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LESSONS AND EXPERIENCES

Empowering community health workers as local and national tuberculosis champions in South Africa using participatory action research: insights from the UseMyVoice project

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Abstract

While community health workers (CHWs) have important contributions to offer the South African health system and tuberculosis (TB) response, their expertise has been insufficiently valued in quality improvement and policy development processes. Realizing the full benefits of CHWs require community systems for health that are responsive to their needs, however, important gaps remain in our knowledge of how to achieve this.

In this Lessons and Experiences article, we describe our experiences and reflections from applying a participatory action research (PAR) framework to empower CHWs in a rural, underserved setting as champions in the South African TB response. Using two action-reflection cycles, this civil society initiative surfaced CHWs perspectives on local TB care, provided spaces for collaboration through dialogue, enabled co-developing innovative actions responding to identified gaps, and strengthened CHWs capacity to engage in collective advocacy for strengthening their role in the national response. CHWs champions identified TB stigma as an under addressed local TB challenge, and identified inadequate training, occupational hazards and unfair remuneration as key impediments to their effectiveness as CHWs. Community theatre productions and multi-pronged advocacy campaigns helped create conditions that led to changes in services at their local clinic, provincial CHWs employment policy, and support from national policymakers.

We identified key lessons and recommendations on four common participatory research challenges that can inform future applications of PAR for CHWs empowerment. First, time and reflexivity discussions promoted trust. Second, we supported emancipatory power development through capacity-strengthening, building networks, developing accessible materials on CHWs policy, and harnessing momentum from shorter-term actions towards higher-impact actions. Third, we challenged narrow definitions of scalability that prioritize replicating outputs of CHWs labour without power-shifting engagements. Fourth, CHWs participation barriers (e.g. language and technology) exacerbated by the COVID-19 pandemic necessitated multiple options for engagement. This work demonstrates how PAR can lead to innovative actions addressing local care barriers and national workforce challenges by leveraging relationship-building, reflexive engagement, emancipatory power dimensions, resisting extractive norms and adapting to challenges.

Keywords: Community health workers, participatory action research, tuberculosis, advocacy, community theater

Abstract in Español at the end of the article

INTRODUCTION

Community health workers (CHWs) can play a crucial role in improving healthcare accessibility and quality in South Africa, yet their devaluation within the health system undermines their impact [1]. CHWs serve as a bridge between facility-based service delivery and the communities where individuals live. They provide a variety of services including health promotion, management of minor health issues, care coordination, adherence support and contact tracing [1,2]. CHWs involvement in primary care systems has enabled significant improvements in health outcomes (particularly in tuberculosis, HIV and maternal health), service coverage, and health system savings across many settings within and beyond South Africa [3–5]. In addition to the value they provide as implementers, they also have important knowledge and insights to offer for improving care. CHWs have an in-depth understanding of community needs, culture, and language, commonly residing alongside and reflecting the social and economic statuses of the communities that they serve [6]. Their embeddedness in the lives and social realities of community members provides them with a vantage point on the functioning of the health system much more proximal to recipients of care than other health system actors [7,8]. This positions them well as positive change agents capable of identifying and addressing care access barriers and advocating for the needs of populations experiencing health inequities within the formal health system [7,8].

The past decade has witnessed a proliferation of policies expanding CHWs programs in South Africa and other countries with healthcare worker shortages with the dual goals of strengthening primary health care and improving equity [1,7]. However, unsupportive environments limit the potential of the CHWs cadre to contribute to achieving these goals [1,9]. In South Africa, CHWs face precarious employment, inadequate and unreliable remuneration, insufficient training and support, high workloads, equipment shortages and limited institutional support for their safety [1,3,6,10]. These reduce CHWs efficacy by hindering their capacity to execute their duties, and by diminishing motivation and job satisfaction [10,11]. CHWs are also subjected to belittling treatment from other health workers [1,12] and hierarchical organizational cultures within clinics where their feedback is ignored and their knowledge is afforded little credibility (8). Thus, their low status and limited power mean the health system has little opportunity to learn from their expertise and advocacy [7,12].

In order to realize the benefits of community health systems, it is important that these systems are implemented in ways that are responsive to CHWs needs and perspectives [13]. The South African government has taken recent steps to improve responsiveness by formalizing the CHWs role within the health system, including transitioning them from primarily being employed by NGOs to more stable government employment [2]. However, implementation of these policies has been slow and uneven, greatly hindered by the historical and present devaluation of the cadre and insufficient resource allocation [12]. In response to these persistent challenges, CHWs in South Africa have engaged in rights-based advocacy for reform including strikes and protests, joining up with global CHWs grassroots movements for empowerment [14–16]. Parallel to this, policymakers, researchers and the World Health Organization have highlighted the need for more contextually-rooted insights on how to incorporate the voices of CHWs in shaping community health systems and equip CHWs as change agents [7,13,17]. Participatory action research (PAR) involves those most affected by an issue generating and applying knowledge through social action [18,19]. It provides a structured yet flexible approach for enlisting CHWs as co-learners identifying barriers to community health system success that implicate their role, co-developing contextually appropriate solutions and reflecting on the outcomes to inform ongoing action [19].

In this lessons and experience article, we describe key reflections and recommendations from a project exploring how a PAR framework might empower CHWs in South Africa, in the context of the tuberculosis (TB) response. TB remains a major public health challenge in the country with 270,000 people newly diagnosed annually and treatment coverage of only 57% [20,21]. CHWs play key roles in efforts to end TB as a public health threat. They strengthen the effectiveness and efficiency of care cascades by finding missing people with TB and linking them to testing, re-engaging people with drug-susceptible and drug-resistant TB who are lost-to-follow-up, communicating about TB in local languages and providing psychosocial support [3,9,22]. They also reduce the financial and emotional burden of TB from the patient perspective by minimizing travel demands/expenses, time off work, and stress [23,24]. TB is a helpful area to examine strategies for empowering CHWs within community health systems in South Africa because, despite having little to no decision-making power, their role is integral to successful service delivery [1,25]. This piece describes the development of a PAR project for the empowerment of CHWs within the South African health system, the experience of the project, and key lessons for future applications of PAR for CHWs empowerment and health system improvement.

PROJECT DEVELOPMENT

In this section, we describe the project initiation, context, participant population, team positionality and the guiding PAR framework. PAR is an emancipatory form of scholarship where populations experiencing social inequities are engaged as collaborators in knowledge generation and social action [18]. This project was initiated by a South African TB advocacy organisation, TB Proof, as a collaboration with a public clinic in Hammanskral from December 2017 to March 2021. Hammanskraal is

a rural, majority-Black African region in the Tshwane Health District of Gauteng Province with chronic public infrastructure challenges [26]. The primary participants (TB champions) were the CHWs (n=15) and their professional nurse supervisor (n=1) who participated as part of their employment at the clinic. All were from and lived in Hamaanskraal, most were women, and some were TB survivors. We also engaged as secondary participants (taking part in fewer project activities) other clinic staff (e.g. managers), CHWs from neighboring clinics, and department of health representatives at the local, provincial and national levels. This was an operational project guided by a memorandum of understanding between the Gauteng Health Department and TB Proof.

Cornish et al. highlight several key principles and building blocks of the PAR approach that guided this project [18]. We undertook multiple activities to build relationships, provide space for collaboration through dialogue, strengthen participants' capacity to serve as TB champions, and develop a shared understanding of the key issues by examining the local and national TB context and the CHWs roles within it [18,27]. The project team and champions regularly held network meetings from September 2018 to March 2021, transitioning from in-person at the clinic to online after the onset of COVID-19 in 2020. Champions received training and mentorship on communication and advocacy, TB prevention and care, and CHWs-related policy. Champions collected survey data from households affected by TB and supported adaptation of data collection materials; they also participated in focus group discussions and surveys delivered by the project team. Results from data-generation activities were presented to champions during regularly-held network meetings where they participated in collaborative analysis, interpretation and sensemaking [18]. Secondary participants attended some network meetings and supported action planning activities but did not receive training.

Unlike traditional scientific research, PAR distinctively involves iterative action-reflection cycles aimed towards creating social transformation; it emphasizes generating knowledge for the sake of informing action aligned with community priorities and generating knowledge through action [18,19,28]. Action-reflection cycles involve participants defining problem(s) of social significance, designing actions capable of illuminating and/or addressing the problem(s), taking action, observing results and reflecting on/analyzing results [18]. The problems targeted by PAR vary widely in their scale and focus [18,27]. We implemented two full iterative action-reflection cycles targeting problems in the tuberculosis response relevant to CHWs roles at the local level (first cycle), then provincial and national levels (second cycle) described in the following section.

Finally, attending to positionality and power within participatory spaces is central to PAR [18,29]. The main projectac facilitators were the project lead (IS), a South African XDR TB survivor and the TB Proof Director, and the project CHWs liaison (PM), a South African CHWs with prior experience in Gauteng. IS and PM regularly had reflexivity discussions about their interactions with champions and one another, which informed project decisions. HvdW and RN, medical doctors and TB social science researchers, provided strategic guidance. MG has experience of TB advocacy and DD has participatory implementation research experience and supported the synthesis of insights.

PROJECT IMPLEMENTATION EXPERIENCE

In this section, we describe what participants' experienced during the two action-reflection cycles and their reflections.

Local cycle: Community theatre for stigma reduction

Define the problem. Champions participated in a structured workshop to decide on a focal problem impacting the local TB care cascade. Using cards (Figure 1) that visually depict common cascade barriers from the literature, they worked in groups to prioritize barriers for each cascade step (accessing TB testing, receiving a diagnosis, starting treatment, completing treatment and returning to normal life/receiving post-TB care). Participants collectively identified TB stigma as the largest barrier because it impedes disclosure and service engagement.

Plan action. Through open deliberation during subsequent network meetings about actions to address stigma, participants reached consensus on theatre because it enables sharing messages in relatable, interesting and accessible ways. Performances staged by non-professionals from and for a community, sometimes with a social purpose, are called community theatre. Theatre has been used to combat stigmas associated with other health conditions but rarely for TB [30,31]. Participants led the identification of important messages, co-developed a script with support from the project team and served as the actors. A well-known television actor from the area was paid to direct the play. The project team leveraged relationships with role-players in the civic and civil sector to identify platforms for sharing the play.

Take action. The 30-minute production was performed in the local language, Setswana, at three local awareness events from 2018 to 2019 (Figure 2). The plays creatively conveyed messaging on TB stigma reduction, TB transmission, TB symptoms, TB prevention and how to support people with TB. Key overarching themes were that anyone can get TB and everyone needs support. Additional planned performances were interrupted by the COVID-19 pandemic. Participants instead relayed messages through public-facing multimedia platforms, such as radio, blogs and video through 2020. They were also supported to create a video capturing their experience [32].

Figure 1. Cards designed for participatory exercise to identify barriers to tuberculosis care cascade in local community.

Observe and reflect on results. The observed impacts of the cycle were a large and diverse turnout of 100+ people at performances and stimulation of conversation within the community on TB stigma. Participants identified several key reflections during network meetings and conversations following the performances. CHWs felt encouraged by the turnout and positive community feedback, and enjoyed making the plays. They felt proud of their impact promoting TB stigma awareness and discussion. Clinic staff indicated that they learned new information through the play and that their opinions on the value and need for CHWs improved over the year of working with the participants. As a result of these communal reflections, several CHWs requests for service-level changes were implemented by clinic leadership: monthly CHWs TB training, increased supervision, reactivation of multisectoral TB meetings, and hosting of TB awareness days.

National cycle: Multi-pronged advocacy campaign for workforce challenges

Define the problem. In cycle 2, participants defined key issues pertinent to strengthening the CHWs role provincially and nationally. No CHW was aware of the national Ward-Based Primary Healthcare Outreach Team (WBPHCOT) policy defining the CHWs scope of work, which was unanticipated, so the project team created and delivered training on the policy [2]. Champions engaged in priority-setting activities reflecting on questions such as: how can CHWs be supported better? How can decision-makers learn from CHWs? Participants generated a ranked list of priorities through group deliberation, and three were selected through consensus. The first was high-quality, standardized training for all CHWs, second was personal protective equipment for TB-related occupational hazards, and third was fair remuneration. Other strategic priorities were also identified such as inclusion of CHWs in WBPHCOT stakeholder consultations, structured input from CHWs in policy implementation processes, and on training priorities.

Plan action. The champions and project team collaboratively designed a multi-pronged advocacy strategy incorporating insights from role-players in multiple government levels to optimize impact. It involved direct advocacy with policymakers at the local, provincial, national and international levels; multisectoral engagement; and collaboration with networks and institutions with aligned agendas. All planning and capacity-strengthening took about 13 engagements over two years.

Take action. Champions shared advocacy priorities and local cycle successes at strategic meetings, including policy fora hosted by governmental agencies. Champions prepared four advocacy letters, including one endorsed by 13 organizations and 51 individuals presented directly to the Deputy President and Minister of Health by PM. Champions joined broader networks advocating for identified priority actions. During COVID-19, advocacy shifted online and became increasingly impor-

Figure 2. Community theatre production

tant as CHWs were expected to take-on new COVID-19 screening responsibilities without sufficient training and protection. We joined five civil society organisations and 42 CHWs across six provinces to participate in the COVID-19 People's Coalition responding to the emerging challenges with advocacy though participation was limited to PM and a few champions due to increased CHWs workload and digital inaccessibility (33). Champion priorities were presented to the National TB Programme Manager and to the National TB Think Tank in 2020. They were also communicated via op-ed publications and COVID-19 reports on community priorities to sustain advocacy for integrated TB and COVID-19 testing and high-quality training on TB and stigma for CHWs.

Observe and reflect on results. A National Department of Health official directing TB and HIV activities described this participatory project as "a very important undertaking" that "needs to be scaled up because CHWs are critical players in achieving the objectives of the END TB strategy." Sustained advocacy at national level COVID-19 response meetings led to successfully securing particulate filter respirators for CHWs from the national department of health. TB Proof's submission to the national expenditure committee on the role of CHWs in health system emergency preparedness advocating for funding CHWs priorities was accepted for presentation to parliament in 2020. A significant victory to which this action may have contributed was the Gauteng Executive Council converting the 8500 CHWs employed by public clinics to a higher job grade with better remuneration and access to benefits in 2020. Participants' reflections included identifying the importance of collective and sustained advocacy for CHWs priorities. They valued receiving training. They reflected on additional dimensions of the training advocacy priority including the need for safety-focused and integrated COVID-19/TB training, and person-centred care training on human-rights, key populations and vulnerable groups.

LESSONS AND RECOMMENDATIONS

In this section, we present lessons and recommendations generated through collective reflection among the author team on project implementation, informed by direct implementation experience, documentary review of project materials and notes, and the synthesis and interpretation of insights. We identified four key lessons mapping onto common PAR challenges that can inform fu-

ture applications in CHWs empowerment, health system improvement efforts, and civil society-based projects.

Building trusting relationships across power imbalances

Relationship-building is a PAR foundational principle, objective and enabling factor, however, power inequalities can reduce relational quality [18,34,35]. In this project, power differentials across socioeconomic status, educational attainment and race made champions initially hesitant to voice their perspectives at network meetings. This hesitancy was reinforced by epistemic injustices within the sector that position CHWs as implementers of projects with pre-defined activities, rather than thinkers and decision-makers shaping goals [36]. These dynamics, embedded within larger historical and ongoing processes of disempowerment, limited prior opportunities for CHWs to develop and act on shared critical consciousness. Consistent in-person meetings over an extended period of time allowed the team to demonstrate sincere investment in understanding CHWs perspectives anden helped increase comfort. Further, reflexivity discussions with project facilitators, one of whom was a CHW serving in a boundary-spanning role, provided space for discussing and addressing power-related questions and concerns. For example, these discussions inspired using structured card-based prioritization exercises to supplement open dialogue in cycle 1. We recommend funders allow time for relationship-building in project timelines and project teams cultivate reflexivity through regular team discussions.

Increasing participant emancipatory power

Community empowerment is core to PAR but realizing its power-disrupting potential is difficult [18,27,34]. Empowerment is a contested concept that can be defined as increasing a group's "collective control," which is their ability to make choices for themselves and to transform their external environment in alignment with those choices [37,38]. Emancipatory power is thus a group's ability to exercise that collective control in the pursuit of greater health/social justice [38]. Many health empowerment (research) initiatives focus predominantly on improving communities' psychological capacities (e.g. self-efficacy), decision-making (e.g. lifestyle changes), and proximal social conditions but stop short of strengthening their ability to bring about larger scale social transformation that attends to structural and political factors impeding health/social justice [34,38–40] Three emancipatory power dimensions have been identified as key targets for community health empowerment initiatives seeking specifically to strengthen collective control at not only the lower but also higher ecological levels: power within, power with, and power to [38]. We offer reflections from the research team on lessons from the project for the development of each dimension.

Power within includes internal community capabilities such as recognition of shared interests, values and identity; it is foundational for other dimensions and key for envisioning and pursuing collective action [38]. PAR, shaped by Freire's concept of praxis (reflection and action on the world in order to transform it), has helped enable critical reflection and consciousness-raising that builds *power within* in many settings [18,27,29]. In our context, CHWs' high workloads and exclusion from decision-making restricted prior opportunities for communal reflection on shared priorities [8,12]. Existing workers' rights movements-allied efforts in the country to improve CHWs working conditions facilitated power within [16]. Project relationship-building activities, reflective discussions, group deliberations, and problem definition/prioritization exercises also facilitated power within. We recommend more teams applying PAR to consider targeting the promotion of power within and critical consciousness among marginalized workers as these internal capabilities are underexplored in health systems strengthening work but well aligned with emancipatory goals [41,42].

Power with includes capabilities to build alliances with others to achieve common ends [38]. In the first cycle, improving healthcare worker attitudes towards CHWs capability increased investment in their training and supervision and was an important avenue for developing *power with* [43]. Prioritizing multisector engagement and alliance development in the second cycle bolstered champion's *power with* as demonstrated by high levels of support from other agencies in the letter campaigns as well as participation in the COVID-19 coalition. Having district and national representatives from the department of health as well as clinic leadership attend some network meetings also helped build the champions' confidence and comfort in engaging with role-players possessing more institutional power than them. Given that CHWs have little formal political power in health systems change and policy development processes, developing *power with* is key to enabling productive collaborations with those who do [39]. We recommend future projects explicitly evaluate how risks of co-option may compromise efforts to build power with given this constraint.

Finally, *power to* reflects the capability to achieve desired changes/goals through implementation of community action. In order to productively engage CHWs in improvement efforts, they must understand current policies relevant to their role. A major barrier in our context was the lack of accessible resources explaining existing policies which we addressed by developing resources in English and Setswana. CHWs had important insights on the content of the policy and how it could be translated into action. CHWs representatives and health worker unions should demand to be part of policy development in future to ensure alignment of goals, to increase awareness of the policy among CHWs and to inform implementation strategies. A challenge in building power to common across PAR projects is differences in expectations on desired pace and scope of change [18,35]. In this project, experiencing success

implementing shorter-term actions that champions defined for themselves enabled and inspired confidence for higher-impact, longer-term actions. Being supported to understand TB policy, their role in the TB response, and to provide high-quality TB care locally positioned the CHWs to see both that their perspectives should be part of higher-level, national policy conversations and that they were capable of productively contributing. More generally, the power to dimension was advanced by the capacity strengthening and action planning activities of the PAR cycles. Successful improvements of power to is evidenced in the changes in the local, provincial and national CHWs practice environment to which this project contributed. A major strength of this project in this domain was that the actions pursued extended beyond the local to challenge provincial and national power structures that drive local CHWs experiences [29,38]. We recommend, where possible, creating deliberative spaces conducive to enacting social action at multiple levels of the health system.

Navigating tensions with institutional infrastructure

PAR remains outside of the mainstream for civil society organizations and academic researchers, and the norms and expectations of their funding institutions can conflict with PAR aims and processes [18,44]. While strategies for university-based PAR teams to overcome these tensions have expanded in recent years, less guidance exists for navigating the particular pressures experienced by civil society teams [18,44]. Demonstrating scalability is a common expectation for funded civil society initiatives, and in global health this is often achieved through developing/implementing discrete, time-bound interventions that can be piloted, measured and (ostensibly) scaled horizontally [45,46]. In the second cycle, rather than scaling community theatre (the context-specific solution to the locally defined care gap) we scaled the process through which the theatre was created by extending the locus of impact for CHWs problem-solving from Hammanskraal to the wider province and country. In this way, the project challenged narrow definitions of scalability that prioritize replicating outputs of CHWs knowledge and labour without sustaining the power-shifting engagement with them that makes such outputs possible. We recommend exploring opportunities to apply PAR creatively in service of resisting norms that may reinforce the extraction of CHWs insight without their continued benefit.

Promoting accessibility and inclusive participation

Maintaining inclusive participation over the course of PAR projects can be challenging [18,35]. Conducting project activities during work hours, facilitated by partnering with the department of health, alleviated financial access barriers. Nonetheless, other constraints reduced accessibility. Policy fora hosted by governmental roleplayers were often in English only and the champions opted to only send fluent representatives, likely reflecting class and education inequalities. The COVID-19 pandemic shifted activities online creating digital access barriers. Ministry-imposed separate TB and COVID-19 testing targets increased CHWs workload, reducing time availability. In light of these, project-hosted activities were conducted in Setswana or multiple languages; participants were supported with data bundles, digital literacy training, and transportation for attending meetings jointly; and champions advocated for integrated TB-COVID-19 testing (recommendation for integrated testing was formally accepted after the project ended in 2022) [47]. We recommend providing multiple options for engagement and acknowledging team limitations to manage participant expectations around accessibility.

Conclusion

As a growing number of governments seek to scale community health programs, it is crucial that CHWs knowledge is respected and elevated in policy development and quality improvement processes. CHWs policies cannot create impact if CHWs are not aware of them or capacitated to deliver them. Further, empowering CHWs to do their local work well gives them a stronger footing from which to advocate for a greater seat at the table in policy development processes, and their insights improve patient experiences. Applying PAR with the goal of empowering CHWs to advocate for change within the health system and to address care gaps based on communally identified priorities led to innovative actions addressing local care barriers and national workforce challenges. Future PAR initiatives ought to facilitate relationship-building with adequate funding and reflexive engagement, target the development of multiple emancipatory power dimensions conducive to promoting social transformation, resist extractive norms within their institutions and adapt to access challenges that arise.

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AI utilization

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Competing interests

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ABSTRACT IN SPANISH

Empoderando a los agentes comunitarios de salud como líderes locales y nacionales en la lucha contra la tuberculosis en Sudáfrica mediante la investigación acción participativa: perspectivas del proyecto UseMyVoice

Si bien los agentes comunitarios de salud (ACS) tienen importantes contribuciones que ofrecer al sistema de salud sudafricano y a la respuesta frente a la tuberculosis (TB), su experiencia ha sido insuficientemente valorada en los procesos de mejora de la calidad y formulación de políticas. Alcanzar plenamente los beneficios de los ACS requiere sistemas comunitarios de salud que respondan a sus necesidades; sin embargo, persisten importantes vacíos en nuestro conocimiento sobre cómo lograrlo.

En este artículo de Lecciones y Experiencias, describimos nuestras experiencias y reflexiones sobre la aplicación de un enfoque de investigación acción participativa (IAP) para empoderar a los ACS en un contexto rural y desatendido como líderes en la respuesta sudafricana contra la TB. Mediante dos ciclos de acción-reflexión, esta iniciativa de la sociedad civil visibilizó las perspectivas de los ACS sobre la atención local de la TB, generó espacios de colaboración mediante el diálogo, desarrolló conjuntamente acciones innovadoras para responder a las brechas identificadas y fortaleció la capacidad de los ACS para participar en acciones colectivas de incidencia política dirigidas a fortalecer su papel en la respuesta nacional.

Los ACS identificaron el estigma relacionado con la TB como un desafío local insuficientemente abordado y señalaron la capacitación inadecuada, los riesgos ocupacionales y la remuneración injusta como obstáculos clave para su efectividad. Las producciones de teatro comunitario y las campañas de incidencia multifacéticas ayudaron a crear condiciones que condujeron a cambios en los servicios de su clínica local, en la política provincial de empleo de ACS y en el apoyo de responsables nacionales de formulación de políticas.

Identificamos lecciones clave y recomendaciones sobre cuatro desafíos comunes de la investigación participativa que pueden orientar futuras aplicaciones de la IAP para el empoderamiento de los ACS. Primero, el tiempo y las discusiones reflexivas promovieron la confianza. Segundo, apoyamos el desarrollo de un poder emancipador mediante el fortalecimiento de capacidades, la construcción de redes, el desarrollo de materiales accesibles sobre políticas para ACS y el aprovechamiento del impulso de acciones de corto plazo hacia acciones de mayor impacto. Tercero, cuestionamos definiciones limitadas de escalabilidad que priorizan la replicación de los resultados del trabajo de los ACS sin procesos que transformen las relaciones de poder. Cuarto, las barreras a la participación de los ACS (por ejemplo, idioma y tecnología), exacerbadas por la pandemia de COVID-19, hicieron necesarias múltiples opciones de participación.

Este trabajo demuestra cómo la IAP puede llevar a acciones innovadoras para abordar barreras locales en la atención y desafíos nacionales relacionados con la fuerza laboral, mediante el fortalecimiento de relaciones, la participación reflexiva, las dimensiones emancipadoras del poder, la resistencia a normas extractivas y la adaptación a los desafíos.

Palabras clave: Agented comunitarios de salud, investigación acción participativa, tuberculosis, incidencia política, teatro comunitario

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