



Community-driven development: understanding the interlinkages between individuals, community-based workers and institutions.

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Literature Review: Community-Based Workers and Service Delivery

By

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Community-driven development: understanding the interlinkages between individuals, community-based workers and institutions.

The purpose of this research is to identify the potential and constraints of community-driven management and service delivery by tracking the evolution of participation, in selected projects as shaped by the interface between individuals, community workers and institutions.

Pro-poor community-driven development is both enabled and constrained by individual identities, the actions of community workers and the workings of institutions. The positive aspects can be enhanced through a greater understanding of individual motivations, institutional processes and improved monitoring techniques. However, the limitations of such models must also be recognised.

This research has three objectives: (1) to understand individual participation in collective action; (2) to understand the contribution of community-workers to participatory processes; and (3) to understand the possibilities of 'getting institutions right' for pro-poor development.

The research analyses case studies of community-driven development activity in relation to water and HIV/AIDS in Tanzania and South Africa.

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*This Working Paper Series is dedicated to the memory of
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enthusiastic research partner in Dar es Salaam.*

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Working Paper 1

**Literature Review: Community Based Workers (CBW) and Service
Delivery**

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Key findings

Definition of community-based worker in service delivery schemes ranging from, for example, water provision, healthcare, agricultural support, mediation and education: ‘volunteer/worker selected from the community they live in, trained to cover a specific task, supported and supervised by a Facilitating Agent (FA), who can be from government or NGO, and in some way accountable to the community or a specific/defined group within that community’ (AICDD 2005).

The **assumptions** prevalent in the literature with regard to community-based workers (CBW) systems are that CBWs increase *accessibility*, *sustainability*, *cost-effectiveness*, and *cultural effectiveness* of service delivery.

Guiding questions in this review: Which factors contribute to the accessibility, sustainability, cost-effectiveness, and cultural effectiveness of CBWs? What are the possibilities and constraints of the interface between micro, meso, and macro level institutional arrangements in service delivery based on CBWs?

Issues for further debate and research:

Micro-level: selection procedures, returns for the CBWs, personal motivation, issues of equity in the community need to be looked at on a case to case basis in order to reduce the chance of conflict and discontent among CBWs, institutions and community-members.

Meso level: CBWs are in need of good and continuous institutional support from the facilitating agent, the funding body, and the community to provide training, supervision, and support (equipment and resources).

Macro level: neo-liberalism, decentralisation, and privatisation provide the political-economic background (larger enabling environment) to CBW systems and need to be questioned in relation to those CBW systems.

Three core points are in need of attention regarding the functioning of CBWs:

- *Autonomy:* CBWs are highly dependent on external institutions for training, resource support, and supervision, which undermine the assumption that CBWs can shape the delivery of services according to the wishes, needs, and demands of the community. CBWs are effectively workers in exogenous development interventions.
- *Responsibility:* CBWs dependency on external agents, be that NGOs or state institutions, undermines the idea that the community could ‘own’ the solutions to their problems. This also underscores the confusion regarding institutional responsibility for the provision of services (public/private, local/national/international).
- *Accountability:* CBWs dependency on exogenous institutions makes them less accountable to the community, and more to these (often absent) institutions. In addition, the assumption that (unregulated and undefined) community accountability would naturally lead to more equitable and sustainable service delivery, seems to prove wrong.
- *Professionalisation:* Professionalisation might not only improve the quality of the services delivered, but could also encourage more independence of local CBW systems. Nevertheless, it is not clear to what extent a further professionalisation would contribute to CBWs effectiveness without undermining the advantages of community-based service delivery?

*Introduction*¹

Since the 1960s, the recruitment of low-paid or voluntary community-based workers has been a popular strategy to increase access to services to underserved populations in a cost-effective way (Swider 2002:11). Both individual states and international organisations such as the World Health Organisation and USAID have not only strongly supported the involvement of local people in the delivery of basic services, but also thought it a more democratic way of service delivery.² As we will see, the idea of the community-based worker links up to participatory approaches to development processes, as well as processes of decentralisation and neo-liberalisation. The community-based worker has been seen as useful to different areas of development, e.g., in agriculture and natural environment management, in research, justice, and education, and especially, in primary health care provision. Although community workers can be found in many different contexts, deliver many and diverse services and are often volunteers, i.e., their use is a cost-effective as well as, arguably, under-funded way of service delivery, the concept of community-based work (and community driven development, see Mansuri and Rao 2004) is under-theorised. By reviewing the existing literature on community-based workers, we intend to help clarify their role in development practice and theory.³ A number of questions guide this review: Which factors contribute to the performance and cost-effectiveness of community-based workers (referred to hereafter as CBW)? How do CBWs increase the accessibility of services, and how sustainable are CBWs in good service delivery? Ultimately, in order to answer these questions, the relationship between processes at the local level and ideas developed at the global level will require further examination.

In the first section, the paper discusses a working definition of CBWs, which will be specified and diversified throughout the text. The text moves on to a discussion of the historical development of the idea of the CBWs: from a 1970s 'community involvement' focus, to ideas regarding participatory development, to a partial cooptation of participatory approaches in neo-liberal reforms. In a second section, the paper examines various case studies as discussed in the available literature. This discussion is structured according to specific subjects: healthcare, justice, education, research, and the natural environment. In addition, we discuss the literature on the motivations of CBWs and on cost-effectiveness. In some concluding reflections, we examine the constraints and possibilities of service delivery through CBWs in developing countries. In doing so, we attempt to trace the interlinkages

¹ This paper has strongly benefited from the critical readings and suggestions from Frances Cleaver and Anna Toner. The document is an output from a project funded by the UK Department for International Development (DFID). The views and opinions expressed are not necessarily those of DFID.

² Although 'community' can mean many small and large-scale entities, in the discussed literature the community is understood as localities in which people share basic services. In general, the community is a geo-political entity: villages, settlements, neighbourhoods in urban centres. The nature of community as an ideal-type is further discussed below.

³ We do not pretend to have reviewed all existing literature on the subject. However, we have included a range of important studies and case studies, reflecting the diversity of evidence and theory.

between CBW systems and institutions, or, how CBWs are embedded (or not) in and related to the micro, meso and macro level institutional and political environments.

I Historical and theoretical background

What is a community-based worker?

In 1987, the World Health Organisation defined CBWs as workers who live in the community they serve, are selected by that community, are accountable to the community they work in, receive a short, defined training, and are not necessarily attached to any formal institution (cited in Swider 2002). The reviewed case studies suggest that community workers are local volunteers who form part of the community and who carry out basic tasks such as HIV/AIDS education, nutritional education and support, primary healthcare provision related to particular diseases, environmental care, agricultural development, and even legal mediation. Community workers often work at the regional level, covering several communities. They may be provided with transport, sometimes with medicines, and, depending on projects, with a monthly basic stipend. They are often recruited, selected and trained by local NGOs, the ‘facilitating agents’, who are, in turn, likely to be financed by international co-operation. Others are directly under the auspices of international NGOs. Large-scale, governmental primary healthcare systems have deployed CBWs to expand services in remote and underserved areas. Thus, in line with the African Institute for Community-Driven Development (AICDD 2005), a South African NGO doing extensive work with CBWs, a CBW can be defined as a ‘volunteer selected from the community they live in, trained to cover a specific task, supported and supervised by a Facilitating Agent (FA), who can be from government or NGO, and in some way accountable to the community or a specific/ defined group within that community’.⁴

The concept ‘volunteer’ should be interpreted widely to include low paid staff who volunteer to be involved. The idea is that the volunteering precedes the agreement of payment. Perhaps ambiguously, paid and unpaid local government officials or religious leaders are not perceived as community-based workers in our definition. Their roles are, in the end, too much linked to long-standing political (religious) structures on both local, meso and macro level. The tasks such leaders perform and the expectations attached to these are, of course, distinct from the rather defined and circumscribed service delivery objectives of CBWs. Motivations and returns are therefore also different and more related to authority within the community and power relations stretching beyond the community they serve. Nevertheless, at community-level the relations between unpaid government representatives and CBWs is not always clear.

⁴ The DfID-funded African Institute for Community-Driven Development, formerly Khanya, has done and is still doing extensive research into the functioning of CBW at local levels in Southern Africa. Their work is accessible at: www.Khanya-mrc.co.za

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CBWs are usually referred to according to the issue they are intended to address and function: health educators, healthcare workers, nutritional educators, paravets, community captains, technical assistants, paralegals, home-based care workers, tutor farmers, pump attendants, research assistants, peer educators, social workers, traditional birth attendants, development agents, or outreach workers. AICDD (2005) further suggests that CBWs' role might include 'being a conduit for information and technologies, a bridge/link between the community and service providers/facilitating agents, mobilising communities for learning, training, demonstration, and follow-up activities'. Despite the variety in tasks and working conditions, we think that the idea behind deploying CBWs is enough to group them and to aim at defining a set of collective possibilities and constraints encountered in case studies.

Rationale of CBW systems

The deployment of community-members in service delivery was, initially, especially popular in healthcare provision. According to an evaluation of community health workers programmes published in 1989, community-based health workers had become a 'prominent feature of primary health care programmes in developing countries', both on small-scale, externally-funded projects and on large-scale, nationally-supported and implemented programmes (Walt, Perera, and Heggenhouwen, 1989). In 1987, Berman et. al. reported on community health worker systems throughout the Third World, suggesting that they were not only widespread, but had been in use since the 1940s. The longest running programme the authors mention is a community health worker scheme in Peru, where, since the 1940s, local health promoters have provided 'curative care, health education and other preventive activities' (Berman et al 1987: 448). The large-scale 'barefoot doctors' scheme in China, in which salaried community health workers received up to a year's training to serve their communities, is another example of such schemes (447).

According to Swider (2002), in the US the use of CBWs emerged in 1960s, to re-emerge strongly in the late 1980s. In between these two periods of popularity, US agencies became involved in setting up CBW systems in the developing world: the first USAID document that appears in their online catalogue and refers to the training of CBWs for technical assistance in development projects in the Third World dates from 1975. In 1977 this manual for training CBWs was translated to Spanish. The library catalogue on the USAID website suggests that such guides have been updated, translated into relevant languages, and reframed to deal with specific issues on a regular basis up to the present date.⁵ In other words, since the 1970s USAID has sought to involve local people in their projects and provided training materials for doing so.

The World Health Organisation, in turn, has been committed to promoting the use of community health workers and volunteers since the 1970s. The popularity of community workers was

⁵ www.usaid.com

spurred by ‘reports of the successful experiences of numerous small-scale, locally initiated community health worker projects throughout the world’ (Berman et. al. 1987: 444). In particular, a book called *Health by the People*, edited by J. Newell and published by the WHO in 1975, helped to generalise the idea that healthcare provision could be democratised and localised within the communities in which people lived.⁶ Three central arguments underpinned such efforts; first, it was shown that the clinic-based system of healthcare provision did not reach large parts of populations, mainly those living further than 3-5 km from such clinics and hospitals, who were also the poorest. Prevention like immunization reached those middle and upper classes that sought such services out, but failed to reach more remote populations. Second, in theory bio-medical, clinic-based healthcare services were designed to be integrative, but, in practice, they were directed at symptomatic curative care. This approach failed to address health issues related to malnutrition, diarrhoea, infections and other preventable health care problems that caused high mortality in certain regions. Third, the cost of clinically-based health care offered by professional doctors was too high to expand into remote areas (Berman et. al. 1987). It is worth highlighting a fourth argument: disparities between socio-cultural understandings about the body and health, between biomedical and ‘local’, ‘traditional’, or otherwise culturally determined notions of health, prevented an effective co-operation between healthcare provider and client (Swider 2002: 12; Berman 1987: 445). According to the supporters of participation in development, the large-scale deployment of community health workers would solve these problems.

The idea of the community worker thus fitted in what became ‘participatory development’. The concepts ‘participation’ and ‘participatory’ entered the development discourse in the 1950s (Rahnema 1992: 117). Participation became a pillar of both ‘self-help’ and ‘bottom-up’ development. Such trends were supported, for example, by the social pastoral Church, which, under the influence of the missionary and development ethos of the Catholic Church after World War II, increasingly supported existing grassroots organisations and also encouraged poor people to organise communally the services the state could or would not provide (Klaiber 1988: 358). Self-help organisations thus relied on the voluntary work of community members. Due to the gendered division of labour, women often played a key role in such organisations. In the 1970s, individual states adopted the idea of community self-help (eg Peru under Velasco, as in: Stepan 1978) as the solution to the problem of the absence of state services in remote, hard to reach, and non-priority regions. As a result, in the 1980s, many countries incorporated community workers into their national health care systems.

According to Robert Chambers, there was a ‘revival’ of participatory thinking in the 1990s, parallel to a paradigm shift: from ‘things’ to ‘people’; from top-down to bottom-up (Chambers 1994). This may seem surprising given that earlier participation thinkers also claimed to be promoting a shift from top-down to bottom-up approaches. Nevertheless, Chambers – a champion of participatory development practice- shifted the emphasis of his work to a more inclusive and democratic practice.

⁶ The study is mentioned as a pillar in the development of community participation in PHC in the developing world by most major works discussed in this paper.

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According to Chambers, participation in development should aim at enabling people to perform their own analysis, to take command, to gain confidence, and to make decisions. Community workers, according to this approach, should be central to these empowering processes given that they could function as the link between the local community and the sources of information, funds, and resources supplied by international and national NGOs and/or national governments. Chambers observed, however, that there were dangers to participatory development rhetoric. In some contexts, he suggested, this rhetoric could become a) a cosmetic label in order to make a project 'look good' in order to obtain funds, or b) a co-optive measure to mobilise local labour in order to carry out 'our' projects and reduce costs (when, according to Chambers, it is 'we' that should participate in 'their' projects). In brief, just as community workers were central to the idea of self-help in the 1960s and 1970s, and to the state-led large-scale service delivery programmes that peaked in popularity in the 1980s, community workers also have become central to participatory processes that today are often called 'community-driven development' (Mansuri & Rao 2004).

It is possible to identify several central assumptions that guide development planners working with local volunteers in order to implement (part of) a project:

- *Accessibility*: By deploying local people, a wider network of services can be set up and more people, especially those in remote areas, can be reached.
- *Sustainability*: Handing over responsibility to the beneficiaries might make them more involved in development planning, and thus, help make development interventions and service delivery sustainable.
- *Cost-effective*: Working with volunteers is a cost effective way of expanding services, especially in low-income areas.
- *Cultural effectiveness*: The relationship between local providers and beneficiaries might be less infested with inequality, and thus reach more people otherwise overlooked. The absence of socio-cultural misunderstandings might improve service delivery.

These factors fit into the participation philosophy. However, as Chambers already warned, they also suggest that motivations can be easily overshadowed by more 'functional' and top-down arguments such as cost-effectiveness by using local labour on a voluntary basis, or even to factor in local community workers for the sake of satisfying the idea of 'good development'.

The 'enabling environment': neoliberalisation, privatisation, decentralisation

In order to understand the different interests that might influence the effectiveness of CBW interventions, it is useful to shortly look at the relation between neo-liberal governance and service delivery of supposedly public goods. Under influence of neo-liberal thinking among large funding bodies such as the World Bank, governments worldwide tend to shift away from state owned service

delivery schemes. This is translated into two processes: decentralisation and privatisation. The wave of privatisations of public services such as drinking water provision, telecommunications, electricity, transport and health care has generated both negative and positive consequences in many countries. In developing countries, where those services were often not fully accessible before privatisation, the retreat of the state could mean a disaster for certain groups. For example, privatisations of water supply and sanitation that ignored economic and political issues proved to be highly problematic (PRINWASS 2004). The water sector privatisations are a good case in point indicating that certain services are in need of some sort of public management and accountability, or at least, fall within a public regulatory framework. Unconditioned privatisation will almost automatically disadvantage the poor, as they will not be able to afford market prices.

However, public administration of services is not ideal either. In Sub-Saharan Africa, inadequately equipped public health care systems should be caring for increasing HIV and AIDS patients. The lack of resources and health care infrastructure in most countries obstructs the testing of people for HIV, the administration of medicines, and of effective prevention campaigns. Within a neo-liberal approach, the state is not supposed –and has no access to the necessary resources- to intervene with a comprehensive and well-funded scheme. Rather, the neo-liberal logic encourages decentralising services by shifting off more of such responsibilities to local governing bodies and to the communities under their rule. This is assumed to be a supposedly ‘cost-effective’ *and* democratic way of delivering prevention and care. However, the result seems to be that the task of caring for the already sick, a palliative task when no medicines are available, is passed on to voluntary, often insufficiently trained and compensated, community members (Farmer 1999). National and international NGOs are slowly filling the gap between inadequate private and public service delivery systems. However, to what extent NGOs can cover the provision of services that are basic to everyone, including those who can hardly pay for the delivery of such services, is still a question.

For example, realising that the deployment of CBWs cannot provide for a complete package of Primary Health Care, and urged by the Millenium Development Goals, the WHO, the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics, made a recent plea for a full coverage of safe motherhood by the deployment of ‘skilled attendants’ (WHO, 2004). The text argues that Traditional Birth Attendants, in our definition CBWs, could not reduce the maternal mortality rates significantly due to a lack of an ‘enabling environment’. Thus, they propose a shift from hastily and partially trained and compensated TBAs, to skilled workers with better defined job responsibilities, i.e., a professionalisation of service delivery, instead of further informalisation. Unfortunately, although the report indicates that to be effective health care workers they need training, supervision, drugs, equipments and institutional back-up, it is not clear who is responsible for delivering the necessary ‘enabling environment’ (WHO, 2004).

In similar vein, Ellis and Freeman (2004) argue that although the idea of an ‘enabling environment’ is indeed often recognised as central to poverty reduction, less attention is given to what

that means and how existing ‘environments’ should change to become enabling. An ‘enabling environment’ implies a more profound process than those that community-based volunteers might be able to provide. An enabling environment might need to include the sum of society: the national and international financiers and non-governmental organisations, the state at all its central and decentralised levels, civil society organisations, community-based organisations (including faith-based organisations), and the private sector. However, in policy documents, an enabling environment seems something that can be fixed, albeit it is unclear how and by whom. Frank and Ellis suggest that there is a wide gap between discourse and practice in such poverty reduction strategies. As such, the authors question the effectiveness of the contemporary policies as promoted by the World Bank and the IMF, in particular, the Poverty Reduction Strategy Papers (PRSPs) and decentralisation schemes. They argue that ‘despite the rhetoric of participation, empowerment and ownership that infuses the discourse on PRSPs, these are nevertheless fundamentally rather centralised processes following blueprints available on World Bank and IMF websites, and connected to central budget support and public expenditure management considerations that are to do with improving governance at high government levels’. In sum, the relation between international blueprints, a retreating state, privatisation, the increasing reliance on national and international NGOs, and the role of CBWs in shifting the responsibility of delivering basic services in poor nations, is an issue in need of further examination.

II Case studies: constraints and possibilities of community workers systems

By shortly reviewing evidence concerning the performance, cost-effectiveness and sustainability of CBW programmes, we will highlight some possibilities and constraints of deploying community workers in development interventions. This section is based on literature on community health workers (health), community-based mediators (justice), peer educators (education), water pump attendants (natural environment), and research assistants (research). In addition, we will review studies related to CBWs motivations and about the cost-effectiveness of deploying CBWs.

Community health care workers: large-scale PHC systems versus small-scale interventions

We have seen that community workers have been popular with international NGOs and government health systems alike. Active community involvement has been promoted in the delivery of reproductive health care, primary health care, and disease prevention strategies. Whereas empirical evidence is often based on different data sets, a distinct use of parameters, and have different goals to meet and are thus difficult to compare, a discussion of several important case studies will give an idea of the possibilities and constraints of the deployment of community health workers.

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In 1987/1988, on authority of the British Governments Overseas Development Administration, a collaborative research was carried out on national, large-scale, community health worker programmes in Colombia, Sri Lanka and Botswana. The Sri Lanka case, published in *Social Science and Medicine*, demonstrates how some of the above discussed assumptions about community based worker systems are undermined in practice (Walt, Perera, and Heggenhouwen, 1989). The case study shows that the introduction of a large-scale governmental healthcare scheme based on community health workers was preceded by small-scale, privately or internationally financed healthcare, nutrition and education projects. The national programme was motivated by a large UNFPA family planning programme, which commenced its activities in the early 1970s. The government intended to train community volunteers not only as agents for education and family planning, but also as local agents for development and community participation. Their health care commitments were intended to carry beyond family planning issues. Public health midwives were responsible for selection, training, supervision, and provision of ongoing support to community health workers, making the programme largely dependent on the dedication and interest of midwives. While the ministry of health claimed that between 1976 and 1987, 100,000 volunteers were trained, with an attrition rate of only ten per cent, the authors suggest that these figures are guesswork and wishful thinking. Instead, the authors cite a 'conservative estimate' of an actual number of 18,000 active volunteers (p 601). In addition, high attrition rates were caused by lack of supervision and support, of incentives and rewards, and of institutionalisation. According to the authors, Ministries of Health around the globe tend to assume that, as a result of communities' self-interests in such health care programmes, communities would select the most capable people and support and reward (in cash or kind) them appropriately. The Sri Lanka case showed that this was a wrong assumption. Instead, local relationships and interests, power structures and socio-economic situations were central to the selection, performance, and status of and support to community health workers. The authors conclude that even if and when enabling conditions are improved, attrition rates in large-scale voluntary community health worker programmes will be high. Small-scale programmes are more likely to succeed, although they are more successful where the 'ingredients of support and supervision are consistent, regular, and where built-in incentives (not necessarily financial)' are included in the programme (Walt, Perera, and Heggenhouwen, 1989).

Building on the above-discussed body of research, Stekelenburg, Kyanamina, and Wolffers (2003) look at the functioning of community health workers in what was left of a supposedly inclusive and participatory primary healthcare system implemented in 1981 in Zambia. The authors locate the emergence of deploying community health workers to increase access to primary health care in Zambia in the international trends of the 1980s of participatory development processes and cost-effective healthcare delivery. Likewise, the authors observe that the experienced constraints and failures of the programme run parallel to a decreasing international interest in community health worker systems. Stekelenburg, Kyanamina, and Wolffers visited a neglected community health

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workers programme in the Kalabo district to investigate the factors contributing to the low performance of the community workers. They encountered several factors that influenced performance in a negative way: a) community workers were supposed to be rewarded for the efforts by the community, but the study indicates that the workers view the received rewards, in labour or kind, inadequate. b) There is no consistent supply of drugs and equipment is poorly maintained, and c) there is insufficient -or absent- supervision and training. A last constraint of the programme (d) was located in the selection procedure. Contrary to other community worker programmes, in this Zambian case study, the volunteers were actually selected by the community members themselves. However, there was no clarity about selection criteria, and there was often no transparency, i.e., community leaders tended to appoint their favourite candidates. The authors conclude that such practices often led to the training of the 'wrong' people –an experience reported for the Sri Lanka case study as well-. Despite these results, the authors confirm that an improved community health care system is the only realistic way 'to attain high coverage with essential healthcare and one of the few achievable, affordable and sustainable methods' for an inclusive healthcare delivery in Zambia (Stekelenburg, Kyanamina, and Wolffers, 2003: 117).

As some scholars indicate, small-scale community health workers projects are more likely to be successful than large-scale national programmes. In 1993-1995, W. Schmeller evaluated the prevalence of skin diseases among school children in western Kenya. The author designed and implemented a programme in which community health workers were trained to diagnose and treat children for several infective skin diseases. The results show that community health workers were successful in dealing with the most common dermatoses in children following a short training period (Schmeller 1998). These results indicate that community health workers can effectively carry out programmes directed at dealing with a specific problem, i.e., a focused and immediate outcome-directed project rather than national, permanent and more general PHC programmes. Of course, this small-scale project was effective because of sufficient training, close supervision, and adequate compensation, i.e., an effective and well-financed 'enabling environment' more difficult to provide in large-scale and low-cost projects.

In similar vein, TB and HIV specialist Paul Farmer reports on a community-based drug-resistant TB treatment programme in Lima, Peru (2004). The project, a collaborative effort of community-based NGOs in Lima and Boston, a Harvard research institute, and the Peruvian Ministry of Health, was evaluated over seven years and showed good results. The success of the programme was grounded in good training, close supervision and a tight-knit working group of physicians, nurses, researchers, administrative support staff, and community volunteers. The volunteers' day-to-day care for some three or four families in their neighbourhoods made close supervision of difficult treatments possible, and help manage additional problems within families. The volunteers were also active outreach workers to identify TB patients, which contributed to minimizing further transmission. They were selected from existing groups of volunteers such as women's groups and Church groups,

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assuring a minimal commitment of the volunteers to the wellbeing of the community. According to Farmer, the biggest challenge was the link between disease and poverty, i.e., the overwhelming poor background of the majority of drug-resistant TB patients. The cycle of illness and poverty in which many people in poor communities fall was addressed through small-scale but vital economic support to families who would otherwise fall back into immediate poverty and disease. The project even provided moral support and counselling to avoid the effects of social isolation and disease. As such, this project is one of the few excellent examples of a good community-based health project. The authors claim that the Lima project could be expanded to other disease control such as HIV and could serve as an example to community-based health care schemes elsewhere (Farmer 2004). From a more sceptical point of view, however, the question is if there would be sufficient political will (both in national states as among facilitating institutions such as international universities or NGOs) to provide for public resources and participation in order to maintain such large-scale, long-term partnerships.

One area in which local volunteers have been actively involved on a larger scale, is birth control programmes. USAID, which provides nearly half of the funds for population programmes around the world, has been promoting community-based distribution of contraceptives since the late 1970s. In the 1990s, under the influence of the UN conferences on population in Cairo (1994) and women in Beijing (1995), distribution of contraceptives was complemented with reproductive health care, peer education, and local research and evaluation. Sidney Ruth Schuler (1999) describes two projects, one in Peru and the other in Ghana, in which community based reproductive health care and promotion of family planning addressed issues of gender inequity and women's empowerment through a system of CBWs. The Peruvian project, financed by USAID, supported by the Peruvian government, implemented by a national feminist NGO, and carried out by local, community-based 'promoters', shows the importance of addressing several tasks in one project: research and evaluation became an important pillar of knowledge generating and sharing, of acquiring skills, and of empowerment (in the form of consciousness raising through discussion and reflection). This became important for women to effectively manage their fertility in an environment often hostile to handing over control over female bodies to the women concerned. The community workers identification with the target group made the sharing of information easier on a cultural level –besides language, the understanding about the body and health and about local gender rules appeared to be important (and previously underestimated) in identifying the obstacles women encountered in managing their fertility (Schuler 1999). Nevertheless, the system also brought to light local hierarchies and conflicts between women. The CBWs were selected from the most capable among existing women's groups, a widespread and well-organised phenomenon in Peru. Although the CBWs did not receive a salary, they received their transport costs and rapidly enhanced their status in a way that promoted a learning gap between CBW and participant. Whereas this must have been important to sustain the motivation for this voluntary work among CBWs, in some cases it also increased conflicts among and within women's groups. Political neglect on the part of the Peruvian government was, however, the biggest obstacle to providing reproductive

health care in remote areas, while the influence of USAID was felt in the backlash concerning contraceptive use and abortion (Boesten 2004). Thus, whereas the Peruvian project seem to be functioning reasonably well when looking at issues of empowerment and participation on the community level, i.e., it might contribute substantially to altering gender relations (although there is no way to 'measure' empowerment, less so on a large-scale), the project did not deliver evidence that they improved reproductive health. As the community workers did not have access to actual contraceptives, drugs, or primary health care skills, they relied on promoting the use of existing clinics (Schuler 1999: 151). The functioning of these clinics was questionable, they were not improved as part of the project, the distance to reach them was often (too) far, and the human relations between patient and doctor was often deplorable (Boesten 2004).⁷

The discussed case studies indicate that it is impossible to look at the performance of community workers without looking at issues such as the interfaces between community members, community workers, and institutions. In addition, while it seems that there are sufficient people who are prepared to take up community work for little financial rewards (see below), they cannot properly carry out their task if they do not receive the proper training, support, and facilities to do so. Even if the CBWs in question are well-motivated, compensated and trained, the Peruvian case studies showed that they also need solid institutional ground and political back-up to make it possible to scale-up (Farmer 2004) or to have a positive effect on the well being of people (Schuler 1999, Boesten 2004). This means that there must be political will to collaborate actively in programmes that aim at expanding access to health care in remote and neglected areas.

Local mediators: reflections of existing injustice?

A less documented use of CBWs is as community-based mediators. Whereas we do not intend to go extensively into such programmes as that would demand more detailed research, and while we do not have enough information on the extent of such projects throughout the developing world, it is useful to shortly refer to a Peruvian example as it highlights the overzealous decentralisation of service delivery in the era of neo-liberalism and cost-effectiveness. Bringing justice to the community through the deployment of local mediators easily overlooks local power structures, social context and conflict, or the possible consequences for the people involved.

In the 1990s, a quest for universal access to justice became a growing concern to the international community. There was a concern that existing justice systems would not be able to incorporate the growing numbers of people who called upon the courts. Following successful example from mediator services set up in the UK and elsewhere, USAID, the World Bank and other collaborative institutions (e.g. Interamerican Development Bank) designed a programme to introduce local, voluntary or low paid, mediator services in several developing countries to conciliate in civil

⁷ The programme included large scale forced sterilisations encouraged by the government. Obviously, this

disputes. For example, the USAID website mentions a project in the Philippines, where so-called 'community captains' were voluntarily deployed to deal with local conflicts, especially within the family, to prevent the courts from clogging up.⁸ No information on the effectiveness of the project is given, and it is not clear if previously underserved populations are now better off. Are battered women protected? How are disputes solved? Is there a local penal system, or are there clear procedures to refer to the official justice system if necessary? Is there a way to provide protection on a community level? The Peruvian attempt to direct people to local mediators gives insights into these questions.

In Peru, the establishment of compulsory mediation on a local level was meant to increase access to justice to underserved populations, i.e., the urban and rural poor. In addition, it was thought that the majority of the Peruvian indigenous populations traditionally solved their conflicts through community mediation (or the widespread system of locally appointed Justices of the Peace), which meant that compulsory mediation in civil conflicts not only expanded access to justice, but incorporated (and formalised) existing local systems into larger society (Estremadoyro 2001). In terms of cost-effectiveness, this extra-judicial system would pull away the burden of civil disputes from the courts, especially the increasing loads of domestic violence cases. The appointed mediators were not necessarily especially trained community workers, as they seemed to be in the Philippines, but were traditional justices of peace, student volunteers, or local attorneys. As Deborah Poole observes, the system of mediation for the poor, instead of giving access to the legal system, led to a paradoxical situation of people lingering at the margins of the state: 'their' communal justice systems were legitimised, however, these were elite, male dominated systems of justice not necessarily based on equality and inclusion. At the same time, the poorest were chased away from the legal system as they were now denied the possibility of turning to the courts in first instance (Poole 2004). In the case of domestic violence, this was a particular problem. The increasing amount of women willing and able to denounce partners and husbands of violence in their homes, were obliged to trust that a conciliation agreement, a signed piece of paper of excuses and a promise it would never happen again, would protect them from further harm. Fortunately, the government yielded to the pressure exerted by feminist organisations, which claimed that domestic, gendered, violence being inherently related to domination and inequality, could not possibly be solved in a conciliation procedure that requires equality as a starting point (Hernandez Cajo 2000; Yanez, 1998; Bardales Mendoza, 2003).⁹ Conciliation was removed from the law on domestic violence in 2001 (Estremadoyro 2001).

Although community-based conciliation might be effective in other disputes than domestic violence cases, the example shows that issues of inequality should be at the centre of ideas concerning the improvement of the wellbeing of people. It also indicates that community responsibility over this improvement of access to services which are meant to improve people's lives, are not necessarily

jeopardised the whole intervention, including the work of the CBWs.

⁸ www.usaid.gov/our_work/cross-cutting_programs/wid/snapshot/ane/philippines/phil_ladr.html

promoting equality between community members, and can even threaten people's lives. As such, the case of community work and justice indicates that we should question the very nature of shifting responsibilities from the state to communities. Before passing responsibilities formerly thought of as pertaining to the state to communities, attention should be given to its consequences, taking into account not only 'traditional', local, ways of dealing with things, but more importantly, to those socio-political relationships at both the local, meso and macro level which persistently disadvantages particular groups of people. We will return to such queries in the conclusion.

Peer education as a means to change social identities

One of the important tasks in promoting Primary Health Care has been the dispersion of information regarding the prevention of disease and control of health, among which reproductive health, nutrition and hygiene. In order to avoid static top-down forms of the dissemination of information, participative forms of education were introduced. By making information accessible through peer education, a collaborative process of change might be established. Especially in the area of HIV/AIDS prevention, peer educators have been very important.

Peer educators are different from CBWs as their primary identification with the group is not their community membership, but any social identity that makes people as a group particularly vulnerable to certain illnesses, in this case, HIV/AIDS (but peer education can also consist of, for example, child nutrition education among young mothers). As such, peer education aims at changing the practices common in particular social groups by re-negotiating social identities (Campbell and Macphail 2002), instead of only transmitting knowledge about the disease and the ways to prevent infection.¹⁰ In HIV/AIDS prevention schemes, peer educators are recruited because of their identification with the 'target group', i.e., they are sex workers and offer courses and workshops to their fellow sex-workers, or, in similar vein, mineworkers, young people, school children, or mothers with small children. As do community health workers, peer educators usually receive a short training conducted by national or international facilitators and guided by NGOs or government institutions. They receive a small allowance, coverage of expenses, or work voluntarily. Similar to community health workers schemes, peer-education is popular worldwide, but is understudied and, according to some, under theorized (Campbell, 2002, and cited there, Milburn 1995; Turner & Shepherd 1999).

Catherine Campbell and Catherine MacPhail sought to fill this gap by introducing the work of the Brazilian educationalist Paulo Freire. According to Campbell and MacPhail, peer education should be actively directed at democratising local social relationships and should be an empowering process with the aim to change social identities towards more equal relations. If not, as the research of the

⁹ Similar arguments were brought to the fore in a 1988 article on mediation in the Western English speaking world (Scutt 1988).

authors shows (see also, Campbell 2003), peer education cannot and will not change sexual behaviour necessary to halt the AIDS epidemic in Africa. This empowering process should be guided by what Freire called the development of ‘critical consciousness’, i.e., the ability to evaluate and understand the circumstances in which one lives. A sociological understanding of the context of one’s own behaviour, especially as shaped by the peer group, might help people to take responsibility to change such behaviour. Through discussion, argument, and reflection, peers might critically change social identities and the norms that determine their sexual behaviour (Campbell and MacPhail, 2002; Campbell 2003: 109).

With reference to a case study of a peer education programme in Summertown, South Africa, among sex-workers, mineworkers and young people, Campbell and MacPhail identify various factors that can undermine the development of critical thinking and empowerment through peer education: a) peer educators’ preference for didactic methods and biomedical frameworks, b) unequal gender dynamics among the peer educators, c) highly regulated and teacher-driven nature of the school environment, d) negative learner attitudes to the programme. In addition, other factors obstructed the development of critical thinking and changes in sexual behaviour in peer education groups: a) limited opportunities for communication about sex outside of the peer educational setting, b) poor adult role models of sexual relationships, c) poverty and unemployment, d) low levels of social capital and poor community facilities. The researchers of this Summertown programme -as the principal researcher states, a well-resourced, well-organised, inclusive, community-wide AIDS prevention and research project-, largely failed to reduce STIs among the target population because of these existing socio-cultural factors that were an obstacle to HIV prevention in the first place. In addition, structural socio-economic constraints and the lack of political will of the different actors, including the target groups, were constraints to the peer education programme (Campbell 2003). The example suggests that changing social relations and identities might be too difficult for short-term peer education programmes.

More positive case study data is reported from rural India (Sivaram and Celentano 2003). The authors looked at a two-year peer education project, supervised by a local NGO and funded mainly by USAID. The results suggest that peer educators were a ‘excellent resource’ during the project itself, but were not sustainable after it ended. Sustainability (as defined by USAID: the ‘ability of activities to continue appropriate to the local context after withdrawal of external funding’ (USAID 1999, cited by Sivaram and Celentano) depended on: a) affiliation with village level institutions to maintain access to resources, and village level willingness to continue, b) quality of interaction with project implementation team, c) strength and leadership of their own institutions, d) perceived benefits from implementing HIV education, e) gender (men more sustainable than women), f) Non-sustainers were often women, poor and unemployed who later found employment. Thus, two factors stand out in the

¹⁰ Studies have indicated that knowledge about STIs, HIV/AIDS, and condom use does not necessarily translate into condom use and safe sex. See Vavrus 2003 and also Campbell 2003.

sustainability of this peer education project in rural India, first, the peer educators social embeddedness in local community, institutions and the interaction with external institutions; and second, the peer educators necessity for paid labour. The attrition rate among women, as the authors suggest, was mainly the consequence of the last argument, as the peer educators had received a monthly stipend from the NGO to implement the programme, but could or would not continue their tasks without such financial contribution. Case studies in Côte de Ivôire and China show similar results: women are more likely to participate in HIV/AIDS prevention schemes when there is an income generating component in the project (Sivaram and Celentano 2003). Learning from this lesson, a women's organisation against AIDS in Kilimanjaro, Tanzania, tries hard to incorporate the facilitation of income generating activities for each of their local branches that commits itself to care and prevention activities in their communities (KIWAKKUKI 2003).

Still other findings are found in a research on a community-based HIV/AIDS education project in rural Uganda (Mitchell, K et al 2001). The authors suggest that the studied community educators did not 'educate' everyone equally, i.e., some would avoid the more educated and richer community members, as well as older relatives. This supports the case for appointing peers to educate peers in order to avoid uncomfortable positions for community-educators in front of their social superiors. The article also claims that educators and participants alike, according to the authors as a result of low literacy rates and a lack of 'reading culture', did not always appreciate reference material.

The discussed case studies suggest that there is not only a lack of theoretical underpinning of peer education, but also a lack in evidence of the benefits and sustainability of peer education methods aiming at changing people's sexual behaviour by targeting them through specific group identities. Although some cases observe tentative positive results, more in-depth studies suggest that the different levels of disinterest, the structural political-economic constraints, and strong resistance of powerful institutions do not provide for a fertile context in which community-members can effectively be deployed to contribute to changing social relationships and identities.

Local researchers: who participates?

A growing body of literature reflects upon participatory research methods. The above discussed peer education methods, for example, are strongly related to participatory, community-based, research. Both aim at empowering 'the poor' (or those specific groups targeted in particular projects) through a process of knowing and learning that eventually leads to what Freire called 'critical consciousness' necessary to change the conditions in which many people live (Freire 1972; Konings 1995). The idea and practice of participatory research, often known as 'participatory action research', was developed in the 1970s by social scientists such as Orlando Fals-Borda and Mohammed Rahman. In the late 1970s, Robert Chambers introduced 'rapid rural appraisal', a method of efficient data collection by relying on the knowledge of local people. Over time, this method was thought to be in need of more participation and the emphasis was shifted towards data sharing, knowing and learning,

instead of mere data collection, also referred to as ‘participatory learning and action’¹¹, or, according to Chambers, ‘participatory rural appraisal’ (PRA) (Chambers 1994).

According to Chambers, using PRA methods in research might correct certain distorting effects of power relations between researchers and community members, i.e., of the myths villagers might tell outsiders. The idea is then that information shared between peers might be more truthful than the information shared with outsiders. Although this might be valid in particular cases, local power structures and community histories might prevent a ‘truthful’ exchange of information even more than an exchange between outsider –who will leave the village and thus not necessarily influence the status of the person involved or gossip about information shared- and villager. A central, though unsolved, problem in PRA processes is the question of who has the power and ability to define and formulate the researched questions. Or, as Chambers puts it, are ‘we’ (western scholars and development planners) participating in ‘their’ (poorer people in developing countries) research or are they participating in ours? In addition, Korrie de Koning suggests we should question the role of facilitators, organisations, and groups in the community to ensure an ongoing process of reflection and action (1995).

De Koning points at the issue of conflicting interests and issues of power between and among groups (1995). In similar vein, Catherine Campbell’s detailed evaluation of the HIV/AIDS prevention project in Summertown, South Africa, provides a good example of the possible problems that could emerge in PRA projects (although Campbell does not use the concept PRA). The research team of the Summertown project employed 40 young people every year (over three) to carry out survey interviews among community members. Thus, the project provided for part-time employment, as well as valuable training, to a large number of young people in the neighbourhood, many of whom found other jobs afterwards, partly due to the experience they received in the Summertown research. However, as Campbell observes, the employment of these youths generated many bitter conflicts between the research team and community members who were not satisfied with the way in which participating youths were selected. Campbell suggests that the selection criteria, based on capabilities (education and language skills), were not the main criteria community members would like to see. Rumours of favouritism and corruption were spread. Young people who had worked selflessly on HIV prevention and voluntary care programmes did not get preference over better-capacitated peers, which generated extra opposition. Adding local power struggles to this well of misunderstanding, and we have a potential explosive situation (Campbell 2003: 176-178).

However, the advantages of setting clear selection criteria at the project management level is supported by the outcomes of the research carried out by Stekelenburg, Kyanamina, and Wolffers (2003) in Zambia. The authors showed that handing the responsibility for selection of community workers over to the community itself could result in the wrong people in the wrong job. As the

¹¹ www.undp.com/eo/documents/whop1.htm

selection criteria used were more based on local political relations than capacity, many community workers appeared inadequate for the job (Stekelenburg, Kyanamina, and Wolffers, 2003). Such political relationships, i.e., the distribution of power and the potential issues for conflict, especially when salaries and training are involved, should be taken into account when employing local research assistants. It is very well possible that the position of former research assistants improves after participation in research projects, due to training, gained confidence, and contacts made throughout the project. Whereas this should be viewed as positive and empowering, it can easily generate envy, jealousy, and misunderstandings that should be taken into account *before* selecting and employing people. Discussing selection criteria and possible community opposition with community members might be a way of avoiding the most destructive conflicts over participation and research.

Water provision and issues of equal access

In the natural environment sector, community-members are also increasingly deployed for the maintenance, supervision, distribution, and knowledge sharing regarding natural resources. The African Institute for Community-Driven Development identified, for example, community plumbers, water committee members, animal health workers, forest advisors, link/facilitator farmers, and farmer extension workers (2005). Here we will shortly discuss the effectiveness of deploying CBWs in the area of water supply and sanitation (WSS).

Water supply and sanitation is a contested field in which responsibilities, possibilities, and constraints are not yet clearly disentangled. At the macro-level, there is a debate surrounding the public nature of WSS: World Bank supported privatisations were received with mixed results (PRINWASS, 2004), while the Millennium Development Goals clearly state that it is necessary to increase access to safe drinking water and sanitation. These two ‘macro’ positions (equity versus cost-recovery) often in conflict when it comes to actual WSS provision. The solution seems to be participation and decentralisation, i.e., water user’s participation and community-based management. However, the effects on accessibility are not always clear.¹² Several scholars have pointed at the often-incompatibility of cost-recovery and equity (Mehta and Ntshona 2004; Cleaver 2004b), and that ‘user participation’ and decentralisation is often about transferring costs from water companies to low-income households (Jaglin 2002).

When users participation is not (only) directed at transferring costs, but about community ownership and inclusion, other problems arise. A study conducted by Toner, Msuya, Mdee, and Mfinanga (2005) to water users associations in rural Tanzania showed that existing normative structures of in and exclusion persisted in community-based management of water resources. The authors conclude that community based management does not necessarily lead to broad community ownership and that benefits from local-level management are not shared equitably while many people

remain water-poor despite increases in supply. The project mechanism seemed unsustainable and communities were asked to bear the costs of expensive and institutionally inappropriate schemes. The notion that the 'elected' CBWs –chosen by a village elite that seemed to have personal interests in the appointment of certain people- did not automatically increase access of resources to the poorest is a severe undermining of the initial objectives of such decentralisation (Toner, Msuya, Mdee, and Mfinanga 2005). Considering the quest for inclusion, equity, and increased accessibility of water, the overarching question arising is if decentralised water governance is necessarily *good* governance (Cleaver, Franks, Boesten, Kiire, 2005).¹³ In addition, questions have been raised concerning the assumption that 'local' is necessarily more equitable and sustainable (Purcell and Brown 2005), a question which is tightly linked to the growing scepticism concerning the 'community' as ideal-type of mutual support and solidarity (Guijt & Shah 1998; Cooke & Kothari 2001; ESRC Water Conference 2005).

CBWs motivations: local and/or institutional returns

In order to understand performance and cost-effectiveness of deploying community workers in service delivery, it is necessary to examine why individual people who are already among the poorest, carry out community work under the guidance of national and international NGOs or governmental institutions. An obvious motivation for participation in health education, research or other types of projects initiated by 'outsiders' (non-community members), is a salary or other financial gains that involvement could bring. Before we go into the question of remuneration, however, we will draw attention to studies that discuss the personal motivations of voluntary community workers.

The motivation of community workers is relevant for their performance –as many of the above discussed studies suggested that community worker programmes suffer from high turn-over, absenteeism, poor work quality, and low morale. In the early 1990s, research showed high attrition rates among community health workers in large-scale community health programmes (as discussed above), which was often associated with weak organisational and managerial capacity of government health systems (lack of training and supervision). A study carried out by Sheila Robinson and Donald Larsen (1990) in Colombia suggests other explanations. The research suggests that community health workers morale and work performance relies stronger on feedback, motivation, and rewards provided by the community than those provided by the national healthcare system. Robinson and Larsen conclude that the community health workers' job performances were more strongly influenced by increased status in their communities, and visible health improvements in that community, than by feedback from the health system and even more than rewards from the system in the form of salaries

¹² For an analysis of the existing debate and the gaps in knowledge, see: Cleaver, Franks, Boesten, and Kiire, 2005.

¹³ Decentralisation of tasks to local politicians and bureaucrats is still a different subject, as examined by: Ellis and Freeman 2004.

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(although the availability of the necessary knowledge and training that allowed them to achieve improvements, i.e., institutional back-up, must have influenced the CBWs performance, and thus status). According to the authors, instead of focussing concerns on the interface between community workers and the national health system, more attention should be paid to the relation between the worker and the community (Robinson and Larsen, 1990).

These findings clearly contradict findings of a HIV/AIDS prevention programme deploying peer educators in rural India, in which job performance was largely dependent on ongoing project management, support and funds. The study in which the project is evaluated, suggests that projects were sustainable after withdrawal of the supervising programme if and when the local contacts of the peer educator with the local authorities were strong, depending on the strength and leadership of their own institutions and on the perceived local benefits from implementing HIV education (Sivaram and Celentano 2003). In similar vein, the evaluation of the HIV/AIDS Summertown project suggested many problems with both peer educators and research assistants generated by a distorted relation with their communities (Campbell and MacPhail, 2002). Thus, a strong feeling of local support, status and effectiveness seems vital to the sustainability and job-performance of community workers. However, for the time being it is not clear how such community support can or should be generated and encouraged. This is a particularly difficult task when CBWs are involved in changing social relationships and identities as such social changes are not often on the list of desired 'visible improvements' of any given community.

The above case studies, however, have a 'top-down' view on the performance of community workers. They look at developmental goals as defined by donors and facilitators and measure performance along these lines. In addition, they look at recruitment and motivation by looking at 'under-performance' in relation to those previously set criteria. An ethnographic point of view is lacking in these studies. Jesus Ramirez-Valles takes a different, micro and ethnographic, point of departure to look at the performance and effectiveness of community health workers in Mexico. Ramirez-Valles starts with the community workers and looks at the possible personal factors that could influence their work and their participation in community worker projects. The author looks specifically at women's community participation as a life changing and empowering factor. By relying on women's personal stories, it becomes clear that, besides the presence of bridging social capital –i.e. community-based associational networks- and support of specialists in the field (NGOs), individual factors play an important role in their motivation to participate in projects. In addition, many community health workers had previously been active in other community work financed and supported by or international cooperation or the state. According to Ramirez-Valles, this suggests that the women in this case study were motivated to work in and for the improvement of their communities with small incentives in the form of training and resources. Motivations such as personal development, increased community status and responsibility, and having a voice in community decisions were very important. The belief that their work actually contributed to the improvement of the community

members' wellbeing, i.e., that there was a palpable result of their efforts, was also an important incentive (Ramirez-Valles 2003).

Fourteen years earlier, Walt, Perera, and Heggenhougen (1989: 606) reached a similar conclusion: community workers motivations were often determined by multiple individual factors. However, the authors also saw some general characteristics that could encourage women and men to participate. Well-educated women, but also men, with few job opportunities might be motivated to engage in community work in the hope to increase their future job opportunities. Also, for young unmarried women, voluntary work sanctioned their moving about the community. Doing research on a large-scale community-based health care system in Sri Lanka (see above), Walt, Perera, and Heggenhougen also suggested that religious values and commitment might play a role, and further, that 'traditional' -with which the authors seemed to refer to authoritarian-, structures might influence community volunteering.

In sum, studies to the motivation of community workers to participate voluntarily or for a small allowance in projects, seems to suggest that personal motivation is strongly linked to community structures and support, and less so to outside supervision and the official reward system. However, perhaps the discussed studies fail to address the power of institutional links in enhancing one's individual status in a community. Surely, institutional links, improved access to resources, and a growing network beyond the community, contribute to empowerment, status enhancement, and the strengthening of social capital. Such a conclusion cries for further research into the changing relation between the community and the volunteer who is part of a wider institutional context, with particular interest for perceptions of empowerment among individual participants (Holmes 2001).

Should the emphasis be on costs or on effectiveness?

Besides the arguments about access and participation, CBW systems are also in great part motivated by its supposed cost-effectiveness. However, although the low costs of using community workers in large-scale healthcare programmes seems obvious, as the costs for personnel are minimal, there has been some debate about the cost-effectiveness of such programmes. As we have discussed above, we might question the effectiveness of under-trained CBWs and the performance of CBWs who have been selected not for their capabilities, but for political reasons. We might want to question how cheap but badly supplied health care workers can be more than palliative carers. And, how do we calculate cost-effectiveness in severely underserved regions?

Berman, Davidson, Gwatkin, and Burger (1987) listed the problems related to assessing the cost-effectiveness of community health worker programmes; a) sufficient data concerning costs and effectiveness is rarely available, b) economic evaluation techniques are inadequate to evaluate the cost-effectiveness of projects with a wide range of goals, techniques, populations, and high irregularity, c) 'false positives': apparent but not actual significant improvements in health status, as a result of the community health workers project as well as 'false negatives': the suggestion that

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community health worker programmes are not contributing anything, while in fact they are (because of a too short time frame or the absence of other conditions necessary for health improvements), and d) community health worker programmes can have other, non-health related benefits which are not taken into account by a cost effectiveness analysis. Nevertheless, the authors claim that one could make an assessment of the functioning of community health workers by evaluating the following accumulative issues: selection of tasks, quality of care, coverage and equity, health impact, low cost. Together, these aspects make a good functioning, cost-effective, project, i.e., if a project fails on one or two of these aspect, that does not mean that the project does not function, but rather, that it should be improved on one or two themes (Berman, Davidson, Gwatkin, and Burger 1987).

The above assessment methods, however, builds on the assumption that CBWs find their main incentives to participate in communal service delivery in the community itself and that they do not need external financial incentives. However, although in theory it might be a good idea to make communities as a whole responsible for the services they consume, this places the community-based workers in a difficult position. One can think of rising conflicts about non-financial rewards and about responsibility for the functioning and quality of the service provided. The discussed case study on CBWs in Zambia showed that rewarding community workers in labour or in kind –as cash was in general not available in the studied villages- was seen as insufficient by the CBWs themselves. Erratic and inconsistent drug supplies from the government were sometimes blamed upon the CBWs, which directly affected their status, and possibly, their returns. The Zambia case study does not provide for proof that placing the responsibility for financial (or labour or kind) reward on the community members had any positive effect on the performance or sustainability of the CBWs (Stekelenburg, Kyanamina, and Wolffers 2003). In general, participants in community projects are very poor and thus need to make up for the time lost in voluntary work. Thus, while CBWs might be largely dependent on their communities' moral support to carry out their tasks, some form of remuneration is advisable to make up for their time and to guarantee their returns, and therefore, their effectiveness as CBWs.

There is, however, no consensus about the type and amount of payment that should be offered to community workers, without undermining the idea of high access service provision in a cost-effective way. According to the World Health Report 2004 of the WHO, both benefits (retention of workers) and negative effects (being viewed by communities as government employees) have been found in cases where financial compensation was provided to community workers. Nevertheless, the WHO concludes that financial compensation helps community workers to do their jobs, as volunteers can usually contribute only a limited time each week. In order to find a 'middle way' between salaried personnel and unpaid volunteers, the WHO-study refers to innovative ways to compensate for time: for example, community volunteers involved in an onchocerciasis control programme in Kabarole district, Uganda, combined the distribution of drugs to control onchocerciasis with the retail of condoms, which became an effective income-generating activity. In other cases, volunteers receive no payment, but do receive incentives with monetary value, for example a bicycle or motorcycle that can

be used for other purposes. The WHO concludes that, despite other important personal or community level incentives, payment is needed to sustain the required level of commitment in the long run whenever community health workers are contributing an amount of time comparable to that given by professionally trained health workers. The report concludes that, although community health workers programmes are cheaper than clinic-based primary healthcare provision, no community health workers' programme, whether relying on volunteers or paid workers, is without costs, and every such programme will need a budget to be effective and sustainable (WHO 2004).

The problem with many interventions seems to be, however, performance and attrition rates are not only directly related to CBW compensation, but also on inconsistent supply of drugs and materials, and on training and supervision, financial posts which were neglected in several of the above discussed case studies. Perhaps, if the emphasis would be shifted from low cost to access, equity, and healthcare efficiency, than the quality of care could be increased substantially by allocating more resources, while still being cheaper than large-scale professional facilities.

III Concluding reflections

On a micro level, the discussed case studies suggest that there are several factors that contribute to the performance of CBWs, or, to the effectiveness of CBW systems: a) selection procedures, b) returns for the CBWs, c) personal motivation, and d) issues of equity in the community. First, the selection procedure of CBWs proves central to their performance: for example, the case studies from Sri Lanka, Tanzania, and Zambia, all indicated that selection by the community was often guided by existing local power structures, leading to people being selected who were not necessarily the most adequate persons to perform the tasks. In addition, community-selected CBWs might reinforce existing inequalities (Tanzania), they might be accused of nepotism (Zambia), and as a result, they might feel inadequately compensated by the community (Sri Lanka and Zambia). However, the South African case study showed that a selection procedure directed by the facilitating organisation and based on competence rather than position in the community might generate fierce opposition to the intervention from community elites. To avoid such conflicts, Campbell (2003) suggests that selection procedures for CBWs should be transparent and be discussed openly with the community in question before actual selection. However, there is no blueprint for avoiding conflicts over the selection of CBWs, especially given the low-access to resources in developing countries and thus the high competition over what is available, and the particular social structures of each community that might clash with ideals of equity and capacity.

Second, the way CBWs are compensated for their time and effort is important. Whereas attempts have been made to assign the receiving communities as responsible for compensation, the case studies show that, in general, CBWs do not find such compensation sufficiently satisfying. At the same time, when there is a financial compensation, conflicts with and suspicion towards CBWs might

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arise among community-members. Nevertheless, the case studies indicate that attrition rates are high when no financial compensation is offered. Voluntary work among people who have too little themselves is, perhaps obviously, difficult to sustain. Whereas alternative remuneration systems have been proposed (WHO 2004), it is questionable if CBW will (or should) maintain a high level of service delivery over time without a consistent return.

Third, the personal motivations of CBWs to participate in community development interventions are important for the systems effectiveness. Case studies from Mexico and India showed that some women participated in projects for reasons other than financial gain, leading to more sustainable interventions. Increased community responsibility, status enhancement, local feedback and support appear as important as a material compensation (Robinson and Larsen, 1990). Linking personal motivations to community benefit might be an opportunity for improving the CBW interventions. In sum, as Holmes observed (2001), there is an urgent necessity for increased understanding of the changing relation between the community and the CBW, with particular interest for perceptions of existing power relations and possible empowerment among individual participants.

Fourth, the idea that a 'community' –meaning, in most discussed case studies, legally defined geo-political areas- is inherently more equal in its distribution of services, is increasingly undermined. Local power struggles, elite capture, and exclusion of those who are perceived as 'less worthy' (HIV/AIDS patients, 'witches', women in general), are not less common on local scales than on larger scales. Equitable access to services and resources cannot depend on ideal-type solidarity networks.

On a meso level –and from there, on a macro level-, the case studies repeatedly point at the need for an improved institutional 'enabling environment'. The lack of consistent training, supervision and support, materials and equipment has contributed to unsustainability of many interventions (eg, Sri Lanka, Zambia). Such a conclusion has to be followed by a sceptical note on 'cost-effectiveness'. The idea of cost reduction should not come in the way of effectiveness. Likewise, objectives such as equity in access and full coverage should be central to effectiveness. If cost is seen as more important than effectiveness, than the entire effort might be useless, as cost-reduction in itself cannot be a goal (as there is little cost in under serving populations). To make a CBW system effective and relatively cheap, the relation between the facilitating organisation and the CBWs need to be strengthened.

However, case studies from Peru and South Africa indicate that material provisions (including training and supervision) is not everything: the Peruvian example showed that well-motivated, compensated and trained CBWs also need solid institutional ground and political back-up if such interventions are to have a positive effect on the well being of people. The South African example showed that structural socio-economic constraints and the lack of political will of the different actors, including the target groups, were constraints to the peer education programme. This well-funded intervention indicated that CBWs cannot be expected to change social identities with the purpose of changing social relations, attitudes and behaviour if such changes are not strongly supported by wider society (economic, political, intellectual, and religious (moral) institutions) at the same time. Thus, on

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a macro-level, the ‘enabling environment’ is the responsibility of all and points at a need to better understand the relationship between community-level processes of change and macro level institutional forces.

These observations lead us to a more general questioning of the perceived role of the CBWs in development interventions. In the first part of this review, we defined CBWs as ‘a volunteer selected from the community they live in, trained to cover a specific task, supported and supervised by a facilitating agent who is either an NGO or government, and in some way accountable to the community or a specific/defined group within that community’ (AICDD 2005: 7). The discussed case studies show that there are multiple problems, not with the definition itself, but with the assumptions embedded in it. A first observation must be that while CBWs are community members who deliver a service to their own community, they are not autonomous in how they carry out their tasks, or accountable to their community. The CBWs are highly dependent on the facilitating agent, on funds from outside, and on institutional and political structures. In addition, while CBW systems, just as CDD systems, are meant to be ‘bottom-up’, in reality they are initiated from above and do not originate in the communities themselves. We might call these shortcomings in CBW systems a lack in autonomy, responsibility, professionalisation, and accountability.

Autonomy: The case studies showed that CBW systems, like most exogenous development initiatives, are dependent on funds, training, and supervision from the initiating institution. If a CBW is supposed to enhance the communities’ performance in, for example, agriculture, water management, health care or disease prevention, than they need to be trained and supervised in a continuous way in order to provide a solid service on which the CBWs’ community can count. This knowledge, training and supervision can, apparently, not be generated from inside the community. The only solution to making such service delivery sustainable without outside interference, would be training people properly, i.e., instead of training several community members for two weeks on nutrition or HIV prevention, sending one of those community members to medical school. However, that would undermine the cost-effectiveness of CBW systems. Thus, the CBWs are highly depended on the facilitating agent to be able to function properly; which, in turn, highly determines the level of autonomy the CBWs have to shape their work.

The above is strongly related to *responsibility*: As community-members, CBWs ‘own’ their community problems as any other neighbour does. However, while they are expected to ‘own’ the solution as well, and are selected to perform certain tasks in improving the situation, in fact, they are dependent on outsiders. The facilitating agency, be that the government or a national or international NGO, are the real owners of solutions. They do not only make the decisions on how, when and where, but they literally own the funds, knowledge and equipment. Thus, while CBWs are perceived as responsible for improving certain aspects in the community, they are often the workers in exogenous development interventions. Chambers’ vision of the ideal situation in which “we” participate in

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“their” project’ instead of “they” in “ours”, has not materialised in any of the discussed case studies. That would only be possible if organisations for development would invest in existing community initiatives and if such agencies would answer to communities’ wishes and demands.

This lack of autonomy and responsibility, highly influences the CBWs *accountability*: Although CBWs are supposed to be accountable to the community, they are dependent on facilitating agencies, i.e., their accountability is divided. None of the case studies discussed the existence of a community-based entity that would supervise and direct CBWs. Nevertheless, some case studies suggested that CBWs who were well-embedded in community structures and institutions were more effective and sustainable than those who were not (Sivaram and Celentano 2003). The same case study indicated that when international funds were retracted, the project collapsed. Other case studies overwhelmingly suggest that CBW systems reflect existing power structures and are not necessarily ‘accountable’ to those persons who might need the support most. Delivering services to the most needy is supposed to be a central objective of CBW systems, but is not met as a result of wrong assumptions about the community. This lack of ‘community’ (as ideal-type of mutual support and solidarity) might be a major flaw of the ideas behind delivering improved access to services through community-based interventions.

If we would be more sceptical towards the ‘community’ as ideal for providing services because of the community’s ‘natural’ inclination for mutual support and solidarity, then we should, perhaps, question levels of *professionalisation*. Is the discussion of effective service delivery not highly dependent on the level of technical capability of the CBWs? Should these jobs not be carried out by people with a thorough education in health care, agriculture, judicial procedures, water management, and environmental issues before they are deployed as service deliverers for vast amounts of people in need of those services? To what extent would further professionalisation contribute to CBWs effectiveness without undermining the advantages of community-based service delivery?

This paper has indicated that we need to question the motivations of governments and NGOs for deploying community-based workers and if and how reality catches up with ideal types. Strategies of service delivery should be modified according to the realities of communities and not according to a global blueprint. In similar vein, it might be useful to further examine the motivations of individuals for participating in CBW systems and the interests that communities have in such projects. Motivations and interests that different stakeholders might have largely determine their mutual understanding, and thus the effectiveness of projects, but are often treated as trivial aspects in the design of development interventions. Issues such as autonomy, responsibility, and accountability should be further examined on micro, meso, and macro levels. In sum, the relationship between these three levels in community-driven development might be in need of revision, but to do so, we first need to enhance our understanding of the possibilities and constraints that dominate the current situation. The studies that are joined in this Working Paper Series are geared towards that goal.

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