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Recognition, Mutual Respect, and Support

A Relational Approach to Training and Supervision in Community Health Work

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Introduction

Community health workers (CHWs) serve as an essential bridge between households, communities, and health facilities. They connect rural communities with health information and services and provide a sometimes underappreciated stopgap within struggling health systems, particularly in low resource settings in a world facing a predicted shortage of over 14 million health workers (WHO, 2018; Winters, O'Donovan & Geniets, 2018). As neighbours, family members, and friends of those in the communities served, CHWs have an intimate knowledge of lived health experiences in their own communities. They are typically relied upon as a means of translating and delivering community health interventions, but also offer valuable insights into understanding the priorities and needs of communities. Recognition of the importance of CHWs (Bhutta et al., 2010; Earth Institute, 2011; WHO, 2018) and pressure to address the predicted worldwide shortage of professional healthcare workers (Joint Learning Initiative, 2004) have fuelled recent government and private philanthropic efforts to scale up large CHW training programmes (Campbell et al., 2013; Cheney, 2018). As reliance on CHWs increases we have an opportunity and responsibility to critically reflect on the values and ethical commitments that have implicitly guided community health work and to consider what values ought to guide training and implementation strategies moving forward.

The ethical culture of a practice is in part shaped and reinforced by training and learning. In this chapter, we consider the values that have shaped professional and community views about the worth and role of CHWs and reflect on the residual impact on CHWs as learners. We argue for greater attention to the inherent worth of CHWs, recognition of their expertise and the value of their positionality in communities, both in their education and in practice. We consider the burdens of care shouldered by CHWs and the importance of educating CHWs to manage moral distress in

Maureen Kelley and Nigel Fancourt, *Recognition, Mutual Respect, and Support* In: *Training for Community Health*. Edited by: Anne Geniets, James O'Donovan, Laura Hakimi, and Niall Winters, Oxford University Press.
DOI: 10.1093/oso/9780198866244.003.0011

their work by ensuring robust ethics planning and supervision. With the recent shift toward a model of shared decision-making and co-production of health in the global health agenda, respectful partnerships will be the cornerstone for successful community health programmes (Crisp & Chen, 2014). Yet, surprisingly little attention has been given to the role of relationships in training or to the particular ethical principles that support such working relationships. Throughout, we draw on work on the ethical character of relationships in workplace settings, and on learning how to collaborate between different types of expertise to guide training, supervision, and practice, with special attention to CHW programmes in the global south.

More than a 'Stopgap' Measure: Promoting the Lasting Value of Respectful Community Health Partnerships

Essential to any sustainable, effective collaboration is an attitude of mutual respect between partners and a sense of self-worth in respective roles. One of the sources of burnout and dissatisfaction for primary care providers in low and middle-income countries (LMICs) is lack of respect from health professionals and others who rely on CHWs in health delivery programmes (Jaskiewicz & Tulenko, 2012; Dugani et al., 2018). The causes of disrespectful treatment may be difficult to trace across diverse programmes, but possible factors include the hierarchical nature of health systems and lack of attention to this issue in health professional training and community health policy. Despite being recognized as a critical role in health delivery for more than four decades, CHWs have for a long time simply been considered part of a pragmatic agenda, as a bridge to essential health services where 'the alternative is no care at all' (Haines et al., 2007; Standing & Chowdhury, 2008). Recently, at the policy level there has been 'growing recognition' of the value of CHWs (WHO, 2018, p. 13), though also acknowledgment that 'support for CHWs and their integration into health systems and communities are uneven across and within countries' (p. 12). (See Panjabi et al. in Chapter 2 for further discussion.) Viewing the CHW role as merely pragmatic or non-ideal at the level of health systems or policy risks sending a message to government agencies, funders, and other organizations that CHW programmes are merely stopgap measures rather than long-term, essential roles in developing and developed health systems alike.

Equally importantly, a starting point of respect and recognition or one of expediency may influence interpersonal relationships between CHWs and health professionals, relationships which are vital to delivering improved care through community health system partnerships. Failing to attend to the 'practices of power' in implementation programmes, perpetuates inequalities across relationships that are central to the success of integrated community-based health programmes (Lehman & Gilson, 2013). The unintended consequence of serving as a perennial stopgap measure for chronic health systems shortcomings is that CHWs are not always given the

recognition enjoyed by their professional counterparts (Cheney, 2018), often experiencing discrimination (Ajuebor et al., 2019). Unsurprisingly, they particularly value 'respectful collaboration and communication' (Scott et al., 2018).

Education and training can play into these structural inequalities and shape the culture of practice. Unlike health professionals, typically understood to be those completing three or more years of secondary education in the health sciences, and para-health professionals, those completing some post-secondary education, CHWs are typically lay health workers with no secondary education. Where health professionals are typically salaried and on contracts, in many countries CHWs work as volunteers or receive a small allowance; others are paid minimal wages. In this way, the financial value of the work is linked to the quality and quantity of education, creating an implicit hierarchy of healthcare employment. The education, training, and supervision of CHWs then reinforces that this is their place within the professional hierarchy, and the curriculum and pedagogy is decided accordingly. However, we are beginning to see a shift in practice. In many middle and high-income countries, such as the USA, South Africa, and India, there has been a move to certify, salary, and integrate CHWs within government health systems (Singh & Chokshi, 2013). Even in settings of extreme poverty, such as Haiti, organizations like Partners in Health have advocated for aligning CHW programmes with health systems and improving financing (Kim et al., 2013). Such efforts represent important models for shifting the professional culture and work environment for CHWs. Importantly, material and other forms of recognition better reflect CHWs' own sense of esteem and pride taken in the creativity and resourcefulness demonstrated in their daily work (Oliver et al., 2015).

Alongside the pragmatic agenda there has been renewed interest in the more idealistic origins of the primary healthcare movement sparked by Alma-Ata in 1978 a vision of CHWs as respected and valued agents of change from within communities (WHO, 1978; Standing & Chowdhury, 2008; Kane et al., 2016;). However, the educational implications of this vision have not been fully realized, partly because, since Alma-Ata, economic constraints and market-driven models of health delivery have increased pressure to deliver on the ideals of universal health access by cheap and cost-effective means (Winters et al., 2018). As such there is still a tendency to view CHWs as an extension of the health system rather than a catalyst for community empowerment, and the relational features of the work are overlooked (Werner, 1977; Haines et al., 2007; Glenton et al., 2010).

Respect is in many ways key here, and it includes both a general respect that is often demanded of everyone, akin to and arising out of a sense of solidarity, with the particular manifestations of respect one might show to certain categories of other people, such as a patient, a patient's relatives, community leaders, or other more qualified health professionals. Respect for the patient involves care, compassion and empathy, whereas respect for a malaria researcher involves politeness, trust, and attention. It is not a uniform duty, or rather must be enacted differently to different persons. The difficulty lies in judging the right form of respect to show and is linked to status, both for

CHWs in showing respect to various others, but also in having expectations about the kinds of respect that are owed to them, as a practice of power itself.

Rooted in a commitment to respect and solidarity, various programmes, such as the lady health worker initiative in Pakistan, have resisted the pragmatic paradigm of cost effectiveness by investing in greater training and support for CHWs (Rabbani et al., 2016). Increasingly, we are beginning to see an approach to CHWs that follows the principled commitments set out by Partners in Health, recognizing CHWs as: (1) professional members of care teams; (2) essential bridges between health systems and communities; and (3) as valued and critically important as health professionals in low resource settings (Palazuelos et al., 2018). This new model challenges the idea of CHW and paraprofessional care as second best and community-based healthcare as 'better than nothing' and rather returns to the idea of the community as a potentially powerful space for social justice in health. With an eye to developing a philosophy of training, this model offers a helpful starting point for considering how to operationalize respect for the worth and unique contributions of CHWs as agents of change in communities.

Educationally, there are three broad themes in considering the educational dimensions of CHWs. First, there is the question of how we conceive of the nature of the professionalism and especially the ethical decision-making of CHWs. Different professions call upon different commitments and values (impartiality in lawyers, fairness in teachers) and they may also have different ways of identifying and reconciling these commitments and values (MacIntyre, 1981; Applbaum, 1999; Hall, 2005). Given these values and commitments, we should then pay attention to when and how these should be learned. One might consider some values to be innate, or simply require them as pre-existing qualities of any potential CHW, so that there is no need to address them in training. Others might simply be considered to be only learned through experience, 'on the job'. Most will be learned or developed through education, but different models of education will be more or less effective at this. Finally, the relationship between professional ethics and educational ethics of any training will be important, not least because any educational programme is likely to have its own 'hidden curriculum' that is, over and above the formal curriculum, an implicit set of ideas and practices sending oblique and potentially counterproductive messages (Hafferty & Franks, 1994). For example, a programme for CHWs that was totally taught by healthcare professionals would send an implicit message about who is valued, and whose knowledge or expertise matters. We would therefore expect some congruence across health professional and CHW training.

Fostering Respect for CHW Contributions: Expanding the Boundaries of Expertise

Taking a relational approach to respectful partnership means fostering appreciation for the value of knowledge and expertise offered by CHWs through the approach and

content of training. Central to this idea is recognition of CHWs as 'experience based experts'—where language, culture, social norms, and community trust are valued on par with medical and technological knowledge (Powell, 2006; Gilkey et al., 2011). In focused, technical interventions on constrained timelines, the learning content and preparation of CHWs may focus on building technical expertise but this content can nonetheless be delivered in ways that are mindful of what CHWs bring to the training. As trainers and teachers, this requires expanding the boundaries of what counts as expertise in learning contexts and greater appreciation of 'everyday understanding' (Collins & Evans, 2002). Explaining how a rapid test for malaria works with a group of CHWs might invite discussion about the best time of day to administer the test to allow families to attend to normal harvest times, or a discussion of how best to explain the test in the local language—both essential knowledge to implementing the rapid test successfully.

Since much of daily work of CHWs is emotional and social labour, our views of expertise need to expand to include these essential but often unrecognized skills. This work includes the difficult and sustained efforts of navigating power structures and social norms, building relationships and trust within the community and with representatives and outreach workers from the health system, government agencies, and NGOs (Maes & Kalofonos, 2013). With the majority of CHW positions filled by women (WHO, 2018), this shift in recognition of the value of emotional and social labour will require that we take a critical stance to entrenched gendered norms and attitudes about 'women's work' and its worth in the highly gendered political economy of global health (George, 2008; Maes et al., 2010; Kane et al., 2016).

These shifts in thinking can be fostered in the approach to CHWs as learners, but must also target approaches to training health professionals who interact with or supervise CHWs. Cultivating respect for local knowledge will shape how CHWs are treated in a particular learning moment and over time by health professionals and support staff. In hierarchical health and social systems where obtaining secondary and university education is a mark of social status, there are often substantial cultural and social barriers to cultivating mutual respect, as noted above. There can be strong norms of superiority for those who have gone away to university as well as deference on the part of some CHWs toward 'superiors' who serve as supervisors or links within hospitals and health systems. Gender may also play an role, for instance, having mostly male supervisors for mostly female CHWs may be inappropriate, reinforce gender barriers, and limit acceptability and effectiveness of supervision (WHO, 2018). Shifting culture will require changes in training content for health professionals, and novel approaches to interactive, bi-directional learning that engages the expertise of all partners in community health programmes and encourages active respect for what others in the partnership contribute to learning. A respectful, inclusive approach to training, will include encouraging health professionals to recognize their own sources of educational privilege and to see their degrees and certificates, not as a rite of passage to superior status, but as an opportunity to share this knowledge with others and to learn from others in the community.

Engaged and bi-directional modes of teaching will further cultivate self-worth and mutual respect for CHWs. Simple exposure to knowledge does not promote respectful engagement with active learners, no matter the educational background of participants. Participatory methods, such as photovoice (O'Donovan et al., 2019), are increasingly being acknowledged as tools for treating CHWs as active, curious learners with deep vested interest in directly contributing to health improvements in their communities. Such training has further potential to engage community members' pride in making an integral contribution to a public good (see Chapter 2).

Indeed, this is but one example of a wider demand for different disciplines to work together. Different forms of knowledge are increasingly divergent and specialized, as new fields and sub-fields emerge, and this is only possible though the creation of clear disciplinary and professional structures, with the concomitant epistemological and ethical standards: to be an oncologist is not to be a paediatrician, nor an occupational therapist. However, as a result, there are more calls for these specialisms to learn to collaborate and cooperate, to work on 'wicked problems' because their complexity makes them almost intractable (Ritchey, 2011). To address these issues, there are increasing demands for working together across disciplinary and professional divides, and for finding ways of thinking about how different professionals should work together.

In terms of CHWs' professional values, this means having confidence in their own professionalism as part of the shared solution to these issues, and therefore neither doubting their own professional standing when confronted by the professional hierarchies of medicine, nor denigrating the potential contributions of others, who may lack any formal education. Their position as mediators between, on one hand, patients and communities who have specific knowledge of contexts and conditions but lack medical expertise, and on the other, those with more institutionalized knowledge, which is more generalizable but potentially quasi-abstract in real world settings. This means valuing local knowledge and the 'experience-based expert', and getting beyond technological knowledge (Powell, 2006), in recognizing what counts as expertise (Collins & Evans, 2002).

This account of the relational ethics of CHWs has begun to show the complexity of their roles in balancing different demands and obligations. Key to this is recognizing that their education is not simply being 'given' technical information about procedures and treatments for essential and preventive health services but is about developing their agentic capacity through practical reasoning (Fulford et al., 2012). Indeed, they are required to combine this technical understanding and practical knowhow with an awareness of the underlying scientific and medical explanations, and with the complex relational issues outlined above, from dealing with patients and communities to implementing new system-level strategies at a local level.

There are clear implications for their education here, notably treating CHWs as agentic adult learners, for whom education and development will be ongoing. Indeed, they will also need to learn how to develop their own practice in the future, both as reflective individuals (Schön, 1983; Eraut, 1994), and also within professional groups,

such as 'communities of practice' (Le May & Wenger, 2008), or 'relational expertise' (Edwards, 2010). Here, approaches that model or build on practice are valuable, through enquiry-led, problem-solving, developmental case studies that require agentic action, and thereby become educative, rather than simply demanding memorization and recall. Some examples would range from problem-based learning, particularly around increasingly complex case studies, in which a scenario can be presented simply and then adjusted and developed, to developing practice-based learning.

Beyond informing training with messages of mutual respect between health professionals and CHWs, other key features of CHW programmes and institutional design signal respect. Foremost is valuing the work and contributions through fair pay. Increasingly, fair compensation is expected and required in international guidance on CHW programmes and yet many programmes still involve volunteers or offer nominal pay for work (WHO, 2008; Maes et al., 2010; Olaniran et al., 2017; Palazuelos, 2018). While the desire to serve one's community by contributing to improvements in health is an important motivator for many CHWs, there is no strong evidence to support the view that fair compensation undermines this volunteer spirit for most. In cultural contexts where there are concerns expressed directly by the CHWs that wages may undermine a civic, religious, or cultural sense of duty, other modes of compensation can be negotiated with CHWs through prior engagement (Glenton et al., 2010). Non-monetary markers of recognition and fair commitment include investment in skills training that has value to a CHW outside a particular, narrow health intervention. For longer standing programmes this may include a pathway to professionalism, where feasible and desired by CHWs. Ethnographic research can contribute to our understanding of the range of expectations and motivations of CHWs, which include fair compensation, useful skills and employment opportunities, learning, meaningful relationships with those helped by their work, and altruistic goals, such as contributing the health of one's community, relieving suffering, or being of service in a religious or cultural sense (Kironde & Klaasen, 2002; Swidler & Watkins, 2009; Akintola, 2013; Maes & Kalofonos, 2013). Training programmes can be more responsive to context by engaging communities well before implementation and by building on other successful programmes in the region—both require sufficient financial support and timelines to accommodate planning, as well as cooperation across institutional boundaries to share information and lessons learned.

Moral Distress in the Face of Structural Needs: Ethics Training, Supervision, and Support

CHWs shoulder substantial responsibilities of care and in low resource settings face complex, unmet needs. Many such needs are due to structural determinants such as poverty, conflict, or geography. A common challenge faced by both health professionals and CHWs alike is the emotional distress of knowing what should be done

(e.g. feeding one's family) but not being able to do what is morally right (the community is experiencing a drought and food insecurity). In the clinical context, rooted in nursing ethics, this phenomenon has become known as 'moral distress' (Campbell et al., 2016; Dudzinski, 2016). Because this emotional distress emanates from deeply felt obligations toward fellow human beings when face to face with suffering, it is especially strong on the front-lines of care—with nurses, social workers, aid workers, field researchers, and CHWs—and yet very little attention is given to equipping front-line caregivers to manage this distress. For CHWs who find the most meaning in helping fellow community members, being unable to help with serious economic and social needs is a source of stress and frustration (Maes, 2013). One of the most difficult features of moral distress in low resource settings is that one's sense of obligation to respond to complex health and social needs encountered in community work is deeply felt, while sustainable responses require structural, institutional, and political solutions that feel out of reach. Over time, chronic confrontation with complex, unmet needs can contribute to the sense of hopelessness and burnout (Zulu et al., 2014).

Recent research has developed effective tools for measuring moral distress in clinical settings and could be adapted to the community health worker context (Lamiani et al., 2017). However, we lack effective training models for equipping health professionals and CHWs to respond to and cope with moral distress. Innovation and development of ethics modules suited to community health work are needed. There has been interesting work in nursing on developing skills of resilience, or the capacity to reduce one's stress in morally challenging lines of work, such as intensive care units (Monteverde, 2016). Here, resilience is understood as a coping response to moral sources of stress, situations viewed as morally wrong, or in the face of moral dilemmas. What characterizes these situations is that no matter what one does, the need is not met, or the harm has merely been minimized, so coping involves recognition of the limits of what can be done, and doing one's best in such circumstances (Monteverde, 2016). A limitation to seeking solutions to moral distress through models of resilience is that it places the onus on the person experiencing distress to learn coping strategies as opposed to addressing the underlying causes of a morally harmful situation or injustice. Importantly, managers and health professionals face the same structural drivers of inequity and struggle to effect lasting change. A potential approach to training and preparation, drawing from experiences of front-line community researchers and community advisory boards, is to establish proactive plans to connect community members to available services and to identify tangible opportunities for collective advocacy across community and health professional networks. This requires robust, supportive supervision and familiarity with the local health and social systems (Madede et al., 2017).

Relational Agency and Empowerment of CHWs

The relational turn in clinical ethics followed important work in social science on the relational nature of agency and empowerment—namely, that meaningful accounts

of a person's ability to act and engage in daily life should recognize that these are deeply influenced by and made possible by important relationships with others, including partners, family, friends, community members, and co-workers (Abrams, 1999; Archer & Maccarini, 2013). In ethics, important concepts, like autonomy and solidarity, have been reconsidered to acknowledge social influence and the value of relationships in determining right action and the scope of obligations to others (MacKenzie & Stoljar, 2000; Jennings, 2016).

Recognizing the value of relational clinical ethics presents a challenge to training and supervision, and in parallel, educational theories of work-based learning have had a relational turn, giving rise to new models of agentic learning in socially embedded contexts. One important theoretical contribution was Lave and Wenger's notion of 'situated learning', in which they pay attention to how collective knowledge develops through shared learning, and this has informed understandings of professional development across many disciplines and professions (Lave & Wenger, 1991; Le May & Wenger, 2009), though this work has been largely overlooked in CHW training (Winters et al., 2019). Others have highlighted how agentic and empowered professionals collaborate in the development of collective knowledge, for example Edwards (2010; 2017) has drawn on cultural-historical and activity theory (Daniels et al. 2010) to explore how individuals learn to work together, engaging with each other's expertise, through a developing 'relational agency' and a shared 'common knowledge'. And Nuttall (2017) has considered the implication of her work for learning within hospital hierarchies. These theories echo some of the findings of Vu Henry (Chapter 7), that simplistic models of learning are insufficient to account for the nuanced development of practices. Pedagogically, as noted above, the use of case studies as a form of problem-based learning has proved invaluable in developing inter-professional practices (e.g. Flaherty et al., 2003), as well as the direct involvement of patients (Wykurz & Kelly, 2002; Towle, 2007).

Exciting, recent work applies insights from relational ethics to CHWs' empowerment. Using Lee and Koh's analytic framework for empowerment, Kane et al. conducted a multi-country comparative study of CHW programmes in six LMICs and assessed CHW empowerment on four dimensions: meaningfulness, competence, self-determination, and impact (Kane et al., 2016). These case studies illustrate how organizational arrangements in LMIC community health programmes either promote or frustrate CHW empowerment along these dimensions. Reflecting on work in organizational studies they consider the potential tension between supervision and digital communication technology as a model of control and empowerment as a degree of independent self-determination (Hardy & O'Sullivan, 1998; Maynard et al., 2012). Following earlier work in psychology they argue that for CHWs in LMICs, 'there is nothing in the psychological definition of empowerment that requires the increase of power of one group to decrease the power of another group; power does not have to be seen as a zero-sum commodity, but can be a 'win-win' situation' (Swift & Levin, 1987; Kane et al., 2016). Relational agency gives greater scope and flexibility to guide this balancing act and encourages an approach to supervision which

is supportive rather than controlling, but at the same time providing critical guidance when CHWs encounter situations that fall outside their clinical abilities (WHO, 2008). However, one of the challenges in striking this balance within working relationships is that shifting from a mode of empowerment to one of more authoritative supervision can be jarring if not done delicately. More engaged, long-term supervision can be both respectful and encouraging, and yet setting important boundaries when task shifting would raise concerns about clinical errors, but this is a skillset requiring careful training and experience for supervisors and CHWs in cultural contexts where authority and hierarchy sometimes take precedence over finding meaning in empowered work. One promising approach in training is to emphasize the nonclinical skills and contributions of CHWs during such boundary-setting (Naimoli et al., 2015).

Fairness and Inclusion

In addition to respect, another vital principle essential to ethically grounded CHW training is that of fairness—treating others with equal moral consideration within institutions and practices, and being mindful of patterns of discrimination that may need to be corrected to improve equity of representation. Grounded in the recognition of the equal worth of individuals, and like respect, fairness in a programme or practice is an ethical consequence of numerous norms, decisions, and moral attitudes toward one another. Indeed, fairness is entwined with respect, in that both require differential treatments of different people (Rawls, 2001). It means not unfairly favouring some in the community more than others, or prioritizing those who are in greatest need and most able to benefit from interventions, and recognizing that CHWs should be fair is implicitly to recognize that they have power to administer it, particularly in the distribution of and access to medical and health provision (Rawls, 2001). For example, CHWs may often find themselves in a position where they must decide who gets treatment access to care, or, 'Is the new clinic to be built in village A or village B?' Where principles of fairness guide us to give priority or greater consideration to those who are worst off in a community or society, CHWs may be in a position to ensure that a community health programme is designed optimally to give fair opportunity to all, not only those in a superior social or economic position (Rawls, 2001; Winters et al., 2020). Believing that the system should be fair means recognizing that it sometimes is not, either in terms of treatment (hence the need for advocacy, noted below) or in terms of the organizational hierarchies at stake. If the CHWs have some power, there are others within the wider medical community who have more. Finally, fairness also means not behaving selfishly or using the role for personal gain, as part of their professional responsibility, as outlined above. CHWs must judge themselves by the same standards and provide the same level of medical or healthcare to others as to themselves, their family, or those in power. Within an education programme, fairness needs to be both an explicit part of the curriculum, as an underpinning principle, but

also inherently embedded within the educational processes, such as pedagogy and assessment (Winters et al., 2020).

Solidarity and Shared Advocacy

It is precisely in contexts of systematic and historical inequity where appeals to fairness and respect are not always enough to effect change at a programmatic level. As Benatar (2003), Harmon (2006), and Farmer et al. (2006) have independently argued, global health discourse has often overlooked the moral and politically transformative power of solidarity. Reconnecting with traditions of solidarity in community health calls on health workers at all levels and skill sets to recognize that we are in a shared struggle for a common purpose, that finding sustainable, more equitable solutions to complex structural problems will require structural, collective interventions. Jennings explains how we can reinvigorate public health ethics by paying attention not only to 'architectonic' ethical theorizing, at the level of principles, but also to 'relational' theorizing, with a combined appeal to solidarity and care ethics:

> Solidarity is characterized as affirming the moral standing of others and their membership in a community of equal dignity and respect. Care is characterized as paying attention to the moral (and mortal) being of others and their needs, suffering, and vulnerability. The wager of relational theorizing in health care and public health is that substantive ethical visions of solidarity and care will provide support for more just and egalitarian health care and public health policies.
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> **(Jennings, 2019, p. 4)**

By recognizing our starting point in an interdependent world and reconnecting with the spirit of community spaces as a powerful place for change, community health programmes can be treated as part of the broader web of geographical and professional communities, across which both health information and practical strategies of social change have the potential to be shared more widely and more quickly than ever before (Frenk et al., 2010).

Building upon a shared responsibility is the obligation that flows from CHWs' solidarity with patients and communities to use their role as professional to speak out on behalf of patients and in setting community health priorities (Hoedemaekers & Dekkers, 2003). Thus, their responsibility is not simply to treat, as outlined above, but also to express, argue, and request—and perhaps complain and demand—on behalf of those needing care. This particularly applies to those who find the medical system hard to navigate for whatever reason—disability, poverty, age, gender, language, and perhaps prejudice. It is linked to fairness and inclusion. Clearly, it is one thing to expect a CHW to engage in advocacy, and another to expect a student to do so, but it should still be addressed in teaching or through practical experience. We, of course, do not envisage advocacy training as student lawyers would learn it, through moots

and debates. Instead, it is through smaller encounters and raising awareness, encouraging active reflection on shared experience in training, and demonstrating a degree of self-worth and even courage in some situations. Here simulation-based approaches could be used, for instance asking CHWs to design a poster for a community on the treatment of disabled members of the community.

Ethical Principles to Guide a Relational Pedagogy

As we have shown, many of the challenges and perceptions discussed so far are relational and ethical in nature. Relational work requires skills in relationship-building and fostering the relational agency of CHWs through engaged supervision. As such, innovative training programmes for CHWs, health professionals, and supervisors could be improved by paying more explicit attention to building capacity in relational ethics. Emerging from clinical ethics in nursing and linked to feminist traditions in care ethics, relational ethics situates moral decision-making, actions, and obligations within relationship (Noddings, 1984; MacDonald, 2007; Gilligan, 2008; Gergen, 2009; Baylis et al., 2008; Held, 2005). As MacDonald has argued, practical ethics teaching following this tradition is concerned with more than teaching students to problem-solve in the face of ethical dilemmas, it is about developing the skills for living and working together. It is also highly sensitive to the context in which those relationships can be fostered and sustained. To this end she offers a pedagogical model based on four core principles: mutual respect, relational engagement, bringing knowledge to life, and creating environment, to better support nurses within roles of moral responsibility and advocacy (MacDonald, 2007). Building on these principles in the context of community health practice and incorporating more explicitly the values we have defended here, we have a useful framework to inform teaching and training for CHWs and health professionals engaged in supervision and support for CHW programmes. We illustrate how each principle can be grounded in professional commitments and inform innovative teaching methodologies and training content (see Table 11.1).

Clearly, the use of these strategies, and indeed the underpinning pedagogical assumptions will raise issues for the design of any assessment criteria, such as standards or competencies. These alignment issues are too complex to address in full, but might be met by the use of portfolios, reflective logs, or observation by experts. Put simply, assessment will also need rethinking. The hope is that by putting the values front and centre we can prompt meaningful consideration of practical ethics considerations as well as dialogue around the deeper systemic injustices that give rise to the desperate need for CHWs as a recognized and valued part of extended health systems.

Table 11.1 Putting ethical principles to work in CHW and health professional training programmes in LMICs

Ethical values and principles	Shared commitment	Practical illustration
Mutual respect and recognition	*We will demonstrate respect for patients, community members, and co-workers, acknowledging the values, choices, and knowledge they bring to the situation.*	A teaching session in rural Kenya begins with an interactive session of imaginative role reversal where CHWs and health professionals step inside each other's roles to appreciate challenges and mutual expertise.
Shared decision-making and solidarity	*We recognize that to achieve improved health for all requires our joint efforts across communities and health systems—we all have the same goal—improved health and a better life for our families and communities.*	After several emotionally challenging cases of domestic violence in their communities, CHWs, health professionals, and community leaders in South Africa convene a workshop with participatory theatre to bring violence in the home out into the open, exploring violence as a common challenge for them.
Relational agency and empowerment	*We are committed to offering the knowledge and support needed for patients, community members and co-workers to engage actively in their health and work.*	In interactive session with new CHWs asks them to solve a complex problem together, through case studies. The dialogue requires them to support and be supported by each other, and a debrief prompts participants to reflect on other ways of empowering each other by sharing knowledge.
Fairness and inclusion	*We are committed to fairness in treatment and support for all patients and co-workers, regardless of gender, ethnicity, disability, or socioeconomic background.*	Through a case study in which the vaccinations are not given fairly, favouring community leaders' extended families. CHWs are asked to consider how they should and would deliver the programme.
Shared advocacy	*We have a shared commitment to advocate for those in need of better health services and to connect patients to existing services where feasible.*	A new CHW programme decides to set aside time for supervisors, CHWs, and mothers to proactively develop an advocacy plan to address expected, urgent needs related to the new antenatal health programme.

Conclusion

It is over a decade on from the Lancet commission on Education of Health Professionals, which called for a transformation of health education to respond to increasing global interdependency, including new technologies, information networks, professional migration, and financing across borders (Frenk et al., 2010). As the global health community, development organizations, and governments set out aspirational targets for equity in health, development, and well-being for a global population through collective commitments like the Sustainable Development Goals, community health programmes need to be recognized as foundational to success (United Nations, 2015). We have reflected on how such commitments to relational ethics and social justice inform CHW and health professional training. Without this admittedly aspirational, shared commitment, there is a tendency for well-meaning, pragmatic efforts and programmes to devolve into siloed agendas with CHWs feeling disconnected and powerless to effect change on their own. We have argued for a shift in policy discourse and training philosophy that gives greater attention to building relationships and support to foster successful, sustainable community health programmes in an increasingly interdependent world.

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