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Retreat from Alma Ata? The WHO's report on task shifting to community health workers for AIDS care in poor countries

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Abstract
This paper examines the potential of community health worker (CHW) programmes, as proposed by the WHO's 2008 *Task shifting to tackle health worker shortages – Global recommendation and guidelines*, to contribute to HIV/AIDS prevention, care and treatment and the achievement of various Millennium Development Goals in low income countries. It examines the WHO proposal through the lens of a literature review of factors that have facilitated the success of previous experiences of shifting tasks from health workers to trained lay people. The WHO has taken account of five key lessons learned from past CHW programmes (the need for strong management, appropriate CHW selection, suitable training, adequate retention and incentive structures, and good relationships with other healthcare workers). It has, however, neglected to emphasise the importance of the 'community embeddedness' of health volunteers, found to be of critical importance to the success of many past CHW programs. We have no doubt that the WHO Plans will increase the number of workers able to perform medically oriented tasks. However, we argue that without community embeddedness CHWs will be unable to perform the socially oriented tasks assigned to them by the WHO, such as health education and counseling. We locate the WHO's neglect of community-embeddedness within the context of a broader global public health trend away from community-focused primary health care towards biomedically-focused selective health care.
Keywords: HIV/AIDS; Task shifting; community health workers; WHO; primary health care.

Introduction

This paper assesses the potential of community health worker (CHW) programs, as proposed by the WHO's 2008 *Task shifting to tackle health*

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worker shortages - Global recommendations and guidelines (herein called *Task Shifting*) to contribute to HIV/AIDS prevention, care and treatment and the achievement of several Millennium Development Goals in low income countries. Our analysis suggests that the WHO's proposal for CHW programs adequately takes into account five key lessons learned from past CHW programs: the need the need for strong management, appropriate CHW selection, suitable training, adequate retention and incentive structures, and good relationships with other healthcare workers. However, the WHO neglects to recommend a sixth factor that has been found to be of critical importance in previous CHW programmes: the need for community embeddedness. We suggest that rather than being an oversight, this omission represents the latest in a broader movement within the WHO and other global health initiatives away from community-focused primary health care to biomedically-focused selective health care. Furthermore we argue that this omission undermines the likelihood that CHWs will be able to achieve many of the goals laid out for them in the *Task Shifting* document.

This paper has four sections. First, we present some background information to place *Task Shifting* and CHW programs in context. Second, we outline the types of tasks that the document recommends should be shifted to CHWs, making a distinction between medically oriented tasks and socially oriented tasks. Third, we review the literature on past CHW programs to produce a systematic account of the types of supports that

CHWs will need in order to successfully implement these tasks, highlighting its neglect of the community level of analysis and action. We conclude with a discussion of why community embeddedness in CHW programs is necessary and how it can be fostered.

Background on WHO *Task Shifting* in International Policy

There is currently a severe global health worker shortage, with a deficit of more than four million people (WHO 2007). The problem has reached a critical level in many sub-Saharan African countries, as well as parts of Asia and the Americas (WHO 2006a). This lack of "human resources for health" (HRH) is significantly impeding progress towards the realization of the Millennium Development Goals to reduce child mortality (Goal 4), improve maternal health (Goal 5), and combat HIV and AIDS, malaria and other diseases (Goal 6) (WHO 2008c).

In 2006 the WHO proposed the *Treat, Train, Retain* (*TTR*) strategy to strengthen and expand health workforces in low income countries (WHO 2007). While *TTR* aims to address the HRH crisis for all health issues, it specifically addresses health worker shortages in the context of HIV/AIDS (WHO 2006b). It aims to better care for health workers who are infected with HIV or other illnesses (the "Treat" component), expand the health workforce by training new people and making more efficient use of health resources ("Train"), and retain current skilled staff through better

incentives, better work environments and preventing HIV transmission to health workers (“Retain”).

Task Shifting is the WHO’s policy to address the “Train” component of *TTR*. It proposes that some healthcare tasks be delegated to less specialized health workers who require shorter training periods. For instance, *Task Shifting* recommends that the prescription of anti-retroviral medication (ARVs) be delegated from physicians to nurses. This shift will free more of the physician’s time for dealing with severe and special illness cases in hospitals. It will also increase access to ARVs for people requiring antiretroviral therapy (ART) in rural areas with health centers staffed only by nurses. Some of the nurse’s tasks, such as health education and administering ARVs, can be further shifted to workers with less training. This shifting necessitates rapidly expanding the human resource pool through recruiting and training community members to serve as “community health workers” (CHWs). CHWs can act as one or more of the following: full- or part-time health workers, educators, nurse assistants, and lay councilors (WHO 2008a). Selecting HIV-positive people to act as lay councilors for HIV/TB treatment adherence has proven successful in several preliminary task shifting efforts (MSF 2007). The final “task shift” proposed is the delegation of some elements of disease management to patients themselves, for example training people living with HIV/AIDS (PLWHA) or people living with diabetes to self-manage their medication. WHO policy documents stress that task shifting

should not result in second-rate medical care, but can instead meet the demand for service while maintaining quality through an adequate regulatory framework, careful monitoring and high standards (WHO 2008b).

Task Shifting was first presented as a specific strategy for dealing with shortages in human resources for health (HRH) in the 2004 *Joint Learning Initiative* (JLI 2004) and the WHO's *Integrated Management of Adult and Adolescent Illness* (IMAI) (WHO 2004). By 2006, health worker shortages was the focus of the WHO's annual *World health report,* with task shifting playing a central role. In 2008 the first official WHO guidelines and recommendation publication was released, accompanied by the first conference on task shifting in Ababa (WHO 2008c).

Background on Community Health Worker Programs and the Alma Ata

The WHO's *Task Shifting* proposes a massive revival of state sponsored CHW programs. Engaging local, non-professional people from marginalized communities in the provision of health education and care for their peers first rose in popularity during the primary healthcare movement of the 1960s. The first CHW programs, which began in the mid 1950s, were China's barefoot doctors and Thailand's village health volunteers and communicators (Lehmann & Sanders 2007; Kauffman & Myers, 1997; Sringernyuang, Hongvivatana & Pradabmuk, 1995; Zhu *et al*., 1989).

Linked to the decolonialization and democratization movements of the time, CHW programs envisioned local people as agents of social change and community self-reliance (Lehmann, Friedman & Sanders 2004).

The WHO's 1978 Alma Ata Conference solidified primary healthcare as the central focus of health-related projects in the developing world, rejecting "medical elitism," emphasizing appropriate technology, the utilization of lay health workers, and community participation (Cueto 2004). Influential health theorists argued that transporting western, hospital-based, medically oriented and technocentric healthcare approaches to developing countries was failing to address the root causes of illness (such as John Bryant's *Health and the Developing World* (1969), Carl Taylor's *Doctors for the Villages* (1976) and Kenneth W. Newell's *Health by the People* (1975)).

As the political climate shifted towards neo-liberalism in the late-1980s and original attempts at CHW programs proved far more difficult than anticipated, CHW programs gradually fell from favour (Abbott 2005). CHW programs tended to have been planned hastily and implemented in a top-down fashion, failing to make any lasting improvement in health outcomes and failing to bring about permanent health-related behaviour change (Schneider, Hlophe & van Rensburg 2008). Originally envisioned as a means of involving local people in making decisions about their health needs and increasing community activism, CHW programs too often came to serve as undervalued and poorly resourced additions to the

existing health service (Schneider *et al*. 2008). By the end of the 1990s, most national CHW programs had been disbanded.

The CHW's tasks: socially oriented vs. medically oriented

The *Task Shifting* document details the WHO's 22 recommendations for the implementation of task shifting. These include fast-tracking amendments to national regulations to enable task shifting, instituting adequate incentives to minimize worker attrition, and suggesting which specific tasks can be shifted to which workers (WHO 2008a). Country specific programming is encouraged.

To guide countries that are considering implementing the *Task Shifting* recommendations, the WHO lists which tasks in the field of HIV treatment and management can be taken on by different health worker cadres (WHO 2008a). Categorized under 12 headings, such as Clinical Management of HIV and Palliative Care, 313 specific tasks are listed as essential for preventing the transmission of HIV, identifying HIV-positive patients, providing basic HIV clinical management, and initiating and maintaining ART. Of the 313 tasks, the WHO recommends that 115 can be preformed by CHW. Of these 115, 48 tasks are related to medical skills such as weighing, taking vital signs, filling out patient registries, determining whether a patient is pregnant and determining Hepatitis B vaccination status. The remaining 67 are more socially oriented, requiring CHWs to counsel, support, advise, educate or give information to patients

and other laypeople (WHO 2008a). These tasks relate both to HIV prevention and to improving HIV management through ART. The importance of having both hard, technical skills and soft, social skills has been emphasized in many studies relating to health care workers (Rotor 2000, Roter & Hall 1993, Carpiac-Claver & Levy-Storms 2007).

Medically oriented tasks are fundamentally different from socially oriented tasks; the former demand technical competence and adequate training in the use of instruments such as thermometers and scales; the later require rapport, trust, understanding and the ability to communicate effectively with the target group or individual. Medically oriented tasks focus on individuals and are performed in clinical environments where biomedical expertise reigns. In contrast, much socially oriented work, such as seeking to increase public awareness and change health related behaviours, takes place in communities.

Noting that CHWs have been assigned both types of task is important because it affects the types of supports that CHWs will need to perform successfully. In the case of CHW programs as envisioned by the WHO, successful CHW programs are those in which CHWs perform as ‘another pair of hands’ in clinics to help nurses and physicians perform medical tasks *and* perform as educators and health promoters in the community (WHO 2008a, Annex 1).

Conditions most likely to enhance the effectiveness of community health workers

Literature review overview

What does existing experience tell us about factors that will increase the likelihood of success of CHW programs? Over sixty years of CHW history offers *Task Shifting* a wealth of past experience to draw from when suggesting future policy. We conducted our literature review keyword searching “community health worker” + review for the years 1960 to 2008. The following additional terms of CHW were also used: lay health worker, lady health worker, family health worker, and indigenous health worker. The search was conducted in PubMed, supported by Google Scholar, which directed us to resources in the journal literature (e.g. Ovid, ProQuest, Wiley-Blackwell Interscience, ScienceDirect). We began by reviewing large-scale review articles of CHW programs for this report. Thereafter, where appropriate, we followed up articles detailing the experiences of specific CHW programs to provide specific examples of themes and commonalities highlighted by the large-scale reviews.

Eight reviews were found that amalgamated lessons learned and suggested key enabling features that can increase likelihood of CHW program success. These were reports by Gilson *et al*. (1989), Ofosu-Amaah (1983), Witmer *et al*. (1995), Bhattacharyya *et al*. (2001), Nemcek and Sabatier (2003), Lehmann, Friedman and Sanders (2004), Haines *et*

al. (2007), Gilroy & Winch (2005) and Lehmann and Sanders (2007). In addition, two large reviews evaluated the literature on CHW programs to determine their effectiveness: Lewin *et al*. (2005) and Swinder (2005). Our review of these documents, as well as twenty reports on specific CHW programs, has enabled us to compile a comprehensive account of the conditions that can improve the outcomes of CHW programs, variously measured by completion of program objectives, program sustainability, or impact on health care access, cost, and quality (Witmer *et al*. 1995).

In the following subsections we isolate the recommendations from these reviews and assess the *Task Shifting* document in relation to these recommendations. The subsections are: (1) strong management and supportive supervision; (2) appropriate selection; (3) suitable training; (4) adequate retention and incentive structures; (5) good relationship with other healthcare workers and (6) community embeddedness.

Strong management and supportive supervision

Strong management and supportive supervision were seen as central to the success of CHW programs (Haines *et al*. 2007; Bhattacharyya *et al*. 2001, Lehmann & Sanders 2007). Strong on-site management is vital to CHW programs because they are situated on the periphery of the health system and in underserved areas where program focus (Lehmann & Sanders 2007, Stinson *et al*., 1998). The physical and experiential distances between program administration (in the city, by the

central government) and implementation (in villages, by local people) can, without strong management and supervision, lead to ill-defined ownership and accountability (Lehmann & Sanders 2007, Stinson *et al*., 1998). Moreover, CHWs need strong supports because they receive only brief training and are equipped with a bare minimum of supplies (Gilson *et al*. 1989).

Most commonly, nurses take primary responsibility for CHW oversight, despite their lack of management training and already high workload (Nemcek & Sabatier 2002, Lehman, Friedman & Sanders 2004). Nurses often respond to this unwelcome burden by transforming CHWs into nurse assistants, removing them from their original role in the community and placing them in the clinic (Gilson *et al*. 1989). Foisting program management onto an unequipped party can lead to frustration for all involved, lower quality service delivery, power struggles and high attrition rates.

How does *Task Shifting* address the need for strong, consistent, supportive management? The document clearly recognizes the complexities and challenges of assigning supervision roles to medical professionals, stressing that supervisors should be competent and have supervisory skills (Recommendation 11, WHO 2008a, p. 31) They suggest that proper supervision may even require hiring extra workers specifically to assume supervisory responsibilities (WHO 2008a, p.32).

Appropriate selection

Several reviews cite appropriate CHW selection as a key enabling condition (Ofosu-Amaah 1983, Witmer *et al*. 1995; Bhattacharyya *et al*. 2001, Lehmann & Sanders 2007). CHWs must be people who are already trusted members of the community (Nemcek and Sabatier 2003), who plan to stay in the community (Robinson & Larsen 1990) and who reflect the linguistic and cultural diversity of the population served (Witmer *et al*.1995). Selecting workers who are not trusted and respected by the community, who misunderstand their role or have unrealistic expectations leads to high attrition rates, poor worker performance, and low community engagement with the program (Bhattacharyya *et al*. 2001; Nemcek and Sabatier 2003; Witmer *et al*. 1995).

The process of finding such a CHW is challenging. While most programs state that CHWs should be selected by the community, in practice they tend to be selected at least in part by health personnel (Gilson *et al*. 1989; Schneider, Hlophe, & van Rensburg 2008). Local people may have limited time and resources to devote to CHW selection and local politics and tradition may lead to the selection of higher status but inappropriate CHWs (Haines *et al*. 2007). These problems led one reviewer to suggest that a balance must be struck between community selection and input from outside administrators (Ofosu-Amaah 1983 in Lehmann and Sanders 2007). Other reviews maintain that despite the difficulties, community selection must remains central to the success of

programs (Bhattacharyya *et al*. 2001; Lehmann, Friedman & Sanders 2004).

Task Shifting does not specifically address the selection of CHWs. Nonetheless, under recommendation 8 on the creation of well-defined roles and competency levels for each cadre of health worker, they do direct readers to the large body of literature on CHW selection and recruitment (p. 27). More attention needs to be paid to finding an effective and realistic CHW selection method.

Suitable training

The duration, location and style of CHW training varies greatly across programs (Lehmann & Sanders 2007) making it difficult to identify specific characteristics of training that are known to increase the likelihood of CHW success. Nonetheless, there is strong support for the implementation of ongoing training that includes multiple refresher and advancement sessions throughout the program's duration (Ashwell & Freeman, 1995; Ande, Oladepo & Brieger, 2004; Lehmann, Friedman & Sanders 2004). Skills-based competency training (Gilroy & Winch 2006) has become more popular in the last decade, whereas training that focused on the more abstract aspects of health and wellness used to be more prevalent (Gilson *et al*. 1989). This shift could suggest that such technical training has been found to increase the likelihood of success;

UNICEF in particular is a strong advocate of skills based competency training (Gilroy & Winch 2006).

CHWs are most likely to succeed when training includes both the medical, technical elements of health and the study of environmental, psychological, economic, cultural and social factors that affect health (Lehmann, Friedman & Sanders 2004; Gilson *et al*. 1989; Bhattacheryya *et al*. 2001; Lehmann & Sanders 2007). Training must equip CHWs to function effectively within their communities, rather than prioritizing technical training over socially oriented training. Lehmann, Friedman & Sanders (2004) also suggest that training should use adult education methods such as being experiential, learner-centred and problem-oriented.

It is difficult to navigate seemingly contradictory lessons about CHW training from reviews of past programs. On one hand, CHW training is supposed to equip the worker to identify social causes of ill health and think about addressing them at the community level (Gilson *et al.*, 1989). Training CHWs to facilitate communities to define and solve their own problems rather than provide information on health problems has been very successful in some interventions (Rifkin, *et al*. *forthcoming*). On the other hand, CHWs have been found to appreciate specialized, clearly defined tasks (Mullan & Frehywot 2007; Dovlo 2004). Attaining proficiency at only a few specific skills requires competency-based, logistical training rather than open dialogue about the community environment. Attempting

to impart specific medical skills and knowledge to CHWs along side discussion of the environmental factors contributing to ill health will require more time and effort. If both are attempted hastily, CHWs may be confused about their role and lack the competency to perform biomedical services and give advice.

Task Shifting has chosen to emphasize nationally standardized, competency-based training (p. 28). This decision recognizes the importance of consistence and quality assurance through accreditation. Unfortunately, such training preemptively stifles the potential of CHWs to perform anything but technical services. Simply training CHWs to be 'another pair of hands' in the sorely deficient health sector would be laudable were this to be the CHW's only task. However, CHWs are expected to perform tasks that extend far beyond biomedical services. They have also been designated educators and counselors. For these tasks, CHWs will require holistic, environmentally sensitive training. This point is taken up below.

Adequate retention and incentive structures

Retaining CHWs once they have been trained will greatly increase the likelihood of CHW program success. Attrition rates of CHWs range from 3.2 to 77 percent and present a major problem for CHW programs (Bhattacharyya *et al*. 2001). It is costly to train new workers, reduces the likelihood of building relationships between workers and communities, and

stunts opportunities to build an experienced worker base. While salaries are the most obvious tool to help retain workers, other incentive structures have proven effective as well, especially when salaries are low and irregular. Bhattacheryya *et al*. emphasizes the potential of non-monetary incentives and cautions that paying workers "often bring[s] a host of problems" because salaries are often unsustainable and can create conflicts between different cadres of workers (2001, p. 35).

Worker recognition (though uniforms, certificates and badges), opportunity for career advancement, supportive supervision and an enjoyable work experience can all encourage CHWs to stay on the job. Clearly defined tasks and a manageable work load increases CHW job satisfaction (Mullan & Frehywot 2007; Dovlo 2004). Moreover, CHW programs have stronger retention if CHWs gain higher social status in the community through their positions, by performing a valued, prestigious role and making useful social contacts. For example, Hadley & Maher (2000) found that enabling CHWs to play a curative role in the community, rather than just a prevention and education role, increases the CHW's ability to provide what the community wants and thereby increase her reputation. However, it must be stressed that for large scale CHW programs taking on extensive public health tasks, building a health workforce on volunteers is unfair to both the workers and service users and unsustainable (Miles, *et al*. 2007; Campbell, Gibbs, Maimaine, & Nair 2008).

Task Shifting has paid close attention to the necessity of proper remuneration. Under recommendation 14 the report recognizes that while volunteers can make a large contribution to national health services, trained health workers providing essential health services must be paid and/or compensated adequately through additional incentives (WHO 2008, p. 35) Recognizing the importance of proper remuneration will go a long way towards reducing attrition and maintaining a highly motivated workforce. However, payment will likely be low, considering that *Task Shifting* is aimed towards low income countries. Therefore, it is valuable to take into account the role that additional incentives can play in retaining CHWs. Developing programs that are well managed and supported will go a long way towards keeping CHW moral and commitment high. Bhattacheryya *et al* (2001) suggest that such non-monetary incentives may in fact be superior to payment in situations where salaries are not reliable and adequate.

Good relationship with other healthcare workers

Regular contact with other members of the healthcare system that is characterized by respect increases the likelihood of CHW program success (Haines *et al*. 2007, Gilson *et al*. 1989, Lehmann, Friedman & Sanders 2004). While closely linked to supportive supervision, CHW programs thrive when workers have a good relationship with other members of the healthcare system. Physicians, nurses and administrators

must be encouraged and taught to interact with CHWs in a way that acknowledges the CHW's specific skills, experience, value and potential (Schneider, Hlophe & van Rensburg 2008). Hierarchical and paternalistic relationships between professionals and CHWs reduce the likelihood of CHW retention and stunt opportunities for the health care system to accommodate the unique, hands on knowledge of CHWs (Lehmann, Friedman & Sanders 2004; Haines *et al* 2007).

Task Shifting notes the importance of training medical professionals on how to best work with CHWs, emphasizing respect and communication. They suggest that new supervisors receive training on management skills and communication and mentoring skills (WHO 2008a, p. 32).

Community embeddedness

The condition for CHW program success that is emphasized most strongly in the literature is the need for CHWs to have a strong relationship with the community (Gilroy & Winch 2005; Mathews, van der Walt & Barron, 1994; Quillian, 1993, Gilson *et al*. 1989; Haines *et al*. 2007; Nemcek & Sabatier 2000, Bhattacharyya *et al*. 2001; Lehmann & Sanders 2007). Bhattacharyya *et al*. (2001, p 36) state concisely:

> In the end, the effectiveness of a CHW comes down to his or her relationship with the

> community. Programs must do everything they can to strengthen and support this relationship.

This strong relationship, termed community embeddedness (Schenider, Hlophe & van Rensburg 2008), is important for several reasons. Evidence suggests that programs managed and developed by communities, often with assistance from religious groups or NGOs, more easily address local perceived needs and interests than those developed by outsiders (Nemcek & Sabatier 2002, Lehmann & Sanders 2004, Kaithanthara 1990, Sundararaman 2007). CHWs will be better able to perform socially oriented tasks if they have the respect in the community and are considered a member of the community (Bhattacharyya *et al*. 2001). Socially oriented tasks, such as health education and behaviour change promotion, demand that health workers understand marginalized people and are understood by them; this communication comes naturally to CHWs since they are themselves members of the community. The daily functioning of CHWs will be easier if those they work with (i.e. community members) support them and have realistic expectations about what they can do (Gilroy & Winch 2005). The attrition rates will be lower if CHWs are valued by the community and gain higher social standing through their work (Gilson *et al*. 1989, Bhattacharyya *et al*. 2001; Lehmann & Sanders 2007)

However, communities are not homogonous and the underserved communities where CHWs programs tend to be implemented are no exception (Bhattaracharyya *et al*. 2001). They will have complex power dynamics and systems of oppression that tend to make the most marginalized people least likely to become involved in CHW programs (*ibid*). Working with existing community groups can guard against CHWs being used as pawns by elite community members (Bhattaracharyya *et al*. 2001*,* Gilroy & Winch 2005, Haines *et al*. 2007).

Community embeddedness can be fostered through a number of measures. Primary among them is community participation, which means involving local people in CHW selection, program goal setting and program management (Haines *et al*. 2007, Lehmann, Friedman & Sanders 2004, Gilroy & Winch 2005, Bhattaracharyya *et al*. 2001). It is also important to insure that CHWs have high standing in community through visible measures such as government recognition, uniforms, badges and drug kits (Haines *et al*. 2007, Gilroy & Winch 2005, Bhattacharyya *et al*. 2001). Community embeddedness can also be fostered through community recognition of CHWs and ensuring that CHW remain close enough to the community to be considered one of them (Schneider, Hlophe & van Rensburg 2008). Fostering local support from institutions already embedded in the community such as local youth groups or churches can increase community support for CHW programs (Gilroy & Winch 2005, Haines *et al*. 2007, Bhattacharyya *et al*. 2001). It is also

important for CHW programs to strike the right balance between government regulation and community control (Haines *et al*. 2007, Schneider, Hlophe & van Rensburg 2008).

How does *Task Shifting* address the necessity for community embeddedness? The literature and guidelines in *Task Shifting* tend to focus on the technical considerations of implementing CHW programs such as training timelines, role delineation, payment structures, credentialing, and supervision hierarchies (Zuniga 2006, Pillay & Mahlati 2008; Samb *et al*. 2007, WHO 2008a). In its current state, there is no mention of how CHW programs will be community-specific and relevant. In fact, there is no mention of community participation in *Task Shifting* at all, aside from a passing reference in the section on wages to a Brazilian family health program that used this technique (WHO 2008a, p. 36).

The only other mention of participation specifically avoids involving the general community in which CHWs live. *Task Shifting* suggests only that PLWHA should be able to participate in discussions on changing national regulations on health workers rights. Communities as a whole, despite the role they play in supporting or rejecting CHW programs (Bhattacharyya *et al* 2001; Lehmann & Sanders 2007; Schneider, Hlophe & van Rensburg 2008) are excluded from consideration.

The report does suggest that ‘stakeholders’ be consulted and that community sensitization and education is necessary (p.16). According to *Task Shifting*, stakeholders include “people living with HIV/AIDS” (p. 3)

and “government representatives from HIV programmes and human resources for health departments from health ministries (including from countries that have experience of implementing a task shifting approach); United Nations agencies; donors; health workforce representatives including professional associations and unions; academic institutions; civil society organizations and representatives of people living with HIV/AIDS” (p. 9). It appears that the communities from which CHWs are recruited, and who are the targets of much of the CHWs health education and HIV prevention work, are not considered stakeholders.

According to *Task Shifting*, the aim of community sensitization is to convince local people to support task shifting policies in the form that the national government has chosen. There is no mention of consulting communities to increase community embeddedness, for example through having community members help structure and control the program.

Country-specific programming is encouraged by the WHO through suggesting that countries adapt *Task Shifting* to meet their needs and circumstances. Community-specific programming is not explicitly encouraged. However, *Task Shifting* does recommend that countries gather information on the extent to which task shifting is already taking place in different regions. This internal research will likely encourage central governments to recognize and bolster regionally developed HIV responses. However, states will likely find it difficult to balance the creation

of “a nationally endorsed framework that can ensure harmonization” with community-specific programming (WHO 2008, p. 3).

Tracing the trajectory of community embeddedness

By failing to emphasize the importance of community embeddedness, *Task Shifting* implicitly encourages the implementation of CHW programs with medically competent CHWs who may be unable to perform their designated socially oriented tasks. Our literature review suggests that without a community focus the likelihood of CHW program success (i.e. CHW competence at both medically and socially oriented tasks) is severely reduced.

The report’s neglect of community embeddedness speaks directly to the broader change in the WHO’s approach to primary health care in low income countries. Between the late 1960s and early 1980s the WHO developed a strong record of supporting community health initiatives and encouraging the devolution of power from medical professionals to marginalized people. In 1978, the WHO and UNICEF put forward the Alma Ata Declaration, which recognized the link between improved global health, primary healthcare, participation and community empowerment (Croetz 2004).

Community embeddedness (especially through community participation) was considered vital to ensure projects were supported on the ground, were responsive to the perceived needs of local people, and

would be sustainable (Croetz 2004). Moreover, it was argued that people would change their health compromising behaviours if they were involved in exploring the consequences of these behaviours (Rifkin 1996). Through participation, marginalized people would gain the skills, confidence and resources necessary to gain control over their own lives and challenge the structures that oppressed them (Rifkin 1996).

In its Technical Report Series document on CHWs in 1989, the WHO enshrined its support for community embeddedness and control in its definition of the CHW:

> Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.

The WHO advocated that community participation be meaningful by pushing for increased citizen control over decisions and resources.

However, by the end of the 1990s the WHO had undergone a fundamental shift in focus. The organization moved from the Alma Ata

approach, which emphasized comprehensive primary health care, socially oriented CHW programs and community participation to selective primary health care which prioritized targeted, technical solutions and the promotion of biomedical expertise (Grodos and De Bethune 1988, Rifkin & Walt 1986, Peterson & Swartz 2002, Litsios 2002, Lawn *et al*. 2008).

Now, in 2008, it appears the WHO continues to prioritize a technical, biomedical approach to health. One can scour *Task Shifting* and find no meaningful discussion of community embeddedness or participation. A prime example of this retreat from Alma Ata is the Task Sharing document's definition of CHWs (compared to the WHO's 1989 definition). They now state that a CHW is:

> A health worker who has received training that is outside the nursing and midwifery medical curricula but is, nevertheless, standardized and nationally endorsed. This category can include health workers with a range of different roles and competencies and those that are providing essential services in a health facility, or in the community as part of, or linked to, a health team at a facility (WHO 2008a, p. 79).

CHWs are now only discussed in terms of their shorter training times and linkages to the health system. There is no mention of community involvement in their selection and accountability.

Consultation is the closest the WHO gets to mentioning community embeddedness in *Task Shifting*. It is largely presented as a tool to bring locals on-side with pre-determined program goals and structures. Under recommendation 2, which encourages consultation with stakeholders, the WHO suggests:

> Community sensitization and education of service users will also be needed to help task shifting find acceptance among people living with HIV/AIDS and others with common unmet health-care needs, the health workforce and the general public (WHO 2008a, p. 16).

Community members are presented as passive objects of the health sector. They are to be engaged with only to encourage their acceptance of the expert-driven task shifting agenda. There is no space for the “general public” (notably not called the community) to control any element of task shifting. The only option is to accept.

Where does the debate between comprehensive and selective primary health care stand now, in early 2009? It seems there are two

schools of thought: one which has moved away from the complicated, politicized Alma Ata goals with a return to seeing health as a technical issue and another that seeks to hold on to the early emphasis on community and social change.

We posit that health problems underscored by socially determined factors (such as behaviour, stigma, and attitudes), cannot be addressed solely by technical solutions. Socially oriented tasks such as promoting behaviour change, discussing stigma, and education about health are vital. Programs with the conditions in place to increase CHWs' ability to perform socially oriented tasks will play a greater role in illness prevention, community mobilization and social change than programs emphasizing technical solutions. CHW programs arising from *Task Shifting* will be unlikely to address the social components of health.

Many might argue that in light of the desperate state of healthcare in developing countries coping with HIV/AIDS, a program that simply implements medical solutions is sufficient. One might further argue that setting up the community embeddedness necessary for CHWs to perform their socially oriented tasks is too difficult and resource intensive to concern the WHO at this stage of the HIV epidemic. In response to these contentions, we suggest that CHW interventions without the ability for CHWs to perform socially oriented tasks focus will be ineffective in preventing future infection with HIV. Without behaviour change promotion

through socially oriented work such as discussion, stigma reduction and education, HIV will continue to spread.

While it is crucial to expand the health work force by training new, technically competent workers, *Task Shifting* preemptively and unnecessarily limits itself by taking failing to encourage the community embeddedness necessary to support CHWs at their socially oriented tasks. The WHO's *Task Shifting* focuses on the short term approach to tackling HIV, specifically through the provision of medical care.

Conclusion

This paper has critically evaluated the WHO's 2008 *Task Shifting* against two standards: First, how well does it account for lessons learned from past CHW programs? And second, how far can CWH programs, as envisioned by *Task Shifting*, go towards addressing the HIV epidemic in low income countries? We have argued that the WHO has drafted a proposal for CHW programs that, while accounting for some lessons from the past, overlooks a fundamental one. *Task Shifting* has not accounted for the importance of community embeddedness, despite it being most frequently cited as the most important determinant of program success.

Strategies outlined by *Task Shifting* will go far towards meeting the medical goals of the WHO report. However the WHO has also assigned CHW a large number of socially oriented goals, such as community based HIV education. Without greater community embeddedness, the ability of

CHWs to tackle the social goals will be considerably limited. If the WHO is serious about these social goals, then they need to pay much greater attention the challenge of involving communities.

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