ReBUILD FOR RESILIENCE

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

The gendered experience of close-to-community providers in fragile and shock-prone settings during the COVID-19 pandemic

American University of Beirut
November 2021

Background to the research

Most countries in the Global South have a shortage of formal healthcare providers and are looking to a range of close-to-community (CTC) providers to meet their shortage and to reach those who cannot otherwise access healthcare services. The experiences of these CTC providers are partly shaped by their gender roles and relations which are context-specific and dynamic. An unpublished desk review, conducted by ReBUILD for Resilience's Lebanon team, identified the critical role that CTC providers have played in the COVID-19 pandemic in the country, however, very little was found relating to the gendered experience of CTC providers in Lebanon. This study sought to reveal that lived experience and make recommendations as to how the working conditions of female CTC health care providers might be improved.

Context

Lebanon is a middle-income country. It hosts more refugees per capita of population than any other country in the world. Its public healthcare services include outpatient services, provided by civil society organizations at a reduced cost, and partly subsidized hospitals outsourced to the private sector. A culture of outreach healthcare provision has developed following the influx of Syrian refugees since 2011. Local organizations, both formal and informal, operate medical and healthcare services which are delivered by CTC providers. Informal facilities in Lebanon provide care for the many refugees with little access to healthcare services. Facilities include field hospitals, out-patient health facilities and mobile clinics. They are not recognized by either the Ministry of Public Health (MoPH) or by the UN - although they are tolerated by both. Their funding, reports, drugs, medical supplies and guidelines are out of the MoPH and UN control and their activities are poorly documented. Both formal and informal sectors are involved in the response to COVID-19.

Methodology

Interviews were conducted with 12 Syrian CTC providers (eight female and four male) and six key informants (three female and three male health facility and outreach managers and supervisors). The respondents came from two sites. Site 1 was an informal health venue serving the Syrian refugee community through both in-facility and outreach services. Site 2 CTC providers were informally (i.e. illegally) employed as 'volunteers' within outreach teams by several local NGOs, providing preventive and curative services.

Interviews were conducted in colloquial Arabic and then transcribed and translated into English. The transcribed narratives underwent thematic analysis.

Key findings

Roles and responsibilities

Respondents felt that non-physician health workers in general, and nurses in particular, were mainly female because of prevalent social norms and the belief that women are more caring than men. However, in both settings respondents reported that managerial positions were predominantly allocated to men.

With regard to COVID-19 specific roles, those working in Site 1 were responsible for detecting COVID-19 infections, referral of those who are unwell and out-patient treatment. Those employed in Site 2 outreach teams provided health education, performed screenings, made referrals, and delivered psycho-social support, while the mobile clinic also provided medical care and dispensed drugs. Respondents from both settings reported that male nurses held posts with greater responsibility, requiring more overtime and different shifts and therefore received more pay. In outreach teams, men worked as healthcare providers, drivers, distributors and translators, and undertook negotiations with informal settlements' gate keepers, whereas women were the direct providers of services. Most of the CTC providers interviewed worked in the same capacities and for the same employers before the first COVID-19 wave and shifted their activities in response to the pandemic. In both settings female health care providers were preferred to men by the communities they serve.

Healthcare workers were motivated by their professional and humane duty and by financial incentives. Men seemed more motivated by their sense of duty while women were more concerned by payment. Most health workers interviewed were demotivated by the fear of contracting COVID-19, the lack of personal protective equipment (PPE), shortfalls in coordination and supervision, and by the frustration of witnessing the deteriorated living conditions of the communities in which they worked.

The involvement of healthcare workers in the pandemic response brought an increased workload, especially for women whose husbands had lost their jobs and whose household responsibilities had increased due to the closure of schools. In most organizations, vacations and other leave were cancelled and only a few organizations awarded bonuses.

Challenges at work

The most important challenge concerned the risk of infection. This was particularly the case in outreach teams where a lack of PPE was the norm, especially at the beginning of the pandemic when health workers were not yet familiar with personal safety measures.

Movement restrictions affected both men and women. Women were not supposed to be on the streets or public transport alone due to societal gender norms and security concerns. Men were more likely to experience movement restrictions due to the risk of being picked up at an army checkpoint and returned to Syria as an army conscript. However, since the beginning of the COVID-19 pandemic Syrian health workers, who used to be scrutinized because they were working illegally, reported that there had been improved flexibility by authorities in a number of municipalities.

Women in senior positions faced the additional challenge of not being listened to or respected in patriarchal communities.

Support

Training

All CTC providers interviewed received training and were still receiving reminders and additional material on protection measures during their COVID-19 response work. The training was rated as being of reasonable quality.

Leadership support

Interviews with managers and health workers revealed two different styles of leadership. Local NGOs delivering outreach activities employing Syrian health worker volunteers adopted a supportive but autocratic style of leadership, influenced by their links to UN and INGOs. This was characterized by rigid reporting and slowness in adapting to contextual changes. The leadership style used by the informal health sector was friendly - paternal, flexible and easily and quickly adaptable to the needs of employees and beneficiaries.

Gender differences in remuneration

The CTC providers and managers did not report any direct gender differences in the allocation of salaries or bonuses. However, men seemed to be in a privileged position with regards to remuneration because of two issues: i) men were more likely to be educated and therefore assigned to higher-level posts with more responsibilities and better pay, and ii) the willingness of men to accept overtime work with its extra pay. In contrast, women rushed home to take care of their families.

Sources of support

Some organizations provided transportation for their workers and had developed safe transport specifically for women. Only one NGO provided female workers with child day care facilities.

Most respondents stated that the local and national health authorities did not provide any support to the teams working in Syrian refugee healthcare provision. Instead, the healthcare teams working in the region benefited from some municipalities cancelling the ban on the movement of illegal workers. All respondents, both men and women, reported being assisted by their close communities and families - women reported that their husbands picked up some of the household chores.

Mental health

Most respondents said that working in the COVID-19 response brought more stress to women than men, due to the pressure of both work and home responsibilities. It was felt that as women are more emotional they are also more vulnerable to vicarious stress, having seen the poor living conditions of their fellow refugees. This was especially the case when beneficiaries vented their emotions at the female CTC providers. To cope with this psychological distress, the CTC providers doubled their efforts to respect personal safety measures, relied on family support, and a few used professional counselling services available through online consultations.

Social norms

Respondents, particularly women, described great changes in their family lives and environments due to lockdown measures and their work in the COVID-19 response. Some of the changes described were negative, such as anxious children, distressed husbands, poverty due to job loss and restrictions on their social lives, e.g. limited socializing and outings with family for health reasons. Others were positive, such as improvements in communications within the family and better family cohesion. It is worth noting that most of the women interviewed did not feel comfortable delegating care for their families to others and preferred to keep control over that aspect of their lives.

Recommendations

Respondents' recommendations for their employers' managers and administrators focused on better salaries, better organization of work, and improved responsiveness to the needs of female workers, such as childcare and transport facilities. The CTC providers recommended that health authorities improve the supply of PPE and medical commodities, are better organized and coordinated, and are more efficient in their organization of the COVID-19 response. Those working informally as volunteers recommended the legalization of their status so it matches their lived position and so they might collect the associated benefits.

Conclusion

Men and women CTC providers have different lived experiences. Gender was found to be a factor in their family, social, legal and professional lives.

1. The social norms that restrict women's freedom and mobility may impact upon their productivity and advancement.
2. Communities' preferences for female health workers leads to more employment for women and but also to greater workloads compared to men in the healthcare sector.
3. Whatever the professional status of working women, within the home they are primarily responsible for caring for children and older family members and for domestic chores. The burden of family responsibilities and overwhelming work schedules, as well as the inherent stress experienced by all CTC providers working on the COVID-19 response, exposed women to tremendous pressure.
4. While women healthcare workers are sought by patients and allocated more tasks, they are also paid less. This is because they generally hold lower positions and avoid working overtime so they can balance paid work with domestic duties.
5. Regarding the status of refugees, women have an advantage as men are more likely to experience movement restrictions due to their illegal resident status and the risk of being picked up at an army checkpoint.

About this research

This summary paper was produced by the American University of Beirut as part of the ReBUILD for Resilience consortium. It is taken from a full report on the study which can be found on the ReBUILD for Resilience website.

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Images:

Front cover left - Lebanon: Helping some of the frailest Syrian refugees in times of need © UNHCR Sara Hoibak via Flickr

Front cover right - Two Syrian women wait to collect a prescription at a health clinic in Lebanon's Bekaa Valley - Russell Watkins/Department for International Development via Flickr

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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.

UKaid from the British people

This project is funded with
UK aid from the British people.
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