocating on behalf of their communities on topics relating to social determinants of health. The cultural broker and social change agent roles are akin to that of an ‘interlocutor’ (Tembo, 2013) in the accountability literature, or individuals capable of identifying problems in the community and conveying them to the health system to seek solutions.

There is abundant evidence supporting the claim that CHWs can effectively bridge the service provision gap between the health system and underserved communities (Bhutta et al., 2010; Gilmore & McAuliffe, 2013; Perry et al., 2017; Perry et al., 2014b). Data supporting the other two bridging functions (cultural broker and social change agent) are more limited.

The cultural broker role can take one of two forms (or both): communicating health system priorities and information to communities in culturally appropriate and acceptable ways, and communicating community needs and concerns to the health system. One might assume the former to be implicit in all CHW programs, given that CHWs are recruited from the communities they serve and therefore understand cultural norms and practices; but this may not always be the case. To be sure, there are programs where CHWs have applied their knowledge of the community to develop contextually relevant communication methods, like CHWs in Bangladesh using folk music or theater to spread awareness of health issues (Bhutta et al., 2010). But developing culturally appropriate approaches requires that CHWs be granted sufficient flexibility to alter health messages as necessary. In Thailand, CHWs have described how supervisory emphasis on specific protocols and activities have limited their ability to tailor their support in response to community needs (Kowitz, Emmerling, Fisher, & Tanasugarn, 2015). On the other hand, affording CHWs flexibility is not without its drawbacks; it can lead to inconsistent services across different CHWs, and may compromise the fidelity of the health messages being delivered. In addition to sufficient flexibility, effectively communicating information to communities also requires a receptive audience, which presupposes community trust in CHWs. This matter is discussed below (see *Community perceptions of CHWs*).

The latter form of the cultural broker role—communicating community needs and concerns to the health system—has been observed in some CHW programs but not others, and may be a promising channel through which CHWs can foster health system accountability. For example, there is a non-governmental organization (NGO)-led CHW program in Haiti with a focus on HIV and TB that tasks CHWs with providing home-based care, active case-finding, and community education. Although the principle aim of the program is to expand community access to clinical care, its CHWs have also identified other community health priorities including clean water and vaccinations. As part of the program the CHWs participate in clinic staff meetings, which provide an opportunity to communicate the community’s self-identified needs to the health system (Bhutta et al., 2010). Similarly, through both formal and informal channels, Roma CHWs in Europe educate health providers on Roma culture and the impact of discrimination against Roma on their health seeking behaviors (Schaaf, 2004). In India, however, this form of dialogue seems to be absent. It is not that CHWs in India are unaware of community health needs, but rather that their interactions with facility staff do not encourage disclosure of such information. One possible explanation for this dynamic is that the hierarchical nature of India’s health system overwhelmingly promotes the downward flow of information, such that health workers are expected to tell CHWs what to do, not gather information from them (Scott & Shanker, 2010). Unfortunately, a review of six other country case studies also found no evidence that CHWs influenced health service priorities or resource allocations based on their identification of local needs (Kane et al., 2016), suggesting that concerted effort may be required to facilitate this form of dialogue.

In addition to *actively* communicating community priorities up to the health system, one can also imagine CHWs doing this *passively* through data collection. CHWs collect data on community health and/or the services they deliver, and they are typically required to pass their records on to local health facilities as part of routine reporting. Analyzing this data provides an opportunity for program planners and policymakers to be more responsive to on-the-ground realities in local communities. For example, in Brazil, CHWs are responsible for collecting a wide range of information from households in their area. This includes not only basic demographic data and health information related to the services CHWs offer, but also data relating to families’ economic and social status. CHWs are expected to update their records on a yearly basis and to use this information to better target their services. This data is also fed up to the Family Health Team (a structure described below; see *CHW program focus countries*) where the information is used to adjust activities as needed. It is then passed on to the municipality to update CHW training programs so that they can respond to the current epidemiological, social, and economic context in the communities where CHWs work (Bhutta et al., 2010). CHWs in Thailand also reported that their data collection efforts informed programs and policies at both the local and national level (Kowitz et al., 2015).

Of the three ‘bridging’ functions CHWs might serve, the role of social change agent may be the least well documented in the literature. This may reflect the relative difficulty of measuring or evaluating the impact of a CHW program on a community’s social determinants of health—factors that are notoriously multifactorial and resistant to change—including, for example, racial and gender-based exclusion or access to health care, education, and other state services. Despite this, the concept of the social change agent remains integral to many CHW programs. CHWs in India have mobilized development efforts beyond the scope of health care for decades, and the change agent role is intended to be a key function of the national government’s current CHW cadre (aptly named Accredited Social Health Activists) (Joshi & George, 2012). In Brazil and Bangladesh, CHW training supposedly “privileges the determination and understanding of social, economic and environmental characteristics of the community;” in Haiti the emphasis is on “instill[ing] a sense of solidarity and social justice” (Bhutta et al., 2010). CHW job descriptions sometimes explicitly include non-health responsibilities relating to literacy, housing, income-generating activities, or reducing social isolation. In Brazil, the language is slightly more nebulous, charging CHWs with “promot[ing] community participation in actions related to improved quality of life” (Bhutta et al., 2010). Even though Brazil’s conceptualization of CHWs imagines them as agents of social change, the program has

been criticized for falling short of this aspiration and focusing too narrowly on the biomedical aspects of the CHW role (Bhutta et al., 2010). This criticism has also been voiced for India's CHW program (Joshi & George, 2012). Further, a review of the literature on health system factors influencing CHW performance arrives at a similar conclusion, commenting that "reflection on norms and values and addressing power relations are rarely the focus of CHW interventions, which could explain why it is difficult for CHWs to address these issues" (Kok et al., 2015b).

It is important to note that there are many examples of NGO-employed community-based health workers who act as social change agents. For example, in Guatemala, Community Defenders collect individual complaints about barriers and discrimination faced while seeking health care, and use this evidence to advocate for municipal, provincial, and national government action to address violations of the state's right to health commitments (Flores, 2015). NGO-employed CHWs raise important questions about sustainability, scale, and governmental fulfillment of obligations to their citizens, however.

#### *CHW interaction with community-based structures*

Virtually all communities have councils or committees to handle the administration of community matters, and many have groups specifically dedicated to health-related issues. These village health committees (VHCs) typically have five to eight members that include political leaders, religious figures, and sometimes health providers from local facilities (Kahssay, Taylor, & Berman, 1998). Involving these groups in CHW selection is a recommended practice (Bhutta et al., 2010), with the potential to promote community acceptance of CHWs as well as CHW accountability to the community (or, at the very least, to those community members involved in recruitment). Women's associations are another potential key partner, as they often play a role in village health activities regardless of whether they are formally represented on VHCs or not, or whether they are supported by the state or not (Kahssay et al., 1998).

VHCs can be an important source of support for CHWs, with some studies showing a link between the level of support a CHW receives from VHCs and that CHW's performance and satisfaction (Kahssay et al., 1998; Kalyango et al., 2012). In some countries, CHW engagement with community-based structures is mandated as part of the national CHW policy (Kok et al., 2016b). For example, in Bangladesh and Pakistan, CHWs are expected to meet with community groups to discuss health problems, elicit community feedback, and collaboratively develop solutions (Bhutta et al., 2010). India's National Rural Health Mission protocols go a step further, requiring CHWs to hold the office of secretary in their local Village Health Nutrition and Sanitation Committee (VHNSC). However, although Indian CHWs' active engagement in these committees appears to be positively correlated with community mobilization (National Health Systems Resource Centre [NHSRC], 2011), not all CHWs participate in VHNSCs (NHSRC, 2011; Scott & Shanker, 2010), and among those that do, some do not understand what their role is supposed to be or lack the skills necessary to facilitate committee action (Saprii et al., 2015). CHWs in Nepal have also been found to lack the skills needed to facilitate meetings of local community structures (Pant et al., 2015). In Mozambique, CHWs are not only expected to engage with VHCs and other activist and volunteer groups, but also to coordinate and sometimes supervise these groups in an effort to link them to the formal health system (Bhutta et al., 2010). Although VHCs may represent a potential tool for CHW accountability efforts, it should be noted that in some contexts VHCs are not operational on a consistent basis as a result of financial, human resource, or geographic challenges, as well as potentially due to ethnic diversity (de Koning et al., 2014).

#### *Treatment of CHWs by the health system*

Expectations regarding CHWs and accountability may fail to consider the limited resources and management challenges that characterize a CHW's working environment. CHWs may not receive adequate or appropriate

remuneration, supervision, supplies, or support (both clinical and social) to fulfill their role, all of which can shape whether and how CHWs can advance accountability.

Remuneration and incentives (financial and otherwise) provided to CHWs vary from country to country, with some programs deeply rooted in the spirit of volunteerism and thus providing no monetary payments whatsoever (Glenton et al., 2010). In general, voluntary programs tend to involve a more limited time commitment, whereas paid programs usually employ CHWs on a full-time or near-full-time basis (Bhutta et al., 2010). There is no single 'best practice' for CHW remuneration or incentives; different approaches have relative strengths and weakness that, depending on the context, may produce either desirable or undesirable outcomes (Singh, Negin, Otim, Orach, & Cumming, 2015b). A number of CHW programs have encountered issues with delayed payment (Nandan et al., 2008; Oxford Policy Management [OPM], 2009; Saprii et al., 2015; Zulu, Kinsman, Michelo, & Hurtig, 2014) or CHW dissatisfaction with the level of salary or incentives they receive (Center for National Health Development in Ethiopia, 2008; de Koning et al., 2014; Kok et al., 2015a; Saprii et al., 2015; United Nations Children's Fund [UNICEF], 2014; see also *CHW professional associations/unionization* below). Inadequate compensation—whether it be delayed or simply insufficient to begin with—can adversely affect CHW motivation and performance (de Koning et al., 2014; Kok et al., 2015a; Nandan et al., 2008; Saprii et al., 2015; UNICEF, 2014), and may result in CHWs demanding informal fees. For example, an evaluation of a CHW program in Pakistan found that two-thirds of the CHW workforce had not been paid the previous month, and that one in ten CHWs was charging clients for their services, which should have been free (OPM, 2002). Another important payment issue in CHW programs relates to incentives paid upon completion of certain tasks, such as accompanying women in labor to facilities, childhood immunizations, etc. Evidence from India seems to consistently support the conclusion that when CHWs encounter incentive-based payments, they focus their efforts on the incentivized activities (usually biomedical care) and neglect other tasks (such as social activism) (Joshi & George, 2012; NHSRC, 2011; Saprii et al., 2015; Scott & Shanker, 2010). Remuneration issues are a broader human resource management problem in many developing countries affecting not only CHWs but other cadres as well; however, the influence of salaries and incentives on motivation, informal payments, and incentivizing biomedical care over other responsibilities is especially germane to the topic of CHWs as accountability agents (Maes, Closser, Vorel, & Tesfaye, 2015; Maes & Kalofonos, 2013).

Another broader human resource management issue that may play a central role in this discussion is supervision. CHWs can be supervised by health facility clinical staff, program officers (employed by either the government or NGOs, depending on the program), or in some cases by more senior CHWs (Bhutta et al., 2010). Much like remuneration, inadequate supervision can demotivate CHWs (Kok et al., 2015a; Kok et al., 2016a; Singh et al., 2015b), and supervision that emphasizes meeting facility health targets can lead to CHWs focusing their efforts solely on biomedical care (Saprii et al., 2015). Supervisory overemphasis on data reporting can also negatively impact CHWs' morale (Kane et al., 2016), as well as limit their ability to flexibly respond to community needs (Kowitt et al., 2015). Both of these dynamics—CHW demotivation and excessive focus on certain tasks—pose challenges to CHWs' potential as accountability agents. Furthermore, a global review of CHW programs recommended that supervision be conducted in a participatory manner that encourages the two-way flow of information (Bhutta et al., 2010). In Uganda, framing supervision as non-hierarchical 'accompaniment' allowed supervisors to experience program delivery from the CHW's perspective, providing insight on how training and strategies for community outreach should be adjusted to increase community acceptance of CHWs (Singh, Cumming, & Negin, 2015a). As discussed earlier (see *CHWs can be a bridge between the health system and the community*), this sort of participatory, non-hierarchical supervision structure may be especially important for fostering the CHW's role as a 'cultural broker.'

Medicine and equipment shortages are another challenge that many programs face, limiting CHWs' ability to perform their duties and gain community trust (Bhutta et al., 2010; NHSRC, 2011; Saprii et al., 2015; Zulu et al.,

2014). An evaluation of a CHW program in four regions of Uganda found less than 15 percent of CHWs had all the basic supplies they needed (Babughirana, Muhirwe Barungi, & Kimurahebwe, 2016). Supply stock-outs at facilities are also a problem for CHW programs, as are shortages of facility personnel or poor quality of care in health facilities. CHWs regularly refer patients to health facilities for further care, and if those clinical services are not available when they arrive, the CHW's credibility can be damaged (Saprii et al., 2015; Scott & Shanker, 2010).

CHWs may also feel disrespected by health providers, which can be detrimental to the formation of positive working relationships necessary to facilitate open dialogue between CHWs and health facilities. In Zambia, CHWs have reported feeling that facility staff did not consider them to be part of the service delivery team, or did not trust them to dispense drugs or even to be in the dispensary alone (Zulu et al., 2014). CHWs in Malawi and Australia felt nurses considered them inferior because their work wasn't as important (Kok et al., 2016a) or because they were less educated: "They're [nurses] talking now about a partnership, but it will never be an equal partnership" (Jackson, Brady, & Stein, 1999). Not only can disrespectful treatment of CHWs harm their relationships with health providers, it can also degrade community trust in the health system more broadly (Kok et al., 2016a). Conversely, when health providers are supportive of CHWs, CHWs feel like they are part of a team (Kok et al., 2015c) and community perceptions of CHW credibility improve (Kok et al., 2015b; Kok et al., 2016a).

The health system issues described above are complex in nature, with no silver bullet. However, a review of the literature on health system factors influencing CHW performance points to the importance of a national CHW policy and comprehensive human resource policy for addressing some of these issues. The review also found that the absence of a national CHW policy can result in a lack of recognition of CHWs by health authorities (Kok et al., 2015b).

#### *CHW professional associations/unionization*

In light of the difficult working conditions that many CHWs face, in some countries they have unionized or formed professional associations to advocate for policy change. Collective voice or action may be necessary in hierarchical government health systems, especially among CHWs who occupy low-status positions both in the health system and—by virtue of their being recruited from poor and often marginalized communities—in society more broadly.

In India, Accredited Social Health Activists (ASHAs) have staged a number of protests and strikes at both the state and national levels seeking increased wages and government employee status (Express News Service, 2014; Jha, 2016; Tribune News Service, 2015; Tribune News Service, 2016; Zee News, 2015), and have met some success (India Today, 2017). The All Pakistan Ladies Health Workers Welfare Association has pursued a legal strategy rather than political advocacy, resulting in a number of favorable rulings from Pakistan's Supreme Court (Daily Times, 2017). In the United States, the Massachusetts Association of Community Health Workers has on two occasions drafted legislation themselves and found a sponsor to introduce their bills into the House of Representatives; both bills were signed into law (Mason et al., 2011). Community health worker associations also exist in Australia, Brazil, Nepal, Niger, Nigeria, Peru, Romania, South Africa, and about half of the states (as well as at national level) in the United States, with varying remits, membership coverage, and achievements.

The formation of such groups introduces the question of whose interests they will represent. In Nepal, for example, Female Community Health Volunteer (FCHV) associations that demanded salaries and improved working conditions have been accused of solely representing urban FCHV interests and not those of their rural counterparts, who make up the majority of the program and prefer to remain unsalaried volunteers (Glenton et al., 2010). Moreover, while the collective action efforts described above have focused on improving conditions for CHWs themselves, the same mechanisms could theoretically be used to advance the interests of the communities CHWs represent. In Peru, NGO-hired CHWs formed committees that arranged trainings and lobbied the

government for better health, while also raising funds to pay for their own activities (Bhattacharyya, Winch, LeBan, & Tien, 2001). Whatever the aim may be for CHW collective action, there are clearly examples of it working in a variety of contexts.

### *Community perceptions of CHWs*

CHWs commonly report that they feel respected or appreciated by the community for their role as a CHW (Babughirana et al., 2016; Bhutta et al., 2010; Okuga, Kemigisa, Namutamba, Namazzi, & Waiswa, 2015), however there are a number of contextual factors that can influence other dimensions of the CHW-community relationship.

One aspect of this relationship is the extent to which CHWs are deemed acceptable by the community. Acceptance is greater when CHWs are from the community they serve,<sup>i</sup> have higher levels of training, and have access to the supplies they need to perform their duties (Saprii et al., 2015). Interestingly, a study in Uganda found community acceptability to be adversely affected by CHWs' low levels of education and social status, characteristics that are often expected to *improve* acceptance by making CHWs more relatable and less intimidating than health facility staff. Community acceptance in this study nevertheless increased as CHWs gained more experience (Okuga et al., 2015), suggesting that even if low education and social status initially weaken CHW acceptability, they are not insurmountable obstacles.

Trust is another important feature of the CHW-community relationship, and can be fostered from the very beginning of a program by engaging the community in discussing and defining the CHW's role (Scott & Shanker, 2010), as well as through the CHW selection process (Singh et al., 2015a). As is the case with acceptability, trust is also enhanced when CHWs come from the communities they serve (Kok et al., 2016a). Once the program is underway, trust can further be promoted during home visits by focusing on non-threatening and engaging issues during early interactions with households, and by trying to build interpersonal relationships with community members (Singh et al., 2015a). CHW referrals to facility level can hamper community trust, however, if patients receive poor quality care once they arrive at the facility (Kok et al., 2016a; Saprii et al., 2015; Scott & Shanker, 2010). Health worker mistreatment of CHWs themselves can also erode community trust, whereas perceptions that facility staff support the CHW can enhance trust (Kok et al., 2016a). Finally, it is important to note that when CHWs are involved in programs that provide financial incentives to volunteers or community members, the recipients of those payments sometimes believe CHWs pocket the incentives rather than passing them on to the rightful recipient (Kok et al., 2016b; Saprii et al., 2015).

There is evidence that when communities perceive CHWs to be affiliated with state actors, they are no longer considered to be accountable to the community. In India, CHWs are expected to encourage women to deliver in facilities even though this may contradict the preferences of some patients. The fact that CHWs promote services that the community does not want aligns them with the health system in the eyes of the community, a notion only further supported by limited community consultation in CHW selection, not to mention the fact that CHWs receive their payment at facilities (Scott & Shanker, 2010). Another study in India also found that CHWs were seen as agents of the health system, but this was due to CHWs' overwhelming focus on curative care at the expense of their intended role as change agents (Joshi & George, 2012). The extent to which health system affiliation damages community perceptions of CHWs depends in part on whether or not the community has a history of mistrusting the government (Singh et al., 2015a). In Thailand, seeing CHWs work alongside public health professionals actually *increased* CHW credibility in the eyes of the community (Kowitt et al., 2015). Across a number of country contexts, however, community perceptions of political influence over CHWs—either through the selection process or during

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<sup>i</sup> In the case of CHWs delivering HIV-related services, if HIV is stigmatized in the community then patients may fear breaches of confidentiality and prefer that their CHW *not* be from the community (Kok et al, 2016b).



performance of CHW duties—weakens community confidence in CHWs (Kok et al., 2015c; Saprii et al., 2015; Turinawe et al., 2015).

#### *CHWs and social accountability programs*

There exist some programs where NGO-employed CHWs are formally tasked with carrying out social accountability activities. One of these (previously discussed; see *CHWs can be a bridge between the health system and the community*) are the Community Defenders in Guatemala who advocate at the municipal, provincial, and national government level to eliminate barriers and discrimination in seeking health care (Flores, 2015). In Mozambique, Health Advocates raise awareness of health-related laws, policies, and protocols so that patients know their rights and report abuses when experienced. They also facilitate dialogue between communities and facility staff to identify and resolve problems in health care delivery, working with and strengthening VHCs in an effort to turn them into effective governance institutions. (In addition, the program entails case work to seek redress for issues that cannot be addressed via dialogue, thereby incorporating legal empowerment approaches as well as social accountability mechanisms.) Cases have been resolved at facility, district, provincial, and even national level, leading to improvements in provider performance, access to services, infrastructure, and essential medicines (Feinglass, Gomes, & Maru, 2016). Programs in India—where activism is supposed to be a key component of the CHW role—have seen mixed results. A 2011 national evaluation found that one-fifth of CHWs in India were actively securing entitlements for their communities relating to water, sanitation, and health care (NHSRC, 2011). More recently, a qualitative study in Manipur State revealed that CHWs “were not aware of what being an activist means or entails,” and that patriarchal village power structures prevented CHWs (who are women) from mobilizing the community, as they were not able to participate in decision-making processes (Saprii et al., 2015).

There are also instances of CHW programs that use social accountability mechanisms to target CHWs themselves. These tend to take the form of community engagement in selection, supervision, and/or monitoring of CHW activities. For example, in Kenya, Community Health Committees participate in supervising CHWs (Kok et al., 2016b), whereas in Uganda the community itself is involved—village members are taught how to assess CHW performance based on certain metrics and are expected to report grievances to their local council leadership or nearest health facility; community satisfaction influences the decision to replace CHWs if they are underperforming (Bhutta et al., 2010). In Ethiopia, CHWs discuss their performance at a variety of different community meetings (political gatherings, women’s forums, local cabinet meetings), and also during joint meetings attended by district and local administrators as well as by the community. These latter meetings have the added benefit of facilitating direct communication between the community and the health system (Kok et al., 2015c); similar joint meetings occur in Brazil and Malawi (Bhutta et al., 2010; Kok et al., 2016a). Less formal monitoring mechanisms may also exist, like CHWs in Malawi getting feedback from traditional leaders on service delivery (Kok et al., 2016a). A synthesis of findings from six countries and a literature review purported that accountability structures aimed at CHWs can foster their accountability to both the health system and the community (de Koning et al., 2014), however more research is needed on the effect of community monitoring on both CHW performance (Bhutta et al., 2010; Green, 2011) and CHW relationships with communities (Kok et al., 2016a).

#### *CHW perceptions of accountability*

Expectations regarding CHW accountability may clash with how CHWs actually experience accountability. Depending on the context, CHWs may feel most accountable to the government (as their employer), as well as to powerful members of the community (if they selected the CHW for their post), or family members (who may want them to share the fruits of their governmental employment).

By design, CHWs are meant to have one foot in the community and one foot in the health system. These two identities are not always balanced, however; CHWs in Malawi saw themselves as fully rooted in the health sector, with lower level volunteers serving the intermediary role commonly ascribed to CHWs (Kok et al., 2016a). Research from a number of countries suggests that financial incentives can make CHWs feel accountable to the health system, but that late or partial payment of those incentives weakens the accountability relationship and can undermine CHW performance (de Koning et al., 2014; Kane et al., 2016). CHWs' accountability to the health system may be mediated through a single reporting relationship (e.g. with a direct supervisor), or it might manifest itself more broadly if CHWs feel accountable to 'the government' in general. For instance, CHWs in Ethiopia sometimes participate in work unrelated to their health duties at the request of government administrators from other sectors: "Sometimes we are involved in the activities coming from women affairs and the education sector. We are also involved in political matters. We are quarrelling many times with people about these things. If we are not involved in these activities, they cut our salary" (Kok et al., 2015c).

Cross-country experience also supports the proposition that CHWs feel accountable to their communities, especially when programs involve active community participation (de Koning et al., 2014). Under certain circumstances, the CHW-community accountability relationship may even trump CHWs' sense of responsibility to the health system. For example, in Ethiopia, traditional birth attendants (TBAs) are prohibited from assisting deliveries, but in an effort to respect community preferences CHWs sometimes disregard the national policy and call them anyway to help women deliver, though this may be in part because CHWs do not want to help women deliver alone (Kok et al., 2015c). In Malawi, CHWs facing supply shortages reported purposefully avoiding their communities and CHW duties rather than dealing with community dissatisfaction (Kok et al., 2016a).

## **CHW program focus countries**

### *Brazil*

In 1991, the Brazilian Ministry of Health launched a national CHW program modeled after a pilot program for maternal and child health in the state of Ceará (Macinko & Harris, 2015). CHWs, known in Brazil as community health agents (CHAs) or *agentes comunitário de saúde*, have eight years of schooling, up to three months of training, and are residents of the community they serve. Each is responsible for approximately 150 households, or 750 people, and is expected to visit each household on a monthly basis (Johnson et al., 2013). Roles of the CHAs span the domains of primary care, public health, and community education; specifically, job functions include chronic disease management, triage and referrals, antenatal care, breastfeeding support, screenings and immunization, health promotion (i.e. hand hygiene, healthy diet, and physical exercise), contact tracing and household assessment for health protection, data collection, health education groups, and liaising between the health system and community leaders, among others (Johnson et al., 2013).

In 1993, the Ministry of Health created the Family Health Program, an initiative of the national health system, or *Sistema Único de Saúde* (SUS) (Macinko, de Souza, Guanais, & da Silva Simoes, 2007). Recently renamed the Family Health Strategy (FHS), the program implemented decentralized universal health access with comprehensive and free care that is organized, implemented, and managed by municipalities and funded by state and federal governments (Perry, Akin-Olugbade, Lailari, & Son, 2016). Multidisciplinary teams of providers (called Family Health Teams) comprised of a physician, dentist, nurse, and several CHAs provide community-based primary care—including clinic-based care, regular home visits, and health promotion activities—to about 3,500 people (Macinko et al., 2007). By 2007, the FHS was one of the world's largest systems of community-based primary care, with 26,730 teams providing care to about 85 million people (about 50 percent of the population) (Macinko et al., 2007). In 2013, the number of CHAs in Brazil exceeded 257,000 (Johnson et al., 2013). Since its implementation,

the program has been associated with declines in infant mortality rates; improvements in child health; reductions in avoidable hospitalizations among women; uptake in breastfeeding, antenatal care, screening, and immunization; and improvements in health equity (The Earth Institute, n.d.; Giugliani, Harzheim, Duncan, & Duncan, 2011; Johnson et al., 2013).

### *India*

NGOs and state governments in India have utilized CHWs to deliver health care services and education since the 1970s. In 2005, the Indian Government's National Rural Health Mission (NRHM) adopted a national strategy to address the Millennium Development Goals (Bajpai & Dholakia, 2011). A central component of this strategy was the Accredited Social Health Activist (ASHA), a trained community health activist who works as an interface between the community and public health system. An ASHA is generally a married, widowed, or divorced woman between the ages of 25 and 45 who is a resident of the village where she works. An ASHA should be literate and have at least an eighth grade education, with preference given to tenth grade or higher (National Health Mission, 2014). According to national guidelines, ASHAs are selected through a public process involving a gram sabha (village committee) and panchayat; in practice, however, the process is not always as participatory as intended (NHSRC, 2011). Once selected, ASHAs are expected to undergo 23 days of training; however, this too has been poorly enforced, with many ASHAs receiving inadequate training (Bajpai & Dholakia, 2011; NHSRC, 2011).

The primary functions of the ASHA are: 1) 'link worker,' building bridges between rural and vulnerable populations and health service centers; 2) 'service extender,' delivering first-contact health care, such as birth control or simple drugs; and 3) 'social change agent,' serving as health activists to create awareness and mobilize the community (Saprii et al., 2015; Scott & Shanker, 2010). ASHAs have an explicit accountability function to the communities they serve (National Health Mission, 2014). To fulfill their roles, ASHAs work closely with local women's committees, Village Health and Sanitation Committees, and peripheral health workers such as auxiliary nurse midwives (ANM) and Anganwadi workers (AAW) (National Health Mission, 2014). ASHAs receive performance- and service-based compensation for completing certain tasks, such as facilitating immunization, antenatal care appointments, and institutional deliveries (Saprii et al., 2015). Some states offer incentives for additional services, while others utilize fixed sum payments. However, the amount of compensation that actually reaches the ASHAs is low, with significant variation between states (NHSRC, 2011).

Currently, there are 873,759 ASHAs in India; this puts the NRHM at 91 percent of its national target of 952,533 (National Health Mission, 2016). Each ASHA covers a population of about 1,000, although this number varies by state (National Health Mission, 2016). Despite the program's wide coverage, there are still barriers limiting ASHAs' performance and effectiveness, including: ASHAs' limited knowledge and skills, availability of services and supplies, and weak incentive and supervision structures (Saprii et al., 2015). Performance in certain areas—postnatal care, newborn care, family planning, childhood illness, and nutrition, for example—has been low and varies widely by state, leaving much room for improvement (Fathima et al., 2015; NHSRC, 2011).

### *South Africa*

South Africa does not have a national CHW policy, though CHWs have been part of the South African public health landscape for many years. This has been a source of frustration for CHW advocates, in part because in the last 20 years the number of CHWs has increased significantly to address the HIV and TB co-epidemics (Schneider, Hlophe, & van Rensburg, 2008). However, in 2011 the government introduced health sector reform focused on reengineering primary health care (Nxumalo & Choonara, 2014) in order to address concurrent epidemics in maternal and child health; HIV/AIDS and TB; non-communicable diseases (NCDs); and violence and injuries (Mayosi et al., 2012). This reform validated the role of CHWs in delivering health and social services at community level,

and incorporated CHWs into the formal health system through Ward-Based Outreach Teams (WBOTs). Each team is comprised of a nurse, health promotion practitioner, and six CHWs (Nxumalo & Choonara, 2014). The WBOT model is based on Brazil's Family Health Teams, using nurses rather than doctors (as is done in Brazil) to lead the team (Nxumalo & Choonara, 2014). According to the national guidelines, each WBOT should serve a population of about 7,660 people (Joint Primary Health Care Forum, 2011). Each CHW should serve 80 to 150 households, depending on whether they cover rural or urban areas; no CHW should serve more than 250 households (Friedman, 2005).

The guidelines state that CHWs should conduct household visits to register all households that have been assigned to them. During these household registration visits, CHWs are expected to identify people at risk and take appropriate steps to link them to care. WBOTs' core service delivery functions at household level include providing household members with information and education on common diseases, and providing psychosocial support such as referral for social grants where needed. CHWs also provide basic treatment for common illnesses, such as oral rehydration solution for children with diarrhea (Joint Primary Health Care Forum, 2011). CHWs are paid monthly stipends by the government, however these stipends are meager (ranging from 800 to 4,000 ZAR, or about 80 to 400 USD) and often delayed (Dageid, Akintola, & Sæberg, 2016; Gonzalez, 2014; Thamela, 2016).

The implementation of WBOTs has varied by province. In North West Province, WBOTs have been implemented since 2011 with both private and public sector funding (Mampe, Schneider, & Reagon, 2016). In Gauteng Province, different models of CHW programs have been implemented; for example, in the districts of Sedibeng and Tshwane, the implementation of WBOTs has been rolled out through health posts—physical structures where a dedicated nurse provides basic care for community members. These structures provide a base for CHWs to meet and from which to provide outreach services, and are relatively easy to access for the community. In other settings, WBOTs are linked to formal clinics (Nxumalo & Choonara, 2014).

### *United States*

For years, community health workers have provided a variety of services in the United States. In the 1990s, there was a coordinated effort to professionalize the field, and CHWs from across the country adopted the term 'community health worker' as an umbrella term for the more than 60 titles being used among the workforce. At that time, CHWs also began to standardize training and organize into professional networks and associations. At the national level, the American Public Health Association (APHA) Community Health Worker Special Primary Interest Group and the American Association of Community Health Workers promote policy, program development, program evaluation, and the growth of the field. CHWs have also organized at state and local levels through fora such as the Massachusetts Association of Community Health Workers (Anthony, Gowler, Hirsch, & Wilkinson, 2009). In 2010, the Patient Protection and Affordable Care Act made provisions for CHWs in recognition of their contributions to health care and outcomes (Brownstein & Allen, 2015).

Although the United States has no national-level community health worker program, CHW programs have been adopted by local governments, NGOs, universities, and hospitals with the aim of connecting marginalized and vulnerable populations to health and social services. In these various contexts, CHWs perform a wide range of roles, including disease prevention, outreach, health education, client advocacy and empowerment, and health system navigation. Many programs focus on chronic disease case management (e.g. HIV/AIDS, diabetes, asthma), but other issues addressed include maternal and child health and substance abuse (Anthony et al., 2009).

Because of the fragmentation and variation in CHW programs in the United States, estimating the total number of CHWs working in the country is challenging. In May 2016, the Bureau of Labor Statistics estimated that 51,900 CHWs were operating nationally, making an average of \$19.80 per hour, or \$41,170 per year. The states employing

the most CHWs were California, New York, Texas, Massachusetts, and Illinois, while the highest concentrations of CHWs were found in Alaska, Vermont, Washington DC, Massachusetts, and Oklahoma (Bureau of Labor Statistics, 2016).

## References

- Anthony, S., Gowler, R., Hirsch, G., & Wilkinson, G. (2009). *Community Health Workers in Massachusetts: Improving Health Care and Public Health*. Boston, MA, USA: Massachusetts Department of Public Health.
- Babughirana, G., Muhirwe Barungi, L., & Kimurahebwe, C. (2016). Village Health Team Functionality in Uganda: Implications for Community System Effectiveness. *Science Journal of Public Health*, 4(2), 117-126.
- Bajpai, N., & Dholakia, R. H. (2011). *Improving the Performance of Accredited Social Health Activists in India* (Working Paper 1). Mumbai, India: Columbia Global Centers South Asia, Columbia University.
- Bhattacharyya, K., Winch, P., LeBan, K., & Tien, M. (2001). *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Arlington, VA, USA: Basic Support for Institutionalizing Child Survival Project (BASICS II), United States Agency for International Development (USAID).
- Bhutta, Z. A., Lassi, Z. S., Pariyo, G., & Huicho, L. (2010). *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. Geneva, Switzerland: WHO, Global Health Workforce Alliance.
- Brinkerhoff, D. W. (2004). Accountability and health systems: toward conceptual clarity and policy relevance. *Health Policy and Planning*, 19(6), 371-379.
- Brownstein, J. N., & Allen, C. (2015). *Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach*. Atlanta, GA, USA: Centers for Disease Control and Prevention.
- Bureau of Labor Statistics [USA]. (2016). Occupational Employment and Wages: 21-1094 Community Health Workers. *United States Department of Labor website*. Retrieved from [https://www.bls.gov/oes/current/oes211094.htm#\(3\)](https://www.bls.gov/oes/current/oes211094.htm#(3)).
- Center for National Health Development in Ethiopia (CNHDE). (2008). *Ethiopia Health Extension Program Evaluation Study, 2005-2007, Volume II: Health Extension Workers Performance Study*. Addis Ababa, Ethiopia: CNHDE.
- Chauls, D. S. (1982). Volunteers Who Work: The Community Health Care Project in Burma. *International Quarterly of Community Health Education*, 3(3), 249-266.
- Dageid, W., Akintola, O., & Sæberg, T. (2016). Sustaining motivation among community health workers in AIDS care in Kwazulu-Natal, South Africa: Challenges and prospects. *Journal of Community Psychology*, 44(5), 569-585.
- Daily Times. (2017, Apr 5). Ministers served notices for not regulating LHWs. *Daily Times*. Retrieved from <http://dailytimes.com.pk/islamabad/05-Apr-17/ministers-served-notices-for-not-regulating-lhws>.
- de Koning, K., Kok, M., Ormel, H., Kane, S., Rashid, S., Sarker, M., ... & Taegtmeier, M. (2014). *A Common Analytical Framework on Factors Influencing Performance of Close-to-Community Providers: Synthesis of the Inter-Country Context Analyses in Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique and the International Literature Review*. Amsterdam, The Netherlands: REACHOUT.

- The Earth Institute. (n.d.). *One Million Community Health Workers: Technical Task Force Report*. New York, NY, USA: The Earth Institute, Columbia University.
- Express News Service. (2014, Aug 19). Asha workers protest, burn effigy of health minister. *The Indian Express*. Retrieved from <http://indianexpress.com/article/cities/ludhiana/asha-workers-protest-burn-effigy-of-health-minister>.
- Fathima, F. N., Raju, M., Varadharajan, K. S., Krishnamurthy, A., Ananthkumar, S. R., & Mony, P. K. (2015). Assessment of 'Accredited Social Health Activists'—A National Community Health Volunteer Scheme in Karnataka State, India. *Journal of Health, Population, and Nutrition*, *33*(1), 137.
- Feinglass, E., Gomes, N., & Maru, V. (2016). Transforming Policy into Justice: The Role of Health Advocates in Mozambique. *Health and Human Rights Journal*, *18*(2), 233-246.
- Flores, W. (2015). Community Defenders of the Right to Health in Guatemala. *Community of Practitioners on Accountability and Social Action in Health (COPASAH) website*. Retrieved from <https://copasah.wordpress.com/2015/04/24/community-defenders-of-the-right-to-health-in-guatemala-walter-flores>.
- Fox, J. A. (2015). Social Accountability: What Does the Evidence Really Say? *World Development*, *72*, 346-361.
- Fox, J., & Akeron, J. (2016). *Doing accountability differently: A proposal for the vertical integration of civil society monitoring and advocacy* (U4 Issue Paper 4). Bergen, Norway: Chr. Michelsen Institute.
- Freedman, L. P., & Schaaf, M. (2013). Act global, but think local: accountability at the frontlines. *Reproductive Health Matters*, *21*(42), 103-112.
- Friedman, I. (2005). CHWs and community caregivers: towards a unified model of practice: human resources. *South African Health Review*, *2005*(1), 176-188.
- Gilmore, B., & McAuliffe, E. (2013). Effectiveness of community health workers delivering preventive interventions for maternal and child health in low-and middle-income countries: a systematic review. *BMC Public Health*, *13*, 847.
- Giugliani, C., Harzheim, E., Duncan, M. S., & Duncan, B. B. (2011). Effectiveness of community health workers in Brazil: a systematic review. *The Journal of Ambulatory Care Management*, *34*(4), 326-338.
- Glenton, C., Scheel, I. B., Pradhan, S., Lewin, S., Hodgins, S., & Shrestha, V. (2010). The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science and Medicine*, *70*(12), 1920-1927.
- Goetz, A. M., & Gaventa, J. (2001). *Bringing citizen voice and client focus into service delivery* (IDS Working Paper 138). Brighton, Sussex, UK: Institute of Development Studies.
- Gonzalez, L. L. (2014, Mar 28). Health dept. to pay community health workers, renew contracts. *Health-E News*. Retrieved from <https://www.health-e.org.za/2014/03/28/department-health-pay-workers-issue-new-contracts>.
- Green, C. (2011). *Community Monitoring in a Volunteer Health Worker Setting: A Review of the Literature*. Kampala, Uganda: Malaria Consortium.

- Halloran, B. (2015). *Strengthening Accountability Ecosystems: A Discussion Paper (Think Piece)*. London, UK: Transparency and Accountability Initiative.
- India Today. (2017, Mar 7). Centre to extend ESIC, EPFO benefits to Anganwadi, ASHA workers. *India Today*. Retrieved from <http://indiatoday.intoday.in/story/esic-epfo-anganwadi-asha-international-women-day-labour/1/899246.html>.
- Jackson, D., Brady, W., & Stein, I. (1999). Towards (re)conciliation: (re)constructing relationships between indigenous health workers and nurses. *Journal of Advanced Nursing*, 29(1), 97-103.
- Jha, V. (2016, Sep 11). For Noida's Asha workers, strike also about respect. *Hindustan Times*. Retrieved from <http://www.hindustantimes.com/noida/for-noida-s-asha-workers-strike-also-about-respect/story-DnMxAq9qbhS2krOCxNKcvl.html>.
- Johnson, C. D., Noyes, J., Haines, A., Thomas, K., Stockport, C., Ribas, A. N., & Harris, M. (2013). Learning from the Brazilian community health worker model in North Wales. *Globalization and Health*, 9(1), 25.
- Joint Primary Health Care Forum. (2011). *Provincial Guidelines for the Implementation of the Three Streams of PHC Re-Engineering*.
- Joshi, S. R., & George, M. (2012). Healthcare through Community Participation: Role of ASHAs. *Economic and Political Weekly*, XLVII(10), 70-76.
- Kahssay, H. M., Taylor, M. E., & Berman, P. A. (1998). *Community health workers: the way forward*. Geneva, Switzerland: WHO.
- Kalyango, J. N., Rutebemberwa, E., Alfvén, T., Ssali, S., Peterson, S., & Karamagi, C. (2012). Performance of community health workers under integrated community case management of childhood illnesses in eastern Uganda. *Malaria Journal*, 11, 282.
- Kane, S., Kok, M., Ormel, H., Otiso, L., Sidat, M., Namakhoma, I., ... & de Koning, K. (2016). Limits and opportunities to community health worker empowerment: A multi-country comparative study. *Social Science and Medicine*, 164, 27-34.
- Kok, M. C., Dieleman, M., Taegtmeier, M., Broerse, J. E. W., Kane, S. S., Ormel, H., ... & de Koning, K. A. M. (2015a). Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy and Planning*, 30(9), 1207-1227.
- Kok, M. C., Kane, S. S., Tulloch, O., Ormel, H., Theobald, S., Dieleman, M., ... & de Koning, K. A. M. (2015b). How does context influence performance of community health workers in low- and middle-income countries? Evidence from the literature. *Health Research Policy and Systems*, 13, 13.
- Kok, M. C., Kea, A. Z., Datiko, D. G., Broerse, J. E., Dieleman, M., Taegtmeier, M., & Tulloch, O. (2015c). A qualitative assessment of health extension workers' relationships with the community and health sector in Ethiopia: opportunities for enhancing maternal health performance. *Human Resources for Health*, 13, 80.
- Kok, M. C., Namakhoma, I., Nyirenda, L., Chikaphupha, K., Broerse, J. E. W., Dieleman, M., ... & Theobald, S. (2016a). Health surveillance assistants as intermediates between the community and health sector in Malawi: exploring how relationships influence performance. *BMC Health Services Research*, 16, 164.



- Kok, M. C., Ormel, H., Broerse, J. E. W., Kane, S., Namakhoma, I., Otiso, L., ... & Dieleman, M. (2016b). Optimising the benefits of community health workers' unique position between communities and the health sector: A comparative analysis of factors shaping relationships in four countries. *Global Public Health*.
- Kowitt, S. D., Emmerling, D., Fisher, E. B., & Tanasugarn, C. (2015). Community Health Workers as Agents of Health Promotion: Analyzing Thailand's Village Health Volunteer Program. *Journal of Community Health, 40*(4), 780-788.
- Lehmann, U., Friedman, I., & Sanders, D. (2004). *Review of the utilization and effectiveness of community-based health workers in Africa*. Cape Town, South Africa: University of the Western Cape and SEED Trust.
- Macinko, J., de Souza, M. D. F. M., Guanais, F. C., & da Silva Simoes, C. C. (2007). Going to scale with community-based primary care: an analysis of the family health program and infant mortality in Brazil, 1999-2004. *Social Science and Medicine, 65*(10), 2070-2080.
- Macinko, J., & Harris, M. J. (2015). Brazil's family health strategy—delivering community-based primary care in a universal health system. *New England Journal of Medicine, 372*(23), 2177-2181.
- Maes, K., Closser, S., Vorel, E., & Tesfaye, Y. (2015). Using community health workers: Discipline and Hierarchy in Ethiopia's Women's Development Army. *Annals of Anthropological Practice, 39*(1), 42-57.
- Maes, K., & Kalofonos, I. (2013). Becoming and remaining community health workers: Perspectives from Ethiopia and Mozambique. *Social Science and Medicine, 87*, 52-59.
- Mampe, T., Schneider, H., & Reagon, G. (2016). *Effectiveness of Ward Based Outreach Teams in the North West Province: an Evaluation*. Cape Town, South Africa: University of the Western Cape.
- Mason, T., Wilkinson, G. W., Nannini, A., Martin, C. M., Fox, D. J., & Hirsch, G. (2011). Winning Policy Change to Promote Community Health Workers: Lessons From Massachusetts in The Health Reform Era. *American Journal of Public Health, 101*(12), 2211-2216.
- Mayosi, B. M., Lawn, J. E., Van Niekerk, A., Bradshaw, D., Karim, S. S. A., Coovadia, H. M., & Lancet South Africa team. (2012). Health in South Africa: changes and challenges since 2009. *The Lancet, 380*(9858), 2029-2043.
- McKenna, B., Fernbacher, S., Furness, T., & Hannon, M. (2015). "Cultural brokerage" and beyond: piloting the role of an urban Aboriginal Mental Health Liaison Officer. *BMC Public Health, 15*, 881.
- Mumtaz, Z., Salway, S., Waseem, M., & Umer, N. (2003). Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. *Health Policy and Planning, 18*(3), 261-269.
- Nandan, D., Jain, N., Srivastva, N., Khan, A. M., Dhar, N., Adhish, V., & Menon, S. (2008). *Assessment of the functioning of ASHAs under NRHM in Uttar Pradesh*. New York, NY, USA, New Delhi, India, and Lucknow, Uttar Pradesh, India: United Nations Population Fund, National Institute of Health and Family Welfare, and State Institute of Health and Family Welfare.
- National Health Mission [India]. (2014). About Accredited Social Health Activist (ASHA). *Ministry of Health and Family Welfare, Government of India website*. Retrieved from <http://nhm.gov.in/communitisation/asha/about-asha.html>.

- National Health Mission [India]. (2016). Update on ASHA Programme, July 2016. *Ministry of Health and Family Welfare, Government of India website*. Retrieved from [http://nhsrcindia.org/index.php?option=com\\_content&view=article&id=286#](http://nhsrcindia.org/index.php?option=com_content&view=article&id=286#).
- National Health Systems Resource Centre (NHSRC) [India]. (2011). *ASHA: Which way forward...? Executive Summary – Evaluation of ASHA Programme*. New Delhi, India: NHSRC.
- Nxumalo, N., & Choonara, S. (2014). *A Rapid Assessment of Ward-based PHC outreach teams in Gauteng Sedibeng District – Emfuleni sub-district*. Johannesburg, South Africa: University of the Witwatersrand.
- O'Connell, L. (2005). Program Accountability as an Emergent Property: The Role of Stakeholders in a Program's Field. *Public Administration Review*, 65(1), 85-93.
- O'Donnell, G. (1998). Horizontal accountability in new democracies. *Journal of Democracy*, 9(3), 1112-1126.
- Okuga, M., Kemigisa, M., Namutamba, S., Namazzi, G., & Waiswa, P. (2015). Engaging community health workers in maternal and newborn care in eastern Uganda. *Global Health Action*, 8, 23968.
- Oxford Policy Management (OPM). (2002). *Lady Health Worker Programme: External Evaluation of the National Programme for Family Planning and Primary Health Care 1999-2002: Final Report*. Islamabad, Pakistan: OPM Ltd.
- Oxford Policy Management (OPM). (2009). *Lady Health Worker Programme: External Evaluation of the National Programme for Family Planning and Primary Health Care: Summary of Results*. Islamabad, Pakistan: OPM Ltd.
- Pant, P. R., Budhathoki, B., Ellis, M., Manandhar, D., Deave, T., & Mytton, J. (2015). The feasibility of community mobilisation for child injury prevention in rural Nepal: a programme for female community health volunteers. *BMC Public Health*, 15, 430.
- Perry, H., Akin-Olugbade, L., Lailari, A., & Son, Y. (2016). *A comprehensive description of three national community health worker programs and their contributions to maternal and child health and primary health care: Case studies from Latin America (Brazil), Africa (Ethiopia) and Asia (Nepal)*. Baltimore, MD, USA: Johns Hopkins Bloomberg School of Public Health.
- Perry, H., Crigler, L., & Hodgins, S. (2014a). *Developing and Strengthening Community Health Worker Programs at Scale*. Washington, DC, USA: Jhpiego Corporation.
- Perry, H., Zulliger, R., & Rogers, M. M. (2014b). Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness. *Annual Review of Public Health*, 35, 399-421.
- Perry, H., Zulliger, R., Scott, K., Javadi, D., Gergen, J., Shelley, K., ... & Strodel, R. (2017). *Case Studies of Large-Scale Community Health Worker Programs: Examples from Afghanistan, Bangladesh, Brazil, Ethiopia, Niger, India, Indonesia, Iran, Nepal, Pakistan, Rwanda, Zambia, and Zimbabwe*. Washington, DC, USA: Jhpiego Corporation.
- Raven, J., Akweongo, P., Baba, A., Baine, S. O., Sall, M. G., Buzuzi, S., & Martineau, T. (2015). Using a human resource management approach to support community health workers: experiences from five African countries. *Human Resources for Health*, 13, 45.
- Sanders, D. (1990). Equity in Health: Zimbabwe Nine Years On. *Journal of Social Development in Africa*, 5(1), 5-22.

- Saprii, L., Richards, E., Kokho, P., & Theobald, S. (2015). Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. *Human Resources for Health, 13*, 95.
- Schaaf, M. (2011). *Roma Health Mediators: Successes and Challenges*. New York, NY, USA: Open Society Foundations.
- Schedler, A. (1999). Conceptualizing Accountability. In A. Schedler, L. Diamond, & M.F. Plattner (Eds.), *The Self-Restraining State: Power and Accountability in New Democracies* (pp. 13-28). Boulder, CO, USA and London, UK: Lynne Rienner Publishers, Inc.
- Schneider, H., Hlophe, H., & van Rensburg, D. (2008). Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy and Planning, 23*(3), 179-187.
- Scott, K., & Shanker, S. (2010). Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India. *AIDS Care, 22*(Suppl 2), 1606-1612.
- Singh, D., Cumming, R., & Negin, J. (2015a). Acceptability and trust of community health workers offering maternal and newborn health education in rural Uganda. *Health Education Research, 30*(6), 947-958.
- Singh, D., Negin, J., Otim, M., Orach, C. G., & Cumming, R. (2015b). The effect of payment and incentives on motivation and focus of community health workers: five case studies from low- and middle-income countries. *Human Resources for Health, 13*, 58.
- Smulovitz, C., & Peruzzotti, E. (2000). Societal Accountability in Latin America. *Journal of Democracy, 11*(4), 147-158.
- Tembo, F. (2013). *Rethinking social accountability in Africa: Lessons from the Mwananchi Programme*. London, UK: Overseas Development Institute.
- Thamela, L. (2016, Jan 4). Community health workers demand more pay. *Health-E News*. Retrieved from <https://www.health-e.org.za/2016/01/04/community-health-workers-demand-more-pay>.
- Tribune News Service. (2015, Aug 20). ASHA workers seek regular jobs, minimum salary. *The Tribune*. Retrieved from <http://www.tribuneindia.com/news/haryana/community/asha-workers-seek-regular-jobs-minimum-salary/122306.html>.
- Tribune News Service. (2016, Nov 10). ASHA workers demand higher pay scale. *The Tribune*. Retrieved from <http://www.tribuneindia.com/news/ludhiana/community/asha-workers-demand-higher-pay-scale/321606.html>.
- Turinawe, E. B., Rwemisisi, J. T., Musinguzi, L. K., de Groot, M., Muhangi, D., de Vries, D. H., ... & Pool, R. (2015). Selection and performance of village health teams (VHTs) in Uganda: lessons from the natural helper model of health promotion. *Human Resources for Health, 13*, 73.
- United Nations Children's Fund (UNICEF). (2014). *Access to healthcare through community health workers in East and Southern Africa* (Maternal, Newborn and Child Health Working Paper). New York, NY, USA: UNICEF.
- Walt, G. (1990). *Community health workers in national programmes: just another pair of hands?* Milton Keynes, Buckinghamshire, UK: Open University Press.

Werner, D. (1981). The village health worker: lackey or liberator? *World Health Forum*, 2(1), 46-68.

World Health Organization (WHO). (2007). *Community health workers: What do we know about them?* Geneva, Switzerland: WHO.

Zee News. (2015, Mar 2). ASHA workers protest seeking regularisation, other demands. *Zee News*. Retrieved from [http://zeenews.india.com/news/delhi/asha-workers-protest-seeking-regularisation-other-demands\\_1555112.html](http://zeenews.india.com/news/delhi/asha-workers-protest-seeking-regularisation-other-demands_1555112.html).

Zulu, J. M., Kinsman, J., Michelo, C., & Hurtig, A. (2014). Hope and despair: community health assistants' experiences of working in a rural district in Zambia. *Human Resources for Health*, 12, 30.