ReBUILD FOR RESILIENCE

Research for resilient health systems in fragile and shock-prone settings

The gendered experience of close-to-community providers in Sierra Leone – policy brief

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Introduction

Close-to-community (CTC) providers, play an important role in community health service provision. This is particularly important in fragile and shock-prone (FASP) settings, where they often link the most marginalised and hard-to-reach communities with the health system. The ongoing COVID-19 pandemic has demonstrated the value of CTC providers in supporting any disease response at the community level, by highlighting their strategic position particularly in contexts where mistrust exists between service users and the formal health system (Knox-Peebles, 2020). It is therefore critical that CTC providers are supported in order to have a positive effect on disease outbreak responses, through a bottom-up approach.

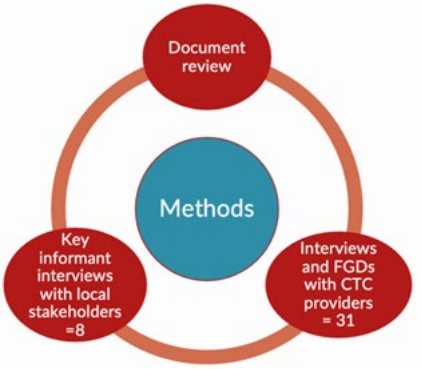
The COVID-19 outbreak has also exposed and, in some cases, further exacerbated, inequalities and vulnerabilities that often hide from plain sight, especially in FASP settings, like Sierra Leone. This includes how gender shapes vulnerabilities and the response to outbreaks, highlighting the need for more research through a gender and equity lens. However, there are evidence gaps, including how policy and practice have adapted to the realities of the COVID-19 pandemic, and the gendered experiences of CTC providers during the pandemic. In this study we have focused on Community Health Workers (CHWs), a specific cadre of CTC provider in Sierra Leone, who are part of the national CHW programme and receive training and support to deliver a package of services at the community level. The aim of the study is to explore the roles of CTC providers and their gendered experiences during the COVID-19 pandemic.

The study objectives are:

1. To map out the range of CTC providers working in the COVID-19 response in Sierra Leone, their changing roles and how these are gendered.
2. To explore CTC providers' gendered experiences in their interactions with the health system, communities and families and in meeting the needs of vulnerable groups during the COVID-19 pandemic.
3. To explore key informant perceptions of CTC providers' gendered roles and work in the COVID-19 response (at health system and community levels), and the support that is provided.
4. To develop policy and practice recommendations on how to support CTC providers in the response to the COVID-19 pandemic and other and future crises in ways that promote gender, equity and justice.

Methodology

We took a qualitative approach, arranging focus group discussions (FGDs) with CHWs, and key informant interviews (KIIs) with health system stakeholders at district and community levels. Two districts were selected: i) Bonthe district in the Southern Province - a hard-to-reach area, which is riverine with several islands, and strong donor support for the CHW programme, and ii) Kenema district in the Eastern Province, with large urban and rural areas, and minimal support from partners for the CHW programme.



Key findings

The following key areas emerged from the analysis.

Selection and recruitment: Recruitment in the face of the COVID-19 outbreak was supported by partners at national and regional levels. Generally, CHWs are selected by the community they serve as a result of a policy spearheaded at national level. This selection involves community stakeholders and reflects the linguistic and cultural diversity of the population, taking into consideration commitment, character, criminal record and influence on others. The selection process is also designed to ensure gender empowerment and it is expected that more woman CHWs are selected than men. However, in practice women were less likely to be selected due to harmful societal and gendered norms.

Motivation to work during COVID-19: Many of the CHWs had experience working at the forefront of a disease outbreak, having been involved in the 2014-16 Ebola outbreak. This served as a motivational factor to be part of the COVID-19 response. They drew upon their prior experience to work with the communities, ensuring that trust was built, awareness raised, myths dispelled, and used their influence to support communities to adhere to preventative measures. Respect from the communities they serve was also a motivational factor. Being respected in their communities empowered them to be involved in conflict resolution during lockdown and in isolation homes.

Roles and responsibilities: General and COVID-19 specific: Generally, CHWs are involved in providing services for child and maternal health, promoting community-based preventive, basic and curative care, and referring to the peripheral health units as needed. During COVID-19, CHWs were initially involved in health education and promotion in line with sanitation and hygiene practices, engaging with communities about risks, and supporting the establishment and operation of a community-led emergency referral system. As the outbreak evolved, additional roles and responsibilities emerged including serving as social mobilisers, disseminating safety messages, providing psychosocial support, contact tracing, monitoring COVID-19 affected patients in quarantine homes, monitoring temperature of isolated individuals, and recording information. There were no reported gender differences in the roles and responsibilities of CHWs. However, there were community preferences for female CHWs for specific tasks, including delivering maternal health care, as this can potentially avoid

conflict between male CHWs and husbands, and provide psychosocial support (as women are seen as being more caring than their male counterparts).

Working conditions: Prior to the COVID-19 outbreak, CHWs worked for two-three hours per day. However, in the face of COVID-19, this increased in line with their larger roles. This had gender implications, as women CHWs faced additional challenges as a result of the increased workload. They had to juggle their caregiving roles at the household/family level alongside the additional COVID-19 related work. In addition, with the closure of schools during the pandemic, female CHWs had to look after the children. This affected their economic earning power as they had little time to engage in other income generation activities, a norm prior to the outbreak.

Remuneration and incentives: All CHWs involved in the COVID-19 response should be given Le 200,000 (equivalent of $20) per week. Their perception on this was mixed, with some saying that the amount was fair as they are working as volunteers, and others reporting that it was not commensurate with their workload. The historical challenge of their remuneration not being forthcoming or being erratic was reported. All CHWs reported that they did not receive adequate non-financial incentives (eg food). There were no reported gender differences.

Training and supervision: CHWs received training in line with their scope of work (centred around child and maternal health services) in the context COVID-19 to support the continuity of health provision. Additional training received included: social mobilisation, community sensitisation, contact tracing, case investigation, counselling people with COVID-19, managing homes in quarantine, and how to address health emergencies, all informed by international guidelines (WHO/UNICEF). There was no gender segregation on the delivery of the training to CHWs. All CHWs perceived that the training was useful in helping them understand more about the illness and how to carry out their roles in the community.

Mobility: Transportation allowance was not provided to CHWs which was a challenge for them, especially those assigned to areas with difficult terrains – often only accessible by using motorcycles. This had gendered implications as female CHWs did not prefer motorcycles as a form of transportation, due to safety concerns. Therefore, they had no choice but to walk long distances to get to the communities they serve, which meant longer working hours, further compounding their income generation challenges and interfering with their household and family caring roles. This was not reported by the men CHWs.

Mental health issues: CHWs feared that the nature of their role meant being at higher risk of being exposed to the disease, contracting the virus and passing it on to their families. This created stress and anxiety. CHW earning power was also impacted – travel restrictions and lockdowns created disruptions in small businesses and other income generation, with the latter having severe impact on the earning power of CHWs as they had to put these on hold, due to their additional roles and responsibilities during COVID-19. Limited earning power, coupled with the increase in the price of staple goods, created stress for the CHWs. This was particularly challenging for women CHWs who were widows or single parents.

Stigma and discrimination: CHWs reported being ostracised by their communities due to their involvement in the response. Some reported being isolated from all social activities in the communities as they were seen as carriers of the virus. Some CHWs felt unappreciated as their response activities were not accepted or taken up by communities due to misconceptions about the virus and accusations of prolonging and monetising the response. CHWs who had to work outside of their home communities faced the additional challenge of rejection by these communities.

Mental health support: Mental health support available at the district level (a mental health nurse in each district) was not made available to CHWs. Some CHWs reported receiving moral support, provided by their peer supervisors, whilst others reported having received some psychosocial support from their families and peer supervisors.

Community, health system and other support: Community leaders and other community stakeholders instituted laws that supported CHWs to work outside of their home communities during the response, helping their entrance and acceptance by the community. In some cases, the security forces were involved in enforcing COVID-19 restriction measures as part of community support. Existing support groups, such as men's and women's support groups, mediation bodies between CHWs and community members, and village development committees, were also reported as being supportive during the response. Support from the health system was perceived as inadequate, due to shortages of equipment (including rain and protective gear) and medicines. In Kenema, vehicles were designated for the referral of patients in emergencies, whereas in Bonthe there were no emergency vehicles. NGO partner support was also reported in Bonthe district.

Recommendations

1. Develop approaches to promote integration of CHWs into communities other than their home communities, especially in the face of a disease outbreak.
2. Work with community leaders to reduce the community stigma that CHWs face when they are working during an emergency like the COVID-19 pandemic.
3. Frequent refresher training and capacity building for CHWs in order to build a stronger health system at the community level that can respond quickly to health crises.
4. Ensure that CHWs receive their financial incentives on time and in full so that they can focus on their responsibilities during an emergency such as the COVID-19 pandemic.
5. Develop local, community-level mechanisms to provide mental health support for CHWs, eg peer-to-peer support.

More on ReBUILD for Resilience and this research can be found on our website.
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Research for resilient health systems
in fragile and shock-prone settings

ReBUILD for Resilience examines health systems in fragile settings experiencing violence, conflict, pandemics and other shocks. Our aim is to produce high-quality, practical, multidisciplinary and scalable health systems research which can be used to improve the health and lives of many millions of people.

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