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Global health's durable dreams: ethnography, 'community health workers' and health without health infrastructure

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In 2007, while conducting ethnographic research on the politics of health work in Mozambique, I visited the offices of the provincial health department in Quelimane, Zambezia Province. I had recently been introduced to a young medical doctor seconded to the department, and I chatted with her and her colleagues (a nurse and a data entry clerk) while I waited for my appointment with the director. Learning that I was an anthropology student, the group nodded and asked about my fieldwork. They suggested that in addition to visiting clinics, I might enjoy talking with community health workers.

Their suggestion was apt. In the context of non-governmental health projects that sought to extend clinical care in the province, community actors were central figures. In my field sites in Quelimane and in rural Morrumbala District, a host of non-governmental organizations (NGOs) addressed diverse topics and problems, from agricultural development to education to HIV/AIDS care and treatment. Amid a wide range of organizations, topics, issues and projects, however, the use of 'community volunteers' to do the work of implementation was a frequently shared strategy, one that often mobilized significant numbers of people. One organization in Morrumbala, for instance, had recruited more than 100 volunteers in two dozen neighbourhoods to participate in home-based care projects linked to HIV treatment. Other projects used volunteers to raise awareness about or implement projects addressing women's empowerment, child protection, environmental and agriculture projects, and hygiene and sanitation schemes. In most cases, volunteers were unpaid, but many received compensation through a hodgepodge of per diem payments, food baskets and material goods such as pens, hats, bicycles or T-shirts.

Alternately called *ativistas* (activists), *voluntários* (volunteers) or CHWs (especially in English-language policy documents), unpaid or low-paid community health workers were central to non-governmental activities. They also seemed to constitute self-evident and even ubiquitous objects of ethnographic research. At NGO offices, in conversations with the district and provincial health directorates, and in interviews with health staff, community health work was consistently presented as an obvious location for ethnographic investigation. Ethnographic research was a familiar and recognizable mode of inquiry to the state and non-governmental actors I met. It was also understood to be most appropriately located in the 'communities' that have long served as sites in which the knowledge

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claims of anthropology and development are legitimated (Ferguson 2005; Maes and Kalofonos 2013).

In Quelimane and Morrumbala, then, CHWs were at once familiar ethnographic figures and long-standing historical actors. Through diverse public health histories – including socialist-era health policy, subsequent policies of decentralization and economic reform and their aftermath – CHWs have been constituted as central technologies of health and governance in Mozambique as elsewhere (Packard 2016). Today, anthropological accounts of CHWs frequently locate them in the wake of aspirations to expansive national health systems – what anthropologist Lawrence Cohen has described as the postcolonial 'dream of the clinic' (2012). In Zambezia, however, CHWs were diverse, embodying a range of historically situated, political and practical orientations towards their work. Moreover, clinical dreams in Mozambique have been ambivalent and politically ambiguous. Often unrealized, they have also been inseparable from experiences of violence and exclusion that accompanied them (Buur 2010; Macamo 2016). At the same time, clinical visions have never monopolized health imaginaries. Rather, in the disjuncture between capacious health imaginaries and limited health infrastructures, community-based health has come to stand in for dreams of healthcare without or outside clinical health infrastructures.

This article asks about the proliferation of the category of CHWs within both health policy and ethnographic research (Haines *et al*. 2007). What makes CHWs such enduring figures, not only in non-governmental and public health policy but also in ethnographic representations of health in and beyond Mozambique? What can this ethnographic and policy durability reveal about the health dreams and global health critiques that CHWs articulate? Drawing on ethnographic research with two long-standing community health actors, with NGO staff and public health officers, as well as on ethnographic and health policy accounts of CHWs, I explore how historical social and political relations become visible or obscured in accounts of CHWs. Key actors in the implementation of both public and non-governmental health projects, the durability of community health workers, I argue, makes clear how health systems depend not only on clinical spaces but also on historically rooted and 'unevenly sedimented' social and political relations (Stoler 2016). At the same time, these relations are not only formed through social bonds and practices of public or humanitarian governmentality, but are also enmeshed in political and party histories and formations. These entail clinical dreams as well as histories of violence, conflict and exclusion (Stevenson 2014). Representations and accounts of CHWs – in the field, in ethnography and in policy – might therefore grapple with the ways in which messy articulations of power, as well as non-governmental and development practice, shape the ambivalent politics of community health.

Dreaming of clinics and communities: CHWs in ethnographies of global health

The ubiquity of CHWs and the apparent self-evidence with which they were understood to be sites of health research were not unique to my visit to the provincial health department offices in Quelimane. Since the late 1970s, community health work has been a central component of public and primary healthcare.

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The World Health Organization's 1978 Alma-Ata Declaration, for instance, promoted community health workers as a key means of achieving 'Health for All by the Year 2000' (WHO 1978). Articulating an expansive vision of health as a 'state of complete physical, mental, and social wellbeing', the declaration advocated for primary healthcare approaches that linked the development of a national health system to community needs and relations. Forty years later, public health initiatives in many places are enacted in 'partnership' with NGOs that provide medical technologies and treatments to patients enrolled in targeted programmes (Braga 2017). While community health workers, activists and volunteers remain central to efforts to extend health services, these global health initiatives are frequently sponsored by humanitarian agencies and development organizations rather than public health institutions. Promoted by non-government and transnational actors, they may be implemented by local volunteers with little training, lack centralized coordination, and focus on specific diseases or narrowly defined categories of intervention (Packard 2016). As a result, although community health workers remain central to the extension of medical technologies and ideologies, especially in rural areas, their articulation to the state and to the notion of a national health service is markedly distinct from the aspirations of Alma-Ata.

Similar to accounts elsewhere (Prince and Brown 2016), in Mozambique, the role played by non-governmental actors in proliferating community health work has been attributed to processes of state restructuring and the expansion of funding for non-governmental health infrastructures. It has also been shaped by past experiences of centralized public services, political conflict, and the economic and social impact of structural adjustment programmes (Abrahamsson and Nilsson 1995). These trajectories of public health transformation have also been identified in other places on and beyond the African continent. Thus, scholars have shown how political economic reform and the rise of global health programmes have transformed structural, institutional, temporal and clinical practices of care (see, for example, Benton 2015; Comaroff 2007; Prince and Marsland 2014; Whyte 2014). As processes of 'projectification' (Prince 2013) have given rise to a multiplicity of disorganized, disarticulated and short-term interventions, scholars have shown how non-governmental initiatives aimed at singular diseases also produce biopolitical exclusion (Braga 2017).

Accounts of community and volunteer labour have been central to these critical accounts of global health practice. Scholars have shown, for instance, how volunteer labour has become a cornerstone of contemporary global health regimes, a shift that reflects not only different dynamics of work but also restricted roles for and visions of national or public health systems (Geissler 2015; Storeng and Mishra 2014). These changes also involve new roles for community volunteers. New and restrictive modes of financing and delivering care, for instance, have made volunteers responsible for enacting medical projects (Maes and Kalofonos 2013) as well as for generating health data and information (Biruk 2018). Thus, even as the category of CHWs has remained central to international health practice since the mid-twentieth century, the meanings and practices associated with local volunteers have changed dramatically. Observing these processes at work, many anthropological critiques have shown how the unmaking of public health systems has harmed both patient well-being and the prospects for primary healthcare and the development of comprehensive health systems (Biehl and Petryna 2013; Janes and Corbett 2009; Pfeiffer 2013). In this context, evocations of

earlier and more robust models of primary healthcare highlight the 'absent presences' of contemporary volunteer programmes and enable claims towards future possibilities (Tousignant 2018).

These claims and transformations have consequences for individual volunteers and public health systems alike. On the one hand, volunteers often struggle to receive recognition and remuneration for their work (Prince and Brown 2016). On the other, as they have come to rely on short-term training and intermittent forms of support, volunteers may fail to deliver the relatively robust forms of community health practice imagined by primary healthcare advocates. Nevertheless, in contexts where non-governmental entities are important sources of healthcare provision, participation in the humanitarian economies of volunteer work are often key means by which individual actors access resources (Whyte 2014). For this reason, the material goods of volunteer work – the hats and T-shirts, participation certificates and per diems – become markers of global health participation, linking individual volunteers across a wide variety of contemporary and historical projects. So too does participation in ethnographic and health research (McKay 2019; Mwambari and Owor 2019).

CHWs before and after Alma-Ata

I became attuned to how long-standing modes of community health labour continue to shape global health practice while conducting fieldwork with NGO volunteers in Morrumbala, a predominantly rural district on the western edge of Zambezia Province. I had arrived in Morrumbala in the course of my fieldwork on medical labour, and it was through conversations with the nurses, logisticians, programme officers and other staff members at NGOs that I met António. At the time, António was an *ativista* and volunteer with about four non-governmental organizations; he also worked occasionally with the district's malaria control programmes, for which he received a small stipend. As a CHW, António participated in a range of activities: delivering health information, helping to register births and deaths in his neighbourhood, facilitating community meetings with NGOs and provincial health staff, and generating information about the health status of nearby residents.

António's responsibilities in the HIV treatment programme through which I met him were more elaborate, including visits to patients, providing basic first aid and emotional support, and facilitating patient access to material support such as food. Although he was also expected to accompany patients to consultations at the hospital, António – like most volunteers – rarely made the journey. Reaching the hospital in Morrumbala from the small hamlet where he lived in the district's *zona baixa*, the rich agricultural terrain along the district's southern and western borders, required a 20-kilometre journey each way. In the absence of regular public transport, these journeys were arduous for patients and volunteers alike. Although the organization that sponsored António's 'project' made frequent truck and motorbike journeys through the district, drivers were officially prohibited from offering lifts to patients and volunteers. This disjuncture between the organization's expectations of accompaniment and programme resources made clear how CHWs were imagined as filling in for, rather than depending on, absent infrastructures (Appel *et al*. 2018). And, while some

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drivers bent these rules, such arrangements often depended on friendly relations or financial transactions (or both), and António was unlikely to receive, or afford, such favours.

In his late forties when I met him, António was older than many other volunteers. Efficient and organized, but also cantankerous and reportedly 'difficult', António's name often elicited eye rolls and sighs from the NGO staff who supervised programmes in his neighbourhood. Although he reliably attended workshops and activities, adding much needed participation numbers to programme measures, he frequently became embroiled in problems and disputes with fellow volunteers and the neighbours they were supposed to assist. He was also outspoken about what he saw as shortcomings of the volunteer programme, principally in the disjuncture between relatively high expectations of work and remuneration through small and infrequent material supports. Although António's views were shared widely, he was among the most insistent in expressing this to programme staff. As an older man, he was also better able to command their attention than many of his colleagues, who were mostly women. Yet if he often complained, António could also be chatty and communicative and I frequently talked to him about his experiences.

It was in the course of one such conversation that I learned about his long experience with community labour of various kinds. I had arrived at António's house together with an NGO-employed nurse. She was there to make arrangements for distributing food packets to households enrolled in a project to support vulnerable children. António assured her that he would organize the families on her list, then asked whether he and his fellow volunteers would also receive food packets. In the past, the programme for which the nurse worked had provided food to volunteer participants. The NGO had recently curtailed this benefit, however, and food was no longer distributed to volunteers – 'Which Sr António knows very well,' the nurse added defensively, before reminding him to attend their meeting the following day. With an expression of exasperation, António insisted he would be there. Then he reminded her that, 'Whenever there are visits, I am here.'

As the nurse continued to the next house, I lingered to chat with António, who described the frequency of meetings and visits his work required. Amid a symbolic economy of global health and development (Gonçalves 2013), such visits were key aspects of the performative repertoire of NGOs. Yet in António's recounting, each of the organizations that he encountered seemed as unhelpful as the next.

> When the health director comes, when the NGOs come, I am here. But I have told them so many times [about the need for financial or material support] and nothing happens. So I've given up. I even suggested to the director at the hospital: why don't you include me as a janitor while I am here working in the community? That way I will receive something, like a janitor, to facilitate my life. Because someone who enters [the] health [service] today, they will receive [a salary] in the same month, but I am here in the same thing since 1981 and I continue impoverished. I spoke with the director and asked him, just to facilitate my life. But it's been four years [since we spoke] and nothing.

António's complaint spoke to well-documented struggles and aspirations in community health work. For some, the aspiration to become a '*servente*' or custodial worker in the health department, and thus to enter into the security of state

employment, was an important factor in their work. Given that António and many of his neighbours made a living through activities such as small-scale agriculture, fishing and odd jobs, the possibility of employment, no matter how unlikely, was a compelling motivation. Although he was no longer youthful, António's comments captured a sense of 'waithood' that Alcinda Honwana has described as characterizing young people's relation to work and economic independence in Mozambique and elsewhere (2012).

Because payment and employment have been central to analyses of the 'volunteer economies' of health on the African continent (Prince and Brown 2016; Maes 2015), it was not António's hope of employment that caught my attention but rather his claim to have been doing 'the same thing since 1981'. As we talked further, I realized that António was not only describing the longevity of humanitarian and non-governmental activity in rural Morrumbala but also drawing equivalences between distinct governmental efforts to mobilize 'community health'. As we chatted, António recalled his experiences as a young man of twenty, when he was nominated to serve as an APE *or agente polivalente elementare*, translated in policy documents as CHW. It was a role he continued to hold, although, as he made clear, neither this work nor his volunteer efforts had yielded the material benefits he had hoped to obtain.

I was surprised to hear him invoke the APE programme, which had been described to me in interviews with public health actors but which I had understood to be mostly defunct. Nevertheless, his comment pointed to how discourses of community-based and primary healthcare had been central to efforts at building a new national health infrastructure in the years after independence. While public health infrastructures were constructed, health services also aimed at extending care to rural areas through a range of non-clinical and 'barefoot' efforts (Barker 1985). In rural areas, including parts of Morrumbala, as well as in communal villages, APEs were tasked with extending the public health system, bringing medical care and expertise beyond urban centres. Comprising a corps of community members trained in first aid, preventative care and the treatment of common illnesses, APEs were to be the first line of public health defence in rural areas and communal villages.

António entered the APE programme as a young man working at a newly nationalized agricultural firm, MICANAGRO. He had been sent on a six-week training session in the neighbouring district of Mocuba. There, he learned techniques of basic first aid (including the distribution of medication for malaria and other common and epidemic diseases), how to monitor height and weight in children, and standards for referring severely ill patients to health centres, and he received instruction in principles of hygiene and sanitation, which he was to disseminate among his neighbours. If some of the tasks in which he had been trained – such as providing first aid, referring neighbours to health services, delivering information on health and hygiene – remained common to community health programmes, this training programme, which included information on anatomy, human biology and principles of health, sanitation and disease, was also markedly more robust than the training he now received from NGOs.

António recalled that, at the end of the training course, APEs were given a supply of medications, bandages and other provisions and asked to return to their villages. There, they were told, their neighbours would help them construct a basic health post. In exchange for their unsalaried labour, APEs were to be

supported by the ongoing donations of their neighbours. From the beginning, António recollected doubts about the viability of this model of unpaid labour, noting that:

> When I was in the course, this is what they told me: that you will not receive a salary but that the community is going to support you. One will bring fish. One will bring pumpkin. One will bring a can of oats. I said, 'OK. Let's see. Let's see what happens.'

António's scepticism was not unfounded. Health policies were soon changed to allow APEs to charge small amounts (2,000 meticais, then equivalent to about US$0.10) for medications as an additional means of subsidizing their activities. Moreover, António returned not to 'the community' but specifically to the agricultural firm. There, his tasks included not just the provision of first aid but also the enforcement of industrial discipline, guarding against malingering and absenteeism – responsibilities that could only have complicated the dynamics of community support that were supposed to sustain him. But his difficulties were also programmatic and widely shared. In one humorous moment, António described asking the community leader in his hamlet for assistance, only to be told, 'Look at me – I too am here working for the community without receiving. If I could make them offer something, do you think I would be working here like this?' As a result, António continued to make use of intermittent benefits provided by NGOs even as the dreams of 'community health' deployed by both state and non-governmental agencies imagined forms of solidarity that failed to materialize.

Yet if struggles for material support united very different examples of community health labour, the APE programme also differed from later non-governmental efforts. Along with practical tasks of community health, APEs also had an ideological and pedagogical role. APE training manuals emphasized the primacy of biomedical principles over religious, traditional and spiritual practices, and healthcare interventions were tied closely to political ideology. Referring to the centralized communal villages into which the FRELIMO government aimed to relocate rural populations, for instance, the APE training manual noted that 'the APE must be a good mobilizer, [and] must have the confidence of the whole population of the communal village'. Furthermore, 'the APE needs to study the FRELIMO party line very carefully' (República Popular de Moçambique 1977: 17). Public health goals, party structures and ideological purity were therefore combined in the making of a narrowly defined political community in ways that nuance and challenge critical accounts of global health as eroding public services (see also Meneses 2015).

Indeed, while the APE programme's emphasis on robust training for CHWs offered an inspiring public health strategy, it also entailed modes of political and ideological intrusion that were complex, contentious and often violent (Macamo 2016). This was particularly true in Morrumbala. Colonial-era agricultural plantations were linked not only to Portuguese rule (Vail and White 1980) but also to racialized regimes of capital investment, rooted in extractive agricultural and labour regimes (Adalima 2016; Araujo 2009; Isaacman 1996). Yet even as these were nationalized and superseded by state-owned agricultural enterprises, socialist efforts to remake everyday life produced new forms of political

subjection. Many rural residents viewed these efforts to remake everyday life with scepticism and resistance (Chichava 2013).

By 1982, fighting had halted production at the agricultural plant and António told me that he was 'transferred' from the company to 'the community'. 'Did someone come and tell you to change,' I asked, 'or did you just change?' António replied:

> The DDS [District Health Department] said to work for the community now. They said, 'You can see how the community is isolated; your role is to stay to secure [*asegurar*] the community.'

In his account, work as an APE gradually shifted – from providing health to enforcing labour discipline to 'securing' and surveilling the community in ways that also involved him in political conflict (Machava 2011). Through these efforts to access the stability of state employment, António also became entangled in relations of conflict that extended through family, neighbourhood and social relations. The public health dream, in this context, was thus inseparable from both political conflict and the demands of the state. It was in this historical moment that António had entered into community health work, not only providing care but also enacting practices of security and surveillance amid increasingly militarized politics (Israel 2014).

The flexible meanings and political ambiguities of CHWs

Despite the facility with which António evoked his past experiences as an APE, the programme was short-lived in many ways, curtailed by the economic restructuring that accompanied and followed it and by changing global health priorities. Today, the programme is most often described in the past tense, undone by the lack of institutional support for goods, supplies and infrastructure, by the failure of community remuneration schemes or state payments, and by the absence of regular training programmes. In interviews with policymakers and health workers, the APE programme was occasionally evoked as a point of reference. Describing contemporary volunteer efforts, for instance, staff in the Zambezia Provincial Health Directorate quipped that contemporary CHWs were at best 'quasi-APEs'. Their limited training meant that CHWs lacked the equipment, medicines and knowledge base that APEs received. By contrast, CHWs were trained and mobilized to intervene in specific diseases. As one health worker put it jokingly, 'Nowadays you go into the community and find "specialists".' Then, listing common areas of non-governmental intervention, he elaborated with irony: 'You'll see this one specializes in TB, this one only HIV, this one does leprosy.' Highlighting the juxtaposition between a language of specialization and very low levels of training and care, the comment underscored the limits of non-governmentalized community health.

Despite the persistence of a small number of APEs across the province, the programme was most frequently described to me as obsolete or anachronistic, less a foundational moment in public health than a symbol of what *was* to be or *might* have been. In interviews and conversations with doctors, scholars and policymakers, the APE programme – like much of the post-independence health

system – was mostly mentioned in the past conditional tense, exemplifying a nostalgic-critical discourse on the aims of Alma-Ata and post-independence medicine as a story of foreclosed health futures. In this view, transnational NGOs were ambivalent agents, making available important forms of care but also weakening robust health services through a reliance on discrete, time-limited and vertically circumscribed emergency programmes. Such sentiments were shared by many health actors in Mozambique during the time of my fieldwork, who observed to me that NGOs were as likely to 'suck up' scarce resources as provide them (McKay 2018) and to pursue agendas rooted in development institutions rather than situated concerns (Mkandawire 2010).

Nevertheless, as community health work proliferated through the late 1990s and the 2000s, animated by the decentralization of health services and the rise of global health interventions, past experiences and identities remained selectively salient, both financially and politically. In Morrumbala, volunteers frequently accessed programmes on the basis of previous experience with 'community campaigns' and 'projects'. Participation in one project, in other words, facilitated access to the next, thus opening up future possibilities for support and employment. In this context, claims to experience served as credentials for potential opportunities even as flexible meanings attached to 'community health' elided important political differences between APEs and volunteers, 'CHWs' and activists.

The unmaking and remaking of CHWs

The fact that past experience enabled future opportunity became particularly clear in the experiences of António's colleague, Caetano. Also a former APE and a volunteer with a number of NGOs, Caetano lived a few kilometres from António, in a neighbourhood near the centre of a flood resettlement programme that was generating much activity in the district. In addition to participating in awareness campaigns related to the flood, Caetano described for me how he regularly conducted consultations and treatments for common illnesses such as diarrhoea, malaria, conjunctivitis and scabies. Like António, he referred ill residents to the hospital in town. In addition, he monitored growth in children (charting the height and weight in children under five years), treated moderate cases of malnutrition with therapeutic food supplements such as fortified milk or Unimix (a high-calorie corn-soy porridge) that were provided by UNICEF, and referred severe cases for treatment in the hospital. He conducted family planning consultations and was responsible for some public health initiatives, such as providing information about Certeza water-purifying solution. Like António, he participated (as a temporary paid member) in intermittent vaccination brigades.

Yet where António had a reputation (among neighbours and NGO staff members alike) for being complicated, Caetano was outgoing and likeable, projecting a sense of animated motivation. Although, like António's, his community-built health post had fallen into disrepair, Caetano had replaced it with a large canvas tent stocked with a cot and basic medical supplies. The tent and supplies had been donated by an Italian aid organization that had arrived to assist with flood relief. Helping to manage their medical station thus allowed Caetano to transform relatively informal community work into highly visible modes of labour and care.

Caetano's relative success was both geographically and historically conditioned. His location at the heart of resettlement and relief projects enabled access to resources unavailable to António, but it also spoke to Caetano's success at working with diverse forms of aid. Unlike António, but in common with many of his neighbours, Caetano had spent much of the 1980s in Malawi (McKay 2012). There, he had volunteered with Médecins Sans Frontières (MSF) in their refugee assistance programmes. While his experience as an APE had facilitated his work with MSF, his time in Malawi had also expanded his repertoire of skills and experience. He learned advanced skills such as inserting intravenous drips and monitoring cholera patients. He also developed social connections, including to MSF, that enabled short-term paid opportunities when he returned. For instance, as health projects were supplemented by flood resettlement and mitigation projects, such as the programme that paid for the health tent, Caetano took on both paid and volunteer positions that provided access to various forms of material support. By 2011, he had saved enough to buy a motorbike, allowing him to make the 25-kilometre trip from his village to Morrumbala town. This provided him with a small source of income from ferrying patients back and forth to the hospital.

Despite this, Caetano, too, was frustrated by the small and unreliable amount of support he received for his efforts. Moreover, his success was precarious. The tent he was using in 2007 was on its last legs by 2011, and while in 1998 the health department had agreed to construct a house and permanent health post for him, these were never built. If Caetano's experiences suggest how opportunities for individual livelihood and for neighbourhood care are possible at the intersection of public structures (providing basic medical training and a tenuous sense of authority) and non-governmental and humanitarian regimes (from MSF to 'the Italians' to contemporary HIV projects), his efforts also demonstrated the tenuousness of these arrangements.

While the material dimensions of volunteer work have been central both to critical accounts of global health and to the accounts provided by António and Caetano, their experiences also made clear how public and non-governmental health programmes alike rely not only on biomedical inputs and infrastructures but also on relations. Although often understood as social – for example by the public health actors who saw affinities between ethnographic research and 'community health' – these relationships were also political and institutional, reflecting important but changing relationships to the state. The experiences of António, Caetano and others thus highlight not only the systemic and infrastructural absences that CHWs are intended to supplement, but also the political relations and non-governmental and material infrastructures through which their efforts are enabled.

If these relations were particularly long-standing in the cases of António and Caetano, similarly implicit, essential but unacknowledged political relations were also visible in the experiences of other NGO volunteers. Carlota, for instance, was a volunteer with a transnational health organization. As I describe elsewhere (McKay 2018), she was a particularly active volunteer, widely recognized for her ability to identify needy patients and her skill in helping them navigate existing NGO and government programmes that offered financial, nutritional or practical support. Yet Carlota, who had moved to Morrumbala only a few years earlier, was successful not because of the length or breadth of her community ties. Rather, she

drew from both her previous experience as a volunteer for the state-run social welfare agency and her ties to political party structures such as the Organization of Mozambican Women (OMM). It was thus experience and recognition within broader political institutions that enabled her efforts. Her experiences, like those of António, Caetano and others, make visible how mobile models of policy and health delivery (Olivier de Sardan *et al.* 2017) may obscure political and social objects and relations, from party affiliations to youth groups to motorbikes, through which health work and individual livelihoods are enabled.

Ethnographic durability and the messiness of power

Across a variety of programmatic and geographic locales, CHWs navigate similar challenges as they mediate between top-down demands and local needs and expectations (Maes *et al.* 2014). In an interview with the Zambezia Provincial AIDS Council in the city of Quelimane, for instance, I was provided with a list of almost fifty local NGOs and church groups involved in community-based HIV care in the city. While many of these groups existed more on paper than in practice, when combined with the many international NGOs that utilized 'community models' of HIV care and health interventions, they made for a remarkable number of community health groups in a population of little more than 200,000 and for a seeming surfeit of sites for ethnographic research.

The presentation of CHWs as 'obvious' subjects of ethnographic work and advocacy speaks not only to the durability and extent of community health work; it also makes clear how anthropological and ethnographic modes of analysis, representation and critique are imbricated with development and global health imaginaries (Gonçalves 2019). For the NGO staff and public health officials who directed me to 'community health', for instance, CHWs seemed to embody anthropological investments in 'grass-roots' social relations, rural places and non-clinical spaces. For policymakers, training and deploying CHWs not only offered inexpensive and easily quantifiable interventions that meshed neatly with metrics-driven global health approaches (Adams 2016; Adams and Biehl 2016; Biruk 2018); they also articulated located forms of knowledge, social relations and expertise in ways imagined to be both locally rooted and efficiently replicable across diverse project sites within and beyond Mozambique (Haines *et al.* 2007).

In response to the flourishing of community-implemented global health programming, the emergent field of critical global health studies has sought to understand not only the role of CHWs in providing care but also the political and economic conditions in which community health programmes emerge (Prince and Brown 2016). In these accounts, the experiences of CHWs are both salient and poignant. Embodying the individual and public health consequences of health liberalization, these accounts also serve as narrative evidence in support of strong health systems. This form of evidence making and advocacy has been one of medical anthropology's important contributions to the practice and analysis of global health (Janes and Corbett 2009). Ethnographies are frequently taught in global public health courses (Farmer *et al.* 2013), for instance, and anthropologists have been advocates for the people-centred approaches that

continue to animate public health efforts (Biehl and Petryna 2013). From state-funded health work to non-governmental volunteerism and from training courses to participation certificates, then, the experiences of António and Caetano seem to poignantly illustrate the performative economy of global health in action. Ethnographic representations of this economy and of the deleterious effects of non-governmental intervention on health systems thus support efforts to realize primary healthcare goals.

Yet because anthropological renderings work to both constitute and critique global health regimes (Biruk and McKay 2019), ethnographic attention to CHWs also contributes to durable imaginations of health and health infrastructures while occluding situated 'units of knowledge production' in the service of a larger global health frame (Ntarangwi 2019: 453). Critical narratives, for instance, may take the force of non-governmental intervention for granted while obscuring the specific political relations through which the trajectories of CHWs are constituted (Asad 1992). Health systems and infrastructures are not only modes of service delivery; they are also normative constructs that work to produce and distribute power and difference in the present and in the memory of the past (Igreja 2013). As a result, ethnographic investments in primary healthcare and health systems may obscure the political complexity of public health histories, especially in contexts where both narrative and silence are important political strategies (Igreja 2008). Like other forms of medicine, in other words, community health is implicated in the 'messiness' of power (Dewachi 2017: 3).

Conclusion

Representing enduring health aspirations or symbolizing lost health commitments, CHWs remain central and widespread actors in the enactment of donor-funded and public health initiatives. As a result of this proliferation, CHWs have been important figures that anthropologists have used to explore the unequal and complex dynamics through which non-governmental and state-based health programmes are realized. In many accounts, community health workers have represented a dream or aspiration of locally situated care, embedded in communities and utilizing 'appropriate' technologies (Cueto 2004). At the same time, as CHWs have been mobilized more often by NGOs than by the state, and more frequently around vertically defined diagnostic categories than for public health commitments, CHWs have also been seen to embody public health nightmares, inadequate substitutes for overextended public systems that introduce vertical programming even into the most localized level of care. In contrast to the holistic dream of Alma-Ata stands the ironic spectre of ill-equipped 'specialists' in 'the bush'.

These ironies and historical juxtapositions are particularly salient as calls for 'health systems strengthening' revive the dream of the clinic once again. In October 2018, marking the fortieth anniversary of the Alma-Ata Declaration, the WHO reconvened a meeting in Astana, Kazakhstan on the topic of primary healthcare. There, delegates affirmed a commitment to 'build[ing] sustainable primary healthcare' and to 'enhanc[ing] capacity and infrastructure for primary care – the first contact with health services – [by] prioritizing essential public health functions' (WHO 2018). As critics have shown, in the absence of

new models for financing and supporting care, 'health systems' approaches often replicate the verticalized methods that have characterized many global health efforts (Storeng and Mishra 2014). Even so, as critiques of vertical programmes and fragmented systems have travelled through and into global health projects, including through the critical work enabled by ethnographic perspectives, health systems have emerged (or re-emerged) as sites of investment and advocacy.

As they come to stand in for existing or eroded principles of primary healthcare, CHWs also build historically constituted relations into practices of care (as in the APE programme), knowledge production and critique. Alongside the dream of Alma-Ata persist more ambivalent and ambiguous relations through which CHWs are constituted and health work transformed into livelihoods. In light of this, tracing the ethnographic investments in, as well as the historical durability of, CHWs might open up critical ethnographic narratives of global health (Gupta and Rodary 2017). As health systems become renewed sites of global health dreaming, ethnographic accounts of CHWs might illuminate how health dreams, nightmares and aspirations come to matter and endure.

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Abstract

Tracing the persistence of community health workers (CHWs) as a key category in both global health policy and anthropological representation, this article asks how enduring scholarly investments in CHWs can reveal changing political stakes for both health work and ethnographic research. Amid renewed calls for a focus on health systems and universal health coverage, the article suggests that the durability of attention to CHWs is instructive. It simultaneously points to the imbrication of health with political and social relations and clinical and technological infrastructures as well as to how ethnographic investments in health systems can sometimes obscure the ambivalent politics of health. Drawing on fieldwork with

CHWs, NGO staff and public health officials, and on public health literature on CHWs, it argues for greater attention to the political ambivalence of health labour. It suggests that the experiences of health workers themselves can serve as analytical examples in this regard, pointing to analyses that begin not with normative notions of health systems or the conceptual boundaries of global health 'projects' but with a focus on the contested relations through which health labour is realized over time. Such attention can also indicate possibilities for health beyond dreams of projects, clinics or health systems.

Résumé

À travers la persistance des agents de santé communautaires en tant que catégorie clé, tant en matière de politique de santé mondiale que de représentation anthropologique, cet article examine en quoi l'attention durable portée aux agents de santé communautaires peut révéler une évolution des enjeux politiques pour le travail de santé et la recherche ethnographique. Face aux appels renouvelés à porter l'attention sur les systèmes de santé et la couverture de santé universelle, l'article suggère que l'héritage des agents de santé communautaires est instructif; il révèle simultanément l'imbrication de la santé avec les relations politiques et sociales ainsi que les infrastructures cliniques et technologiques, et la manière dont l'investissement ethnographique dans le travail de santé et les systèmes de santé peut à la fois illuminer et masquer l'ambivalence de la politique de santé. S'appuyant sur des travaux menés sur le terrain auprès d'agents de santé communautaires, de membres d'ONG et de responsables de la santé publique, et sur la littérature de santé publique consacrée aux agents de santé communautaires, il plaide pour une attention accrue sur l'ambivalence politique du travail de santé. Il suggère que les expériences des agents de santé eux-mêmes peuvent servir d'exemples analytiques à cet égard, en se référant à des analyses qui commencent non pas par des notions normatives de systèmes de santé ou les limites conceptuelles des « projets » de santé mondiale, mais par une focalisation sur les relations contestées au travers desquelles le travail de santé est réalisé au fil du temps. Une telle attention peut aussi indiquer des possibilités pour la santé au-delà de rêves de projets, de cliniques ou de systèmes de santé.