

Gender and Community Health Worker programmes in fragile and conflict-affected settings. Findings from Sierra Leone, the Democratic Republic of Congo and Liberia

As an employer of a significant proportion of the population - and a sector that interacts with citizens from the moment of their birth to their death - health systems have the potential to be a positive force in reshaping and transforming harmful gender norms. Community health workers (CHWs) extend services to the community and are often relied on in fragile and conflict-affected settings where there is often a shortage of formal health workers.

While some CHW policies and programmes have an explicit commitment to gender equality this may not have a significant impact at the community level. Efforts to treat men and women equally may fail to take account of the fact that gender influences male and female CHWs' ability to perform their role because of the influence of gender norms at programme, community and household level. Policies that appear progressive, or at least aim to do no harm, may not be as neutral as is first perceived.

The policies in Sierra Leone and Liberia prioritise the selection of female CHWs or CHAs; in Sierra Leone, this is because the services provided by these workers largely focus on maternal, newborn and child health. Despite these policies, there are more male CHWs than female, for example in Grand Bassa County in Liberia there are 91 male CHAs and only ten female CHAs. In the Democratic Republic of Congo (DRC), selection criteria for CHWs promote equal opportunities for women and men, which appears to influence the number of female CHWs. For example, in Bunia district there are a total of 480 CHWs, of whom over a half (288) are female, and in Aru district there are 403 female CHWs out of a total of 840.

CHWs work within the same gender norms and power relations that influence the households, communities and societies they serve. Harmful gender norms shape vulnerability to ill-health and impact on health seeking behaviour and access to health services in negative ways. Conflict, fragility and disease outbreaks such as Ebola can create and exacerbate gendered vulnerabilities and effect households in profound ways. These

CHW policies in Sierra Leone, Democratic Republic of Congo and Liberia

- In Sierra Leone, a revised national Community Health Policy and Programme was launched in February 2017. The programme was rolled out nationwide with 15000 CHWs trained to provide a basic package of services at the community level including reproductive, maternal, newborn and child health, integrated community case management of sick children, and infection prevention and control.
- There is no overarching CHW programme in Democratic Republic of Congo. There are three types of CHW: Site CHWs who provide the minimum package of community activities, such as the distribution of Ivermectin and contraceptives, case management of malaria, diarrhoea, and acute respiratory infections; Promotional CHWs who provide health education to communities; and Disease-programme CHWs who provide specific services for the programme.
- In 2016, the Ministry of Health in Liberia launched its Revised National Community Health Services Policy 2016-2021. It focuses on the development of Community Health Assistants (CHAs) trained to deliver a package of preventive, curative, promotive, rehabilitative, and palliative services as well as surveillance. CHAs are supervised by Community Health Services Supervisors (CHSS) - a new cadre of health worker who has been formally trained e.g. as a nurse. Previous cadres of community health volunteers (CHVs), for example, traditional midwives and community drug distributors remain in operation and are supervised by CHAs.

norms can be internalised and reproduced within the health system leading to inefficiencies and inequities in the way that services function. Because of these norms, and related power relations, CHW programmes can inadvertently deliver a service which reinforces rather than challenges gender inequity and

is less efficient as a result. However, CHWs are well placed to understand gender norms and act to counter them.

This brief provides recommendations and guidance for practitioners and policy makers who have responsibility for CHW programmes. It suggests some ways that their workforce may be affected by gender norms and recommends what actions can be taken to address them.

Methods

This brief draws on a review of the international evidence and adds detail on the focus countries through additional research from Sierra Leone, DRC and Liberia. While the gendered findings from these countries are not vastly different from those found elsewhere, there are tensions and challenges unique to these settings and their fragility.

The methods used in Sierra Leone included in-depth interviews with managers, photovoice, life histories with CHWs, community mapping and document review. In Liberia and DRC document reviews were conducted alongside key informant interviews with decision makers, managers and supervisors of CHWs at national, county, district and health facility level. The relatively small scale of the studies in DRC and Liberia, means we did not have a chance to hear from CHWs themselves which is a weakness. Findings from all three countries were presented to academic and policy stakeholders in Sierra Leone and recommendations in this brief were developed collaboratively based on their feedback.

Implications of our findings for managing and supporting CHWs

Access to education and literacy is gendered and affects selection

Selection and recruitment processes can be gendered. Inequity in educational access can be a common phenomenon in post-conflict settings as the education of both boys and girls is often disrupted. This was clearly demonstrated in the life histories in Sierra Leone where CHWs explicitly discussed how displacement and or death of a parent led to them having to drop out of school. In Liberia identifying literate CHWs was a general challenge, however this was exacerbated when prioritising the selection of women because fewer were literate.

“We always encourage the women to apply more but they don’t have the level of education. The men have the level of education.”
(District Health Officer, male, Liberia)

To overcome these challenges, one district in Liberia introduced literacy interventions for women and young people. Community-based elders’ education programmes in Liberia were also said to have increased the participation of women.

Who does what within households affects selection, retention and performance

People working as CHWs balance unpaid household responsibilities and (other) paid work with their role in the health system. In many settings women are in charge of domestic duties and men are considered the ‘breadwinners’ in families. Women’s ability to work can be constrained by patriarchal hierarchies within the family. These norms and dynamics can affect selection, time commitment and worker attrition.

Women’s ability to work as a CHW can be constrained as they have to fit it around childcare, care for the sick and elderly and other household responsibilities. Women’s work in the household can be particularly arduous in times of conflict when men leave to fight while women remain and take on more domestic and caring responsibilities.

In the DRC, timekeeping was perceived to be a problem for married women, who were reported as often being late due to childcare responsibilities. In this case flexibility was built into programme management to take account of the various pressures on CHWs.

“As for female community health workers, especially married women, due to their family responsibilities, in most of the cases they arrive late, as they need to make sure they have covered home need. If they have a child who is unwell, that also affects their presence as they need to care for the child. To overcome it, we just make sure that we understand them, as when they are there, there are really productive.”

(District Health Officer, male, DRC)

Unequal decision making within communities and households affects selection, retention and performance

Communities select CHWs and this process can be shaped by gender norms, and ways in which hierarchies play out within communities. In Liberia, community-based selection processes were described as favouring the selection of men as CHAs/CHVs. Some informants described this as difficult to change as the selection should be about:

“What satisfies the community...and if the community bring a male and I tell them no, they won’t feel good because it’s the person they feel comfortable with.”

(Manager of health facility, female, Liberia).

In Sierra Leone, male CHWs outnumber female CHWs (10652 male CHWs vs 3283 female CHWs). One reason for this was women’s limited voice or presence in community affairs and a culture of selecting men to do work.

"Women do not even show up to the community event when selecting CHWs. When it comes to community affairs, only men show up, women don't, they don't even talk. Should they show up, then the community members would have selected them."

(District Health Manager, male, Sierra Leone)

It is unclear why women do not participate more in community events in Sierra Leone or what efforts have been put into place to challenge the status quo although some CHWs have attempted to sensitise the community to the importance of employing women. In the DRC, the existence of women's groups in some areas was found to improve the rates of women taking up the CHW role.

Within households, male family members can prevent women taking up work as a CHW, or limit what responsibilities they take on in the job, by asserting their patriarchal dominance. For example, in DRC, women and programme managers, often sought husbands' permission for women to take on the role of CHW and attend training sessions.

"To overcome that challenge, as for married female community health workers, what I do, I go to see the husband and explain why it is important for her wife to realise community-based activities, especially as she was selected by the community members, that means that they trust her."

(Manager of health facility, male, DRC)

While programme managers are using initiative in conferring with male family members in DRC their actions inadvertently strengthen the norm that men have the ultimate say in how women apportion their working time, undermining efforts towards equality.

The decision to employ men rather than women as a way of avoiding domestic disharmony may appear a pragmatic approach to the management of community health programmes. However, it does not fundamentally challenge the views of male community members who equate female mobility with disloyal behaviour. In Sierra Leone men were not subject to the same sanctions:

"Some women, their husband will tell them, 'I will not allow you to undertake this kind of activities because of so and so you have to take care of your children' but for men, nobody can stop them even their wives cannot stop them."

(District manager, female, Sierra Leone)

The failure to question why men are not subject to similar disapproval from female family members means that the supervisor inadvertently reinforces harmful norms.

Mobility constraints and insecurity influences attraction, selection, retention and performance



The smooth road: Hard to reach and still need to pay for a ride in Kenema by Margaret Kini

Cultural restrictions around women's movement obstruct both women's access to healthcare, and CHWs access to client's homes and can also have implications for programme implementation. In Sierra Leone there was a perception that women do not know how to ride bicycles/motorbikes or that they are fearful of traversing difficult terrains which limited their ability to carry out their role as a CHW.

"It is easier for men to do this job. They can ride motor bikes especially for longer distances. There are certain areas you have to cross water - women are more scared of this than men... [Men] cannot shy away from they cannot fear the roads, they cannot fear the distance, they can ride... I do ride a motor bike but most women cannot do that. If they were even given bicycles they cannot ride but the men can."

(CHW, female, Sierra Leone)

Issues of topography can also make mobility difficult, which can be amplified in fragile and conflict-affected settings. In Liberia, there was a perception that women are less able to cover long distances which may lead programme managers to allocate roles differently during specific campaign activities. One respondent described how the ability of men to travel longer distances unescorted resulted in men completing more work.

"For the time I have been dealing with them, one way or the other the men are doing more because some distances the women may look for someone to escort them but for the men they feel that they can go there, and nothing can happen to them. So, they can walk distances without asking for help or somebody to carry them or escort."

(Community Health Services Supervisor, female, Liberia)

It was suggested that high rates of attrition among female CHWs in Liberia may have been due to the difficulties in travelling:

“The issue is that when it comes to recruitment, you will always see more men than women. Actually, we can prioritize women, but our setting is hard, very, very hard. Some will come but then they will drop and in replacing them finding other women can be hard. Maybe they drop because of the distances. You see more men travelling the longer distances than women.”

(District Health Officer, male, Liberia)

Female CHWs in Sierra Leone also experienced different mobility issues based on cultural norms that limit their access to attend to pregnant mothers:

“Female CHWs cannot enter into villages where there are societal activities [special areas of the villages where local customs are carried out]... because you as a woman you are not part of the male society... and so if a pregnant woman is there, definitely the woman will not go there, but the male CHWs can go there to bring the patient.”

(District manager, female, Sierra Leone)

Insecurity can also threaten the safety of CHWs. Studies from many countries demonstrate that female CHWs are often subject to sexual harassment while doing their work (which often requires them attending to expectant mothers at night). Sexual violence, largely directed against women and girls, is also heightened in conflict contexts. Even after a conflict has ended, women and girls often continue to be subject to sexual and other violence due to the normalisation of violence. In DRC, CHWs were made more vulnerable to this kind of violence than other cadres of health staff as many of the richer and more senior cadres of the health system left their posts when war broke out for more secure environments. CHWs who were unable to leave,

took on responsibility for health care provision.

The gender of the CHW can shape service acceptability at the community level

Gender norms can impact upon whether men or women are considered a suitable service provider. In Sierra Leone women were considered more dedicated CHWs. Men however, were more able to accompany pregnant women to facilities due to fewer domestic obligations. However, sometimes men’s motives for caring for female community members were questioned. They were often accused of ulterior, sexual motives if talking to pregnant women in communities. Following advocacy meetings men and women were sent out in pairs and men were encouraged to only attend to pregnant women in the daytime.

“Complaints from men that male CHWs are talking with pregnant women - thought they were wanting to have sexual relationship with her. If female CHWs do this there is no problem. [It’s a] common problem. so there was a time we held a meeting and decided that the men should not go alone but should be accompanied by a female so that all of us can do the work together; and go in the day and not at night.”

(Community manager, male, Sierra Leone)

In the DRC there were more men than women working as CHWs, which had implications for acceptability in the community. Women were perceived to be more able to counsel men and women over health matters than men.

“Well, female community health workers, we have them, yes because as I said before they have very good communication skills as far as dealing with women is concerned, they can better understand themselves. They are also able to communicate to men without any problem.”

(Health facility manager, male, DRC).

CHAs in Liberia by Laura Dean



In Liberia, it was felt that community members would hide issues related to pregnancy and 'feminine hygiene' from male CHWs.

"For a man to go into detail about pregnancy with a woman, they will find it difficult. When [a man] comes she will just say I am not feeling well. But if she has any danger sign, maybe she has sore between her leg, she will [show the] female, but she will not be able to show it to the male."

(Health facility manager, male, Liberia).

The experience of volunteerism and pay is shaped by gender

Whether CHWs are paid can impact on the gender dynamics of programmes and the wellbeing of employees. In many settings men are deemed worthy of, and are more attracted to, paid positions. They also have higher rates of attrition especially in voluntary programmes as they leave for paid employment to fulfil the role of 'breadwinner'.

In settings where CHWs are volunteers there is a possibility that this can reinforce 'gender segregation' in the health workforce – with men at the higher levels of the system and women at the bottom – as women and girls made up the bulk of the people providing informal and unpaid care.

In Sierra Leone limited CHW remuneration impacted on men differently to women due to the pressures men faced in providing for (sometimes multiple) families. This was seen to cause poor focus on the job and high attrition rates among men who were reported to leave for higher-paid jobs when they became available. Single women also felt the need for financial compensation as they were, *"without a man to support."* (CHW, female, Sierra Leone)

In the DRC men were seen to be less committed to the role of CHW, which seemed to be reflected in higher rates of attrition. This was in part, linked to the lack of remuneration where men would often leave to take up paid positions elsewhere.

"Male community health workers' challenge is mainly on the working responsibilities. Sometimes, when they find a stable and paid job, they just leave community health workers job."

(District manager, female, DRC)

In DRC, some supervisors reported paying male recruits from their own pocket, which may reinforce gender norms that men's work is worthy of payment, whereas their female counterparts should work for free.

Gendered expectations influence career progression and other opportunities

Our data shows that in some cases women may have limited opportunities to input into decision making and for career progression, which can be de-motivating. As one respondent from the DRC noted:

"Something surprising is that females are the majority, but men seem to be more active, and are more available to serve, and there are males who occupy responsibility positions."

(Facility manager, female, DRC)

In Sierra Leone, most peer supervisors are male, with women rarely taking on this role because of lower literacy and education levels.

CHWs associated with women groups for the maternity building construction in Leri Health catchment area, Aru Health District, DRC, by Amuda Baba



Recommendations

The development of strategies to manage and support CHWs must address gender disparities in selection, retention, remuneration, performance, and career progression. This means attending to how gender norms and power dynamics play out at the family, community and health system level. This is particularly critical in fragile and conflict-affected contexts where there are opportunities to break down gender barriers and stereotypes and 'build back better' after conflict when reorganization of health system governance and delivery often occurs.

- It is important to challenge the patriarchal notion that men should make decisions about whether their female household members can work outside the home. This needs to occur in communities and with CHW supervisors and managers who can inadvertently reinforce this notion, whilst simultaneously supporting and being responsive to the strategic interests of women in these settings.
- To encourage the selection of women there is a need to sensitise communities to encourage women to volunteer and to be selected at the same rates as men. Ensuring women's active participation in community dialogue via the creation of spaces where women are listened to and feel comfortable to talk could support this. Women may also be empowered to volunteer when associated with community development programmes or women's groups, as demonstrated in DRC.
- Training should be offered in a flexible, module-based approach close to CHWs homes to avoid long periods of time away from family and other responsibilities.
- On some issues being in male-female CHW pairs may also help alleviate issues of community acceptability by gender as well as provide safety for men and women travelling away from communities, or attending their community at night, tackling issues of restricted mobility.
- Bicycles and motorbikes, distributed as part of CHW programmes, should be provided equally to men and women and training in their use should be factored into CHW programmes.
- Equal remuneration should be offered for men and women working as CHWs to ensure that the work is not seen as 'voluntary', and therefore feminised labour. Paid work would also ensure lower rates of attrition and may motivate all CHWs to give the role greater priority. Equal remuneration would support the idea that women's care work is as valuable as men's and would avoid instances of supervisors paying male recruits but not women, as is the case in DRC.
- Contracts should ideally be issued to formalise labour rights for CHWs, such as maternity and paternity leave. This could also provide a framework to recognise flexible working approaches that support CHWs to balance community health work with domestic responsibilities.

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Recommended reading:

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Contact

Joanna Raven, Department of International Public Health, Liverpool School of Tropical Medicine.

Joanna.raven@lstmed.ac.uk