Abstract

Title: Limits and Opportunities to Community Health Worker Empowerment: A multi-country comparative study.

Background: In LMICs, Community Health Workers (CHW) increasingly play health promotion related roles involving 'Empowerment of communities'. To be able to empower the communities they serve, we argue, it is essential that CHWs themselves be, and feel, empowered. We present here a critique of how diverse national CHW programs affect CHW's empowerment experience.

Methods: We present an analysis of findings from a systematic review of literature on CHW programs in LMICs and 6 country case studies (Bangladesh, Ethiopia, Indonesia, Kenya, Malawi, Mozambique). Lee & Koh's analytical framework (4 dimensions of empowerment: meaningfulness, competence, self-determination and impact), is used.

Results: CHW programs empower CHWs by providing CHWs, access to privileged medical knowledge, linking CHWs to the formal health system, and providing them an opportunity to do meaningful and impactful work. However, these empowering influences are constantly frustrated by - the sense of lack/absence of control over one's work environment, and the feelings of being unsupported, unappreciated, and undervalued. CHWs expressed feelings of powerlessness, and frustrations about how organisational processual and relational arrangements hindered them from achieving the desired impact.

Conclusions: While increasingly the onus is on CHWs and CHW programs to solve the problem of health access, attention should be given to the experiences of CHWs themselves. CHW programs need to move beyond an instrumentalist approach to CHWs, and take a developmental and empowerment perspective when engaging with CHWs. CHW programs should systematically identify disempowering organisational arrangements and take steps to remedy these. Doing so will not only improve CHW

performance, it will pave the way for CHWs to meet their potential as agents of social change, beyond perhaps their role as health promoters.

Keywords: Community Health Workers; Empowerment; Performance; Agents of social change

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Introduction

Community health workers (CHWs) are well established as major actors in promoting healthy behaviours and extending the reach of health systems in low and middle income countries (LMICs). CHWs are well positioned to deliver promotive, preventive and some curative health services to communities while working in partnership with other frontline health workers (1,2,3). This becomes particularly relevant given the massive shortage of health workers in LMICs, estimated by World Health Organisation at around 4.25 million workers (4), the inequitable distribution of health workers within countries, and the need to accelerate progress in working towards universal health coverage (UHC) and the achievement of the proposed sustainable development goals for beyond 2015 (5). According to Perry et al (1), more than 5 million CHWs are active globally and recent reviews of evidence on the subject point to both the effectiveness and importance of CHWs in providing services to communities (6,7,8).

Community health workers, in many countries, hail from modest social, economic, educational backgrounds, and are often women (9,10,11). In most LMICs CHWs are the lowest level cadre of health workers and they constitute a diverse group of health workers who work primarily outside of health facilities, and close to the communities they serve (2, 6, 8). In LMIC settings, CHW provide a wide range of services, ranging from provision of safe delivery, counselling on breast-feeding, management of uncomplicated childhood illnesses, health education and promotion on malaria, TB, HIV/AIDs, STDs and NCDs, facilitating access to services, and at places also supporting rehabilitation services (2, 6, 8). Similarly CHWs' roles vary across countries - extension worker, a health promotor and educator, a facilitator, community mobiliser, first line care provider, and sometimes counsellor and advisor. Irrespective of the LMIC context,

a common feature is the centrality of 'health promotion' related activities in CHW's work. Labonte & Laverack (p 29) define health promotion as "an empowering practice aimed at social change" (12). According to Rootman et al (p 530), the core of health promotion practice is "empowerment: enhancing capacities of individuals and communities to exercise control over the determinants of health" (13). Indeed, as the recent systematic review of the global experience of CHWs shows, 'empowerment of communities' is a notion that is well established in CHW policies and programs globally, and many, if not all CHW programs have an explicit or implicit commitment to the 'empowerment of beneficiary communities' (2).

For CHWs to be able to function as health promotion practitioners, and to be able to empower the citizens and communities they serve, we argue, it is essential that they themselves be, and feel, empowered. Tulenko et al (p 847) concur and contend that "In moving towards UHC, much can be gained by investing in building CHWs' skills and supporting them as valued members of the health team" (14). Few have explored the subject of empowerment of CHWs (15,16); this study aims to contribute to this body of knowledge. We examine the 'empowerment experience' of CHWs as part of the REACHOUT study which is being conducted in Ethiopia, Malawi, Mozambique, Kenya, Bangladesh and Indonesia; we critically analyse what facilitates or hinders this experience.

Methodology

Two complementary perspectives have been used to study and understand employee/worker empowerment: the social-structural perspective and the psychological perspective. The 'social-structural perspective' emphasizes the importance of social, economic, political and organizational structures and arrangements and how they affect or condition the employee's state of empowerment

(or powerlessness). It refers to policies, practices and relations that involve sharing decision-making power between managers and workers (17, 18). In the 'psychological perspective' the emphasis is on employee's perceptions and experiences, on the employee's perceptions and beliefs of power, competence, control and self-efficacy (19,20,21). The psychological perspective thus builds on the social-structural perspective and conceptualises the social-structural arrangements as powers that shape the individual's experience of empowerment. Lee & Koh (21), drawing upon Thomas & Velthouse's (19) original work, use this understanding as the basis to define employee empowerment as "the psychological state of a subordinate perceiving four dimensions of meaningfulness, competence, impact, and self-determination, which are affected by empowering behaviours of the supervisor (and other structures)".

According to them 'meaningfulness' refers to the meaning ascribed to, or the value of a task goal or purpose, judged in relation to an individual's own ideals or standards. 'Competence' is an individual's belief in his/her capability to perform activities skilfully. 'Impact' refers to the perception of the degree to which an individual thinks he/she can influence certain outcomes at work. Thomas & Velthouse (19) originally used the term 'choice' in preference over 'self-determination' and this referred to whether a person perceived his/her behaviour as being self-determined, and of his/her own choice – we also choose to use the term 'choice' for the purpose of this study. We do so with the understanding that the locus of causality can be either invested in the person or be in the external environment.

Using Lee & Koh's (21) conceptual framework we analyse how program design and implementation processes, in different LMIC contexts, facilitate or constrain the empowerment experience of CHWs. Literature from organizational and management studies shows the benefits of empowerment of workers to the organizations they work

for and for workers themselves (22,23,24). We reflect upon the limits of and opportunities for improving CHW programs so that CHWs are empowered, perform better, are enabled to serve and empower their communities, better.

Our analysis is based on findings from Phase 1 of the five year REACHOUT project which explores factors influencing the performance of CHWs globally, and in Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique, in particular. The REACHOUT study scope is broader than just CHWs; as the study participants are a wide range of care providers, all with one common characteristic – their proximity to the communities they serve. Phase 1 of the REACHOUT project involved a review of the international literature on the subject (150 studies and 46 reviews) (6), six reviews of country level literature on the subject in the REACHOUT countries, and, six country level qualitative context analysis that explored a range of CHW related issues. These literature reviews and qualitative studies were done over 2013-2014. Phase 2 is currently ongoing and involves action research cycles to test interventions developed based on findings from Phase 1. Overall ethical approval was received from Ethics Committees at KIT Royal Tropical Institute, Amsterdam; country level approvals were received from Ethics Committees in each of the six study countries.

Based on the reviews of literature, including of different frameworks examining the performance of a variety of close to community care providers, a common conceptual framework (6) was developed to guide the six country level qualitative context analyses. The framework formed the basis of common topic guides for in-depth interviews and focus group discussions (FGDs); it provided a shared frame for the six country teams to explore factors that enabled or hindered the performance of CHWs. Together the six country level qualitative context analysis involved 250 interviews and 65 FGDs; hereafter we collectively refer to these as REACHOUT country case studies

(25, 26, 27, 28, 29, 30). The respondents, across the six study countries, included: CHWs, CHW supervisors, healthcare service managers, formal care providers, citizens – men and women. Details of sampling and recruitment are summarised in Table 1 and are presented in detail in the six REACHOUT country case study reports.

Table 1. Interviews and focus group discussions conducted per country, by informant type

	Ethiopia	Kenya	Malawi	Mozambique	Bangladesh	Indonesia
CHWs						
FGDs	HEWs - 6	CHWs - 6	HSAs - 3			Village Midwives and Village Nurse - 3
SSIs	HEWs - 12		HSAs - 8	APEs - 18	Formal CTCPs - 8 Informal CTCPs - 16	Village Midwife & Village Nurse - 44
CHW supervisors, managers, key informants						
SSIs	Kebele administrator - 3 Health centre in charge - 3 delivery case team leaders - 3 HEP coordinators - 3 Regional HEP coordinator - 1 Zonal HEP coordinator - 1	CHEWs - 16 SCHMT members - 3 Facility in-charges - 4 National level policy makers - 4	District level staff - 13 health centre in charges - 2 NGO staff - 9	Health facility supervisors - 3 District supervisors - 2	Paramedic -2, Clinic Manger -2, Counsellor - 2, Nurse - 1, Program officer - 1	Head of PHC or Puskesmas - 4 Midwife coordinator - 2 Head of district MCH section - 2
Community members						
FGDs	Women - 6 Men - 2	Community members - 4	Women - 7 Volunteers - 6	Mothers - 8	Married women - 8, Married men-4	Men - 2
SSIs	Mothers - 12 TBAs - 6	Community members - 10	Mothers - 1 TBAs - 6 Traditional leaders - 3 Volunteers - 2	Community leaders - 6		Mothers - 39 TBAs - 8 Head of village & head of PKK - 17

APE = Agentes Polivalentes Elementares; CHEW = community health extension worker; CHW = community health worker; FGD = focus group discussion; HEP = health extension programme; HEW = health extension worker; HSA = health surveillance assistant; SSI = semi-structured interview; NGO = non-governmental organization; SCHMT = sub-county health management team; TBA = traditional birth attendant; CTCP= close –to- community providers, FWV = family welfare volunteer; FWA= family welfare assistant; TTBA= trained traditional birth attendance; TBA = traditional birth attendance; PKK = Refers to the 'family welfare movement' – an Indonesian women's organization; Kader = Village Health Volunteer in Indonesia; Puskesmas = sub-district community health centre.

The data gathered during Phase 1 was interrogated from a variety of perspectives, including, as is the case in this paper, a human resource management and worker

empowerment perspective. For this paper, we initially analysed the six country case study reports; to further clarify and elucidate the themes that emerged from this initial analysis, we ran queries on the primary data (in the NVivo 10 files).

Findings

This section presents an analysis of how, in the six REACHOUT study countries, program design choices and implementation processes, facilitated or constrained CHW's experience of the four dimensions of employee empowerment: meaningfulness, competence, choice and impact.

CHWs views on the 'meaningfulness' of their work

'Meaningfulness' refers to the meaning ascribed to or the value of a task goal or purpose judged in relation to an individual's own ideals or standards. This refers to a congruence between the work, the role and an individual's beliefs, values and behaviors. Both, the literature (7, 8, 31, 32, 33, 34, 35) and the six REACHOUT country case studies (25-30) point out that some form of meaning in their work is a dominant source of feelings of empowerment for CHWs across the world. What is 'meaningful', and what makes it 'meaningful' is derived from of a variety of things – and relates to a combination of the nature of work that CHWs do, the roles that they are now ascribed, the tasks that their society privileges, past personal experiences, and religion.

As the following quotes from CHWs in Indonesia, Kenya, Malawi, illustrate, CHWs feel empowered as a result of them being viewed and identified by their communities, as being associated with the formal medical and health system, a highly privileged professional system in these countries, and generally across the world.

"If you're a midwife, it looks good. I like seeing people using white clothes. It's nice, cool..." (Indonesia Case Study – Community Midwife)

"It motivates you … even the households will see you and say "my doctor is here" they start calling you doctor" (Kenya Case Study - CHW)

" *… the uniforms we wear are our identity. People in the village or at the clinic identify us easily because of the uniform …* "(Malawi Case Study - CHW)

Similarly, being able to serve their communities, in times of their need and being appreciated for it, was something that CHWs attached great importance and meaning to; as the quotes from Kenya and Indonesia illustrate, being a CHW - the tasks and roles it entails, allows them to fulfil their dreams, and their 'calling'. :

"[I] saw that it was a 'calling' and I accepted and I was once helped and I want to return the favor" (Kenya Case Study - CHW)

"Since in primary school I always have a dream to help people. So I became a midwife. I like to serve the people around me." (Indonesia Case Study – Village Midwife)

For many CHWs, the opportunity to make a difference to the lives of their people, including through saving lives, the gratitude they receive for doing so, and being trusted, gives value and meaning to their work - makes their work, as this CHW from Ethiopia says, "great".

"When I see the result I feel happy, and the community also thanks us after we saved their life: health extension workers are doing a great job. Health extension work is great …." (Ethiopia Case Study - CHW)

"From my job, I feel happy by attending delivery. They trust us and we are attending delivery at day as well as night. In addition, they are using vaccination; they are giving birth with space." (Ethiopia Case Study - CHW)

For some, working as a CHW allows opportunities to channel their values and beliefs into concrete actions. For many, as these CHWs from Mozambique and Bangladesh say, this work allows them to achieve in its fullness, what Lee & Koh (21) define as meaningfulness "congruence between the requirements of a work role and an individual's beliefs, values and behaviours".

".. it is our duty to motivate a newly married girl to take a method (family planning) and show the right path …" (Bangladesh Case Study - CHW)

*"Working for health is equal to a pastor who works for God, works for the people and for God, is a complete work. ... It is not because of the money that people go to work in health." (*Mozambique Case Study – *CHW)*

These findings mirror our experiences in this field generally; that for most CHWs, the work they do also carries a deeper meaning; for many it is an opportunity for self-actualization, for some a means to reify their faith and humanity, and for others a means to even define their identities.

The power of newly gained 'competence'

Competence refers to an individual's belief in his/her capability to perform task activities skilfully (21). This refers to agency, beliefs, personal enactive mastery of tasks or self-efficacy (21). Our analysis of the literature revealed that almost all CHW program designs involve competence-based training of CHWs on specific tasks targeted at specific situations, supplemented by practice sessions and on-job mentoring (6,9,32,36). The literature shows that CHWs universally value these, and often express desires to gain more knowledge and skills (6,9,32,36). This, as illustrated by the quotes below, together with the difference that CHWS can make in wielding this knowledge and skills, and the consequent meaning it adds to their lives, makes these newly gained competencies an important driver of the empowerment experience for the CHWs.

"This [training] has really helped [me make] my community be healthy and free of disease" (Kenya Case Study - CHW)

"It would be good to give us more training courses and increase the medicines. Giving us new skills to treat other diseases, because there are things that is missing here in the community…" (Mozambique Case Study - CHW)

In our analysis we recognised Kane et al's (32) conclusions on the matter - the knowledge based training aspects of CHW programmes provide access to new, specialised, and socially privileged knowledge, and thereby trigger a sense of self-efficacy amongst CHWs.These findings are also consistent with recent empirical work by Nandi & Schneider (38), Bhatia (11), Ingram et al (39), and Becker et al (40). It is however worth noting that the knowledge and competence that CHWs value the most tend to be related to curative tasks. The next section also shows how it is through the

application of curative knowledge and competencies CHWs are able to see a clear impact of their work, and feel empowered.

Clear and present 'impact' of their work

Impact refers to the perceptions of the degree to which an individual can influence strategic, administrative or operating outcomes at work (21). The literature consistently points out that CHWs across the board believe that they make a major impact on the lives of the people in their communities, through helping protect the health of their people, through supporting their people to make right and healthy decisions, and through saving lives, (6, 8, 31, 32, 33).

As the following quotes highlight, being able to serve their people in their time of need, and particularly being able to help save lives, gives CHWs a sense of doing impactful work.

"The most interesting thing is saving the life of women and children. I feel happy when one mother calls me at her delivery. Previously, I was attending delivery at their home, now I am attending in the health post since the bed is available…." (Ethiopia Case Study - CHW)

*"The village clinics are also helping children a lot, when the get sick, they easily access drugs and we have helped in saving a number of lives for these children."(*Kenya Case Study – CHW)

"I do work with Mai Khanda in so many programs. For example, the safe motherhood programme …this group do some follow ups on pregnant women. To ensure that

pregnant women attend antenatal and that pregnant women give birth at the hospital to save the life of the mother and the baby." (Malawi Case Study – CHW)

Some CHWs saw themselves as making an impact in terms of being able to guide their people to make the right decisions through sharing their newly acquired knowledge; others, as the quote from a CHW in Malawi illustrates, saw the impact of their work at an even higher level – as a contribution to building a healthier, better society.

"*I feel happy because, first, I have so many friends, so much knowledge. …I didn't know about immunization, I didn't know about BCG. Now, I know about that … I have more knowledge, so I share my experience with friends, give them advice …"* (Indonesia Case Study – Village Midwife)

"The work of an HSA has been my desired job ... I was interested to help the children who are being born, the expectant mothers, all the women and the under-five to have a healthy life. We have to give the services to these people, because they are the leaders of tomorrow. If these people cannot have better services then this country will not be good in future" (Malawi Case Study - CHW)

We found that the CHWs feel able to influence operational level outcomes at work; outcomes related to activities like sharing knowledge, giving advice and helping people gain access to health services. We did not find any instances of them being able to influence strategic level outcomes at work – for example, instances of contributing to identifying local needs, or setting local service priorities, or influencing resource allocation and planning. This however did not hinder the empowerment experience of the CHWs, probably because of both, as this section shows, them themselves imagining the difference *they make*, and also perhaps them accepting the constraints

315 set by the program design and implementation processes on the difference *they can*
316 make. Thus, this sense of empowerment, one might argue, is in many ways both
317 because of and inspite of CHW program design and implementation processes. This is
318 highlighted further in the next section which shows how the managerial imperatives
319 constrain CHWs ability to exercise 'choice'.
320
321 **The perceptions of 'choice'**
322 The fourth dimension of the cognitive construct of employee empowerment is 'choice'.
323 It refers to perceptions of autonomy in the initiation and continuation of work
324 behaviours and processes; it refers to whether a person perceives his/her behaviour
325 as being self-determined. The point being that perceiving oneself as the locus of
326 causality for one's behaviour (as the originator, rather than the pawn) is essential for
327 intrinsic motivation (19), and thereby for feeling empowered. CHWs consistently
328 express feelings of helplessness, feelings of being undervalued and not having control
329 in their work sphere. This paucity of control and its erosive effects on their sense of
330 self-worth and self-esteem is a recurring underlying theme; although, and expectedly,
331 there are variations depending upon the program designs and the decision space it
332 offers to CHWs. The findings below illustrate how programs by not providing good and
333 timely support and resources (not necessarily deliberately) and authority to CHWs,
334 undermine their empowerment experience.
335
336 For instance, CHWs in Indonesia expressed feelings of powerlessness and helplessness
337 about program implementation processes that hindered their work.
338
339 *"When I participated in the asphyxia training, I wanted to disseminate it to village*
340 *midwives, but we don't have Ambu bag [breathing aids] up until now. So when I*

wanted to disseminate it, I didn't have any related materials, which made it useless."
(Indonesia Case Study – Village Midwife)

"*Many pregnant mothers like to come to Posyandu because they want have their blood pressure measured or they want to listen to baby's heart rate. They really like these, but not all village midwives have these instrument. Or some of them have but then broken and cannot immediately replaced*" (Indonesia Case Study – Community Midwife)

Clearly flawed program design features, for example inadequate and rushed trainings which did not take into account the learning needs of the CHWs in Malawi, accentuated their sense of inadequacy, were a source of frustration, and clearly disempowering.

*"The other thing is about trainings, things that you are supposed to learn for two or three weeks they teach us for three days only, so it becomes very difficult to apply them when we are in the community we fail as we don't know where to start from." (*Malawi Case Study – Health Surveillance Assistant*)*

Management failures around the timely payment of allowances, particularly when compared to how well things worked for other cadres, were a source of feelings of being undervalued and of not having control in their work sphere; a CHW in Mozambique tellingly expressed his frustrations:

*"When I was chosen as APE they spoke about the monthly allowance and I hoped that allowance was monthly … this is my 4th month and I have not received … is just not enough for anything .. I have my wife, two sons and my mother is elderly .. and I have to support my family" (*Mozambique Case Study – APE)

Similarly, management apathy around allowances for CHWs, as the CHW from Kenya points out, are also a source of feelings of being undervalued and of not having control over one's work sphere.

*"And even when you're a senior HSA you receive a salary which is the same with any HSA. For example our senior HSA started working as an HSA in 1993 while I started working as HSA in 2007 but we receive the same salary. This demotivates us and makes us not work extra hard" (*Malawi Case Study – Health Surveillance Assistant*)*

In all the six country case studies – CHWs indicated that very often the supervision processes were too focused on reporting data and fault finding. CHWs reported various ways in which this undermined their morale and sense of self-worth.

*"What makes us not work hard is, when the higher health office comes for supervision, they leave our strong parts and take very minor things and discourage us ….". (*Ethiopia Case Study – Health Extension Worker)

"*The downside of maternal and child health revolution in this province is we (midwives) are always blamed, especially when a mother died. What we want actually is a more support like trainings and instruments so we can work better*" (Indonesia Case Study – Community Midwife)

On being explicitly asked about the control they have over their own work, and decision making, a CHW in Malawi responded,

"I don't have such influence … We here are juniors, when we are voicing our concerns on what needs to be done to create a conducive working environment, it is referred to as insubordination". (Malawi Case Study – Health Surveillance Assistant)

Similarly, in Kenya on being asked whether they would like their roles to be expanded, CHWs in a FGD expressed how expanding their roles and decision space would empower them and would help to improve their performance.

"Yeah they should … they should empower us to be able to nurse them before reaching the (hospital) to avoid women deaths during giving birth" (Kenya Case Study - CHW).

Discussion and Conclusions

In this paper we have critically analysed the international literature and the six REACHOUT study country context analysis findings with a view to understand the empowerment experience of the CHWs. While this explicit focus on examining the 'empowerment experience' of CHWs who are meant to 'empower' the communities they serve, is an under researched area within the field of health services research in LMICs, its importance has been recognized before (15, 16).

In 2003, Shrestha from Nepal presented a conceptual model for the empowerment of CHWs (FCHVs - female community health volunteers), and argued that only when FCHVs are empowered themselves, can they bring sustainable change and improve the health outcomes of the communities they serve (42). That empowerment of CHWs is an essential prelude to them being effective in enacting their roles as health promoters, has also been highlighted, in different parts of the world. In the ASHA Plus project (43) in India, CHWs explicitly reported being empowered as a result of access to new knowledge, new freedoms, and new opportunities. Bhatia (11) also discusses

the contradictions and tensions inherent in the CHW program designs and management; she highlights how the empowering influence of access to new knowledge, meaningful and socially relevant work on one hand, is often at odds with the managerial imperative to maintain control and contain costs on the other hand.. Similarly, Campbell et al (44), drawing on their experience in South Africa, contend that the process of challenging entrenched structural power inequalities, within organisations, across professional boundaries, is essential, but bound to be messy. They argue that meeting of the 'empowerment objectives' of such initiatives, both the empowerment of CHWs and the communities they serve and seek to empower, while necessarily slow and gradual, is an essential precondition to achieving change. Mc Creary et al (45) also report how voluntary peer group leaders identified the experience of being empowered, as central to their development of an identity and to be effective as peer and community health promoters.

Methodologically, while Lee and Koh's framework (21) helped us unpack the different dimensions of the CHWs' empowerment experience, it fell short in guiding us in explaining the antecedents of the four dimensions. The framework was perhaps originally designed to examine the situation of workers who had clearly defined profiles, clear identities, were formally employed and paid, and operated in well-defined relational environments. These reference points do not consistently apply to all CHW program contexts and this sometimes hindered the use of the framework to examine the situation of CHWs within different contexts. Along the same lines, in some ways the framework assumes that, once empowered, employees would want to stay on in the organizations they work in. It does not take into account the possibility that an empowered worker might have higher expectations and is more likely to leave if service conditions do not meet these new expectations (expectations about role or compensation or conditions generally).

In 2012, Maynard, Gilson and Mathieu, in their review of the past two decades of research on empowerment within organizational settings, have articulated the importance of researching empowerment from a multilevel perspective (23). They distinguish between a hierarchy of organizational, team and individual empowerment, and their antecedents. They indicate that research should examine different or multiple levels and the influence that higher levels have on individual psychological empowerment. They also identify the importance for research to explore and expose, sometimes competing mediators of individual psychological empowerment. In this paper, we have focused on the individual level psychological empowerment experience of the CHWs – and we have considered the program design, organizational arrangements, relational features, and their interactions, as being antecedents that shape the individual/CHW level psychological empowerment experience. We interpret these as multiple levels of antecedents determining the four dimensions of Lee and Koh's (21) empowerment experience. Maynard, Gilson and Mathieu (23) further argue that while researchers too often, and understandably, collapse the dimensions of individual level psychological empowerment (choice, competence, meaningfulness and impact) into a composite measure, it would be better if these dimensions are analysed using an interactional approach. In this paper, we have attempted to do this – a limitation of our effort however is the fact that the REACHOUT study looked at a wide range of issues affecting CHW's performance, and our data collection tools were not always explicitly oriented to uncover the empowerment experience of CHWs. In addition, and in retrospect, we could have organised our sampling strategy differently. For example, had we stratified our informants by characteristics that could influence their empowerment experience, such as, years in service, age, gender, or common tasks (curative vs promotive vs linkage), we would have been able to get a better understanding of the antecedents of the empowerment experience.

In their recent work, Maes et al (15) make a compelling case for researchers and development practitioners to take a critical view on the gendered political economy of CHW programs; they argue that it is important to unpack the multiple simultaneous narratives at play, and to go beyond the simplistic narratives about CHW's provision of health services. They urge researchers to analyse the claims and narratives of empowerment (and participation), taking due cognizance of existing political, historical and relational context (16). This paper, while it does not cover the whole distance, does cover in detail how the organizational and relational contexts shape CHW's empowerment. Our data does not allow us to comment on the broader socio-political-economic contexts shaping the empowerment potential of community health workers, hence the omission. We have however illustrated how organisational arrangements within CHW programs in LMICs both facilitate and frustrate the CHWs empowerment experience, and argued for the need for CHW programs to be reoriented to enhance the empowerment experience of CHWs. Worker empowerment and its operationalization is a much studied and contested subject in organizational studies (23). While there are those who see it as key to the well-being of all parties, others argue that empowerment initiatives within organizations are always designed to achieve managerial goals – conflict containment, productivity gains, and to maintain the power balance between the employees and the employers (46, 47). Some argue, echoing the Foucaultian understanding of the concept of governmentality (48), that the worker empowerment project is but merely an insidious form of managerialism operating through considered and calculated modes of managerial action intended to structure and subject the actions of others – just another forms of subjugation of the worker. Their point being that organisational claims notwithstanding, employee empowerment initiatives are always at odds with managerial imperatives and interests; and that this would be so for the CHWs too. This is echoed to some extent

in the REACHOUT country case studies; CHWs and other similar cadres are often left to their own devices, are rarely visited by supervisors and have little decision space to construct approaches that would allow them to better respond to the needs of the communities they serve.

We however agree with Hardy et al (47) that while there might be some point to these arguments, one misses the point if one generalizes them. And that empowerment initiatives may improve the quality of the work environment for the workers. We believe that this is probably more so the situation in the case of CHWs and CHW programs in LMICs. This is because of the unique situation of CHWs in most LMICs – of them being not the usual worker within health systems, them being at the interface of the health system and the communities, and their role as community based, and not facility based health workers, all of which fundamentally limits the control that their managers can exercise on them. Even from a purely organizational and operational perspective, the limitations of the technologies of supervision and control inherent to the delivery of community-based services, necessitates a partnership approach towards CHW cadres. We argue that CHW programs can perform better if they systematically partner with and empower CHWs; any managerial attempts at control along the same lines as controlling other health worker cadres can only occur at the expense of frustrating an important purpose of CHW programs – community-based health promotion and contribution to social change. Swift & Levin (49) have convincingly argued that there is nothing in the psychological definition of empowerment that requires the increase of power of one group to decrease the power of another group, and that power does not have to be seen as a zero-sum commodity, but can be a 'win-win' situation – we argue that in the case of CHWs in the LMIC health systems, this is the case.

One must however recognize that the healthcare profession is highly hierarchical, with often rigidly defined roles and the privileges that go with these roles. We appreciate that initiative to increase the scope of work of a new group, like CHWs, particularly to include curative tasks, will expectedly be contested and will face resistance, for various reasons, from various existing cadres within the system. Furthermore, evidence on the shifting of curative tasks to CHWs warns of the problems of misdiagnosis, delays, and inappropriate disease management; evidence shows that shifting of curative tasks to CHWs should only be done within the context of well-functioning health system, and should be limited to few tasks (50, 51). We acknowledge this evidence; our call for creating an empowering work environment of CHWs should thus not be seen as a call for indiscriminately expanding the scope of curative tasks of CHWs (tasks which CHWs expectedly find very empowering). Perhaps, as the recent review by Naimoli et ai (52) highlights, helping CHWs and communities to better appreciate the importance of the non-curative tasks and the critical role they play as the bridge between communities and the health system, through clear inclusion of these messages in the CHW training curriculum, and its regular reiteration by other cadres, could be a way forward.

We contend that CHW programs in LMICs already have many elements that offer an empowering experience to CHWs through improving competence, enhancing self-esteem, offering opportunities for meaningful and socially impactful work. We argue that while this is good, these empowerment influences fall short in translating into CHW's performance whenever and wherever they are undermined by organizational arrangements and relations that trigger cognitions of being helpless, undervalued and not in control, amongst CHWs. We contend the latter need not be the case; that CHW programs would benefit from systematically interrogating their program design and implementation to identify disempowering organizational and management arrangements, both relational and processual, and to take steps to remedy these.

Doing so would not only improve CHW program performance, it would also pave the way for CHWs to meet their potential as agents of social change, beyond their role as links between the community and the health system.

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