ReBUILD
FOR RESILIENCE

The gendered experience of close-to-community providers in fragile and shock-prone settings

Implications for policy and practice during and post COVID-19 – A qualitative study report

Sierra Leone
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1. Introduction

1.1 Overview of the study

Close-to-community (CTC) providers play an important role in providing health services within communities in fragile and shock-prone (FASP) settings, often characterized by inadequate human resources for health, with rural and hard-to-reach communities further disadvantaged. They are often the first point of contact at community level. The COVID-19 pandemic has further demonstrated the value of CTC providers in supporting the response at the community level. It has highlighted the importance of CTC providers' strategic position between communities and health systems, often in a context where mistrust exists between service users and the formal health system. In addition, they are often seen as "sons and daughters of the soil", and accordingly are trusted by the communities they serve in delivering essential health services at the community level (Knox-Peebles, 2020). It is therefore imperative that they are supported in order to create a positive ripple effect in disease responses, through a bottom-up approach (ARISE Hub., 2020).

The ongoing COVID-19 outbreak has also exposed inequalities and vulnerabilities that often hide from plain sight, in some cases further exacerbating them (Blundell et al., 2020). This includes how gender shapes vulnerabilities and responses, highlighting the need for more research through a gender and equity lens. COVID-19 is increasingly affecting ReBUILD for Resilience's FASP study settings of Lebanon, Nepal, Myanmar and Sierra Leone. CTC providers are part of the response to the pandemic in these settings. However, there are evidence gaps, including how policy and practice (e.g. support structures) have adapted to the realities of the COVID-19 pandemic, and the CTC providers' experiences during the pandemic and how these are gendered. This study will contribute evidence on gender equitable approaches to supporting CTC providers in FASP contexts to fulfil their vital role in the COVID-19 response and future disease outbreaks and shocks.

1.2 Sierra Leone and CTC providers

In Sierra Leone, there is shortage of key and formal health care workers. To address this, innovative strategies, such as the development of alternative cadres and task shifting, are needed. Thus, this led to the initiation of the Community Health Worker (CHW) program. The health situation analysis of Sierra Leone reveals facts and figures on country population, household size, family planning and use of high impact interventions (GoSL, 2016). These facts indicate that the country has a high number of maternal, new-born and child deaths; very low use of family planning and a high number of teenage pregnancies; and a high level of under-nutrition. Low use of high impact preventive and curative interventions result in mortality, many of which are

recommended for implementation at community and household level. CHWs have an important role in the implementation of these life-saving interventions (GoSL, 2020).

In Sierra Leone, a CHW is a community-based worker selected by the community and trained to provide basic, essential health services and information at community level. They help individuals and groups in their own communities to access health and social services and educate community members on health issues. The basic package that he/she can provide has been defined by the Ministry of Health and Sanitation (MoHS) and includes serving as an effective link between the community and the formal health system and complimenting the existing roles of formally-trained care service providers to increase and improve access to health care and services, counselling of caregivers and, ultimately, improved health outcomes (GoSL, 2016). Their roles include community sensitization and advocacy for environmental sanitation and hygiene practices, home visits to promote appropriate hygiene and sanitation, birth preparedness for pregnant women, and timely utilization of immunization services. They also provide therapy for malaria, pneumonia and diarrhoea, screen for malnutrition, and report event such as births, deaths, including maternal deaths, and outbreaks of epidemics.

Several community members perform specific but different roles that are all linked to health working under different names and labels, such as Traditional Birth Attendants (TBAs), Community Drug Distributors (CDDs), Community-Based Distributors of contraceptives (CBDs), Community-Based Providers (CBPs), Blue Flag volunteers, Red Cross Volunteers and Community-Owned Resources Persons (CORPs) (GoSL, 2016).

The COVID-19 outbreak has led to various challenges for the continuation of primary health care (PHC) services, with a significant decline in access to and utilization of health facilities by community members due to fear of COVID-19 transmission in health facilities (most were repurposed for the COVID-19 response). In this situation, CHWs need to take on increasingly large roles to help communities respond to COVID-19, to continue to access regular health services and address key child killer diseases (GoSL, 2020). As trusted members of the community who have the ability to provide lifesaving treatments and care for children as well as other essential PHC care services, CHWs can help ensure continued access to prompt and effective treatment for malaria (for all), pneumonia and diarrhoea (for children under five) in rural, hard-to -reach areas. In other epidemic emergencies, such as Ebola, CHWs and other community volunteers have proven themselves to be very effective in contact tracing, therefore they also support contact tracing, and referral of suspected COVID-19 cases to the isolation and treatment centres, while providing key COVID-19 prevention messages to communities and families (GoSL, 2020). A recent review from the interim Community Health Worker (CHW) policy for COVID-19 in Sierra Leone (Government of Sierra Leone (GoSL), 2020) identified the critical role that CTC providers play in pandemics, highlighting the importance of role clarity, training and

supportive supervision, as well as highlighting CTC providers' health and well-being (Bhaumik et al., 2020).

The overall aim of this study is to explore the roles of CTC providers and their gendered experiences during the COVID-19 pandemic in FASP settings. Several methods were used including focus group discussions (FGDs) with CTC providers, key informant interviews (KIIs) with health system actors and a document review. This report describes the methods and findings from the FGDs and KIIs.

1.3 Objectives of the study

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 meeting the needs of particularly 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 that promote gender, equity and justice.

2. Methodology

2.1 Study design

We conducted a qualitative exploratory study to explore roles of CTC providers and their gendered experiences during the COVID-19 pandemic in FASP settings. This included key informant interviews (KIIs) at the district level and Focus Group Discussions (FGDs) with CTC providers. This is supplemented by a document review (separate report).

2.2 Study sites

We selected two districts following a stakeholder engagement exercise and discussions between the research team and the Community Health Worker Hub in the Ministry of Health and Sanitation. Bonthe district is in the Southern Province, is hard to reach, riverine with several islands, and was less affected by the Ebola outbreak than other areas. It has strong donor support for the CHW programme. Kenema is in the Eastern Province, is large with urban and rural areas, and was heavily affected by

the Ebola outbreak. It has no support from partners for the CHW programme. We had worked in both districts before and have good working relationships with the District Health Management Teams there.

2.3 Methods

2.3.1 Key informant interviews

We purposively sampled for interviews with local level stakeholders, based on their knowledge and experience of CHWs' work. We carried out eight (8) key informant interviews, four from each district; three (3) male, one (1) female from Bonthe and two male and two female from Kenema. They included one DHMT representative, one CHW Peer Supervisor, One Section Chief and one Mammy Queen (Chairlady) from each district.

Interviews were conducted between 14 and 18 December 2020. The interviews were face-to-face, following strict COVID-19 protocols. A topic guide was developed to structure the interviews, with questions around the types of CTC providers, their roles and responsibilities, management and support, and recommendations *(see annex 1 for the topic guide)*. The topic guide was pre-tested before interviews with the district informants, with the research assistant playing as either interviewer or interviewee. After each pilot interview, the team discussed the experience in order to finetune the tool, ensuring it was fit for purpose. The researcher led the interviews using Krio language, with the research assistant taking notes. Interviews were conducted at the District Health Office in Mattru Jong, Bonthe District and at the District Health Office and participants' homes in Kenema town, Kenema District, and lasted between and 30 and 90 minutes. They were recorded once consent had been given by the participants.

2.3.2 Focus group discussions

We conducted two FGDs in each district: one with female CHWs (8 women in each FGD) from each district, and one with male CHWs (7 men in Bonthe and 8 men in Kenema). CHWs were contacted by the DHMT representative to participate in the study. They were selected based on their availability and willingness to participate in the study. FGDs were conducted face-to-face, following strict COVID-19 safety measures including hand washing, physical distancing, using hand sanitizer and face masks, between 14 and 18 December 2020. We developed a topic guide to structure the discussions, with questions around the areas of: range of CTC providers, gendered roles of the CTC providers and working at the COVID-19 frontline, managing / supporting CTC providers during COVID-19, CTC provider motivations, CTC provider experiences of working during COVID-19, CTC providers' experiences of management and support during the COVID-19 outbreak, and recommendations

(see topic guide in annex 1). The topic guide was tested beforehand with a small number of selected community health workers in health facilities around the premises of College of Medicine and Allied Health Sciences, University of Sierra Leone. A mock FGD was conducted using the tool with these selected community health workers, with one research assistant facilitating the discussion, the other taking notes and the country team lead making observations. This was fed back in the post pilot meeting. The researcher led the discussion using Krio language.

They were conducted at the hall of the Yea Mammy Guest House in Mattru Jong, Bonthe District and the District Health Office in Kenema town, Kenema District and lasted between 120 and 150 minutes. They were recorded following consent of the participants.

2.4 Data management and analysis

A thematic framework analysis approach was used to analyse the data (Ritchie et al 2003). Before data analysis, we developed an analysis framework based on Morgan et al's gender analysis framework (Morgan et al., 2016) that looks at four aspects of gender relations which have been used as our high-level themes: who has what (what are the available resources for CTC providers, do they have access to resources); who does what (what are the CTC providers' roles and responsibilities during COVID-19 response); how values are defined (what are the common social norms and how they influence the CTC providers and their work during the pandemic); who decides (what are the common rules governing the work of CTC providers, and what are the decision-making dynamics).

After data collection, we translated the data from Krio to English and transcribed it into English. We familiarised ourselves with the data by reading each transcript and the coding framework was adapted and further refined throughout the process of data analysis *(see in annex 2).* We coded each transcript with this framework using NVIVO qualitative data analysis software. We then charted the coded data, identified patterns and themes, and then summarised the data under these themes.

We assured the quality of the analysis through checking the transcription, careful storage of files to avoid being accidental alteration during analysis, and a team approach to analysis.

2.5 Ethical issues

Before the beginning of data collection, we obtained ethical approval from the Scientific and Ethics Review Committee, Ministry of Health and Sanitation, Sierra Leone (dated 9 October 2021) and from the Research Ethics Committee at Liverpool School of Tropical Medicine. Before the initiation of any interviews or discussions, we clearly stated the purpose of the study by sharing an information sheet on the contents of the study, followed by informed written consents *(see in annex 3)* from participants. Also, we clearly stated the respondents' right to withdraw from the study. Privacy and confidentiality of participants were ensured; data collected were stored securely and only shared among project team members. Also, data may be shared with other stakeholders only on legal grounds or through a request from the ethical review board. Anonymity was strictly maintained by the assignment of a unique ID to each and every respondent. Due to the ongoing COVID-19 restriction, the use of face masks and physical distancing was maintained throughout the interviews and discussions.

2.6. Study limitations

This study draws on qualitative methods and explores the issues from the perspectives of policy, CHWs, decision makers and managers, and does not reveal other important perspectives, such as those of the community and patients. The sample of CHWs from two districts was relatively small, although this included a mix of genders, experiences and settings.

3. Findings

3.1 Background information

3.1.1 Socio-demographic information about the participants

The majority of respondents were married with children. A few were single and without children, while a few were widowed with children. Some of the key informants and a few of the CHWs had some level of higher education, such as Tertiary (Bachelor's degree, Higher National Diploma, Teachers Certificate, Higher Teachers Certificate). Most of the CHWs had formal secondary education, a few had primary education and a few of were uneducated. The duration of work experience of respondents ranged between two to ten years. See tables 1 and 2 for details about the participants.

Table 1 Information about CHW participants

District	FGD		Age	Occupation	Marital status	Education	No. of children
Bonthe	Female	1	32	CHW	Married	Secondary	5
		2	29	CHW	Widowed	Secondary	4
		3	45	CHW/ Teacher	Married	Tertiary	4
		4	47	CHW	Single	No Education	6
		5	30	CHW	Married	Secondary	2
		6	45	CHW/ Teacher	Married	Tertiary	3
		7	49	CHW	Widowed	Primary	6
		8	36	CHW	Married	Secondary	6
	Male	1	42	CHW/ Teacher	Married	Secondary	6
		2	35	CHW	Married	Secondary	2
		3	55	CHW/ Farming	Married	Secondary	10
		4	28	CHW/Student	Single	Tertiary	1
		5	45	CHW/ Farming	Married	Secondary	6
		6	30	CHW/ Teacher	Married	Tertiary	2
		7	40	CHW/ Head Teacher	Married	Tertiary	2
Kenema	Female	1	39	CHW	Married	Secondary	4
		2	26	CHW	Single	Secondary	1
		3	46	CHW	Married	Secondary	4
		4	40	CHW	Married	Secondary	4
		5	25	CHW	Married	No Education	4
		6	26	CHW	Single	Secondary	1
		7	30	CHW	Married	Secondary	2
		8	40	CHW	Married	Secondary	4
	Male	1	30	CHW/ Farming	Married	Tertiary	2
		2	41	CHW/ Farming	Married	Secondary	4
		3	60	CHW/ Teacher	Married	Tertiary	3
		4	48	CHW/ Mason	Married	Secondary	2
		5	49	CHW	Married	Secondary	2
		6	48	CHW	Married	Secondary	5
		7	24	CHW	Single	Secondary	0
		8	25	CHW	Single	Secondary	1

Table 2 Information about Key Informants

District	KII		Age	Occupation	Marital status	Education
Bonthe	Female	1	32	Chairlady/ Mammy Queen	Single	Primary
	Male	1	58	Section Chief	Married	Tertiary
		2	40	DHMT member	Married	Tertiary
		3	39	CHW Peer Supervisor	Married	Tertiary
Kenema	Female	1	30	CHW Peer Supervisor	Single	Secondary
		2	32	Chairlady/ Mammy Queen	Single	Primary
	Male	1	49	DHMT member	Married	Tertiary
		2	63	Section Chief	Married	Secondary

3.1.2 Initiation of CHW program

The key informants explained that the CHW program has been in existence since 2008, largely donor and disease programme funded. However, most of the respondents reported that the program had been fully taken over by the Government of Sierra Leone in 2017, in the wake of the Ebola Virus Disease (EVD) outbreak. This was largely due to the role the CHWs played in the EVD response (mostly as contact tracers), and the general shortage of health workers and emergency responders at the community level. The influence of CHWs in their community, coupled with a reduction in workload of health care workers, were among reasons for its initiation.

> **"From my understanding it was around 2016… they initiated it to help the health workers reduce their workload, as the population that was going to the hospital was too much and they have limited health workers to serve all this population… so they thought it fit to include us, the CHWs, and ever since we joined the health workforce we have reduced the number of people going to the hospital, hence the workload on the health workers in the hospital has reduced."**
> **Kenema, Key Informant, CHW Peer Supervisor, Female**

The policy was initiated to support efforts to achieve Universal Health Coverage (UHC) as CTC service provision by CHWs has addressed issues of confidentiality and created a link between communities and healthcare facilities.

> **"We have been talking about "access to healthcare for all", right… So, as the current number of health workers cannot cover the whole country, there might be cases of emergencies which needs immediate medical attention."**
> **Kenema, Key Informant, District, Male**

3.2 Who does what?

3.2.1 General roles and responsibilities of CHWs during COVID-19

The general roles and responsibilities of CHWs were assigned according to their scope of work, which is largely centred around child and maternal health. The general roles reported by CHWs in both districts included:

- Monitoring and counselling of pregnant women and lactating mothers.
- Community-based surveillance for monitoring priority and reportable diseases like pneumonia, diarrhoea and malaria among children and pregnant women.
- Integrated community case management (ICCM) at community level.
- Nutritional surveillance among under five children and referral of children identified as malnourished.
- Referral of pregnant women and lactating mothers to seek health care in order to minimize complications due to pregnancy and home delivery, and maternal and child mortality.
- Monitoring new-born babies for immunization and vaccination.
- Active case search for malaria, pneumonia and diarrhoea among pregnant women and under five children and other childhood illnesses among children in general.
- Rapid Diagnostic Tests for malaria.
- Sensitize community members on hygiene practices, e.g. hand washing.
- Develop community profile, e.g. register water wells, toilet facilities.

Peer supervisors, more experienced CHWs, serve as an intermediary between CHWs and Peripheral Health Units (PHUs). They manage and supervise the work of other CHWs in their catchment areas, schedule monthly meetings, collect and consolidate all data collected by CHWs on a monthly basis, input them into their register, and submit to PHU in-charges. Peer supervisors also serve as coaches and mentors to CHWs, to ensure that they work as required and to try to address challenges faced.

> **”My role as a peer supervisor is that I am an intermediary between the CHWs and the PHU… at least I should visit them twice a month to see what they are doing… do on the spot checks on their jobs and also manage and supervise their work… I am also serving as a coach to them in terms of the area they are not quite familiar with or do not understand… I also try to know their challenges and find a way to manage them.”**
> **Bonthe, Key Informant, CHW peer supervisor, Male**

3.2.2 COVID-19 specific roles and responsibilities of CHWs

Responsibilities of CHWs in both districts during the COVID-19 pandemic included:

- Social mobilization - sensitize people in the community, schools, motor parks, marketplaces about the use of facemasks, hand washing and social distancing
- Psychosocial support by counselling COVID-19 patients and also serving in the treatment centres and quarantine homes
- Active COVID-19 case searching by looking for and enquiring about people with symptoms
- Monitoring of COVID-19-affected patients in quarantine homes and contact tracing

Both the Peer Supervisor and CHWs serve as contact tracers. According to a response from the Peer Supervisor, both the health facility and community want the CHWs to do contact tracing, to sensitize people in the community about COVID-19, to report sick people to the PHUs, to engage in active case searching, to report strangers coming into their communities, and to check patients' temperatures in quarantine homes. The surveillance officers should check whether there is a positive case or not.

The CHW Focal Person serves as case investigator and also the pillar and contact tracing lead at district level, as explained here:

> **"I serve as case investigator and also the pillar and contact tracing lead at district level in the district. In terms of the roles and responsibilities of CHWs, there are no differences based on gender, which is why there are male and female peer supervisors."**
> **Kenema, Key informant, District, Male**

It was reported by CHWs that every CHW plays an equally important role in providing services to members in their respective communities. According to one of the CHWs, there are no gender differences in their roles and responsibilities.

> **"There is no difference in the role and responsibilities {between male and female CHWs]. We do the same job equally."**
> **Kenema, CHW, Male**

However, one of the key informants in Kenema reported that there are preferences for female CTC providers with regard to certain activities including child delivery, home visits (to avoid potential conflicts between male CHWs and husbands), counselling of pregnant women and lactating mothers, and other reproductive and maternal health issues due to culture and traditional factors in most communities.

"We have some very specific aspects in our various communities… Owing to our culture and tradition, there has to be gender-specific roles for certain issues… Like the RMNCH (Reproductive, Maternal and New-born Child Health), I hardly go to the delivery room, irrespective of me being the community health officer in charge… Even home visits in certain communities are specifically done by female CTC providers… For instance, counselling on reproductive health, family planning and contraceptive use, demonstration of how mosquito nets should be used, are preferably done by female CTC providers in order to avoid any potential conflicts among spouses and other misinformation from gossips by community members… So, those are some of the few gender-specific roles."
Kenema, Key Informant, District, Male

Even though all frontline responders were significant actors, one key informant in Kenema identified case investigators as the most important in terms of the COVID-19 response as they are the ones who pick up cases from communities in order to stop the spread of disease.

"The thing is, everyone is important… because the functioning of the response depends on each and every one and without any, issues might arise… We have the case investigators going to the field to investigate cases, but without the confirmation from the lab, then the response is not complete… things like that… And some time ago, we had a serious case of COVID-19 denial, but those issues were addressed through the help of the psychosocial unit… So in essence, everyone is important… But in my own opinion, those picking out cases from communities – as we have learnt was the main reasons for higher fatality from other countries due to twenty or thirty cases coming from the root cause of a single index case – like case investigators, are the most important in order to stop the spread of the disease."
Kenema, Key Informant, District, Male

3.2.3 Specific roles during the first three month of the COVID-19 and during lockdown

CHWs reported that their roles in the first three month of the COVID-19 response included community sensitization on hand washing, social distancing and the use of facemasks, monitoring quarantine homes to check temperatures, referral of COVID-19 positive cases, and reporting all deaths whether COVID-19 related or not to the alert desk as part of their community-based surveillance activities.

"Our role in the first three month of the COVID-19 outbreak was on community sensitization… on how to hand wash and use of face mask… we

were doing that until the initiation of the lockdown… We also thought that the lockdown was an opportunity to fish out (identify) sick members of the community."
Kenema, CHW, Male

During this period, deworming, malaria testing and enforcing community by-laws to stop possible disease transmission and contact tracing were also part of the normal CHW routine. In the lockdown phase, they conducted house-to-house visits, active case identification and isolation, encouraged people to be engaged in best practices to avoid COVID-19 infection and to accept rules and disease control measures set by the government. There were no reported differences in the COVID-19 specific roles and responsibilities in terms of gender or between the two districts as CHWs were all assigned to the same tasks. However, one key informant stated that:

"**Females go to work where females are required and males likewise, as we were faced with a series of challenges that were gender-specific… And the fact of the matter is, sending the wrong person to where they are not needed, would not yield desired results."**
Kenema, Key Informant, District, Male

3.2.4 Selection and recruitment in general

Most CHWs were motivated to volunteer so as to be of service to their community, particularly in order to save lives. According to one of the key informants in Kenema, the mandate for the recruitment of CHWs was given by the national level, which saw the involvement of community stakeholders who have no gender preference in the recruitment process.

"Since community stakeholders select CHWs there is no gender preference."
Kenema, Key informant, District, Male

The selection and recruitment of CHWs also depends on their commitment, character, lack of criminal record or reputation, and influence of the individual in their communities. It is also believed that CHWs are educated, trained and qualified, they know their people better, have the capacity to work effectively, and are the right people to do the work as community members can easily listen to them. Both men and women are recruited as CHWs, but biasness against women has been identified in the recruitment and selection of CHWs at community level due to societal norms. In an effort to achieve gender equality, the current 2016-20 CHW policy under review is considering the recruitment of more women to avoid male dominance.

> **“There is a little biasness from the community level… This is one of the reasons they are trying to restructure the system and the policy in order to bring more women on board as most times there is male dominance… It is still inherent in our culture that everything has to do more with males and not females… So women are often less considered.”**
> **Kenema, Key informant, District, Male**

Although CHWs comprise both males and females, there were differences in their work across the two districts for several reasons. Certain roles demand that women are in charge of the expectant mother and child delivery, more females have worked as TBA volunteers for longer and have much more health service experience than their male counterparts, and in other situations women are more comfortable and confident discussing their issues with other women, which led to more female than male CHWs in Bonthe according to the CHWs. Another reason was that male community members may suspect male CHWs of having extra marital affairs with their spouses, especially when they go to provide services in the absence of husbands.

> **“Female providers are more than male simply because women are more comfortable discussing their problems to their female counterparts… and in some communities, males talking to women might send a wrong signal or message… but female to female makes it easier… that is why there are more females than males CTC providers.”**
> **Bonthe, CHW, Male**

In Kenema on the other hand, male CHWs are more numerous than females according to key informants. Low levels of formal education, jealousy from spouses and the unwillingness of females to volunteer were some of the reasons identified for the disparity. Also, there are more males than females in most communities, skewing the balance.

> **“In our community they have more male than female because women refuse to volunteer.”**
> **Kenema, Key informant, CHW Peer Supervisor, Female**

Irrespective of this, more women are involved in certain areas such as psychosocial support and the care of pregnant, labouring and postnatal women, as they can better handle some issues and people tend to listen to them:

> “**CHWs are a combination of both male and female but women are more involved in psychosocial unit as people do easily listen to them.”**
> **Kenema, Key informant, District, Male**

3.2.5 Selection and recruitment during COVID-19

The Government of Sierra Leone and community stakeholders purposely involved CHWs in the COVID-19 response for several reasons: they are part of their communities and are familiar its members, they can ensure movement restrictions are adhered to, can easily identify people coming in from other communities which can help prevent the spread of the virus, and their existing health work experience stands them in good stead, including their role in the reduction of maternal and child deaths and malnutrition. They are strategically placed to support sensitization about COVID-19, and accordingly were asked by the district COVID-19 response team (DICOVEREC) to support the response in this capacity.

> **"Why they involved us in this COVID-19 is because we have been working in our community as CHW… we know them all, tell them what to do and they will take it as gospel truth… because already we have been interacting with them. So DICOVERC thought it fit to involve us."**
> **Bonthe, CHW, Female**

Key informants explained that inadequate numbers of health workers is another reason that the COVID-19 response utilised the service of CHWs. CHWs are trained and capable of doing their work effectively, they are trusted and respected, and they have the knowledge of disease prevention at community level:

> **"Technical staff are not enough… CHWs have been trained in the community and they know their people… the community respects them and believes whatever they say to them so sensitizing the community will be much easier."**
> **Bonthe, Key Informant, District, Male**

As there was a high work burden for the surveillance team, tasks of contact tracing and surveillance were also shifted to CHWs.

> **"Because the workload was too much on the surveillance team, serving as both contact tracers and surveillance officers, so the government thought it fit to call the CHWs, go through training to know what they will have them do."**
> **Kenema, Key Informant, CHW Peer Supervisor, Female**

No gender differences were reported in selection and recruitment of CHWs during the COVID-19 response.

3.2.6 Motivation for working as CHWs - in general

Both CHWs and Key Informants reported several reasons for the involvement of CTC providers in the CHW program including wanting to prevent their communities from contracting reportable diseases, contributing to a reduction in maternal and child deaths in the face of a lack of transport to health facilities, and to meet the lack of health care information and trust in health facilities. Some were passionate about saving the lives of their families and community members and filling the gaps of health care workers in hard-to-reach areas. Some see it as a moral obligation to serve their communities. Others were passionate about being a health worker from a very young age, while others deemed it necessary to serve as a link between the community and the health system. To improve immunisation equity at the community level, CHWs were also motivated to become involved in campaigns and home visits in an effort to increase immunization coverage and vaccine uptake. Their involvement as CHWs also saw them settle disputes in homes in order to reduce gender-based violence in households.

> "**When they were immunizing children, our people will not agree for their children to be vaccinated… They will hide them because they thought that nurses wanted to give them poison… that is why they were having fever and they were getting sick and so on… So when I saw this one, I volunteered to become a CHW, and by talking to them they have accepted for their children to take vaccination… They are now cooperating."**
> **Bonthe, CHW, Female**

3.2.7 Motivation for working as CHWs during COVID-19

CHWs were involved in the COVID-19 response to sensitise people on health issues, to prevent the spread of the virus (drawing on their community-level experiences in the EVD response) and to raise awareness about the COVID-19 virus at the community level, dispelling denial among community members. CHWs are easily accepted due to their influence in communities which led to an adherence by communities to preventive measures and respect for CHWs from community members, which saw them enjoying their work. A male CHW in Bonthe reported:

> **"People were confused about the disease and had no idea about the disease… As CHWs, we are well known by communities… that is why we are involved for people to know that the disease is real… it is no fun."**
> **Kenema, CHW, Male**

During isolation periods, CHWs were satisfied when they were able to resolve conflicts among members in the community and in quarantine homes. This motivated them to continuing working as CHWs during COVID-19.

"In my community like before when men normally beat up their wives, it no longer happening because of us, the CHW."
Bonthe, CHW, Female

3.2.8 Demotivation for working as CHWs (general and during COVID-19)

CHWs reported several factors that demotivated them in their usual work. They included delays in the payment of stipends and unfulfilled promises in terms of their welfare in general. During COVID-19, demotivating factors included lack of working tools, like phones, rain gear, IPC material, lack of transport facilities and communication allowances, and increased verbal abuse from some community members. These challenges made it difficult for CHWs to do their work.

"Most of the working tools were promised – phones, rain gear, and a lot more - were never given to us... that leads to my demotivation sometimes... but thinking about saving lives and lack of donor funding, I just need to do the job as the situation around the globe is unstable."
Bonthe, CHW, Male

Some reported that they were risking their lives in the COVID response without any protection:

"We were not protected... we were risking our lives to talk to the people... they didn't give us anything to protect ourselves... so that is what I didn't enjoy."

Bonthe, CHW, Female

Shortages of food stuff and other essential commodities in quarantine homes also created a lot of demotivation:

"**What I didn't like at all, like some quarantines home there will be a shortage of food... there will be no food for them to eat three, four days... so I hate to see that or hear about that."**
Bonthe, CHW, Female

CHWs were viewed as carriers of the disease and their stigmatization and abusive languages from friends, families and community members were also reported as demotivators.

"Abusive words uttered by some community members... I only had to endure... but it was difficult."
Kenema, CHW, Male

3.2.9 Workload and burden

Most CHWs reported that they usually worked for 2-3 hours per day. In the context of the COVID-19 outbreak, their working hours depended on their workload, number of COVID-19 cases and the number of homes quarantined, i.e. the higher the number of cases from quarantine homes, the longer the working hours. According to a male CHW in Kenema, their working hours were not specific:

"We did not have definite work hours... partners NGO, human right activist and others were frequently visiting our community especially during the first three month of the outbreak... so we had to be at work for the rest of the day... Aside of that, CHWs are always called upon, whenever there is a reported illness... so we don't have defined work hours... even at night."
Kenema, CHW, Male

Their responsibilities in quarantine homes included: monitoring temperatures of isolated individuals, looking for symptoms of COVID-19, and recording information on reporting forms provided for them. According to a female CHW, they were expected to provide updates which required visiting each quarantine home twice a day. This was deemed a burden:

"The workload was much... we have to visit quarantine homes twice a day and talk to them and check their temperature... And in some households, there are many people."
Bonthe, CHW, Female

CHWs reported that they visited 10-15 quarantine homes a day. Monitoring these quarantine homes was a big burden as they were mostly faced with quarrels from those in isolation. CHWs were not given a definite time to work, meaning they should always be prepared to work whenever their services were needed. They also carried out community-based surveillance activities to identify people coming into the community from other areas in order to prevent disease transmission. Some CHW felt that their work hours should not be defined as they are health workers.

"As a health worker, you do not need a definite time to work... you should always be in readiness to render the required services to your community... as the name implies – health worker- you are a civil servant... And we are always ready to do our job... be it voluntary or paid."
Bonthe, CHW, Male

"The workload was too much on them because sometimes they will have to visit up to 10 to 15 quarantine homes per day… After all, only a small number among them were selected."
Bonthe, CHW Peer Supervisor, Male

In addition, integrated community case management and drug distribution were part of their usual workload, as well as working as social mobilizers and community sensitizers, seven days a week and four to five hours a day. Some reported that their workload was excessive as they were working as contact tracers and surveillance officers in addition to their pre-COVID-19 duties.

However, despite male and female CHWs being charged with similar roles and responsibilities, some female CHWs reported facing challenges balancing their work loads and family responsibilities. According to a female CHW in Bonthe:

"It was hard because sometimes I will leave my children early in the morning without looking after them… because I have to go to work."
Bonthe, CHW, Female

3.3 Who has what?

3.3.1 COVID-19 specific training

All CHWs reported that they received training on how to check body temperatures, how to address health emergencies and counsel COVID-19 infected patients, sensitization of communities, contact tracing and case investigation. They were also trained on how to approach quarantine homes and execute their work without being infected. The training component on social mobilization included how to talk to people on using facemasks, hand hygiene, and social distancing to minimize interaction among community members. All CHWs were trained together and not separated by gender.

"We were trained on contact tracing of people that have come in contact with an infected person… We were also trained on how to check the vital signs of people in quarantined homes… to determine whether they would manifest the COVID-19 symptoms."
Kenema, CHW, Male

Some CHWs in Bonthe reported having two or more training sessions; one on COVID-19 response and the rest on social mobilization, while others reported having had only two from partner NGOs such as CUAAM (Doctors without Borders), Partners in Health (PIH), International Rescue Committee (IRC), Sierra Leone Red

Cross, and Welt Hunger in collaboration with District Health Management Team (DHMT) on contact tracing and social mobilization.

> **"Our first was from Partners in Health in collaboration with the DHMT on contact tracing and the second on social mobilization by CUAAM (Doctors without borders)... one to two hours a day... the time was not much"**
> **Bonthe, CHW, Male**

On the other hand, one of the male CHWs in Kenema reported only two training sessions, one of which was by Medicine San Frontier (MSF) on the COVID-19 response. The other was a whole day on social mobilization by Partners in Health (PIH), after which there were no subsequent or refresher training.

> **"The training we received was from two different sites... the first from Hangah conducted by MSF (Medicine San Frontier) and the second from environmental health department... by Partners in Health... all on the same day due to social distancing."**
> **Kenema, CHW, Male**

According to the same respondent, their training also covered how they should check for vital signs and contact tracing.

> **"We were trained on contact tracing of people that have come in contact with an infected person... We were also trained on how to check the vital signs of people in quarantined homes... to determine whether they would manifest the COVID-19 symptoms."**
> **Kenema, CHW, Male**

All CHWs perceived that the training provided to them was helpful in making them understand what the disease was and its mode of transmission, social distancing, correct use of facemasks, temperature checks and patient referrals. This helped them do their jobs and increased awareness among community members in terms of hand hygiene and other public health measures.

> **"It helped us understand a lot about the disease... we now understand what social distance is, use of face mask and temperature check... patient referral is also another... a lot of awareness has been created among community members."**
> **Bonthe, CHW, Male**

3.3.2. Supervision during COVID-19

All CHWs reported that supervision was mainly done by peer supervisors and PHU in-charges. Methods of supervision included on the spot checks by supervisors to ensure proper implementation of daily activities by CHWs. Both CHWs and key informants did not report any form of virtual supervision as travel restrictions do not apply to frontline workers.

> **"We were supervised on what we were trained… like CBS, sensitization… to know whether we are really implementing what we were trained in our various communities…and also based on various activities we undertake… sometimes they will even go to communities unannounced to find out whether we are really doing our job… and that is confirmed by community members that indeed they have been told what to do to keep themselves protected"**
> **Bonthe, CHW, Male**

In general, the CHWs report on a monthly basis but this changed during COVID-19 to daily reporting of Community-Based Surveillance (CBS), sensitization, and daily field activities, like contact tracing and case investigation. With regards to data collection (for CBS), CHWs were supervised by disease surveillance team members, peer supervisors and focal persons on how to correctly fill-in data collection forms. These were then submitted to the COVID-19 response at the district level (to the relevant pillar – there were a number of pillars focusing on key areas of the response of which surveillance was one of them), and finally fed into the response at the national level. COVID-19 response report submissions were overseen by each pillar lead for various arms of the COVID response units including contact tracing, case investigator, quarantine and psychosocial unit.

> **"We have been supervised by our partners, especially those helping us in our response… we are given forms to fill every day in order to determine whether we are doing our job or not."**
> **Bonthe, CHW, Male**

CHWs perceived that supervision helped them do the right thing and in the right way for better results. It also served as an easy reminder on how to do their jobs when they might forget and helped create trust among community members when they were being supervised. It served as a morale boost to CHWs in some communities, increased their knowledge, helped them do their work better, and also improved their effort and time management. No gender issues were reported by CHWs.

> **"It (supervision) gives us weight in doing our job… people seeing us supervised serves as a boost to our job… they can easily accept whatever we**

tell them…It also keeps us on our toes in doing our job the right way."
Bonthe, CHW, Male

The supervision also helped CHWs to be punctual. According to a male CHW in Kenema:

"Supervision makes me go to work early."
Kenema, CHW, Male

It also helped them do their jobs as required of them

"It helps us to do our work better because once they are behind us you will do the work better and hold it with your two hands."
Kenema, CHW, Female

3.3.3 Protocols, guidelines, IEC materials on COVID-19

Manuals, guidelines, posters, wall posters and booklets containing information on community sensitization on the prevention of COVID-19 – such as frequent hand washing, correct use of facemasks, use of thermometers and other protective gear - were provided for CHWs.

"During the training at the council, they gave us posters that we used to sensitize people… telling people about the prevention of COVID-19, they gave us megaphones to do the sensitization."
Bonthe, CHW, Female

According to CHWs, the information was useful, especially for social distancing, self-protection during field work, use of equipment and helping them remember quickly if they forget their training. It helped both CHWs and community members to understand the disease better. It also helped CHWs to do their work better.

"Even if you want to forget what you have been taught, when you watch the posters you will remember."
Kenema, CHW, Female

3.3.4. Supplies and equipment during COVID-19

In Bonthe, most male CHWs reported that although they received kit - such as thermometers, hand sanitizers, rain gear, facemasks, buckets and liquid soap for hand washing, case investigation and survey forms, and megaphones from community-based organizations to sensitize people – they were inadequate to do their work.

Some CHWs had to improvise and teach communities on how to convert jerry cans to be used as buckets and use ash in the absence of hand soap.

> **"We were encouraging communities to improvise where these materials were not available… By converting jerry cans to be used as hand washing stations… so people were taught how to do that… in the absence of liquid hand soap, people were encouraged to use firewood ash or the locally made soap available to them… which they accepted."**
> **Bonthe, CHW, Male**

Female CHWs on the other hand reported having received only reporting forms for case investigation which was also not sufficient. Face masks and other working tools, like rain gear, were not provided for them, and in some cases they had to pay for work materials out of their own pockets, such as printing extra forms, which impeded their work.

> **"It affected us because we were not having our equipment, everything we have to take from our pocket… and that slows down our work."**
> **Bonthe, CHW, Female**

Promises on provision of airtime (mobile phone credit), mobile phones for reporting any issues they might be face with during their response were made to all CHWs. They were also supposed to be provided with PPEs to enhance their work, but unfortunately were never made available to them.

> **"From our own section (community), we were only promised working tools like phones and rain gears… but none were given to us…we were only given hand sanitizers, face masks and thermometer for temperature check… also the forms for contact tracing were not sufficient."**
> **Bonthe, CHW, Male**

In Kenema, male CHWs reported that they did not receive essential drugs for treatment of common ailments, like malaria, pneumonia and diarrhoea. They also reported having been provided with reporting forms and thermometer for contact tracing by the surveillance unit, but they were not sufficient. One of them also reported that only a one-time face mask was provided to them and that they had to provide for themselves during the COVID-19 response.

> **"Initially we were given two cloth face masks each…subsequent mask were on us to date [CHWs buy themselves]."**
> **Kenema, CHW, Male**

Shortages of logistics were reported by some CHWs to their peer supervisors, others to their focal person, while most did not even know where or to whom they should report. The shortages of materials led to challenges for some CHWs in executing their work in the community as required.

> **"Five of us were using a single thermometer… we were using it by turn… one uses it for a few hours… then give to the other and so on… it caused a lot of delay in our work… especially in quarantine homes."**
> **Kenema, CHW, Male**

Female CHWs on the other hand reported having not received any working tools or personal protective equipment and hand washing materials, except pen and papers for reporting.

> **"They didn't give us anything to prevent ourselves… we only provide it by ourselves… they didn't give us any equipment for this job… it only by God's grace that saves us in this job… The only thing they gave us was a pen and paper, even the thermometers were not enough."**
> **Kenema, CHW, Female**

According to one of the male CHWs in Bonthe, the shortages or lack of hand washing materials in some communities led to accusations against some CHWs of embezzlement of these materials and led to mistrust from community members. Such disputes with community members were resolved through community engagement.

> **"Due to shortage of materials, some community members were assuming that we as CTC providers were the one embezzling supplies…So that created some amount of mistrust."**
> **Bonthe, CHW, Male**

3.3.4.1 Challenges from the health systems (Logistics, supports, training)

Unfulfilled promises about the provision of logistics, like working tools, protective equipment, rain gear and incentives, and a lack of transportation were named as major challenges, especially for peer supervisors covering large areas. Delayed or non-payment of incentives to CHWs, lack of subsequent or refresher training for CHWs (in terms of capacity building and opportunities for CHWs), insurance or end of service benefits for CHWs, and shortage of drug supplies for normal routine CHW services were also among several health system challenges reported by CHWs. Collectively, these factors had a negative impact on the work of CHWs.

> **"Challenges were numerous… there were shortages of contact tracing materials… a lot of working tools were promised but not delivered on time…**

except the thermometer… because we cannot work without that.”
Kenema, CHW, Male

Also, workloads were not commensurate with their economic standing. In some cases, it was reported that this resulted in CHWs leaving their work to engage in other income generating activities to sustain themselves and their families.

3.3.5. Remuneration and other financial incentives

CHWs in Kenema and Bonthe were meant to be given stipends (Le 200,000 ~$20) per week for their involvement in the COVID-19 response. According to a male CHW in Bonthe:

> **“We are given a monthly stipend as contact tracers for the COVID-19 response… Every CHW involved in the COVID-19 response was given a monthly stipend.”**
> **Bonthe, CHW, Male**

Some reported not having received any payments, while most reported to have not received their full payment. According to a male CHW in Kenema:

> **“We had later payments but we did not receive our two months backlogged, as I was one of the forty people who did not receive my stipend for the first two months.”**
> **Kenema, CHW, Male**

Some felt that the amount given to them as incentives for their involvement in the COVID-19 was appreciable as they are working as volunteers. Others felt that the amount was less than the workload. A female CHW in Bonthe reported that:

> **“The money that they gave us was too small; during a lockdown, we have to buy things in the house to eat. The family burden is too much on us we have our children to look after and other family members.”**
> **Bonthe, CHW, Female**

Initially, incentives were paid cash-in-hand, but later done through banks and mobile money transfers. There was no gender bias for payment of stipends to CHWs as there was equal payment of incentives for both male and female CHWs. The amount given to CHWs did not change from the onset of the COVID-19 response up until the time of interview. All CHWs reported that they were not given other incentives, like food and non-food items, for their work in the COVID-19 response.

Recommendations from CHWs about their incentives from the government included:

- Provision of food items to CHWs on credit for which they will pay later
- Increase their stipends and pay them on time

3.3.6 Other types of support

3.3.6.1. Support from the community

Although CHWs were only working on a voluntary basis, effort had been made, especially for those working outside their residence, to be supported in terms of accommodation, food and moral support though this was not sufficient. According to key informants from Bonthe and Kenema, there were well-organized community systems in both districts, which further supported the work of CHWs. This included community leaders and other community stakeholders instituting laws guarding CHWs for ease of community entrance during case investigation, contact tracing and management of isolated or quarantine homes. The military and other security personnel were also involved in enforcing COVID-19 health measures as part of community support. This community support, supported by a series of workshops and community engagement by the government, raised awareness and made CHWs' work easier.

> **"They have helped a lot… One instance is when we had a positive COVID-19 case in one of the surrounding villages which was out rightly denied and let to our rejection to entry and was a very challenging task… Even though we were also working with the Military to reinforce rules for the response, they also failed in their effort… It was only the local administrators were able to help in persuading those people to go for hospitalization… That is why before we initiate any type of work in any community, we first pay a courtesy call to leaders of those communities by informing them early about our arrival."**
> **Kenema, Key Informant, Male**

Both male and female CHWs from both districts reported having garnered a lot of praise from community leaders and some community members in recognition of their hard work.

> **"We have got a lot of praise from community leaders…our work did not go unnoticed… we were really recognized by leaders that our work is saving our communities… our wok was also recognized by some community members, women especially, that we have been saving lives and people from different diseases in our communities."**
> **Bonthe, CHW, Male**

They also reported support, especially from community leaders, for serving their communities both before and during the COVID-19 outbreak. This enabled their work.

> **"My gratitude goes to our community leaders… they were really giving us the zeal and motivation to do our job… It made my job easy… there were no confrontations from any quarantine homes in my community."**
> **Kenema, CHW, Male**

According to a female CHW from Kenema, most community members often adhered to and complied with measures communicated by CHWs due to sensitization. There were also support groups, like men's and women's support groups, mediation bodies between CHWs and community members, and village development committees that supported CHWs. CHWs had more zeal and courage in doing their work due to such effective and unchanged community support.

> **"In my community, they were not supporting me financially but what I was telling them to do, they will do it… They do accept anything I say… They will do anything I asked of them and that gives me the zeal to work in the community."**
> **Kenema, CHW, Female**

In Bonthe, CHWs reported that similar community support was provided to male and female CHWs. However, male CHWs in Kenema reported that a women's support group existed but not one for male CHWs, which they would also want.

3.3.6.2. Support from the administrative level

CHWs received support from the health system but the support provided was reported as not enough to do their jobs as required. Although there was some support in terms of ambulance services and stand-by vehicles for emergencies in Kenema district, this was not the case for Bonthe. Logistics and other administrative support was available but neither sufficient nor effective. This had a negative impact on the work of CHWs. One of the male key informants from Bonthe reported that CHWs received support from their peer supervisors, helping them with their reports and settling disputes between them and their communities. However, this support was reported as not too effective, and additional measures were not put in place to address this during COVID-19.

3.4.6.3. Support from partners and other organizations

In Bonthe, the CHWs received support from partner NGOs, like World Vision, and other community-based organizations with hand washing materials and other logistics. World Vision normally engages with peer supervisors and focal persons in a meeting, to discuss the challenges the CHWs are facing in doing their work and tries to address the identified challenges. World Vision also provided infection prevention and control materials for the CHWs and conducted several workshops during COVID-19 to motivate them:

> **"After realizing the intensity of the outbreak, we started getting support from some other local NGOs… materials like thermometer and hand washing materials were provided to us… we distributed those at strategic points that could be easily accessed by people to use."**
> **Bonthe, CHW, Male**

In Kenema, there is no NGO providing support to the CHW programme at the district level. This narrative was confirmed by the respondents in this study. However, it was reported that the MoHS also works with other partners, like IRC, GOAL Ireland and Welt-hunger, that gave general support with regards their daily work during the COVID-19 response, albeit not specifically to CHWs, or at least not to the knowledge of the CHWs.

> **"Even there were such support… it is not to our knowledge."**
> **Kenema, CHW, Male**

A male key informant from the same district also reported that MSF provided transportation by allocating vehicles to the DHMT as stand-by for emergency use and also helped in the psychosocial unit.

> **"Some other NGOs, like MSF, were helping greatly… They were providing transportation… even allocated four vehicles to the DHMT as stand by for emergency cases… They were also helping in terms of psychosocial and other support."**
> **Kenema, Key Informant, District, Male**

No one reported any gender issues or considerations in the support provided by partners.

3.3.7 Mental health

3.3.7.1 Mental health issues

CHWs were faced with several additional challenges, including some community members verbally abusing them, mocking them, and accusing them of being 'super spreaders' of the virus. Two CHWs were traumatized due to their female dependents becoming pregnant following school closure due to COVID-19 and while they were away working on the COVID-19 response. A male CHW in Kenema reported his younger sister been impregnated by her lover who refused to give support, for which he had to bear the extra burden of looking after the mother and the child.

> **"I was really traumatized due to the pregnancy of my younger sister… life was so stressful for me due to additional burden… I have to take care of both the mother and the child… My job was affected due to stress… no help from anywhere else… I have now got more burden on me with less income."**
> **Kenema, CHW, Male**

All CHWs reported having experienced some mental stress due to having to work without or with limited working tools, equipment and support, as they were in constant fear of contracting the virus. They also reported fear of stigmatisation from the community and some of their family members because of their involvement in the COVID-19 response.

> **"We were bashed at in some communities… sometimes we cannot even do our work… as most were claiming that we were disease carriers… coupled with a lot of provocation so that led to serious mental health issue amongst us."**
> **Bonthe, CHW, Male**

There were no reported gender differences in mental health triggers.

3.3.7.2. Fear of contracting COVID-19

Some of the CHWs found their work difficult, especially those attached to quarantine homes, fearing that they might contract the virus. Some reported that physical distancing was hard to maintain due to available space in the quarantine homes, and when they visited homes to trace contacts. Most CHWs had to walk to work to avoid overloaded motorbikes and to save themselves from being infected by the virus. Some were afraid of contracting the virus and passing it on to their families and other relatives.

"Physical distance was hard to maintain… so I had to be really careful… I had to be a role model to other people, especially at quarantine homes."
Bonthe, CHW, Male

3.3.7.3. Fear of passing COVID-19 virus to family and others

CHWs reported that their friends and families were afraid of being close to them. A male CHW from Kenema reported having to abandon his place of worship for fear of passing the virus to others. This affected workers spiritually and mentally as they always worried about passing the virus to their families. Another female CHW reported having to shower outside before entering her home after work:

"When I leave work and come home, I will have to undress and take a shower outside before I enter my house so that I will not pass it on to my relatives, and also fear of contracting the virus."
Kenema, CHW, Female

3.3.7.4. Impact of COVID-19 on economic activities and mental health

The impact of COVID-19 was enormous as it led to the disruption of small businesses and other sources of income generation due to lock down and travel restriction. All CHWs reported having experienced some mental health stress due acute shortages and increased prices of staple foods, and the economic impact of COVID-19 as most of their income generating activities came to halt. Some CHWs also reported having only focused on COVID-19 responses, which give them no extra time to engage in other income generating activities, further compounding their economic problems due to the non-payment of incentives. It was also reported by the study participants that the COVID-19 outbreak also led to mass failure of children in publics due to disrupted schooling and long stay-at-home periods.

As head of their families, activities carried by male CHWs as additional sources of income, like masonry, teaching and hawking, were halted as a result of the COVID-19 pandemic and their involvement in the response:

"COVID-19 has disrupted our economic activities severely… we used to engage in cassava production and trade… "garri" (a by-product of cassava) processing has been our main source of income generation… Having one of the best "garri" products in the country, we used to have buyers flocking in… but all that has come to halt… even if we process it, selling it is seems nearly impossible due to the restriction in movements of people…Also as a result of result of the COVID-19 response, our activities have come to halt as well."
Bonthe, CHW, Male

It was particularly challenging for female CHWs who were widows or single parents who found it difficult to feed their families due to restrictions on small businesses as a source of income:

> **"It was not easy… especially for us with kids… we were just working in the community, and we had nothing… so the little we had is the only thing we were using."**
> **Bonthe, CHW, Female**

3.3.7.5. Mental health support

Despite the complaints of the CHWs to their managers, there were no reports of CHWs having received any mental health support, even though there were dedicated mental health nurses in each district. They only reported having been advised by their managers to ignore criticisms from community members and to continue doing their work.

> **"We forwarded several complaints to our superiors…we were admonished to give deaf ears and do the job as we have decided to help our communities… Our superiors also had engagements with community leaders, so that they can take measures as safeguards for responders to do their work effectively."**
> **Bonthe, CHW, Male**

However, CHWs reported having received some psychosocial support from their families and peer supervisors. Therefore, CHWs recommended such support be provided which would help their wellbeing and make their work easier. This was the case for both male and female CHWs.

> **"Providing us with the support we need will make our work easy…Without support, the work cannot be done as required."**
> **Kenema, CHW, Male**

3.3.6.7. Coping mechanisms and strategies in dealing with mental health issues

CHWs had to find coping mechanisms due to the inadequate psychosocial support available. To dispel some of the community's misconceptions about the role the CHWs played in the response (documented in *section 3.2* in the report), CHWs encouraged their communities to follow public health measures to avoid infection. The use of facemasks and constant hand washing was a daily routine for CHWs in order for the community members to gain trust in them and in the response. Issues at the individual level were managed by talking to community members and explaining the severity of the disease to encourage them to abide by the rules and regulations

laid down by the government. This was important for their mental wellbeing as having the communities' faith in them and the role they played, addressed the issue of the communities having misconceptions about the roles they played, which in turn addressed the issue of confrontations.

> "**We had to talk to them… make them understand that this disease knows no boundary… so we need to protect ourselves as a community… we are doing it for you… not for money."**
> **Bonthe, CHW, Male**

Generally, CHWs reported that the incentives given to them were not enough to take care of their basic needs. Irrespective of this, they were motivated by their sense of duty to serve their communities.

> "**We are doing it for the love of our people… and we will continue to do it."**
> **Bonthe, CHW, Female**

Despite this, it was reported that the issues around incentives (both financial and non-financial) should be looked into.

3.5 Social norms and values

3.5.1. Family and household support

Most CHWs were encouraged by their extended family members via frequent phone calls to remind them about self-protection during their COVID-19 work. They also received advice and concerns from family members both home and abroad on using preventive measures to protect themselves and save their family members. Some of the CHWs reported having received support from their spouses, siblings and other extended family members, giving them words encouragement to continue the work they were doing. The differences in magnitude of support received by CHWs was not reported.

> **"My family and friends supported me, and they encourage us to do the work… They listen to whatever we tell them to do that alone is a big support, because they are making our work easy."**
> **Bonthe, CHW, Female**

Supports received from families and friends helped CHWs to always be careful and on the alert, especially those working in quarantine homes. It also motivated them to work more and earn the respect they deserved. However, one female CHW reported

having not received support from anyone and was also distanced by her only brother for fear of contracting the virus.

> **“My mother and sister are no longer alive… even my father’s lineage, there is only one surviving member… my children are young… I am not having support from anybody… my brothers are alive… one of my brothers who knows that I am a contact tracer has distanced me.”**
> **Kenema, CHW, Female**

3.5.2. Family and household reluctance for CHW work

CHWs from both districts reported that family and household reluctance for them to engage in CHW work was not common, but there were some fear among male and female community members of losing their spouse to other men or women.

> **“There are other issues of husbands complaining of fear of losing their spouses also to other men… which is not that common.”**
> **Kenema, Key Informant, District, Male**

One of the key informants from Kenema reported that there were protests from spouses of some female CHWs, demanding that wives give up their roles as CHWs, as it was perceived that their duties, both before and during the COVID-19 pandemic, caused them to abandon their roles in their homes.

> **“I have got cases of two female CHWs abandoning their homes for their work, which led to protests from their husbands demanding that their wives be laid off from the jobs… There are other issues of husbands complaining of fear of losing their spouses also… which is not that common.”**
> **Kenema, Key Informant, District, Male**

Also, other communities denied visits from CHWs to their relatives in COVID-19 affected areas.

> **“Some CHW working in COVID-19 affected communities were not allowed to visit their families in non-affected communities saying that they might bring COVID to the community, hence the issue of marginalization.”**
> **Bonthe, Key Informant, District, Male**

Though it was not common, as most CHWs were selected by their communities and health facilities in-charges based on their residence, some CHWs working outside their residences were rejected by some communities according to some of the key

informants. However, communities were encouraged to accept them through engagement. According to one of the key informants from Kenema:

> **"In terms of acceptability at first, the community rejects some of them saying they were not selected by community members, but after sensitization, they accepted them and make them part of the community."**
> **Kenema, Key Informant, District, Male**

Male CHWs also reported that they were not allowed to visit and provide services to female clients in the absence of their husbands as they are often suspected of having an affair with their spouses, leading to confrontations with male community members. A male CHW reported in Bonthe:

> **"As a male CTC provider, sometimes we are misunderstood… in an instance where male providers go to provide services to women in the absence of their husbands, sometime we are easily misinterpreted… as most men think that we are having an affair with their spouses, especially in these parts of our communities."**
> **Bonthe, CHW, Male**

Also, some community members do not listen to female CHWs, unless they are accompanied by a male as a back up to address emergencies:

> **"Communities do not tend to often listen to women in certain situations due to cultural beliefs… they are not given the audience they need… so in some cases we provide them with a male back up if there should be pressing issues to be addressed."**
> **Kenema, Key Informant, District, Male**

3.5.3. Communities do not accept CHWs deployed from other communities

According to a male key informant from Bonthe, some communities were reluctant to accept CHWs from other communities.

> **"One of the challenges we face is that in one chiefdom they don't accept the CHW in their community saying that he has bribed the chief to let me accept that there is COVID and he is the one that has brought COVID into the community… This went to an extent where he was not allowed to touch patients to the point a child lost her life because they didn't allow the CHW to give pre-referral treatment to the child… and also for the CHW to refer the child to the hospital."**

3.5.4. Community stigma and discrimination

Stigmatization had a huge toll on CHWs responding to COVID-19. Some community members avoided CHWs involved in the response, while others were totally isolated from all social activities in the communities they served as they were viewed as carriers of the virus. Some were rendered powerless, and their response activities thwarted by communities due to misconceptions about the virus and accusations of prolonging and monetizing the response:

> **"Some of us are tenants… so, flat owners are assuming that we are also playing a huge part in prolonging the period of the disease in communities… In communities, we are only regarded by old people… while young people are accusing us of monetizing the whole response program… that creates a kind of stigma around us in our communities."**
> **Bonthe, CHW, Male**

3.6 Who decides?

3.6.1 Decision-making power

As decision-making powers are centralized, CHWs were not able to make decisions on their own and instead reported to their managers (peer supervisors and in charges in the PHUs). It was also captured that some do not know where to report because they don't know who makes decisions about their affairs, including equipment, supplies and other administrative issues they may face.

> **"We don't know where to report."**
> **Bonthe, CHW, Female**

3.7 Challenges

3.7.1. Challenges from CHWs (both male and female)

Some CHWs see their supervisors as equal due to overfamiliarity, which can affect the supervisor/supervisee relationship, and ultimately lead to ineffective work. Downstream effects of this captured included monthly reports not being submitted at all or on time, which would have severe consequences during the response, as this information was needed for decision making.

Low levels of formal education among CHWs leading to an inability to use reporting tools, coupled with high CHW turnover, is leaving a huge vacuum in communities and the system as a whole. This can have dire consequences on the response at the community level.

> **"The challenges that I faced in managing the CHWs is that most of them are not literate… so it's difficult sometimes to manage and train them because**

report writing involves a lot of writing and most of them are not literate. Late report submission is also a challenge… others will have family responsibilities saying, 'I have to go and cook for my family', while others will say 'I have to take care of my family'."
Bonthe, Key Informant, CHW Peer Supervisor, Male

With regard to female CHWs, non-provision of maternity leave affected expectant and new mothers serving as CHWs. It was also reported that there was a high attrition rate among male CHWs, with the tendency to leave without giving their supervisors prior notice. This was due to the underlying challenges faced, including lack of working tools and incentives:

"Because they do not have their incentives as promised, they do not cooperate with their given roles and responsibilities."
Bonthe, Key Informant, CHW Peer Supervisor, Male

Despite CHWs being trained on community approach, some were reported as engaging in unprofessional conduct. Also, issues with male CHWs not following orders or instructions from female peer supervisors were reported by a female key informant from Kenema:

"Since I am a woman, some will make like they know it all, because I am a woman, I should not be a peer supervisor for them."
Kenema, Key Informant, CHW Peer Supervisor, Female

3.7.2. Challenges from the community (gender-related, other challenges)

A number of significant challenges were faced by CHWs, including from traditional or secret societies. A male from Bonthe reported that male CHWs faced challenges in entering communities:

"Male CHW face traditional societal issues, so they are not allowed to go certain places when there is a female society going on because they are male."
Bonthe, Key Informant, District, Male

Provision of accommodation (by the new communities) for CHWs working outside their own communities was also a challenge captured. This challenge will be more profound for female CHWs, taking their safety in a different environment into consideration.

According to the respondents, communities tend to pressurise CHWs in an effort to attain referrals to health facilities for medical care. It was also reported that some community members challenge female CHWs, claiming they are not trained medical professionals and therefore should not act like one. Such issues were reportedly resolved through community engagement according to one of the key informants in Kenema.

> **"There have been an issue where we had a report of female CHW acting like a medical doctor… often abusing her roles and responsibilities and talking to people in a very unprofessional fashion… So those issues are often resolved through community engagement and admonition of providers."**
> **Kenema, Key Informant, District, Male**

3.7.2.1. Expectation vs. reality

Male CHWs often quarrel with their spouses, accused of not providing for their families following the non-payment of supposedly attractive and timely incentives. Community members also assume that CHWs, being health workers who are involved in the COVID-19 response, are paid a hefty amount, citing the Ebola response in comparison.

> **"People assume that one can earn money from healthcare work, but we as CHWs do not realize such… it does not reflect on us in any way… we are facing pressures in that regard due to peoples' assumptions…it's really not easy on us."**
> **Bonthe, CHW, Male**

3.7.3. Challenges related to daily work and family dynamics (gendered dynamics)

Huge family responsibilities compounded by the delayed payment of incentives were a big challenge. CHWs had limited time to engage in other income generating activities, even more so for the female CHWs who also had care-giving roles in their homes. This posed a lot of problems for male CHWs as heads of their families, so they engaged in other income generating activities where possible:

> **"Family responsibility is too much on them (CHWs)… especially when their incentives have not been given for some time now… They have to feed their families… So some do extra work like farming just to feed."**
> **Key informant, Male, Bonthe**

Early morning shift work was reported as another challenge for nursing mothers.

Lack of mobility was a challenge for male CHWs, covering long distances to provide care. Most areas are not accessible to women and some male CHWs due to topographic issues.

> **"Most areas in my community are not accessible either by motorbike or vehicle… they are only accessible by trekking, especially hilly areas."**
> **Kenema, CHW, Male**

Lack of transportation facilities posed a huge challenge for both male and female CHWs as they sometime had to fund travel out of their pockets.

> **"The little they gave to us, I finish it on transportation because I was coming from Samai town to Tobuai town, which is a long distance."**
> **Kenema, CHW, Female**

3.7.4. How challenges were addressed

Accommodation challenges faced by CHWs working away from home were reported to have been addressed by community leaders, engaging health facility in-charges to address such issues. Resolution of conflict between communities and CHWs was done via community engagement. Peer supervisors engaged in 3-4 days visits to CHWs before final deadlines for report submission to avoid late reporting. To address the issue of a lack of hand washing facilities, CHWs encouraged community members to use local materials, like wood ash, in the absence of hand soap, and jerry cans converted into hand washing stations when buckets were not available. Some of the CHWs tried their best to spend more time with their families as they could not always meet their basic needs. A male CHW from Kenema reported the presence of security in communities resisting CHWs efforts.

> **"There was a presence of security forces at every quarantine home to ensure our safety… Our CHW identity cards were also helpful for easy identification… throughout our contact tracing activities, our cards were on us…"**
> **Kenema, CHW, Male**

Customary laws were also instituted by community leaders to guard CHWs and enable them to do their work.

3.8. Recommendations from respondents

3.8.1. Health system recommendations

A number of health systems recommendations were provided by respondents from both districts. They concerned enabling the work of CHWs, both in general and during the outbreak response, and focused on existing factors aggravated by the COVID-19 pandemic which included:

1. The MOHS should do more to promote integration of CHWs into communities other than their home communities, This is especially in the face of a disease outbreak when poor integration means challenges in penetrating these communities with vital information needed to address the disease outbreak.
2. Effective supervision processes should be put in place for CHWs, with holistic support structures.
3. Frequent refresher training and capacity building should be provided to CHWs for stronger health systems at the community level.
4. Scholarship opportunities should also be provided to CHWs who wish to pursue further studies in support of their professional development. This will further harness the investment already made with regards to training CHWs.
5. Increased and timely payment of incentives should be ensured to motivate CHWs. Non-financial incentives (rain gear, working tools, and protective equipment) should also be made available to create an enabling environment for CHWs to work in and to enable their effectiveness and motivation.

> **"Support for healthcare logistics and incentives for their (CHW) job should be continuous and on a regular basis… as motivation is key in keeping anyone in a job… So there should be a higher level of motivation… Their working tools should also be made available to them."**
> **Bonthe, Key Informant, District, Male**

> **"I am appealing to donor partners and the government as a whole… please pay our incentives on time… timely payment of incentives… we have gone eighteen months and counting… yet no payment of incentives to us… this creates lapses in our job… If we are working voluntarily without expecting any financial incentive, that is a different situation… we will still do the job like we were doing it before with IRC… but once incentive is now available, we need it on time… it raises our expectations… imagine we were promised an amount of Le 150,000 monthly incentive for CHWs covering less than 3km and Le 180,000 for those over 3km… and on quarterly basis… and we are still going through hell to receive our incentives."**
> **Kenema, CHW, Male**

6. Transportation facilities should be provided to CHWs to facilitate and ease their movement from one community to another:

> **"When they are through with their work, they usually face transportation challenges returning to their various homes… So it could be helpful if the government can provide them with mobility… The government should provide motorcycles to them, so they can easily reach us."**
> **Kenema, Key Informant, Community, Male**

7. It was also recommended that CHWs should be put on payrolls instead of being given incentives to ensure they do their work and improve retention:

   "I am also recommending that the CHW program be recognized by the MOHS and they should be on payroll and given pin codes like other health workers."
   Kenema, Key Informant, Community, Male

8. The work of CHWs should be recognized and given prominence by issuance of work certificates, and end of service benefits and social security should also be part of the CHW package.

3.8.2. Community recommendation

At the community level, the following recommendations were made:

1. Communities should be more receptive of CHWs and should not discriminate against them.
2. To address communication gaps and possible misunderstandings between CHWs and communities, frequent community engagement should be ensured:

   "Communities should be regularly updated on what is expected of service providers and community members as a whole… as communication gaps can be a problem."
   Kenema, Key Informant, District, Male

3. CHWs should be provided with accommodation if they are working away from their residences.
4. Community stakeholders should clearly communicate the role of CHWs to community members, so that they can be respected and fully accepted by the communities they serve.
5. Local NGOs/CSOs should also be engaged to provide support to CHWs at community level.
6. Community members should always adhere to health messages from CHWs in order to make them happy doing their job.
7. In general, men's support groups should also be established; there are existing women's support groups trying meet the needs of female CHWs:

   "There are women support groups for female CTC providers in some communities… So a men's support group should also be formed for us… so we can have the support we need even in the absence of stipend."
   Bonthe, CHW, Male

3.8.3. Recommendations for managing shocks from future health emergency

With regards to lessons learnt in managing future health shocks, the following recommendations were captured:

1. Refresher training for all CHWs should be done on a regular basis as part of readiness to respond to future shocks.
2. Pandemic and emergency preparedness should always be in place in order to effectively manage future health system shocks as events are always unexpected. Therefore, the MoHS should always be on high alert for future outbreak.

   "**Early planning for response and disaster management as most events happens unexpectedly… Reflecting back to the Ebola outbreak which claimed many lives due to late preparation… So, we should not wait for events to occur before planning for response… So early planning is key."**
   Kenema, Key Informant, District, Male

3. The government should look after the welfare of health workers including CHWs, ensuring that their remuneration is in line with their workload.
4. Boarder security should be ensured for future outbreak containment:

   "**Tight boarder security should be ensured for prevention of future outbreaks "The government should ensure tight boarder security so that we can prevent future outbreaks… We just want to live in peace and disease free… We don't need outbreaks from other countries coming into our country… We just want to die peacefully… rather from outbreaks coming from other countries… The government should also ensure quick containment of any disease outbreak."**
   Kenema, Key Informant, Community, Male

3.9 Lessons and conclusions

To ensure the successful implementation of any health sector policy, gender, traditional and cultural considerations should always be taken into consideration in its design, taking into account the context-specific and societal norms that often cause unintended consequences during the implementation phase.

The long-standing issue of a lack of remuneration for CHWs/incentives should be treated with utmost importance as incentives have been shown to be one of the key motivating factors for health worker retention.

A lack of health commodities is a winnable fight if a functional commodity tracking system is put into place as part of an effective monitoring system, avoiding competition with other health emergency priorities in the future.

Human capital development should also be considered in order to build a resilient, strong and functional human resources for health system. This should be achieved through capacity building of individuals and the creation of stronger health research and development institutions.

The roles of CHWs at community level should be strengthened, coupled with the need for community engagement during the national response to outbreaks and shocks.

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Annexes

Annex 1: Topic guide (Data collection tools)

R4R CTC study Annex 1 Tools V3.0 final post

Annex 2: The coding framework

CTC SL Coding Framework.docx

Annex 3: Information sheet and written consent form

Annex 2 Information sheets final R4R CTC s

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