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Health by the people, again? The lost lessons of Alma-Ata in a community health worker programme in Zambia

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ABSTRACT

National community health worker (CHW) programmes were central to the vision of primary health care that emerged from the Alma-Ata declaration of 1978. CHWs were identified as agents who could offer basic medical treatment and promote community participation and empowerment. Despite the ambitions of this era, many national CHW programmes were neglected, starved of funding, or discontinued in the decades that followed. These programmes were difficult to sustain in a context of rising debt and structural adjustment, but they also suffered due to poor implementation and a lack of clarity about the role and identity of CHWs. Nevertheless, national CHW programmes have returned to the policy agenda in the past fifteen years and key figures and organisations within global health have begun to argue that they offer a way of strengthening health systems and achieving universal health coverage (UHC). Based on ethnographic research conducted between 2019 and 2020, this article examines a new national CHW programme that has been introduced in Zambia. However, as I show in this article, Zambia's new CHW programme has suffered from many of the same key problems that affected the programmes of the Alma-Ata era: insufficient funding, poor implementation, and a lack of clarity about the role of CHWs. This article shows how these mistakes have been repeated and asks why the lessons of the Alma-Ata era have been lost. Three central problems are identified: national CHW programmes continue to be underfunded and regarded as a "cheap" solution; global health organisations and actors today prioritise technical and quantitative approaches when they design and implement these programmes and therefore overlook the historical experiences and qualitative research of the past thirty years; and, finally, policymakers continue to gloss over the tensions and contradictions within the idea of the "community health worker" itself, creating unclear and unrealistic expectations for CHWs.

1. Introduction

In 2011, the Zambian government introduced a new national community health worker (CHW) programme with the aim of recruiting and training 5000 new CHWs who could provide basic forms of medical treatment and engage in health promotion activities in rural Zambia. This new programme was developed in partnership with a range of outside organisations, including the Clinton Foundation, the United States Agency for International Development (USAID), and Innovations for Poverty Action (IPA). These outside organisations offered advice and technical assistance: they funded a large situational analysis in order to provide key information about rural healthcare in Zambia (MoH, 2010), they commissioned a group of economists from Harvard University and the London School of Economics to design a randomised control trial (RCT) that would inform the implementation of the new programme (Ashraf et al., 2015), and they arranged for Zambian government officials to visit Uganda, Malawi, Thailand, and Ethiopia in order to learn more about the CHW programmes in these countries (Zulu et al., 2013).

When I interviewed officials who were involved in Zambia's new programme, I was often told that this outside assistance was crucial because this was Zambia's first national CHW programme. An official who was involved in the design of the curriculum told me that "Zambia never had a community health worker programme", while a civil servant from the Ministry of Health explained to me that Zambia "didn't have experience of how to implement a new programme for community health workers". The idea that the Zambian government needed the expertise of outside actors in order to compensate for its own lack of knowledge and experience was common among those who worked on the programme – particularly among officials who worked for the global health organisations that played a prominent role in the design and implementation of the programme.

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As I discovered later in my research, these officials were mistaken. In the aftermath of the Alma-Ata declaration of 1978 – when the idea of primary health care and the vision of "health for all" was first articulated – Zambia held a conference on primary health care that resulted in the publication of *Health by the People: Implementing Primary Health Care in Zambia* (1980). The Zambian government subsequently introduced a national CHW programme and trained over 2000 new CHWs by 1984 (Heggenhougen et al., 1987, p. 149). This was a period when many countries introduced similar programmes – India, Tanzania, Mozambique, Nicaragua, and other countries in Latin America, Asia and Africa all introduced ambitious CHW programmes during the 1970s and 1980s (Lehmann and Sanders, 2007). During this period, the figure of the community health worker (CHW) became central to the idea of primary health care and CHWs were identified as agents who could offer basic forms of medical treatment and promote "community" participation and empowerment (Basilico et al., 2013; Cueto, 2004; Maes, 2015).

Despite the enthusiasm for these programmes, they faced serious problems in the years that followed. Many of these programmes – although not all – were neglected, underfunded, or even discontinued during the late 1980s and 1990s (Lehmann and Sanders, 2007; Maupin, 2015). This was a period when many countries in the Global South found it difficult to maintain comprehensive national healthcare programmes as "structural adjustment" programmes were being imposed on them, healthcare funding was being cut, and the idea of "selective primary health care" came to take the place of the Alma-Ata vision of comprehensive primary health care (Basilico et al., 2013; Cueto, 2004; Kraef and Kallestrup, 2019; Warren, 1988).

Although these programmes have faced many challenges, a number of influential actors and organisations within global health have returned to the idea of national CHW programmes in recent years. CHWs programmes have continued to "gain favour in national and international health initiatives" (Maupin, 2015: 86) and there is a "rapidly growing global awareness of the potential of large-scale community health worker (CHW) programmes" (Zulu and Perry, 2021, p. 1). A range of prominent advocates have begun to argue that comprehensive national CHW programmes can help countries in the Global South to overcome their shortage of health workers, address the problems of fragmentation and inefficiency associated with single-disease programmes, and move towards the aim of universal health coverage (UHC) (Schneider and Lehmann, 2016; Lewin et al., 2021; Rifkin et al., 2021). During the course of my research, I was told by several officials that Zambia's decision to implement a new CHW programme was influenced by this broader growing enthusiasm for CHW programmes among donors and global health organisations (see also Zulu et al., 2013).

In this context, it is striking that officials and policymakers involved in the programme had no recollection of Zambia's first CHW programme of the 1980s. As I argue in this article, the fact that these officials and policymakers were unaware of Zambia's experiences during the Alma-Ata era is a sign of a broader problem. It is not simply that a single health programme was forgotten, but rather that many of the key lessons of the Alma-Ata era continue to be overlooked by major global health organisations who are involved in the design and implementation of national CHW programmes today. In Zambia, this led to avoidable mistakes being repeated. As I discovered during my research, Zambia's CHW programme suffered from several key problems: the programme was not funded adequately, it was implemented in a "vertical" or "top-down" manner with limited community involvement, and the role of these new CHWs often remained unclear to other health professionals and community members. These problems are not new or unique – they are precisely the same problems that affected many of the national CHW programmes of the Alma-Ata era. Despite the "relative neglect of the history of CHW programmes in the academic literature" (Medcalf and Nunes, 2018, p. 423), there is a large body of policy research from the period, written by social scientists who conducted qualitative research on these national programmes (e.g., Berman et al., 1987; Gilson et al., 1989; Twumasi and Freund, 1985; Walt, 1988). This literature offers key insights into the problems of the CHW programmes of the 1970s and 1980s.

In this article, I draw on this work alongside my own research on Zambia's new CHW programme in order to show how the same mistakes were repeated. In line with the focus of this special issue on the pasts and futures of "health for all", I ask why the various actors involved in designing and implementing Zambia's new CHW programme overlooked these key lessons from the Alma-Ata era. I identify three central and related reasons. First of all, national CHW programmes continue to be identified as a "cheap" solution for countries with weak health systems in contexts shaped by debt, austerity, and dependence on donor funding (Masis et al., 2021). Secondly, global health organisations continue to emphasise "technical" approaches to policy implementation and prioritise quantitative measures, such as randomised control trials (RCTs) (Adams, 2016; Kabeer, 2019; Maes, 2015, 2017; Maupin, 2015). Consequently, other forms of evidence (such as qualitative evidence) and institutional memories of failure are overlooked or undervalued (Graboyes and Carr, 2016). Finally, policymakers continue to gloss over the tensions that are inherent in the idea of the "community health worker" itself. CHWs are depicted as actors with an expansive set of roles and responsibilities: they are expected to be able to act as "change agents" who can address the social determinants of health at the same time as "extending" health services by acting as technical providers of healthcare (Colvin and Swartz, 2015; Schaaf et al., 2020). This broad definition continues to create confusions and conflicts about the role and identity of CHWs, particularly among health professionals and community members. One of the enduring dynamics here – from the 1970s to the present-day – is that "outside" actors, rather than rural populations themselves, continue to control the design, implementation, and evaluation of these programmes.

2. Methods

This article is based on 6 months of ethnographic research (conducted between 2019 and 2020) with various actors who were involved in Zambia's CHW programme. For this research, I interviewed 15 officials who had worked on the programme from the Ministry of Health, the Clinton Foundation, and several other organisations. I interviewed provincial and district level officials in the rural province where I conducted fieldwork and, with the help of a research assistant, conducted participant observation and interviews with several CHWs working in a rural province as they carried out their work. We travelled with these CHWs and conducted follow-up interviews with members of the households who had been visited by them. Overall, I conducted detailed interviews with more than 30 new CHWs – who are formally known as Community Health Assistants (CHAs) – who were in work, being trained, or waiting to be deployed. Ethical clearance for the research was obtained from the University of Zambia (UNZA), the Zambian Ministry of Health, the National Health Research Authority (NHRA) of Zambia, and from the Provincial and District Medical Offices in the areas where I conducted research. Informed consent was given for all interviews and pseudonyms have been given to the names of all participants in order to ensure anonymity.

3. Community health worker programmes: from Alma-Ata to universal health coverage

The Alma-Ata declaration of 1978 promoted the idea of community participation in the planning and delivery of healthcare and offered a critique of "top-down" health interventions that prioritised biomedical technologies and overlooked the social determinants of health (Basilico et al., 2013; Cueto, 2004). The philosophy of primary health care was shaped by the longer history – from the nineteenth century onwards – of "social medicine" approaches and experiments, which shared "the conviction that improving the health of populations can be achieved only by changing living conditions, starting with nutrition, work, and

housing" (Lachenal, 2022, p. 69). In the 1970s, the architects of primary health care were also concerned by the failures of the vertical disease interventions of the 1950s and 1960s – such as the global malaria eradication programme – which led policymakers to look for "more comprehensive" approaches (Basilico et al., 2013, p. 76). In this context, the World Health Organisation (WHO) became increasingly interested in the role of CHWs. This can be seen clearly in Kenneth Newell's famous edited volume, *Health by the People* (1975). In his contribution to the book, Newell argued that it is crucial to take "wider issues into account" and focus on "community responsibility and involvement" in healthcare (Newell, 1975, p. 192). Community health workers and frontline primary health care workers were central to this: the "primary health care worker is no butterfly flitting in or out but is both present when wanted and still there to live with the results of his or her actions" (Newell, 1975, p. 192). According to Newell, this "total health approach" was the most effective way of improving health and would eventually make western health systems "seem to be the anachronism" (1975, p. 194).

The philosophy of primary healthcare also took shape in the political context of the demand for a New International Economic Order in the early 1970s (Sharma, 2015) and in the context of movements for decolonisation and democratisation throughout Africa, Asia, and Latin America (Campbell and Scott, 2009). During the late 1970s and 1980s, "the presence of active CHWs in developing countries became a proxy for the political empowerment of underserved populations" (Nading, 2013, p. 90; Campbell and Scott, 2009; Maes, 2015). This was also a period in which books such as E. F. Schumacher's *Small is Beautiful* (1973) became popular – and the idea of "thinking small" resonated with "community development and community-centred approaches" (Medcalf and Nunes, 2018, p. 405). The famous model of the "barefoot doctors" – who provided basic healthcare in rural China from the late 1960s onwards – also inspired and influenced the first CHW programmes (Zhou, 2016). To borrow the words of Colvin and Swartz, this "alignment of local and global agendas, interests, and institutions … made it possible for CHWs to be 'thinkable'" (2015, p. 39). In the aftermath of the Alma-Ata declaration, many countries introduced large-scale national community health worker programmes, including Indonesia, India, Nepal, Tanzania, Zimbabwe, Malawi, Mozambique, Nicaragua, and others (Lehmann and Sanders, 2007).

During the 1970s and 1980s, the WHO played a key role in constructing the image of the CHW. Alexander Medcalf and Nunes (2018) have analysed the production of the image of the CHW and the associated idea of "the community" that these new health workers were supposed to serve and represent. As they point out, CHWs were chosen as "key protagonists" in the WHO's "visual strategy": they were "presented as inextricably linked with the push towards [primary health care]" and photo stories were used to present them as "heroes" whose work was "characterised by tales of courage and determination" (Medcalf and Nunes, 2018, p. 411). The WHO used visual images carefully in order to show how CHWs could administer effective basic healthcare while gaining the trust of their communities and remaining "of the people" (2018, p. 413). This era produced an image of the CHW that can still be found in the present-day – images of CHWs produced by governments and global health organisations regularly repeat these tropes of CHWs as "altruistic" and "heroic" (Maes, 2017; Colvin and Swartz, 2015) and CHWs continue to be seen as actors who are "locally situated [and] said to have special insight into the lives and needs of those around them" (McKay, 2018, p. 71).

Nevertheless, as a range of scholars have pointed out, the image of the CHW that emerged at this historical moment contained certain important "tensions" or contradictions (Colvin and Swartz, 2015; Werner, 1981). CHWs were seen as agents who could "empower" communities, and yet they were also regarded as technical workers who could "extend" basic medical care to marginalised populations (Campbell and Scott, 2009; Colvin and Swartz, 2015; Schaaf et al., 2020). This tension was present from the Alma-Ata era onwards, although it has often been overlooked. When the first national CHW programmes were introduced, the precise role and identity of CHWs became a key problem – although this was not the only problem these programmes faced.

3.1. *Under strain: problems of the CHW programmes of the Alma-Ata era*

Despite the ambitions of the Alma-Ata period, the first national CHW programmes were implemented at a time of "mounting pessimism and criticism of Alma-Ata's goals, which were said to be unrealistic and idealistic" (Medcalf and Nunes, 2018, p. 417; Cueto, 2004). Historians are beginning to explore the "local" trajectories and manifestations of primary health care in new ways in order to challenge the conventional historiography of this period (see Beaudevin, Gaudillière and Gradmann, this issue). However, in broad terms, many countries in the Global South – especially in Latin America and Africa – faced economic crisis and escalating debt in the 1970s and 1980s. This context negatively affected the first CHW programmes and researchers soon began to ask why these national CHW programmes were "under strain" (Gilson et al., 1989, p. 519) or even "in crisis" (Walt, 1988). As this research demonstrates, the national CHW programmes of the Alma-Ata era suffered from a range of problems. Three of the most important were: a lack of sufficient funding, poor implementation, and the unclear role of CHWs.

First of all, the CHW programmes of the Alma-Ata era were not well-funded. Many governments regarded CHW programmes "as the cheapest, easiest and most obvious way to [introduce primary health care]" (World Health Organisation, 1989, pp. 10–11). This lack of funding caused a number of practical problems. For example, CHWs were not consistently supplied with drugs and struggled with inadequate payment. Indeed, there was little agreement about how to fund these programmes or whether to pay CHWs a salary – some of these programmes involved CHWs being paid a salary (such as Botswana, Colombia, and Jamaica), while others involved CHWs being recruited as volunteers (such as Indonesia, Thailand, and Sri Lanka) (see Walt et al., 1989, p. 599; Masis et al., 2021). The question of whether CHWs should be paid a salary has remained central to the policy debates about CHWs in subsequent decades (Closer et al., 2017; Glenton et al., 2010; Maes et al., 2010).

Secondly, the CHW programmes of this period were often poorly implemented. The key problem was that many of these programmes were implemented in a "top-down" or "vertical" manner, with limited community participation or understanding. Despite being framed as comprehensive community-oriented programmes, these programmes were often implemented "vertically" (Gilson et al., 1989; Rifkin, 1986; Walt, 1988). According to some, these programmes were "implemented relatively autocratically as 'vertical' programmes, rather than as part of the PHC approach" (Walt, 1988, p. 2). Other researchers came to the same conclusion, noting that these programmes were "largely imposed from the centre as a response to an international emphasis on primary health care" (Gilson et al., 1989, p. 521; Nichter, 1999). This point was acknowledged by the WHO in a report on CHW programmes that was published at the end of the 1980s:

> the moral force of the arguments for [primary health care] obliged countries to demonstrate their active commitment to it … Plans were made enthusiastically but hastily, involved only a few policy-makers at top levels, and were largely imposed on health workers … little thought was given to … integration into existing health systems. (World Health Organisation, 1989 pp. 10–11).

These problems of funding and implementation were connected to a third problem: the lack of clarity about the role of CHWs. Because the role of CHWs had been defined so broadly, they were viewed as actors who could achieve a huge amount, including mobilising their communities, providing basic healthcare, addressing the social determinants of health, and extending the health system. The first CHWs therefore had "formidable expectations thrust upon them" (Walt, 1988, p. 1).

The research from the period identified this problem. Researchers at

the time noticed the problems caused by this lack of clarity about the role of CHWs. A comparative study of CHW programmes in Botswana, Colombia, and Sri Lanka during this period found that the tasks of CHWs were "not always clearly defined" (Gilson et al., 1989, p. 523). CHWs were supposed to encourage community participation, but both "'community' and 'participation' meant different things to different people in different circumstances" (Rifkin, 2009, p. 32; cf. Rifkin, 1986). In some cases, the notion of "empowerment" became defined through "compliance" as CHWs referred people to higher levels of biomedical care (Maupin, 2015, p. 83). These problems were exacerbated by a romantic image of the "community" that had informed the design of these programmes and which overlooked "structural conflict, inequality, class or professional dissonance" (Walt, 1988, p. 12). Countries that adopted CHW programmes often had to "grapple with the complex political realities on the ground" (Medcalf and Nunes, 2018, p. 418). As Randall Packard has pointed out, advocates of primary health care often found that they had been operating with an "idealised view of rural societies as homogeneous, without any disparities in power [or] … the ability to participate in decision making" (2016, p. 250). Consequently, CHWs were drawn into local power dynamics and conflicts in the areas where they worked – including in their relationships with political officials and traditional healers, but also with other health workers, particularly nurses (Gilson et al., 1989; Twumasi and Freund, 1985; Rifkin, 1986). These CHWs found that their "communities" regularly misunderstood their work or even felt threatened by their presence.

Due to the lack of clarity about their role, CHWs faced a variety of different expectations. For example, CHWs were often given an unrealistic range of technical tasks. This led some observers to conclude that "greater attention" needed to be paid to "practical, task-oriented training" (Berman et al., 1987, p. 451). Other research found that health professionals – particularly nurses – did not understand the role of these new CHWs and often saw CHWs as people who could help them in clinical settings, rather than as agents who had a role to play in "the community" (Gilson et al., 1989). In practice, this meant that other health workers "tended to use CHWs as useful extra pairs of hands in the clinics, as nurse aides rather than community health workers" (Walt, 1988).

In the past thirty years these enduring "tensions" have been highlighted repeatedly by researchers. David Werner (1981) famously asked during this era whether CHWs were working to extend the health system or working as social justice advocates to empower communities? In his words, the question was whether CHWs were "lackeys" or "liberators". Although Werner's language demonstrates his commitment to the social justice orientation of CHWs, scholars have continued to write about this tension using different language (Perry and Hodgins, 2021). Campbell and Scott (2009) have distinguished between "medically oriented tasks" and "socially oriented tasks" of CHWs, while Colvin and Swartz (2015) discuss the two "ideal types" of the CHW as the "extension agent" of biomedical services and the "agent of change" working to mobilise communities and address the social determinants of health (see also Schaaf et al., 2018). In broad terms, the CHW programmes of the 1970s and 1980s suffered due to a lack of funding, poor implementation, and the unclear role of CHWs. However, in the 1990s and 2000s, the role of CHWs began to change.

3.2. The fall and rise of national CHW programmes

In light of these problems and the broader political and economic context, many countries in the Global South found it difficult to maintain comprehensive national healthcare programmes during the 1980s and 1990s. After the Cold War ended, global health organisations and donors became central to the provision of health services in many countries in the Global South (Pfeiffer and Chapman, 2009; Packard, 2016). These organisations tended to implement selective health programmes to address diseases such as malaria, HIV/AIDS, and tuberculosis. During this period, CHWs continued to play a key role. However, instead of being employed as government health workers who were part of national health systems, CHWs were more often recruited by global health organisations and NGOs – on a voluntary basis or for per diem payments. There are many ways of characterising the changing role of CHWs during this period. As Ramah McKay has put it, although CHWs remained a prominent part of the landscape of healthcare provision during this time, "their articulation to the state and to the notion of a national health service [became] markedly distinct from the aspirations of Alma-Ata" (2020, p. 97). As other scholars have observed, during this period the apolitical and technical aspects of CHW work were foregrounded and there was a "general shift in the role of CHWs from advocates for social change to a technical … function" (Maupin, 2015: 74; Lehmann and Sanders, 2007; Maes, 2015). Global health organisations and NGOs were more inclined to see CHWs as "effective delivery mechanisms—apolitical human resources … who save lives by wielding smartphones and medical technologies" (Maes, 2015: 2; Lehmann and Sanders, 2007; Maupin, 2015; Kalofonos, 2014). Although they are still regarded as actors who are "driven by altruistic impulses", these have become "largely moral rather than political" (Colvin and Swartz, 2015, p. 30).

In the past fifteen years, there has been a further reassessment of the role of CHWs. There has been a rediscovery of the potential of national CHW programmes and a growing enthusiasm for them among leading figures and organisations within global health. These advocates have begun to argue that comprehensive national CHW programmes can help to strengthen health systems by reducing the health worker shortage within countries in the Global South and addressing the problems of fragmentation associated with single-disease programmes (Pfeiffer, 2003; Tulenko et al., 2013). According to some observers, there has been a recognition that CHW programmes are "an integral part of achieving the goal of Universal Health Coverage (UHC)" (Schneider and Lehmann, 2016, p. 112).

There are several reasons for this gradual change in attitude. Global health organisations and donors have been persuaded of the success of national CHW programmes in countries that did not abandon them or who established new programmes during the 1990s and 2000s (Perry et al., 2021). One of the most prominent examples is Ethiopia's national CHW programmes (introduced in 2004), which has been consistently praised as a success by global health organisations and donors, including by the World Bank (see Wang et al., 2016: 81; but see Maes, 2014; Maes, 2017). CHW programmes have also become attractive within the context of the broader universal health coverage (UHC) agenda. In recent years, a number of high-profile campaign groups have also been established, such as the Earth Institute's "One Million Community Health Workers" campaign led by Prabhjot Singh and Jeffrey Sachs (Singh and Sachs, 2013; Earth Institute, 2012; see also Maes, 2015, p. 5). The WHO has promoted CHW programmes energetically from its 2008 report on "task shifting" – which signalled "a massive revival of state-sponsored CHW programmes" (Campbell and Scott, 2009, p. 126) – to its more recent comprehensive guidelines for countries that wish to implement national CHW programmes (WHO, 2018). It is within this context that Zambia decided to introduce a new national CHW programme in 2011.

4. Zambia's CHA programme

In 2011, Zambia began implementing its new national CHW programme, with the aim of training 5000 CHWs by the year 2020. These CHWs – whose formal title is Community Health Assistant (CHA) – are given 12 months of training before being deployed back to their home communities in order to engage in health promotion activities, including encouraging the use of mosquito nets, advising on water and sanitation issues, and showing people how to deal with minor illnesses (Phiri et al., 2017). A few years after the programme was introduced, policymakers expanded the tasks of CHAs, training them to inject contraceptives, deliver babies in emergencies, and screen for complications during

pregnancy (Phiri et al., 2017, p. 3). The partner organisations involved provided the funding for the first five years on the basis that they would hand over this responsibility to the government so that the programme would become "self-sufficient" (Zulu et al., 2013). However, when I interviewed officials in 2019 and 2020, the programme was struggling financially – the "handover" to the government had not occurred and basic aspects of the programme (such as the training schools and the salaries of CHAs) were no longer being funded properly.

The lack of funding is reflected in the data available on the number of CHAs who have been trained and are currently in employment. In November 2021, I spoke to an official in the Ministry of Health who told me that there are currently 3191 CHAs who have been trained. Of these, only 1354 are currently being paid by the Zambian government, while 300 further CHAs have their salaries paid by donors. This means that only 52% are being paid a salary for their work. Among those who are not being paid, the majority are working on a volunteer basis at their health posts. Researchers who observed the CHW programmes of the 1970s and 1980s warned of the problems that resulted when these programmes were not funded properly. In Zambia, as in many other countries in the Global South, the government does not have the capacity to fund this national CHW programme. At the same time, the multinational companies who extract resources from in Zambia – such as copper and sugar – can avoid paying taxes that could contribute to public health expenditure (Fraser, 2010). The broader global political economic context within which Zambia's CHW programme was designed and implemented is shaped by the same inequalities of wealth and power that undermined the introduction of the first national CHW programmes in the 1970s and 1980s (see Masis et al., 2021). Zambia's new CHW programme has suffered from other problems that echo those of the Alma-Ata era.

4.1. *"We are an extension of the Ministry of Health": the vertical implementation of the programme*

During my research, it became clear that the CHA programme was designed and implemented without rural populations or local health workers participating to any significant extent (cf. Zulu et al., 2013). The programme was largely implemented by global health organisations who acted as "partners" to the Zambian government. The major organisation here was the Clinton Foundation. A retired official from the Ministry of Health explained to me the inequalities that shape the relationship between the government and the Clinton Foundation:

> One of the problems was that the Ministry of Health did not have the same number of staff as the Clinton Foundation looking at the CHA scheme. So, the Ministry of Health people are looking at the scheme once in a while when they have the time, but the Clinton Foundation has somebody working on the scheme the whole time.

This created a dynamic in which the Clinton Foundation began to implement the programme relatively independently of the government, particularly in rural areas (Wintrup, 2021). An official from the Clinton Foundation told me that this was necessary because there were key figures within the government who supported the programme from the outset, but who subsequently left the Ministry of Health. This meant that the Clinton Foundation became, in the words of this official, the holder of "institutional memory". When people in the Ministry of Health forgot about the importance of the programme, the Clinton Foundation was able to continue to prioritise it. This is how officials from the Clinton Foundation legitimized their decision to work independently of the government. Indeed, this official told me that "it almost feels that we are an extension of the Ministry of Health in some ways".

This dynamic led many people in rural areas of Zambia – particularly government health workers – to view CHAs as "outsiders" who were not part of a government programme. Instead, they appeared to be like other CHWs working on the kind of "vertical" disease programmes that global health organisations often implement. A different official from the Clinton Foundation explained that they needed to implement the programme quickly and independently in rural areas because they had a limited time frame and wished to avoid becoming entangled within the bureaucracy of the provincial and district level health system. This official described how Clinton Foundation officials would, for example, deliver items to CHAs:

> The first 2 years we had the funding to repair bicycles and other supplies for the CHAs so, because of that, sometimes [The Clinton Foundation] would drop off a bicycle… when they were in the district. So, this was one of the reasons why people would always think that the CHAs were volunteers from [the Clinton Foundation]… This made some people… [at the district level] say "well, you aren't really one of us".

Unsurprisingly, district medical officials described their frustration with this dynamic and felt that they did not have ownership of the programme (cf. Brown, 2015).

These dynamics are strikingly similar to those of the Alma-Ata era. Although the national CHW programmes of the Alma-Ata era were more often coordinated by governments rather than global health organisations acting as "partners", they were often implemented vertically. A comparative study of these programmes concluded that they were often "conceived as 'vertical' programs, with little reference to existing health systems … The programs were grafted onto, rather than integrated into, existing health systems" (Gilson et al., 1989, p. 521). This description captures precisely the same dynamic that occurred when Zambia's CHA programme was implemented.

4.2. *"What is their role really in health?" the ambiguous role of the CHW*

During fieldwork and interviews, it became clear that many people were confused about the role of CHAs. Local residents articulated their confusion about whether CHAs were employed by the government or worked for an NGO, and many wondered why these CHAs could not offer more sophisticated forms of treatment or dispense medication like other health professionals (cf. Hodgins et al., 2021; Schaaf et al., 2020). In interviews, CHAs themselves confirmed that there was considerable confusion about their role and identity and described how local residents would question their role or even challenge their expertise. A CHA named Paula – who had volunteered at her nearest rural health clinic before becoming a CHA – explained that people in her community felt that she did not have the same expertise as other health workers: "When I go to the community, they say, 'This one has only been to school for one year!'". At the same time, Paula noted that few people knew about the new CHW programme:

> The CHA programme hasn't really been exposed in the community. When we are coming, very few people know who a CHA is, and so I think that if there were workshops to educate the influential leaders – like the chiefs and those people who are influential in the community – that would really help, because we need them. Without them, who are the ones who will introduce us to the community?

But it was not only local residents who were confused about the role of CHAs. Other health professionals – especially nurses – were unsure about these new CHWs. Many of Zambia's CHAs experienced problems when they returned to their home communities to begin their work. The government's original plan was for CHAs to spend the majority of their time working in the community and only 20% of their time working in rural clinics and health centres (Zulu et al., 2013). In practice, many CHAs ended up spending the majority of their time at rural health clinics (cf. Campbell and Scott, 2009; Schaaf et al., 2020). In part, this was because other health workers – such as nurses and clinical officers – expected them to provide help at understaffed rural health centres as "an extra pair of hands".

Before training to become a CHA, Caroline had worked as a volunteer CHW for a global health organisation in her home area. When she visited

a rural health clinic – while on placement during her training – the other health workers did not know anything about the CHA position. Caroline explained, "most of the clinics did not have any information about CHAs. They asked, 'These CHAs, what is their role really in health?'" Other CHAs explained that health workers at clinics would make them do cleaning jobs and prohibit them from undertaking the clinical roles they had been trained to perform. A CHA called Simon explained this:

> That's what they know … that we are cleaners. And it doesn't feel good that somebody is underrating you and not feeling that you are important – even at the same facility they would tell you, 'No, you guys first you have to clean, this is the only thing you have to do'… When we go over to that side [to the clinic] we discover there is a barrier. They say, 'You can't do this because you are only CHAs'.

It was common for CHAs to encounter hostility from health workers at clinics. A CHA called Mutinta suggested that nurses felt threatened by her: "CHAs and nurses there is a big conflict … they think we are stealing their job". These dynamics have been reported in other studies of the CHA programme. Some of the first research that studied the CHA programme found that many CHAs were excluded from meetings, or prohibited from carrying out basic tasks (Zulu et al., 2014, p. 7).

These are the same problems that affected the CHW programmes of the 1970s and 1980s. A study from the mid-1980s notes that the problem of community acceptance in Zambia's CHW programme "will continue to plague CHW workers … unless their roles are understood and properly institutionalized and legitimized within the local power structure" (Twumasi and Freund, 1985, p. 1077). Researchers elsewhere noted that health professionals often felt that CHWs had been "thrust upon them" (Gilson et al., 1989, p. 519) and health workers with "often felt threatened by CHWs and tried to subvert local efforts" (Berman et al., 1987, p. 445). Several studies from the period found that excluding nurses and other health workers from the planning of these CHW programmes led these health workers "to use CHWs as useful extra pairs of hands in the clinics, as nurse aides rather than community health workers" (Walt, 1988, p. 15). Gilson et al. noted that nurses often "resisted" the "imposition" of these new CHWs and came to view them as "as extra pairs of hands in clinics, where they then spend the majority of their time." (Gilson et al., 1989, p. 519). This problem has been identified in a range of different settings in subsequent decades (Perry and Hodgins, 2021).

As with the CHW programmes of the 1970s and 1980s, it is unsurprising that confusion or even hostility persisted when the programme was implemented in a "top-down" fashion without involvement or participation from CHWs, communities, or other health professionals. In light of the striking similarities between the programmes of the 1970s and 1980s and Zambia's recent programme, it is important to ask how these mistakes were repeated and why the lessons of the Alma-Ata era were not learned.

5. Lessons lost

There are several reasons why the same mistakes were repeated as Zambia's CHW programme was designed and implemented. First of all, national CHW programmes continue to be poorly funded and regarded as a "cheaper" option than other health interventions and programmes (Masis et al. 2021). One of the reasons why Zambia's CHW programme repeated this mistake is that the broader global political economic situation of the present-day is strikingly similar to that of the 1970s and 1980s. Zambia cannot afford to implement a well-funded CHW programme, and the donors and global health organisations involved were unable to commit to funding the programme indefinitely. This is why it is important to situate Zambia's CHW programme in the context of the broader political economic forces that shape global health today (Packard, 2016). This global economic inequality gives wealthy global health organisations the power to design and implement policies without the participation of rural populations (Crane, 2013; Wendland, 2017). At this scale, the repetition of the mistakes of the Alma-Ata era reflects this continued political economic inequality.

The second reason that these lessons were lost is that global health organisations and policymakers today emphasise "technical" approaches to policy implementation and prioritise quantitative measures (Adams, 2016). For several decades anthropologists have shown how "technical" knowledge is used by global health and development organisations in order depoliticise and reframe interventions (Ferguson, 1994; Li, 2007). Today global health organisations prioritise these approaches for a number of reasons – not least because they often operate on a short-term timescale and have to demonstrate the quantifiable "results" of their interventions. These organisations often base their policymaking on quantitative evidence and techniques such as randomised control trials (RCTs), which have become central to the evaluation of CHW programmes (Maes and Kalofonos, 2013).

This is true of Zambia's new CHW programme, which based its recruitment method on an RCT conducted by economists from the LSE and Harvard (Ashraf et al., 2015). This approach to policymaking limits the possibility of community participation because people are treated as experimental subjects, rather than as agents whose personhood and capacity for decision-making is foregrounded (Hoffman, 2020, p. 2; see Wintrup, 2022). Furthermore, proponents of these approaches often downplay the importance of other sources of evidence, including in this case qualitative data on past CHW programmes (Deaton and Cartwright, 2018; Kabeer, 2019). Some of the failures of Zambia's new CHW programme might have been avoided if policymakers had consulted this large body of qualitative literature on past CHW programmes or adopted an approach that was genuinely based on community participation and engagement. As Angus Deaton has recently argued, however, major organisations and actors within global health today often believe that "technical knowledge, even in the absence of full democratic participation, can solve social problems" (2020, p. 22). This approach assumes that "there is no great difference between designing a gadget and designing a social policy" and actors believe "they can develop other people's countries from the outside, because they know how to find out what works" (2020, p. 22; cf. Reubi, 2018). When qualitative knowledge is devalued, the cultivation of "institutional memory" is not valued either. As Graboyes and Carr have argued, capacity is "built and maintained by having a functional institutional memory, which includes recounting failure and an ability to integrate knowledge from failure" (2016, p. 362). In the absence of this kind of institutional memory, officials can easily come to believe that the data produced by RCTs is the key to implementing programmes successfully.

This technical policy making can still be motivated by strong moral sentiments. The WHO's report on CHW programmes in 1989 noted that many governments felt the "moral force" of the arguments for primary health care and then implemented CHW programmes without much planning because they thought this was the "cheapest" and "easiest" way of achieving primary health care (World Health Organisation, 1989, pp. 10–11). Today, the "moral force" of arguments for UHC might be leading governments and global health organisations to make similar mistakes. As Kenneth Maes has pointed out, the "simplifying narratives and emotional expressions" that emerge from "powerful global health actors" are a part of the moral economy that surrounds these interventions, and which often obscure the underlying political and economic realities (Maes, 2015, p. 5; see also Maes, 2014; see also Fassin, 2013). Global health organisations and actors express their "empathy and concern for certain categories of people, often women and children" (Maes, 2015, p. 5) in order to justify policies that do not involve genuine participation or accountability..

Finally, the tensions and contradictions in the idea of the "community health worker" itself is a key and enduring problem that we can identify from the Alma-Ata era to the present – despite the fact that it has been raised consistently by researchers throughout the past thirty years. A great deal of work has been invested in making the category of the CHW – alongside that of the "community" – appear to be natural. The

language of "empowering communities" that was central to the Alma-Ata era continues to be used today, but it often obscures a great deal and creates the idea that CHWs are capable of heroically improving rural healthcare. As anthropologists have noted, the work of CHWs has often "been framed as a form of empowerment but often serves as a mechanism to devolve state responsibilities for health care onto local communities" (Closer et al., 2017, p. 58).

Again, this problem was recognised at the end of the 1980s. As the authors of the WHO's 1989 report on CHW programmes put it:

> The very title *community health worker* could be seen as a terminological attempt to gloss over the tension inherent in this position. Progress can be achieved only by acknowledging this tension and by controlling and exploiting it appropriately and fully. (World Health Organisation, 1989, p. 16).

This progress has not been achieved and policymakers have failed to take seriously this tension. The problem is not that the political aspirations of the Alma-Ata era were undesirable, but that the language has been easy to appropriate by policymakers who have not examined these tensions and contradictions. Referring to CHWs as agents who can bring about "empowerment" or "social justice" and referring to them as altruistic and heroic is entirety consistent with excluding them from the policymaking process and allowing them to be left to define their own roles with limited support. As Schaaf et al. have pointed out, CHWs continue to operate within the following broad and overlapping categories: "extenders, providers, activists, or volunteers" (Schaaf et al., 2018, p. 9). The category of the CHW itself needs to be rethought or reimagined by CHWs and communities themselves, rather than by global health organisations and policymakers.

6. Conclusion

The reasons for the repetition of past mistakes in Zambia's CHW programme are multi-dimensional and interconnected: the political and moral economy of global health, the dominance of technical policymaking, and the lack of clarity about the identity and role of CHWs. In conclusion, it is important to observe that the key mistakes – from the 1970s to the present-day – have occurred when external actors have been in control of the design, implementation, and evaluation of CHW programmes. It is worth questioning the widespread assumption that "external solutions" are required (see Tangwa, 2017). Researchers, activists, health workers, and citizens – from the Alma-Ata era to the present – have argued that CHWs and the people they serve should be given the opportunity to participate in the design and implementation of their own programmes – including defining the role and identity of CHWs. In the 1980s and 1990s, scholars observed that governments spoke about "empowering" communities, without seeking genuine participation from them. These observers argued that it was "essential to involve the health professionals and the community at the planning stages – to ensure that their perspectives about what is required are considered, and to facilitate their understanding" (Gilson et al., 1989, p. 528). Observers of the CHA programme in Zambia have noted likewise that there was a "lack of involvement of CHWs in formulating, finalizing, and launching the strategy", which reflected the "lack of voice and power of the community-based health workforce in the contemporary policy development process and reform" (Zulu et al., 2013, p. 10). This returns us to perhaps the central lesson that emerges most strongly from the research on CHWs over the decades: those who are involved in developing these programmes must prioritise the involvement and participation of CHWs and the people they care for and seek to represent. This will involve challenging the broader dynamics of accountability and power within the field of global health today.

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