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’Our hands are bound’: Pathways to community health labour in Kenya

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A B S T R A C T

An ideal model of Community Health Worker (CHW) selection has existed since long before Alma Ata catalysed the community health approach, dating to late colonial times. In this model, a willing, trusted, relatively well-educated and secure member of the community with proven aptitude is openly elected by their leadership, peers or relevant committee. Their participation is entirely voluntary and that voluntarism is symbolic of their community’s participation as a whole. While this imagery is long-embedded in CHW storytelling, such practice is rare. While elements of this ‘model pathway’ exist, a myriad of structural and agential factors shape who becomes a CHW, how and why. Through life history interviews over twelve months 2022–2023 with 68 CHWs in Isiolo, northern Kenya (known as CHVs), we explore predominant pathways to community health labour as told through stories. We articulate five such pathways: model, handpicked, shadow, outsider and, most importantly, dispossession. Through telling five CHVs’ stories, we present each ‘ideal type’ but also explore how each pathway is not singular, rather overlapping in complex, context-specific ways. These pathways confound Western-centric, Western-promoted notions of voluntarism and indeed community health, which cannot explain why such labour endures. We conclude that our findings provide a timely commentary on how voluntary labour within health continues to tax structural poverty and frustrated life chances in lieu of concrete and expansive investments in human resources for health by governments and health agencies both North and South. In understanding voluntary labour as a form of structural violence, we can better elucidate the historical dependency on this work in impoverished regions and how the undervaluing of such work persists over time.

1. Introduction

The community health approach has existed in international health for over a century (Packard, 2016; Rifkin, 2014), but was codified and catalysed by the UN Declaration of Alma Ata in 1978. The post-war landscape and the rapid decolonization of large swathes of the globe from the late 1950s reinvigorated communitarian, ‘people-led’ responses to newly independent states’ challenges (Immerwahr, 2018; Mayo, 1994:64–65). Given such countries were now at least nominally equal players in the global governance architecture, their influence was becoming tangible (Slobodian, 2018). This influence arguably peaked with the UN Declaration of the New International Economic Order in 1974, which sought to protect states’ newfound sovereignty and to further resource equity globally. It was against this backdrop that Alma Ata codified the role of ‘the community’ as part of bottom-up, inclusionary and comprehensive healthcare for all. Not only did the conference take place within the USSR during the cold war as a result of Soviet politicking, other non-Western players such as China were also invested (Basilico et al., 2013; Packard, 2016). Alma Ata was therefore, in many ways, revolutionary.

The treaty marked out radical new principles of primary health as comprehensive, holistic and preventative as well as curative. Health interventions should not be top-down impositions, as in the colonial past (Fanon, 1965; also Greene et al., 2013; Packard, 2016) but conducted with the people, for the people and, famously, by the people (Newell, 1975). A flipside was that the people’s participation and compliance would be voluntary, with citizens ‘responsibilized’ (Brown and Baker, 2012) to steward their own healthcare. However, the principles ensconced by Alma Ata drew water from selectively drawn case studies (Rifkin, 2014), wherein the mandating of unpaid labour at the local level had become increasingly enacted through force, sanction and censure, primarily in left-wing authoritarian regimes. In any case, the heady

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visions of Alma Ata faltered quickly, as the sovereign debt crisis, natural and manmade crises in the 1980s, checked the ascendency of non-Western powers and meant liberalization and state retrenchment won out over any alternative order (Basilico et al., 2013; Packard, 2016; also Immerwahr, 2018; Moyn, 2018; Slobodian, 2018 on the clash of ideas beyond health).

A rump of community voluntarism and self-help, however, has endured, speaking to right wing ideals of cutting state cost and state responsibility (Bloom and Kilgore, 2003; Davies and Pill, 2012), as well as left-wing communitarianism and empowerment. This ability of voluntarism to be 'what states make of it' allowed its embrace under the soft-left governments of Bill Clinton in the US and Tony Blair in the UK from the late 1990s (Anheier and Salamon, 1999:45; Rose, 1999:171). In 1997, the UN General Assembly declared 2001 to be the Year of the Volunteer, stating volunteerism to be at the heart of its ideals and calling for all to volunteer (UN Press, 2001); the EU similarly promoted voluntarism as part of healthy democratic life (Anheier and Salamon, 1999: 46). Then, in what Rose identified as 'ethico-politics', these principles were readily embraced by successors to the right (Rose, 1999: 188; also Cruikshank, 2019). More recently, some industrialized countries sought to capture a wellspring of voluntarism during the COVID-19 pandemic (BBC News, 2020; Hellen, 2019), re-embedding self-help and volunteering to buffer demands on the state (Atkinson, 2021; Gilburt, 2020). Voluntarism's cross-spectrum appeal thus allows it to be promoted as a leveller and a signifier of common humanity 'transcending national boundaries' (Anheier and Salamon, 1999:43), in ways, we will argue, that mask structural inequalities and the full 'spectrum of voluntariness' (Badurdeen, 2020).

We use the example of community health in Kenya to spotlight the dark underbelly of voluntarism in poor and marginalized communities. While CHWs are salaried in some parts of the globe, recent estimates suggest only 14% are in Africa (Nepomnyashchiy et al., 2020). In Kenya, community health work is explicitly voluntary (Government of Kenya, 2020), meaning any financial incentives are ad hoc and unreliable. We examine the case of Isiolo County, geographically central but historically viewed by ruling elites as buttress to the ungovernable north (Amutabi, 2005; Carrier and Kochore, 2014; Elliott, 2020). While Isiolo's urban centre is dynamic and diverse, its outlying pastoralist areas were strategically marginalized in the colonial era, disproportionately affected by drought and resource conflict ever since (Cox, 2015; Hogg, 1986; Mkutu et al., 2021; Schlee and Shongolo, 2012; Wagura, 2016). Within this precariousness, over 700 Community Health Volunteers (CHVs) were incorporated into a partnership between the county and a US non-profit organization in 2018: most had been volunteering for many years. 2019 marked an uptick in CHV duties, households and reporting demands. CHVs were equipped with a smartphone for data collection and given a base monthly stipend of 2000 Kenyan Shillings (averaging ~17 USD over the four years) by the county, with performance-related top-ups. Trainings and outreach conducted by non-governmental organizations (NGOs) supplemented income for a select few. Stipends were subject to long delays, exacerbated by COVID-19 and drought-related emergencies: a gap of eleven months triggered an attempted strike in July 2021 and our fieldwork coincided with a further six month delay. All phones had degraded considerably, with 1/3 of phones not functioning by 2023.

To explain why CHVs continue to work, despite visible upset, we eschew the individualistic, 'prosocial' modelling of voluntary behaviour in the West (Anheier and Salamon, 1999; Aydinli et al., 2016; Penner, 2002), arguing the recruitment, monitoring and maintenance of Isiolo's Community Health Volunteers (CHVs) to be structured by disadvantage and even violence. While we do not discount individual motivations, we favour a 'historical understanding of the large-scale social and economic structures' (Farmer, 2004:305) that leverage labour 'on the cheap' (Boesten et al., 2011; also Campbell and Scott, 2011; Maes, 2012), half a century on from Alma Ata's progressive vision (Wintrup, 2022). Understanding so-termed voluntary work must take into consideration historiographies of forced or mandated labour in Kenya by colonial, missionary and post-independence regimes (Bellucci and Eckert, 2019; Cooper, 1996; Cunningham, 2022; Fall and Roberts, 2019; Van Zwanenberg, 1975), as well as how colonial-like frames of self-help continue to leverage unpaid labour in contemporary development (Rossi, 2017). With regards to Isiolo, its marginalization, followed by its recent incorporation into modernist visioning (Elliott, 2020; Mkutu et al., 2021; Wagura, 2016), shape moral, political and economic horizons that affect who undertakes voluntary labour and why. We thus do not overlook the advantages in undertaking part-remunerated labour but rather explore the relative disadvantage that makes such work a realisable and, for some, inevitable undertaking from which exit is impossible.

Specifically, our overriding finding was a profound sense of *dispossession* for the majority of CHVs. Rather than dispossession's classical formulation in Marxist thought, which focuses on the forcible loss of tangible assets from the poor to the rich (Das, 2017; Harvey, 2003), although this happened so starkly in settler Kenya, we point to a more expansive and often painful sense of loss, whether of land, an education or a broader life chance on the part of CHVs. We embrace Bin's framing, whereby dispossession in the early lives of many CHVs is a form of more wide-ranging, 'expanding dispossession', which in turn sets the stage for 'additional labor exploitation to take place' (Bin, 2018:83). Despite community health's radical inception, exploring lives in historical context spotlights how long term dispossession has thrown workers 'into a labor pool targeted by 21st century CHW recruiters' (Maes, 2017:56). We thus conclude that community health, as a buffer for low resource investment in impoverished regions, demonstrates how 'global health priorities in the present have been patterned by social forces with roots in the colonial past' (Greene et al., 2013:34).

2. Methodology

In this article, we present the stories of five CHVs, offering each as an 'ideal type' in probing pathways to community labour as well as its spectrum of 'voluntariness' (Badurdeen, 2020; also Dodworth, 2019). Ideal types are associated with the writings of Max Weber and can prove helpful devices in ordering complex socio-economic phenomena. Such types have at times been misread as an attempt to portray a complete or perfect representation of a particular modality. Goodson suggests the ideal type to be a 'methodological sidestep' in the service of quantification that avoids the necessary 'messy confrontation with human subjectivity' (2013:33). Weber was clear, however, that ideal types are a heuristic device (Cahnman, 1965:271), resulting from 'the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena' (Weber, 1949:90 [1904]). Types do not stand in isolation but intertwine in complex ways, which applies here. We hold that there is value in presenting each story as true to the CHVs' sharing of them as we can. Our storytellers have reviewed our presentation and chosen their pseudonyms.

While there is subjectivity in our selection of these stories, this presentation is informed by a larger study. We undertook what we initially termed life history interviews with 68 CHVs in Isiolo County, Kenya, between April 2022 and March 2023, with follow-up interviews, calls, messages and interactions. Half were men, reflecting the CHV population in Isiolo. Of the five here, Echwa and Yusuf were interviewed three times: Sarah, Judy and Jacinta twice. Almost half were conducted by Mukungu and a handful by Dodworth alone, with the remainder by both authors. Interviews took place in Swahili (interspersed with English terms as is common in Kenya), given Swahili had been identified as the language of business for CHVs in multi-lingual Isiolo. While we initially snowballed our sample, our participation in monthly CHV administrative meetings at the invitation of the county yielded an improved selection process. These meetings were compulsory, called by government and co-convened by INGO staff, and were the main vehicle to surveil and discipline CHVs with regards to performance. These were generally not

cordial encounters for CHVs, or indeed ourselves.

We attended 25 such meetings across the county observing CHVs' interactions with government workers, each other and ourselves, cross-checking with individuals' performance data to allow a more varied dataset. Our role was limited to introducing ourselves and our project mid-meeting, emphasizing that we were not government or NGO representatives. We approached possible interviewees afterwards, returning to interview them, if agreed, some days later. At first we gravitated towards those most vocal but learned to locate the quietly engaged as well as disengaged. Over time, we undertook 61 days' participant observation, or rather 'negotiated interactive observation' (Wind, 2008), making no claim to have *participated* in healthcare or to have achieved insidership. As visible outsiders, we negotiated access and observations continuously, observing meetings, household visits and community outreach, withdrawing where appropriate. The life history interview, however, remained the project's centrepiece.

The life history approach was developed by anthropologists and expanded by sociologists, before losing ground to statistical methods post-war (Goodson, 2013:32–34; Lewis, 2008). It was resuscitated by historians aiming to reconstruct a particular era or event. In doing so, historians were able to gap-fill periods where documentation was sparse but also construct a bottom-up, even democratic approach to writing history (Abrams, 2016:18; also Portelli, 2009; Thompson, 2000; Yow, 1994). Life histories are now used in a wide range of settings, including community health (Jessee, 2019; Maes, 2017; Maes and Kalofonos, 2013; Yarrow, 2008). While we adopted the term life history, however, at a certain point we relinquished part of its intent. Goodson expounds on the need to move from life *story* to a more complete *history*, whereby the interviewer cross-questions the storyteller drawing from other data sources in order to access broader structures (2013:37; also J. Elliott, 2005). While we did triangulate, and indeed aspired to probe the institutional superstructures that effected unpaid labour, it was not our goal to write history. We simply collected stories without conceding any epistemological demotion. It was an unstructured, at times haphazard approach that allowed CHVs to re-present, misrepresent or de-represent their lives as they wished.

Despite this flexibility, we experienced challenges within contexts of poverty, low levels of education and where suspicion of outsider interventions ran high (all of which related to the selection of Isiolo). The success of the interview was mediated by gender, age, ethnic group, religion, urbanity and level of education. At times, the approach worked akin to its textbook formulation. At others, such as with women in remote areas with strict gender norms and distrust of outsiders, it foundered. While the research had obviously been through conventional ethical review (approved by The University of Edinburgh's School of Social and Political Science Ethics Board and the Kenyan National Commission for Science Technology and Innovation, March 2022), we strove to go beyond the edicts of conventional review by constantly honing praxes regarding entry, consent, reciprocity and managing relationships. One key challenge involved the relaying of traumatic events. As we were not targeting groups *by virtue of* presumed trauma - for example those affected by conflict or (as Mukungu previously) genital mutilation - we were not fully prepared. In prompting CHVs, they relayed stories of violence, dispossession and other forms of trauma for which we did not have specialist training (Abrams, 2016:117). As such, we put CHVs and, to a lesser extent, ourselves at risk of harm and rapidly put improved 'difficult interview' protocols in place. We were reassured by CHVs expressing the encounter to be cathartic, for example:

> No one has ever taken the time to sit me down in an interview [...] I am happy that you are the first people to do so. Nobody has ever asked about my story [...] I am grateful that you have asked and I have told you my story (interview with Jacinta, June 2022).

To create our ideal types, we manually conducted an inductive, reflexive thematic analysis, which emphasizes the active role of the researcher in knowledge production (see Braun et al., 2018:848). Our first iterations, based on the first third of fieldwork, were honed, merged and sometimes rejected on the basis of subsequent data. While our full dataset has since been coded using Nvivo software, with each volunteer designated a primary, secondary and possible tertiary pathway, computer analysis was not necessary here. Our aim here is not to slice and dice experiences in the service of analytical categories but rather to 'sit down with people in their multi-layered political, economic, social and moral contexts' (Maes, 2015:11 drawing on Biehl, 2010). As such, we feel a deep-seated, ongoing ethical commitment to treat CHVs and their stories with the utmost care.

3. Yusuf: modelling community health

Our first story details the life of Yusuf, recommended by another senior CHV. Yusuf was the first CHV we interviewed as a pair, so we were finding our feet. The day we first met Yusuf was the day we interviewed him, a practice we quickly changed. Yusuf requested to meet us at the dispensary, rather than his home, which we later understood as his way of keeping us at a distance while uncertain as to our objective but it also underlined his centrality to the clinic. Despite delimiting his personal life, it was a memorable and animated first interview, where he spoke 'warmly and at length on all issues', signifying considerable expertise, self-assurance and experience. As we conducted the interview, Yusuf skilfully fielded requests from anxious patients arriving at the clinic, before mediating an unexpected shipment ofmegovernment supplies after a two year hiatus due to COVID. As captured in fieldnotes, he 'seemed central to the clinic business, well-liked and well-known'.

While he looked older than his 62 years and gaunt, Yusuf demonstrated boundless energy for his work working seamlessly alongside government workers, demonstrating skills, commitment and interpersonal relationships that were truly **model**:

> You'll find me at the facility or in the community doing my work. I have no time to stay at home when my people need my services. I am working on a daily basis and I love doing my job.

This statement was borne out by interactions and shadowing over an eight-month period, where we saw Yusuf spend the vast majority of his time serving this community. He was also unusually forthright about the challenges CHVs faced, both to us and government staff, disclosing his seniority and security in that role.

As we built trust over time and Yusuf became more candid, we began to weave his life story together. Yusuf was born and raised in Isiolo Town in the 1960s, thus living in an urban environment with a diverse mix of ethnic groups. As the third born in a family of seven, he spoke warmly about his early childhood before the mood changed, when explaining he dropped out of secondary school:

> I left school at Form Three. My father did not have money for school fees - this really affected him psychologically. The principal wanted to get me a scholarship but he died before this came to pass. I had to survive so I started working as a casual labourer building houses around our area.

He spoke with a sombre tone and blank, disassociated stare when describing his father's distress, moving on to his precarious early life and the responsibilities he shouldered:

> I started hustling at an early age due to our situation at home. Being an elder brother from a humble background, I had to put myself out there to make ends meet. I got into masonry and casual work at the livestock market before becoming a CHV.

Later, after reading a draft of this story, Yusuf reiterated the lack of choice in becoming a CHV without realistic alternative means, having felt the unreliability of ad hoc labouring.

Even after months of knowing Yusuf, he remained uncomfortable discussing painful personal matters, brushing over events that saw him

and his wife separate and his grown-up daughter to be in Nairobi. When later probed, he rebuffed:

> You know, I don't like to remember that stuff … I lived with my wife for a while. After some years our child was about four years old. I was at loggerheads with my mother-in-law ….So I decided to leave her daughter.

Despite, or perhaps because of, these private difficulties, Yusuf channelled vast energy into his public role.

> I came to realise that people in my village are suffering from various diseases and sometimes they came to inform me of the symptoms. In this, I saw this as an opportunity to offer my help.

A call for CHVs by the public health officer in 2010 saw Yusuf endorsed by community members as long-time resident and consummate insider: the epitome of model practice. Yusuf went on to receive large amounts of training over the years, persevering when many others dropped away due to lack of payment. He masterfully monitored around 100 households, his skill in dealing with community members notable. He took great pride in this:

> I do not think there is anyone else who can be reliable enough to do this kind of work. I have been here for so long and in the process gained a lot of experience. I even go round with the medical students who learn a lot from me. There is nothing that can go wrong if I am in the community. This role has made me influential in the community.

His pride was affirmed by others. A senior nurse from Isiolo's main hospital applauded Yusuf in a monthly meeting: 'If only you knew how you are praised in the whole county. You are the one putting Isiolo on the map and getting us to the top in our performance'. Yusuf continued to send his performance data to us, consistently hitting the top performer rank.

In many ways, Yusuf's story is the **model**. A trusted insider, with the virtues and skills to become as senior and effective a CHV as we saw, he crafted an immutable identity and authority. He had become a strong voice for CHVs, uniquely speaking truth to power when he felt slighted or injustice on the part of the government workers who constantly disciplined him and fellow CHVs. At the same time, through probing his personal story (which sat less comfortably than his public persona), we saw that he had experienced some form of **dispossession** at an early age. Yusuf was forced to become what is referred to in Kenya as a hustler, whereby through grit and determination 'anyone can rise from nowhere … and become somebody' (Mwaura, 2021). Yusuf had hustled his rise as a CHV to such a degree that he was peerless, selected for every training and activity. With these coming with a financial incentive, he could semi-professionalize but also became unassailable. Without competing responsibilities and his family gone, a source of underlying pain, Yusuf worked all day every day to maintain such.

4. Echwa: outsider

As explored, the 'model' CHW is a trusted insider at the heart of the community. In the Kenyan government's Community Health Policy, it stipulates that volunteers have been resident in a community for five years (Government of Kenya, 2020:15), although that is not enforced. In many of our interviews, however, CHVs were outsiders by virtue of ethnic group, place of birth or other identity markers but also, less tangibly, by mediating life events. Mindful that insidership is at best 'partial' (Narayan, 1993: 676; also Dodworth, 2021; Naples, 1996), we refer to the negotiation of outsiderness via the use of voluntary labour to embed oneself in a locality. In this modality, such work is a 'step up' for disadvantaged outsiders to do that eschewed by insiders as a 'step down' and of insufficient personal benefit. In this account, we explore the story of Echwa who was, by virtue of conventional markers, an insider and yet articulated a pronounced sense of outsiderness, which he linked to becoming a CHV.

Echwa was Turkana, born in a predominantly Turkana, peri-urban area. His village was marred by clashes between its resident populations, specifically Turkana, Borana and Somali. These groups had clashed historically due to inadequate pastures and water access (Awuondo, 1990; Mkutu et al., 2021; Osamba, 2000). When Echwa was born in the early 1990s, prolonged tensions had led to groups to segregate within the village along religious lines, leading to Muslim and Christian areas. Given these divisions, Echwa became suspicious of many within his own village as well as of 'outsiders', not least ourselves. On the day of our first interview, for example, he brought Mukungu to his mother's house so that, as a 'seer' whose role was to foresee threats, she could evaluate our intentions. At the end of that visit, Echwa stated openly that he had withheld his stories, declaring he was not ready to share them and that we were not ready to hear them.

It took time to understand the impact of these divisions on Echwa. He gradually shared more stories, including the painful loss of his uncle who 'died protecting our community from its enemies'. Insider-outsider divisions felt interwoven into everyday life: 'when the night falls in this place, you encounter enemies'. Further to such fears at 'home', Echwa's parents adhered to customs whereby the maternal grandmother raises the firstborn as a means to support her in old age. He was given to his grandmother at six months, severing familial relationships: 'I only got to know my parents as an adult'. Echwa thus grappled with his sense of identity and belonging from an early age. He remained inseparable from his grandmother who had 'fended' for him, his face lighting up when speaking about her:

> 'she can't live without me; even if I go see her today, I'll long to see her again the next morning'.

Ongoing tensions made it difficult for Echwa to finish school:

> In 2012, the conflict intensified. It got really bad and made things very hard; I finished my primary school studies with difficulty because of that awful ethnic animosity, even in the classroom.

This environment pushed Echwa to default divisions, stating 'I had to defend my fellow Turkana and they also defended their own'. Given his negative associations, we never learned how Echwa performed academically but we did know that he was desperate to continue schooling. In the final year of primary, he returned to live with his parents, which derailed the possibility:

> I had an estranged relationship with my father. He was constantly on my case and I knew it was because we did not have that bond when I was young. He looked at me as an enemy and made sure to sabotage all my efforts in trying to get some money to get me back into school. I would say he dimmed my light and ruined chances of me being successful in life.

Echwa tried to take action himself, cultivating vegetables to sell but lamented, 'my dad would tell the village women to come and pick them; I really felt hurt', with the bitterness palpable:

> What kind of father would allow their child to suffer like that? I felt like I did not belong in that household and would have been really far if it was not for him thwarting my efforts. I had to move out and become self-reliant.

With Echwa an outsider at home, feeling no affinity with his peers, he began crafting a new identity, immersing himself in the church and becoming a youth leader. He volunteered for a number of initiatives, including as secretary to a women's kitchen garden group. Through the church, there came a call for people to mobilize the community to get tested for HIV, who would be known as Community Health Workers. Since he was becoming known as a leader, he volunteered and was the youngest in the cohort.

Echwa's formative years were thus spent continually constructing an identity apart from his family, enjoying his growing influence and responsibilities as a volunteer:

> I usually walk around this area; there is no place that I am not known because I get to know how people are faring. The way you interact with people they become happy. So when I go to other areas and see them getting help, I will get the spirit to help my community. And when you are in the community there are things that you won't allow to happen on your watch.

In Echwa's stories, we discerned different pathways. His commitment, resilience and performance signifies a **model** CHV: he was on paper a lifelong resident and insider. In reality, his **outsiderness** derived from the trauma of his perceived childhood abandonment, compounded by other forms of **dispossession,** had disadvantaged him socially and economically. Echwa used voluntary labour as a way to embed himself into a community he had felt alienated from, to validate himself in lieu of family and, ultimately, to bolster self-esteem. The negotiation of insider-outsider dynamics with respect to their assumed communities and the use of unpaid labour to overcome disadvantage was a dominant theme throughout our interviews.

5. Jacinta: handpicked

Jacinta lived in a particularly conflict-affected area of Isiolo County that was unpredictable for outsiders, county and national government and other service providers to access. This area had been affected by long-standing grievances between pastoralist and settled business-owning populations, the latter seen to suck resources from an impoverished region. After months of being out of bounds, we seized a window of stability to enter the region. The stories we collected from CHVs in this area were as impactful as we encountered. Despite our apprehensiveness in reaching this area, we received our most memorable receptions from CHVs.

Jacinta seemed especially happy and enthused by our interest in her life. Jacinta was a mother of six and born in another county. She was one of ten siblings and, in her words, in her culture, girls are 'offered' for marriage at a very young age. As she was heading into Primary Eight, she was 'offered out' for marriage, ending her education. She joked about this **dispossession** in a playful way that, to our minds, deflected from her sadness. Nevertheless, Jacinta reflected positively about her childhood and the time she did have at school, where she loved studying science, music and history:

> My childhood wasn't so bad. I was at a boarding school; we didn't live near the school. I was enjoying it because you know at that time, kids loved boarding [laughs]. You feel it's a very relaxed environment […] Even the lessons weren't all that but it was just really lovely for a child to be at school.

After being forced to leave school, Jacinta was 'handpicked' by Catholic Missionaries in 1998 for health work on the basis of her literacy and aptitude:

> I was chosen by the Sisters near the mission. I was helping out at the hospital and when they saw the project they contracted me because they needed someone who could speak to white people, who could understand English. Then they just had me stay.

Her work within the mission eventually led to her selection to work with the prestigious NGO Médecins Sans Frontières among other NGOs, gaining recognition from her community: 'I was now accepted as a CHV and the community preferred me and had chosen me'. Given this, external actors sought Jacinta out:

> They were telling us to choose someone who can understand and who can work with them. So I did and they were really happy; even after they left they came back to look for me, but I had already moved.

When Jacinta moved to a new area, closer to relatives on her father's side, she started from scratch, seeking out NGO opportunities. She began volunteering with a smaller NGO that worked with children, as well as supporting a Sister running a mobile clinic. Eventually, as the drive to recruit and formalize CHWs gathered momentum in the 2000s, Jacinta was selected given her previous work. When such work was viewed as potentially beneficial, Jacinta's outsiderness sparked challenges from within her adopted community:

> They said, because I'm from another place, let's take this one of them to go and be trained then I should go next. Now I'm sitting with those CHVs who have been selected, they know my work. They spoke up and said that we are not leaving Jacinta; we must go with Jacinta to training. They themselves decided.

At this point, her history of being handpicked by missionaries, NGOs and finally fellow CHVs, overrode any movement to deselect her by her community. After returning from training, her fellow CHWs 'moved slowly' due to no incentive, eventually dropping out. Jacinta was left alone, adding 'the only voice heard was mine: the voice heard everywhere', signifying growing influence. Over time, she began to be involved in more initiatives, including mobile clinics, bumping into a doctor from her previous life:

> There was a doctor there I had already worked with at MSF; he found me there and said, 'Oh, Jacinta, how come you're here!' He said, 'I need three CHVs. For those CHVs, Sister, you choose two, but I'm picking Jacinta because I know her.'

Every time Jacinta was excluded, she found ways to continue working, remaining 'seen' by NGOs. The doctor's preference again overrode pushback from the community. When Isiolo's considerable upscaling of CHV coverage began in earnest in 2018, with over 700 CHVs selected or confirmed for training and to receive smartphones for data collection, Jacinta could not be excluded. She was by then embedded in healthcare in her adopted community and the role had become integral to her identity. Like all CHVs we interviewed, it would be impossible to stop: 'our hands are bound [lit. tied with a rope]', a dynamic to which we return. She resolutely continued, even when subject to violence from her husband for neglecting duties at home for a role not seen as beneficial.

There are multiple pathways in Jacinta's story. She was, given her aptitude and commitment, a **model** and yet confounded such given that she was not an original resident, trusted or insider. As an **outsider**, she used the increasing influence of her experience and reputation to embed herself more deeply into healthcare delivery and, by proxy, her adopted community. As someone **dispossessed** of a secondary education, she compensated with voluntary work as an outlet to use her knowledge, intelligence and interpersonal skills. On our reading, however, it was being **handpicked** by influential outsiders that overrode community pushback to her outsiderness, a dynamic that we witnessed in other areas.

6. Judy: shadow

CHVs' trajectories are thus shaped by encounters with influential individuals. In the case of **handpicked**, government or NGO post-holders identify and nurture the potential of either a **model** or someone favoured for another reason. In a small but distinct number of cases, CHVs were profoundly influenced by a relative who were CHVs before them, taking up the mantle after them. In one such story, Judy grew up in a village on the outskirts of Isiolo, where there were fears of attacks between ethnic groups, with an attack taking place the week before our interview. The main cause of conflict again revolved around access to pasture, as well as cattle rustling, which had strained relationships historically and proven a pervasive challenge to state authorities.

Judy was born and raised in the area in the 1990s, the fifth born in a family of six siblings. In our initial meeting, she mentioned only four siblings but it was revealed to us in our second interview that she had two older siblings who were sent to live with their grandmother as per

customs. She felt no connection with these siblings, saying 'I never got to see them; I just heard of them and we have a non-existent relationship'. Judy and her siblings were orphaned when very young and the eldest brother took over raising them. She recounted this with pain, acknowledging his heroic role:

> When I was in Class Four, my mother and father died. The person who has been supporting me throughout my life up until now is my elder brother. He made sure I finished my secondary education.

Being orphaned meant that Judy took on responsibilities early:

> My brother was just hustling, which meant that we had many challenges. I could stay out of school for a whole term. Once I completed school I thought there is no need to keep on hampering my siblings; let me just continue with my life. Now I am done with school - let me be on my own. I now care for our last born and she's 18.

Judy had vivid memories of shadowing her elder brother going about his CHV work, including household visits after school:

> When I was following him around while he went about his duties, I was very proud of the kind of work he was doing. Sometimes I filled in the forms for him while he spoke to the parents.

Judy made it clear that these experiences shaped her own journey, following in her brother's and later sister's footsteps:

> My brother was the first to become a CHV; he served for five years then decided to stop after having his family and my elder sister took over but then stopped after getting married in a different area. Once they had stopped, I joined.

As for many, completing secondary school raised expectations but brought no job, so she saw volunteering as a hustle in its place, despite the work being so 'hard and intense', working as a hairdresser to garner additional income. Echoing Yusuf, Judy intertwined volunteering and hustling, growing in experience and profile before being duly selected by the Public Health Officer in 2019 as a formal volunteer. As she became embedded, pressures from the community, NGOs and government mounted, exacerbating the opportunity costs:

> When any organisation needs work done in the community, they look for me. There are other times I might be doing my volunteering work in the village even if it doesn't pay. They find me performing my duties, assessing the children, taking medicine to those affected - especially diarrhoea cases.

This immersion made it difficult to cease duties, having been invested in by organizations and the community: 'As long as I am in this community, I will continue to volunteer'. In sum, while Judy was eventually **handpicked** on the basis of having become a **model** volunteer, it was through **shadowing** at a formative age that her pathway was constructed. While a handful of our interviewees fell cleanly into this 'shadow' modality, many CHVs cited the influence of those close to them in their journey.

7. Sarah: dispossession

Our last story speaks to a dynamic expressed by almost every CHV we spoke to: dispossession. As noted, Marxist dispossession focuses on the forcible redistribution of tangible assets away from the working classes. While we adopt a more expansive sense of loss, in Sarah's case classical dispossession occurred. Sarah lived in a conflict-affected area, chequered by long-standing grievances between pastoralist and business-owning groups. She was one of seven siblings, five of whom were girls. She was brought up by her mother and felt extremely lucky to have gone through secondary education in such a big family.

Her childhood was not happy, however, with Sarah learning too early the 'difference between childhood and adulthood'. Due to her mother being a second wife, her family were dispossessed when her father died when she was nearing the end of primary school, sobbing 'we did not have anyone to help us'. The strength of her response to an opening question about her childhood took us aback, our eyes welling. We paused for a while, then checked-in with how she felt. She was adamant she wished to continue.

After speaking of her mother's struggle to get her children through secondary, she spoke of the impact of her father's death and subsequent dispossession:

> After our dad died, they took everything, even the land left for us. They snatched the title deed from my mother and we were left just like that. That's the life I found when I was young. After my brother was done with secondary, he took it on himself to get me through school as well as my younger siblings who are now on their own and we help our mum in whatever way we can. That's my childhood story; I cannot forget because it's the life that I have come through. […] [It] brings up so much hurt, even now.

Sarah was sponsored by the church to complete secondary school but the family did not have the means to go further, lamenting 'now I have only the dream: I'll go back to school'. After secondary, she returned home, married and had two children, feeling the need to help others:

> Let's say the call to help the people of my village just came by itself. I managed to be included as one of the people called for training and from that point onwards I took on the responsibility of helping my community completely.

Sarah became involved with many NGOs and initiatives over the next ten years, including water treatment projects and promoting the digging of pit latrines through drama groups, receiving ad hoc payments for such. She had also been a voluntary teacher at the local primary but when the weight of two jobs forced her to choose, she chose health work to balance it more easily with duties at home. She was selected and endorsed by her community and so, in many ways, a **model** CHV:

> The community chose me - that's why we were given that training. The community chose one person in each place; here they chose me. So when I had just finished school, I was taken to the village centre [to formalize].

While we do not explore remuneration at length here, we discussed with every CHV how they 'put food on the table' given that their basic monthly stipend was 2000 KES and normally delayed. Sarah had been selling small amounts of fuel but stopped as escalating fuel prices diminished demand, compounded by COVID-19 lockdowns. It also transpired she was the secretary of a women's savings group, **modelling** leadership within her community. Only as we parted ways did Sarah mention she was from a different minority, suggesting she had long overcome any outsiderness.

When asked whether her painful past affected her in the present, she was emphatic:

> It has *definitely* contributed because the state I was in when young is not the state I am in now. [Having so little] gave me the motivation to help people: to give myself completely to others and not to expect anything back […] I don't think there is anyone who can stop being a CHV now: it is in our blood. You keep going to people until they are used to you. I don't think, even if they stop this [project] at the top and we aren't getting paid anymore that we would stop. […] There is no future I can see where I can leave them.

Often when we asked why people volunteered, we received platitudes about serving the community that felt rote, shaped by what CHVs thought we should hear or they themselves heard regularly from salaried workers. For Sarah, however, the link with her childhood was clear and her responses heartfelt, including hopes for her future:

> I don't want to be stuck in this life; I will have moved on, I will have built a permanent home because this one is just temporary: a good

place to live. And my life as a CHV won't be like this - I'll have improved things. Let's say I'll have studied and my life will have changed.

Sarah is the **model** CHW: hardworking, committed, intelligent, experienced and trusted **insider**. The quality of her work was known to government post-holders and NGOs and she was **handpicked** by default. In her stories, however, we saw the pain of being **dispossessed** so young: the loss of her father, their property, her studies and, in her words, her childhood. Sarah's trauma was raw, giving weight to the view that 'dispossession and its associated forms of structural violence remain lingering, ghostlike presences in the lives and cultures of laborers long after the event' (Kasmir and Carbonella, 2008:16).

8. Conclusion

It was our aim to trace real-life pathways to community health labour that are not reflected in the CHW 'effectiveness' literature, which seeks to tweak and optimize CHW inputs so as to maximise health outcomes (also Maes, 2015, 2017). These stories are not reflected in the communications of international NGOs and health bodies, who prefer 'heroines of health' strategies that evidence worth first, advocate second (Closser, 2015; Maes, 2015). Both areas of industry replicate long-standing practices that have made CHWs and their altruism the face of Alma Ata and of progressing universal healthcare more broadly (Medcalf and Nunes, 2018). Lastly, these stories are not reflected within policy-making in global health agencies such as UNAIDS, who target the perceived pool of economically inactive young people and women in Africa as an untapped resource (UNAIDS, 2017; WHO, 2010), drawing a simplistic win-win of expanding community health work. We believe, as others, that mythologizing community voluntarism has insidiously allowed its exemption from labour studies and rights (Hlatshwayo, 2018). We wished to redress the balance of storytelling.

Ours was an unashamedly qualitative endeavour, drawing on unstructured life stories, in which we wished to demonstrate the complex, context-specific interrelationships between 'ideal types'. However, there was an overriding sense of dispossession among almost all CHVs, with only a tiny handful coming from a more secure, privileged background. The overwhelming majority were visibly pained, angered or wistful about lost life chances, opting for voluntary labour to fill a void, restoring a sense of meaning and/or self-esteem. The secondary core dynamic was that of outsiderness, which the majority of CHVs grappled with in some shape or form, confounding dominant drawings of CHVs as consummate insiders. In one of the most extreme cases, a man was burdened with the CHV role by village leaders *explicitly* because he was an outsider, leaving him with over 100 households many kilometres apart in a drought and conflict-stricken area. The man simply sobbed while telling us of this and the futility that he might one day stop.

In privileging structural analysis, we have bracketed individualistic presentations, even though CHVs' agency and choices remain discernible. We have bracketed the benefits health labour generates in favour of what has conditioned the continuation of unsalaried, undervalued community health labour for so long. In this, we identify a number of threads. The first is the path dependency that CHVs experience in having invested themselves and been invested in over years. It takes considerable time and perseverance to be accepted in the role by community members, for example regarding sensitive health information, which is not easily transferable. Further, CHVs feared retribution or anger from community leaders if they forsake their training. For all five, being a CHV is an all-consuming experience but also identity, experiencing 'lock-in'. Sarah patently does not want to stop this work, but nor could she. Similarly, Jacinta states their 'hands are bound', which, in the context of her broader interview, intimated a sense of bondage as much as commitment.

The second is that in demoting CHWs to volunteers in around 2009, not only did the Kenyan government abdicate any responsibility to salary or provide healthcare to these workers, it undermined their ability to organize. In response to a strike by CHVs in July 2021, Isiolo's Clinical Officer (according to CHVs present) addressed them shouting 'You are striking as who? You are just volunteers - if you don't like it, you can leave!' And yet, a 2021 Community Health Bill passed into law in 2022 criminalized its contravention, which could include CHVs' decreed responsibilities (Isiolo County, 2021): they are answerable to the state but the state is not answerable to them. Restrictions on organizing resonate elsewhere, such as in contemporary Ethiopia (Maes, 2017) or India in the 1970s where workers were similarly demoted to volunteers (Frankel, 1992:36). There were, at the time of writing, promising developments regarding the remuneration of CHVs under President Ruto's new administration (Mueni, 2022; Nzau, 2023). Nonetheless, given our analysis about the structuration of unpaid labour, we remain sceptical how fundamental reforms will prove. By example, CHVs were rebranded as Community Health Promoters amidst much fanfare in early 2023 (The Citizen, 2023; Wanjala, 2023), yet the Community Health Services Bill first read in June the same year made it clear that workers remained legally volunteers (Government of Kenya, 2023).

As a final comment, most invested in the effectiveness of CHWs cannot afford to reflect on why so much has stayed the same over a century of community health thinking (Maes, 2015; Wintrup, 2022). Our stories point to 'expanding dispossession', leveraged in the making and entrenchment of cheap labour, with many hanging to hope that conditions will improve. More strongly put, our interviews point to recurrent forms of structural violence (also Farmer, 2004; Galtung, 1971; Maes, 2015:8) along gender, class, religious and ethnic lines. After all, where cheap health labour is needed most and proves most effective is where investment has been poorest. While NGOs and global health agencies trumpet the heroism of CHWs, we point to the insidiousness of 'self-help' and 'community responsibility' in impoverished areas. Forced labour in colonial Kenya was violence masked as 'civilizing missions' by companies, missionaries and governors (Fall and Roberts, 2019:79; also Bellucci and Eckert, 2019; Cunningham, 2022; Van Zwanenberg, 1975), boasting at its peak the 'cheapest labour in the world' (Report on Trade Conditions in East Africa cited in Berman and Lonsdale, 1980: 67). As Fall and Roberts set out, barely subsistence wages meant workers became dependent for longer, labour was coerced as 'educational' and requisitioning justified by 'communal public works' in exchange for 'token cash payments' (2019:83–89; also Van Zwanenberg, 1975). All of these resonate in the recruitment, maintenance and sanctioning of CHVs in Isiolo, including by INGOs, suggesting the 'boundaries of the possible' regarding unpaid labour (Cooper, 1996:5) remain untouched.

Data availability

The data that has been used is confidential.

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