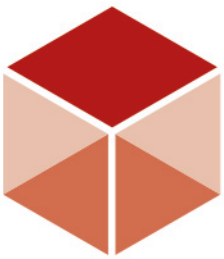

ReBUILD FOR RESILIENCE

The gendered experience of close-to-community providers in fragile and shock-prone settings: implications for policy and practice during and post COVID-19

Global document review

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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 (Raven et al 2020). They are often the first point of contact at community level (REACHOUT nd). The COVID-19 pandemic has further demonstrated the value of CTC providers. It has shone the spotlight on how gender shapes vulnerabilities and response, the importance of CTC providers' intermediary position between communities and health systems, the trust they enjoy and their importance in offering support and care (Wenham et al 2020; ARISE Hub 2020; Knox-Peebles 2020). A recent review identified the critical role that CTC providers play in pandemics, highlighting the importance of role clarity, training, supportive supervision, as well as CTC providers' health and well-being, and the need for more research focusing on gender and equity (Bhaumik et al 2020).

COVID-19 is increasingly affecting our 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. The overall aim of the study is to explore the roles of CTC providers and their gendered experiences during the COVID-19 pandemic in FASP Settings. Several methods will be used including qualitative interviews or focus group discussion with CTC providers, key informant interviews with health system actors and document reviews at global and national levels. This report describes the methods and findings from the document review at global level.

1.2. Aim of document review

The aim of this review is to examine relevant existing global literature on CTC providers during the COVID-19 pandemic in FASP settings, applying a critical gender, equity and justice lens. This provides a wide understanding of the gendered experiences of CTC providers during COVID-19 pandemic at the global level.

2. Methods

2.1. Search strategy

We searched for literature on the gendered experience of CTC providers during COVID-19 pandemic in FASP settings in two electronic databases (PubMed and Google Scholar). To maximize the search results, we also searched NGOs and networks' websites for any relevant reports, commentaries or working papers on CTC providers in FASP settings during the pandemic, these included:

- Community Health Worker (CHW) Central: https://chwcentral.org/
- Thematic Working Groups – Health Systems Global (HSG TWG) on CHWs: https://healthsystemsglobal.org/thematic-groups/community-health-workers/
- HIFA (Healthcare Information for All): https://www.hifa.org/

- Community Health Systems Community of Practice: https://www.thecollectivity.org/en/communities/community-health-community-of-practice-ch-cop
- International organisations websites such as the WHO, ReliefWeb, UNHCR, IRC
- The gender and COVID 19 project - https://www.genderandcovid-19.org

Finally, we searched the reference lists of all included documents to identify additional relevant documents. The search was conducted in October-November 2020.

2.2. Search terms

The main keywords used in our search were: close to community provider, COVID-19, gender, intersectionality, fragile and shock prone settings, low-and-middle-income countries, and developing countries. MeSH terms were used to maximise our search in electronic databases (Table 1).

Table 1: Search terms

	Topic specific key word	MeSH terms	Free text term
OR	Close-to-community provider	Community health worker Community health provider Community health aide Frontline health worker Frontline health provider Community health practitioner Community health volunteer Community worker CHW	"close to community provider*" "health worker*" "health provider*" "health practitioner*" "health aide*" "health volunteer*" "community provider*" "community worker*" "Community health worker*" "Village health worker*" "CHW*"

AND

	Topic specific key word	Mesh term	Free Text Term
OR	COVID-19	COVID-19 2019-nCoV 2019nCoV SARS-CoV-2 SARS-2	"COVID-19" "2019-nCoV" "2019nCoV" "SARS-CoV-2" "SARS-2"
OR		Epidemic Pandemic Outbreak Disease outbreak	"epidemic*" "pandemic*" "outbreak*" "disease outbreak*"

AND

	Topic specific key word	MeSH terms	Free text term
OR	Gender	Gender Sex Woman Women Man Men Non-binary	"gender*" "sex*" "woman" "women" "man" "men" "non-binary"
OR	Intersectionality		"intersection*"

AND

	Context specific key word	Mesh term	Free text terms
OR	Fragile and shock prone settings	Fragile and shock prone Fragility Shock Crisis Crises Disaster Emergency Conflict	"fragil*" "shock*" "disaster*" "emergenc*" "conflict*"
OR	Low-and Middle- Income Countries		LMIC "low and middle income" "low resource"
OR	Developing countries	Developing countries	"developing countr*"

2.3. Inclusion and exclusion criteria

Studies that met the following criteria were included:

1. Context: gendered experience of CTC providers during COVID-19 epidemic in FASP settings
2. Participants: close to community providers are identified differently in different health systems across the world, so we have not used any specific definitions for them. Synonyms for CTC providers, gender, and fragility have been included using MeSH terms (see Table 1).
3. Primary research studies of any design, qualitative or quantitative
4. Commentaries, reports, or other studies that did report on primary data/ review existing data
5. Articles or documents related to COVID-19 epidemic since December 2019.
6. Articles in English language.

Studies that have the following criteria were excluded:

1. Not related to COVID-19 context
2. Not looking at CTC providers
3. Not in FASP settings
4. Not discussing gendered experiences of CTC providers

5. Before December 2019
6. Not in English

2.4. Data extraction

One reviewer (WM) reviewed the relevance of all titles and abstracts, if available. Full texts were gathered for suitable titles and abstracts identified and were reviewed against the inclusion criteria for inclusion of the paper or the document within the review. All full text documents reviewed were tracked in an excel file to document them against the inclusion criteria. Once a suitable document was identified which met all inclusion criteria, then data was extracted using a data extraction tool.

We developed a data extraction tool that draws on gender analysis and community health workers frameworks. The tool was deductively developed (Annex 1) guided by Morgan'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:

(i) who has what (what are the available resources for CTC providers, do they have access to resources),
(ii) who does what (what are the CTC providers' roles and responsibilities during COVID-19 response),
(iii) how values are defined (what are the common social norms and how they influence the CTC providers and their work during the pandemic)
(iv) who decides (what are the common rules governing the work of CTC providers, and what are the decision-making dynamics?)

Steege et al (2018) gender analysis framework that focuses on CTC providers helped with identifying sub-themes that developed further as document review was going on. We developed a code book (Annex 2) to agree on a common definition for code in order to facilitate the data extraction process and eliminate confusion among the research team. We critically reviewed documents to assess the impact of gender on CTC providers' experiences and programmes and extract this data.

2.5. Thematic analysis and synthesis

The reviewer then synthesised the extracted data for each theme and sub theme by reading the extracts thoroughly. The reviewer developed narratives for each theme and sub-theme drawing upon examples from the literature for each theme. The reviewer then developed a framework matrix was then developed (Annex 3) and reviewed in order to make connections and highlight any patterns within and across different themes and subthemes.

3. Findings

3.1. Description of documents

The global review search revealed 591 documents including peer review article, organisation reports and blogposts. After removing duplicates 499 unique documents were identified. Of these 88 potentially relevant studies were identified and full texts were reviewed against the inclusion criteria. Additionally, reference lists of particularly suitable papers were reviewed, and an additional 25 papers not already captured by the search were identified and all were included as full text documents to be assessed for eligibility, which made 113 documents in

total. 15 studies were selected for inclusion, with 98 excluded due to failure to meet one or more of the inclusion criteria previously described. The whole flow of studies is shown in the PRISM diagram (Figure 1). Of the 15 studies included, there was one policy brief, one organisational report, one blogpost, one research perspective, one interim guidance, five reviews, and five commentaries (see table 3). All were published in 2020. To note, the search returned only a few numbers of documents from FASP settings (1,12,13 and 14), with others focused on LMICs in general, or specific LMICs and sub-Saharan African countries (3,5,6,7,8,9,10, and 11), there were also three global reviews (2,4, and 12), one of them focused on low-income countries and another one on FASP settings, as shown in table 3. Most of the reviewed studies have identified lessons learned from previous outbreaks and how to use them during COVID-19 pandemic. No empirical data studies were identified.

Table 3: Documents included in the final review

Documents included in the review	Study context	Type of document
1. CHWs in humanitarian settings (UNICEF, 2020)	Humanitarian context	Policy brief
2. Rapid Literature Review: Community Health Workers (Srinivasan and Arora, 2020)	Global	Review
3. Protecting Community Health Workers PPE Needs and Recommendations for Policy Action (Nepomnyashchiy et al, 2020)	LMICs	Commentary
4. Prioritising the role of community health workers in the COVID-19 response (Ballard et al, 2020)	Global - with a focus on LICs	Review
5. Gender, Economic Precarity and Uganda Government's COVID-19 Response (Ssali, 2020)	Uganda	Review
6. Community health workers for pandemic response: a rapid evidence synthesis (Bhaumik et al. 2020)	India	Review
7. COVID-19 Outbreak Situation in Nigeria and the Need for Effective Engagement of Community Health Workers for Epidemic Response (Ajisegiri et al, 2020)	Nigeria	Review
8. Community health workers reveal COVID-19 disaster in Brazil (Lotta et al, 2020)	Brazil	Commentary
9. COVID-19: Africa needs unprecedented attention to strengthen community health systems (Nepomnyashchiy et al, 2020)	Sub-Saharan Africa	Commentary
10. Gender and COVID-19 in Africa (Gender working group)	Africa	Commentary
11. From the frontlines to centre stage: resilience of frontline health workers in the context of COVID-19 (Nanda et al, 2020)	India	Commentary
12. COVID-19 exacerbates violence against health workers (Devi, 2020)	Global with a focus on FASP settings	Report
13. Health workers mental health during COVID-19 - Lessons from, and for, fragile and conflict-affected settings (Wurie and Lohmann, 2020)	FASP settings	Blogpost
14. Considerations for planning COVID-19 treatment services in humanitarian responses (Garry et al, 2020)	Humanitarian context	Perspective
15. Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic (WHO and UNICEF, 2020)	Global	Interim guidance

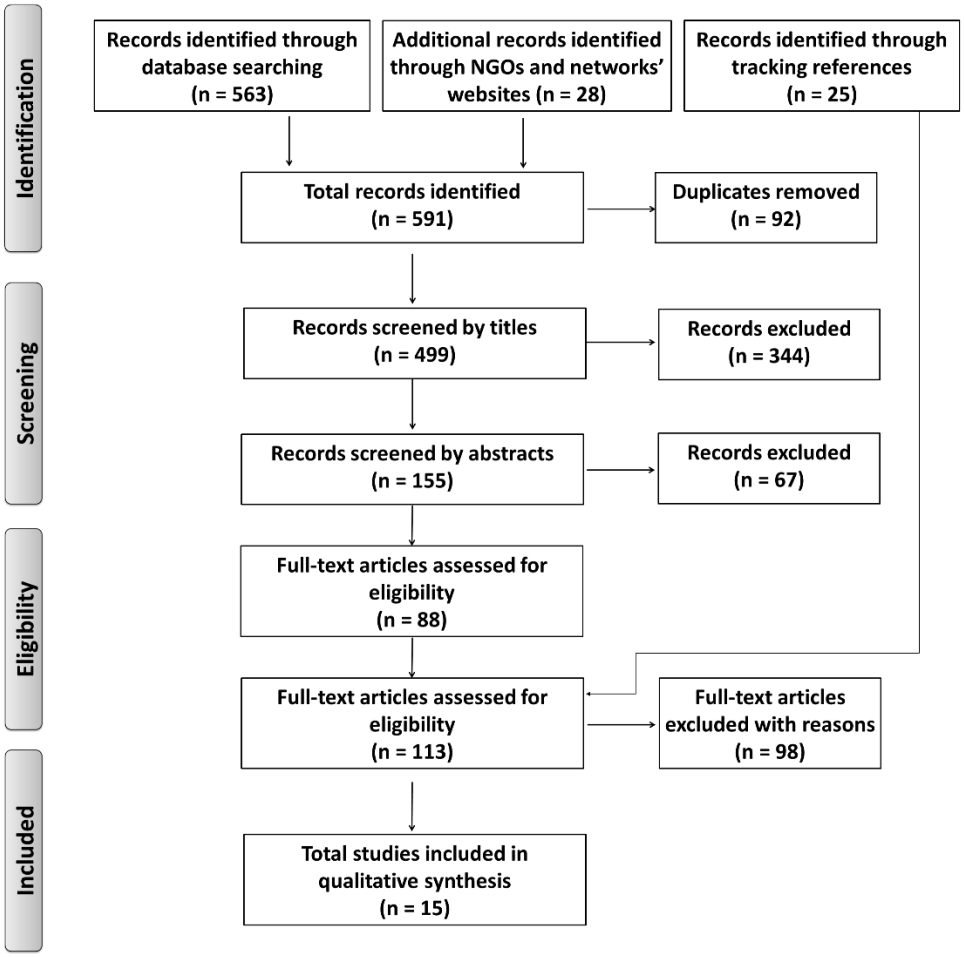

Figure 1: PRISMA flowchart of the study selection process

3.2. Themes

As mentioned earlier, our themes and sub-themes are based on Morgan and Steege's framework for gender analysis and how gender is considered as a power relation and driver of inequality (Morgan et al, 2016; Steege et al, 2018). Within the 15 included documents in our analysis, eight documents focused on the CTC working conditions during the COVID-19 pandemic, five documents looked at the financial support needed, while 12 documents addressed the non-financial support needed or provided to CTC providers during the pandemic. Six documents pointed out the mental health issues that CTC providers face during the pandemic and the need of mental health support. Eight documents focused on their roles and responsibilities, and four documents highlighted their selection and recruitment. Community factors were discussed in five documents, one document focused on the challenges with CTC providers' mobility during the pandemic, and one document looked at the family and household issues. Seven documents referred to the policies and guidelines that guide the roles and responsibilities of CTC providers during the pandemic, only the interim guidance by the WHO and UNICEF discussed them in detail, and only two documents highlighted the issue of the decision-making power. In general, there is a gap in the literature regarding the gendered experiences of the CTC providers during the COVID-19 pandemic. Each of the themes will be described in more detail below.

3.2.1. Who does what?

3.2.1.1.Roles and responsibilities

CTC providers live and work within the community, they are often well trusted by the people. They are therefore better positioned to help with community awareness, engagement and sensitisation (including for countering stigma) and contact tracing (Bhaumik et al. 2020), combat misinformation, fear and mistrust by acting as a bridge to the formal health system and national authorities (Ballard et al, 2020; Aijsegiri et al, 2020). They provide health education to the community on the clinical features, route of transmission, home care and self-isolation; identification, monitoring and advice to people at high-risk of severe COVID-19; community surveillance, door-to-door surveys to assess returning migrants; and delivery of drugs and supplies to reduce patients' need to visit health facilities, and other preventive measures such as social distancing, hand hygiene and cough etiquette compliance (Garry et al, 2020; Aijsegiri et al, 2020; Bhaumik et al. 2020; Nanda et al, 2020).

In addition to maintaining routine services to minimise secondary effects (Srinivasan and Arora, 2020), CTC providers are also often involved in COVID-19 case identification, and reporting, and referring them to seek care (Srinivasan and Arora, 2020). CTC providers can be trained to identify signs and symptoms of COVID-19 among community members (Aijsegiri et al, 2020). They support safe collection of samples in communities and health facilities, and facilitate rapid transport to laboratories for analysis, thus reducing risks of nosocomial transmission. Where available, they conduct COVID-19 rapid tests (Ballard et al, 2020). In Nigeria, CTC providers have also been trained in some areas to support various aspects of management of patients that have died from COVID-19, such as body preparation for burial, maintaining the national guidelines for safe and dignified burial for people who died from COVID-19 when families are not permitted to perform final burial rites. They also help in providing psychological support for the family members since this disruption of traditional burial rites is often seen as sign of disrespect across various religions and ethnic groups, putting family members under severe stress (Aijsegiri et al, 2020).

Maintaining routine health services during the COVID-19 pandemic is also important to minimise secondary effects (Srinivasan and Arora, 2020). The role of CTC providers during COVID-19 is being increasingly acknowledged as a critical role in achieving universal health care, particularly in health system outreach to women for sexual and reproductive health services (SRHS), and other primary healthcare services such as maternal, newborn and child health (MNCH), and increasingly for identifying and supporting people living with chronic diseases (Nanda et al, 2020). In India, the evidence shows that door-to-door counselling and community outreach to women does lead to improved health and nutrition behaviours and service uptake such as routine immunisation, contraceptive use, and infant feeding practices (Nanda et al, 2020).

No differences between the roles and responsibilities between male and female CTC providers were reported in the literature.

3.2.1.2.Selection and recruitment

Since the onset of the pandemic, some governments started recruiting from the pool of qualified but unemployed CTC providers and have reengaged some CTC providers who have retired. No prioritisation of male or female CTC providers was reported in the literature.

Optimising staffing ratios and distribution at all levels of the community health system to promote continuity of care is needed (Ballard et al, 2020; Aijsegiri et al, 2020). At the community, triage or outpatient level, additional capacity could be sourced by mobilising networks of allied health professionals (e.g. HIV or TB community outreach), volunteers (e.g. Red Cross / Red Crescent) and professionals from other sectors (e.g. teachers) (Garry et al, 2020).

3.2.2. How are values defined?

3.2.2.1.Family and household dynamics

Given the challenges that have been reported across countries in relation to personal protective equipment (PPE) (will be discussed later in the working conditions section), it means that women are at an increased risk of exposure and infection in the line of duty (Gender working group, 2020). In India, CTC providers —the vast majority of whom are women—are conducting contact tracing with neither masks nor hand sanitiser (Nanda et al, 2020). CTC providers mainly midwives are complaining of fear of infection due to lack of PPE (Ssali, 2020). This subsequently puts their families at greater risk, or entails having to be separated from loved ones, including children, for extended periods of time to protect them (Gender working group, 2020). Therefore, it is important to engage husbands of CTC providers, and communities to help gain greater acceptance of and support for female CTC providers' roles and work duties.

3.2.2.2.Community factors

CTC providers have often been stigmatised or socially ostracised during pandemics including COVID-19 (Bhaumik et al. 2020) especially when trust in health workers and the health system at the community level is already missing (Srinivasan and Arora, 2020). People fear health workers are spreading COVID-19, and harassment and disrespect fuelled by fears of COVID-19 have also been reported (Nanda et al, 2020). In Liberia, some caregivers refuse to attend mobile clinics or facilities for routine vaccinations and there has been a reduction in care seeking among some adults because of the fear of infection from health workers. Insufficient PPE for health workers has exacerbated this situation (Nepomnyashchiy et al, 2020a).

CTC providers have faced threats and aggression in some areas where they work (Lotta et al, 2020). More than 600 incidents of violence, harassment, or stigmatisation took place against healthcare workers, patients, and medical infrastructure in relation to the COVID-19 pandemic as reported by the International Committee of the Red Cross (ICRC). Although patients and medical infrastructure were often targeted, 67% of incidents were directed at healthcare workers. More than 20% involved physical assaults, 15% were incidents of fear-based discrimination, and 15% were verbal assaults or threats (Devi 2020).

Female CTC providers are more at risk of harassment and physical assault (UNICEF 2020). Efforts should be made to reduce these challenges such as engagement of community leaders, husbands of CTC providers, and communities in general that can promote greater acceptance of and support for female CTC providers' roles and work duties (UNICEF, 2020).

3.2.2.3.Mobility

The transport ban and curfew in Uganda posed access challenges for CTC providers, particularly women (Ssali, 2020). Although the government provided stickers to enable healthcare workers to travel to work, this largely benefited health workers who owned cars. Most lower cadre workers who did not own cars or who worked in facilities with no vehicles had to cycle or walk to work. For example, most of the nursing staff in rural health facilities had to ride a bicycle or walk several kilometres to work, which posed an extra challenge to female health care workers. With most health facilities not providing staff accommodation or transportation to work, many workers had challenges getting to work and when they did, had to leave early to beat the curfew (Ssali, 2020).

3.2.3. Who has what?

3.2.3.1.Working conditions

Disruption in supply chain, logistics and supportive supervision for CTC providers have been common in pandemic scenarios (Bhaumik et al, 2020). There have been numerous complaints relating to workload and the shortages of PPE and ventilators needed to combat COVID-19. CTC providers have COVID-19 infections as a result of occupational exposures (Ajisegiri et al, 2020; Ssali, 2020). In Brazil, unions estimate that at least 50 CTC providers have died as a result of COVID-19 (Lotta et al, 2020). Most sub-Saharan African countries seem to have not prioritized CTC providers in their PPE allocation in order to ensure sufficient PPE for other key providers. Consequently, some CTC providers are given the option to stay home or else do their job unprotected, putting themselves, their families, and their communities at risk (Nepomnyashchiy et al, 2020a). In some areas, CTC providers have been asked to work remotely, away from their homes, using telemedicine and social networks to keep in touch with families (Lotta et al, 2020).

The situation with CTC providers reveals how lack of leadership translates into inadequate local-level responses to COVID-19. Their low salary and risky working conditions reflect longstanding resource difficulties of the health system and the lack of political commitment to health as a public good (Lotta et al, 2020). In India, the mandate outlining the responsibilities of CTC providers and the expectations of their significant role in the COVID-19 response also reveal little or no shift in existing issues of high workload, challenging working conditions, poor support, and limited agency in decision making relating to their work (Nanda et al, 2020).

Women have been recruited as CTC providers because of their ability to access and reach other women with health education and preventive services. However, gender biases, lack of power, and discrimination can shape the ways in which CTC providers are treated (Nanda et al, 2020). For example, gender studies of Uganda's health workers including CTC providers have demonstrated how females tend to occupy the lower cadres, with more work and yet with less pay, incentives, and protective equipment. The emergence of COVID-19 only worsened this situation, with health workers, particularly midwives complaining of fear of infection due to lack of PPE, increased workload, and frequent changes in their schedules, leading to exhaustion. Moreover, nurses were also not among those to be considered for relief food (Ssali, 2020).

3.2.3.2.Financial incentives

There is a variation globally in how CTC providers are remunerated; in some contexts they are salaried (such as Lady Health Workers in Pakistan), in some they are paid just through incentives (such as ASHAs in India), and in some they are volunteers e.g., Ethiopia, Kenya, and Malawi (Srinivasan and Arora, 2020). Working with governments to pay CTC providers for supplemental hours is particularly relevant for part-time or currently unpaid CTC providers and those without guaranteed paid sick leave. Given the risk posed by COVID-19 to CTC providers and the disruption of their workflows, money currently reserved for performance-based incentives should be reallocated to cover routine salaries or stipends for all active health workers including CTC providers?(Ballard et al, 2020), especially when disruption of their routine work has meant less incentive-based income and may therefore lead to income uncertainty (Nanda et al, 2020).

Health workers must also be entitled to compensation as acknowledgement of the occupational risk and as protection in the line of duty during COVID19 (Srinivasan and Arora, 2020). Although many programmes who use CTC providers do not pay them, financial incentives for CTC providers' work can improve motivation and retention provide compensation for the societal stigma that CTC providers often experience, and allows CTC providers to meet their basic household needs (UNICEF, 2020, Bhaumik et al, 2020). CTC providers are often publicly compensated via incentives and honoraria (as opposed to fair wages) and often receive delayed payments, for example, during COVID-19; the Government of India provided special incentives and health insurance coverage for all CTC providers involved in COVID-19 response (Nanda et al, 2020).

Providing financial remuneration will also facilitate the work of female CTC providers (UNICEF, 2020), especially that females tend to occupy the lower cadres, with more work and yet with less pay as mentioned earlier (Ssali, 2020).

3.2.3.3.Non-financial support

Supervision and training

Having supervisors who are from the same communities as the CTC providers allows for greater levels of familiarity and trust among community members and enables supervisors to use local networks to obtain information on the local security situation and population movements. CTC providers peer supervisors may be able to carry out supervision when outside supervisors cannot reach or contact affected communities (UNICEF, 2020). Frequent supportive supervision may be needed, given how rapidly the pandemic and its associated protocols, procedures and problems will evolve (Ballard et al, 2020).

Consequently, there is a need to consider adaptable, cost-effective ways of rapidly and frequently sharing information and updates on guidelines and protocols with CTC providers (text messages, mobile applications, 24-hour support phone number, and phone trees which is a system of delivering the same message to a group of health workers that has been used widely during COVID-19 pandemic) (Ballard et al, 2020). Additional tasks may be added to the role of the CTC provider such as collection and transportation of sample, case identification and screening, contact tracing, follow up of isolated individuals and referral of cases that need medical attention (Ajisegiri et al, 2020). National and sub-national governments need to, quickly and adequately, train current and newly engaged CTC providers, in these areas. In Nigeria, for example, graduates and residents of the Field Epidemiologist Training Program in were trained on case identification and screening and

contact tracing, so they can help other health workers (Ajisegiri et al, 2020). In settings where referral is not possible, it may be necessary to train CTC providers to provide urgent care for severely ill patients (UNICEF, 2020).

Equal training opportunities should be considered and in settings where literacy levels are low, it is necessary to recruit low-literacy CTC providers, especially if it is a priority to recruit female CTC providers from the community in which they serve. In this case, it is necessary to develop low-literacy tools and to provide the necessary support to CTC providers to manage their tasks (UNICEF, 2020).

Workplace

Ensuring the health, safety and well-being of CTC providers is essential (Bhaumik et al. 2020). CTC providers should be provided with an enabling environment within the workplace that reduces the chances of occupational exposure. This includes provision of care and infection prevention protocols or guidelines, PPE, an environment that allows for adequate physical distancing during encounter with patients, hand hygiene facilities (availability of running water and soap), and disinfection facilities (Ajisegiri et al, 2020). Actions to facilitate referrals, such as mobilization of community transportation, providing compensation for transportation, and/or providing CTC providers with the supplies needed to accompany referred patients, should be considered (UNICEF, 2020). Rehabilitation and curative services for health workers affected with COVID-19 in the line of duty should be provided as a right (Srinivasan and Arora, 2020). Job security beyond the engagement for the current pandemic should also be strongly considered (Ajisegiri et al, 2020).

Digital technology

In addition to supporting routine CTC provider activities, digital tools can enable real-time decision-support, community-based surveillance, and contact tracing during COVID-19 (Nepomnyashchiy et al, 2020a). Where there is sufficient access to phone and data networks, mobile technology can be used to carry out supervision, transmit data, transfer payments, and to track CTC providers when it is not possible for supervisors to travel to them. For this to be feasible, all CTC providers need to have access to mobile phones and sufficient phone credit (UNICEF, 2020). In India, the health system has rapidly improved its support of CTC providers through digitally enabled training, digitally sharing guidelines, videos and PowerPoint decks, increased remuneration, and occupational support through disseminating a large amount of content (Nanda et al, 2020).

Safety and security

Both male and female CTC providers face some safety and security challenges during the COVID-19 pandemic. Health issues include the risk of contracting the virus due to close contact with infected patients, especially with lack of PPE in many countries (Ssali, 2020). CTC providers are often stigmatised as being the source of the virus and this makes them prone to threats, aggression; and violence, (Bhaumik et al. 2020; Devi, 2020; Lotta et al, 2020). The transport ban and curfew posed access challenges for CTC providers, particularly women who are more vulnerable to physical assaults and harassment at the community level in times of conflict (Devi, 2020; Nanda et al, 2020).

Measures should be put in place to reduce the risks to CTC providers and supervisors, particularly in FASP settings (UNICEF, 2020; Ballard et al, 2020; Devi, 2020). During COVID-19, health services should be designed to protect frontline healthcare and protect workers from infection (Garry et al, 2020), particularly in places with the worst health workforce shortages such as in Africa which has 3% of the world's health workforce but nearly a quarter

of the world's burden of disease (Ballard et al, 2020). CTC providers in Brazil are not considered to be health professionals, and only an estimated 9% have received infection control training and PPE (Lotta et al, 2020).

Several strategies to mitigate the safety and security challenges that CTC providers face. These include: including CTC providers and supervisors in the development of emergency preparedness plans; coordinating with local communities to reinforce social distancing and infection control measures among people; ensuring that CTC providers only work in their home communities,; carrying out remote supervision and monitoring using mobile technology; providing larger stocks of commodities including PPE, to reduce the frequency of travel; providing security training and health insurance (UNICEF, 2020). To protect women health workers especially in remote areas pairing male and female CTC providers can be considered (UNICEF, 2020).

With regard to health risks associated with COVID-19, several strategies were identified. Prioritising SARS-CoV-2 testing for CTC providers who have symptoms is also important, so that they can return to work if negative (rather than self-isolate), and to identify those who need to stay away from work if positive (Garry et al, 2020). CTC providers require other tools specific to their contexts including water, sanitation and hygiene (WASH) solutions and thermometers (Nepomnyashchiy et al, 2020a). CTC providers at high risk of severe outcomes (e.g. those with co-morbidities) are preferentially allocated to routine non-COVID-19 care; those who live with high-risk family members should also either avoid direct COVID-19 care or be supported to live separately from their household (Garry et al, 2020).

Policy reform to create an enabling environment for CTC providers has been painfully slow, again reflecting the lack of power and voice of a feminised workforce (Nanda et al, 2020). In May 2020, 13 humanitarian organisations including the ICRC called on governments to implement laws against attacks on healthcare workers including CTC providers during the COVID-19 pandemic, to provide safer working environments, offer mental health support, and tackle misinformation (Devi, 2020). Harassment and disrespect fuelled by fears of COVID-19 have also been reported. These incidents have also been the impetus for applying special protections from acts of violence against healthcare workers and the launch of anti-stigma campaigns (Nanda et al, 2020).

Mental health support

In addition to physical harm, the psychological trauma that CTC providers may experience should also be considered. Efforts should be made to monitor CTC providers' mental health, to reduce sources of distress in the workplace, to provide strong organisational support, and to provide psychosocial support as needed (UNICEF, 2020). CTC providers routinely described feeling alone, disrespected, and ostracised, and in the presence of restriction of physical touch, mobility, and contact prevented them from coping with these feelings (Bhaumik et al. 2020). Studies also point to stigma and fear that they experience as a consequence of their work, where they are viewed as 'carriers of the disease' (Srinivasan and Arora, 2020). Psychological support for staff is imperative to address trauma from capacity limitations or high case-fatality, both of which may also increase the risks of attacks on healthcare workers including CTC providers (Garry et al, 2020).

A recent survey undertaken in Kenya, highlighted psychosocial issues and challenges around balancing work and family life as being of importance to nurses during this period (Gender working group, 2020). Despite the magnitude of the workload and associated risks, there has been limited attention to the psychosocial wellbeing of CTC providers (Nanda et al, 2020).

Motivation

CTC providers have been at increased risk of contracting disease and experienced stigmatisation, isolation and social ostracization. Providing PPE, housing allowance, equal training opportunities, transportation allowance, improving salaries (paid on time and for a broad range of services), public recognition, countering societal stigma, and provision of psychosocial support contributed to improve CTC providers motivation and retention (Bhaumik et al. 2020, Nanda et al, 2020). In India, to sustain the motivation of CTC providers the government has publicly recognised them as "stars", and through phone calls by senior health officials to express appreciation (Nanda et al, 2020).

3.2.4. Who decides?

3.2.4.1.Policies and guidelines

There is also a need to standardise and endorse a protocol for CTC providers responding to COVID-19 (Ballard et al, 2020, Bhaumik et al. 2020). Policies for defining CHW roles were reported to be crucial for the purpose of bringing accountability and building trust in health systems, although this was not discussed more specifically (Bhaumik et al. 2020). The WHO/UNICEF/IFRC guidance for community care recommends that certain activities may need to be anticipated in areas where COVID-19 transmission has not yet begun, modified where an alternative mode of delivery is safe, or temporarily suspended where the risk of COVID-19 transmission is high (WHO and UNICEF 2020). Where appropriate, in-person encounters should be limited through the use of alternative delivery mechanisms, such as mobile phone applications, telemedicine and other digital platforms. Specific adaptations will depend on the context, including the local overall disease burden, the COVID-19 transmission scenario, and the local capacity to deliver services safely and effectively (WHO and UNICEF, 2020). The main aim is to distinguish tasks as essential (routine activities that need to be continued but with modifications for decreased transmission risk), non-essential (non-essential activities that could be postponed) and additional activities that need to be carried out. New roles and tasks for CTC providers pertaining specifically to pandemic control varied according to disease risk factors and symptoms, and appropriate preventive practices (Bhaumik et al. 2020). The WHO's guidance (WHO and UNICEF, 2020) on contact tracing recommends contact identification and listing to be conducted by a trained epidemiologist or surveillance officer, while contact follow-up might be done through CTC providers.

In order to keep health workers and communities safe, initial screening and appropriate IPC measures should be incorporated into all community-based healthcare activities. Adherence to the use of standard precautions for all patients at all times should be strengthened, particularly regarding hand hygiene, surface and environmental cleaning and disinfection, and the appropriate use of PPE (WHO and UNICEF, 2020). Physical distancing should be implemented as much as possible. To ensure the occupational safety and health of the CTC providers, all health staff should be provided with adequate PPE and trained in its use and safe disposal. The WHO/UNICEF /IFRC guidance (2020) advises a basic package of PPE required to protect CTC providers to ensure continuity in essential service provision: surgical masks (disposable), eye protection (goggles or face shields), gloves (disposable), gowns (reusable), and disposable bags (or other container to safely store and discard contaminated items). Logistics planning, budgeting and supply-chain and waste management for PPE and hand hygiene supplies should address the needs of the CTC providers. Potential shortages in PPE must be addressed proactively, and clear guidance must be provided on how to adapt essential activities and services in the absence of PPE (WHO and UNICEF, 2020).

The guidance also highlights that the work in the COVID-19 context may result in stigmatization, and health workers may need mental health and psychosocial support, and particular consideration should be given to gender issues. Older workers and those with high-risk conditions should be assigned to duties that do not put them at additional risk (WHO and UNICEF, 2020). Finally, the guidance did not make any difference to gender or different needs of male and female CTC providers during COVID-19 response.

3.2.4.2.Decision making power

There is a need to integrate all frontline health workers, including CTC providers, in the design and implementation of the response (Ballard et al, 2020). Decisions should be aligned with relevant national and subnational policies and should be re-evaluated at regular intervals as the outbreak evolves (WHO and UNICEF, 2020). The limited power and positionality – amplified by gender considerations – of CTC providers limit their participation in decision-making about how to respond to the pandemic, which in turn, continues to constrain the health system response during outbreaks (Nanda et al, 2020).

4. Summary of findings

This next table summarises our findings and highlights some gendered experiences of CTC providers during COVID-19 response as reported in the reviewed literature.

Table 4: Summary of findings

Themes	Sub-themes	Findings
Who does what?	Roles and responsibilities	- Maintaining routine services to minimise secondary effects - Help with community awareness, engagement and sensitisation - Provide health education to the community on the clinical features, route of transmission, home care and self-isolation, social distancing, hand hygiene and cough etiquette compliance etc. - COVID-19 case identification, and reporting, and referral, contact tracing - Management of patients that have died from COVID-19, such as dead body preparation
	Selection and recruitment	- Recruiting from the pool of qualified but unemployed CTC providers - Reengaging some CTC providers who have retired - Mobilising networks of allied health professionals (e.g. HIV or TB community outreach), volunteers (e.g. Red Cross / Red Crescent) and professionals from other sectors (e.g. teachers)
How are values defined?	Family and household dynamics	***Gendered issues:*** - Women are at an increased risk of exposure and infection - CTC providers mainly midwives are complaining of fear of infection due to lack of PPE - Put their families at greater risk, or entails having to be separated from loved ones, including children

	Community factors	- People fear health workers are spreading COVID-19 – CTC providers faced threats and aggression, harassment, or stigmatisation, verbal and physical assaults and disrespect
	Mobility	***Gendered issues:*** - Transport ban and curfew posed access challenges for CTC providers, particularly women - Although some governments provided stickers to enable CTC providers to travel to work, this benefited HCWs who owned cars only. Lower cadre workers who did not own cars or who worked in facilities with no vehicles had to ride or walk to work - posed an extra challenge to female CTC providers - Health facilities do not provide staff accommodation or transportation to work
Who has what?	Working conditions	- Disruption in supply chain, logistics and supportive supervision - Workload and shortages of PPE and ventilators - Reported COVID-19 infection among CTC providers as a result of occupational exposures - Lack of leadership translates into inadequate local-level responses to COVID-19 - Low salary and risky working conditions ***Gendered issues:*** - Women have often been recruited as CTC providers - gender biases, lack of power, and discrimination shape the ways in which CTC providers are treated - Females tend to occupy the lower cadres, with more work but less pay, incentives and protective equipment Midwives complaining of fear of infection due to lack of PPE - Nurses were not considered for relief food
	Financial incentives	- Financial remuneration - Compensation via incentives and honoraria - Compensation as acknowledgement of the occupational threat - Poorly delayed payments ***Gendered issues:*** - Considering gender-specific aspects will facilitate the work of female CTC providers, especially that females tend to occupy the lower cadres, with more work but less pay
	Supervision and training	- Frequent supportive supervision – rapid evolving of the pandemic and its protocols, procedures and problems - Adaptable, cost-effective ways of sharing information and updates (text messages, mobile applications, phone trees, 24-hour support phone number) - Train the current and newly engaged CTC providers in case identification and screening, contact tracing ***Gendered issues:*** - Equal training opportunities should be considered - Where literacy levels are low, it is necessary to recruit low-literacy CTC providers, especially if it is a priority to recruit female CTC providers from the community in which they serve -- develop low-literacy tools to support CTC providers to manage their tasks

	Workplace	- Ensuring the health, safety, well-being and support for CTC providers - Providing an enabling environment within the workplace to reduce the chances of occupational exposure - Provision of care and infection prevention protocols or guidelines, PPE, ensuring physical distancing with patients, hand hygiene facilities (availability of running water and soap), and disinfection facilities - Rehabilitation, and curative services for health workers affected with COVID-19 ***Gendered issues:*** - Efforts should be made to reduce the challenges that female CTC providers face in their work because of their gender -- engagement of community leaders, husbands of CTC providers, and communities in general may help to gain greater acceptance of and support for female CTC providers' roles and work duties
	Digital technology	- Digital tools e.g. mobile technology can enable real-time decision-support, community-based surveillance, contact tracing during COVID-19, carry out supervision, and to track down CTC providers when it is not possible for supervisors to travel to communities -- need sufficient access to phone and data networks
	Safety and security	- CTC providers and supervisors should be involved in emergency preparedness plans, coordinating with local communities, - CTC providers adhere to infection control measures for any contact with patients -- provide PPE, security training, and health insurance - Carry out remote supervision and monitoring using mobile technology - Providing larger stocks of commodities to reduce the frequency of travel - Prioritise testing for CTC providers who have symptoms, so that they can return to work if negative ***Gendered issues:*** - Pairing male and female CTC providers was a strategy used in some areas to protect female health workers - Consider gender specific security issues
	Mental health support	- CTC providers often described feeling alone, disrespected, stigmatised, being viewed as 'carriers of the disease' - Balancing work and family life as being of importance to female CTC providers during this period
	Motivation	- Providing PPE, housing allowance, equal training opportunities, transportation allowance, improving salaries, public recognition, countering societal stigma, and provision of psychosocial support contributed to better recruitment and retention
Who decides?	Policies and guidelines	The UNICEF/WHO/IFRC guidance for community care during COVID-19 advises: - Anticipation of certain activities in areas where COVID-19 transmission has not yet begun, modifications where an alternative mode of delivery is safe or temporarily suspension where the risk of COVID-19 transmission is high

		- Appropriate IPC measures should be incorporated into all community-based healthcare activities - A basic package of PPE required to protect CTC providers includes disposable surgical masks, eye protection, disposable gloves, reusable gowns, and disposable bags - Standardise and endorse a protocol for CTC providers responding to COVID-19 - Policies, guidance and training for contact tracing have to also be developed - The CTC providers' need for mental health and psychosocial support and particular consideration should be given to gender issues. - Older workers and those with high-risk conditions should be assigned to duties that do not put them at additional risk
	Decision-making power	***Gendered issues:*** - The limited power and positionality – amplified by gender considerations – of CTC providers within the system continues to constrain the system response during pandemic

5. Conclusion

There is limited literature on the gendered experiences of CTC providers working in FASP settings during COVID-19 pandemic. The included studies in the literature review mostly identified lessons learned from Ebola and Zika outbreaks and how to use these lessons during the COVID-19 pandemic. Evidence from previous outbreaks suggest that female CTC providers are often occupy lower cadres, do more work and get less pay and incentives. The review identified some evidence during COVID-19 pandemic, for example, women are at an increased risk of exposure and infection especially with the lack of PPE, they fear contracting the virus and passing it on to their families and children, which took an emotional toll on them. Therefore, mental health support should be prioritised during the time of the pandemic especially with health workers being stigmatised and seen as source of infection. The lockdown and curfews in many countries have posed access and security challenges for CTC providers, particularly females. Digital technology can play a significant role in tackling such challenges by enabling real-time decision-support, carrying out remote supervision and tracking CTC providers when it is not possible for supervisors to travel to communities. Efforts should also be made to reduce the challenges that female CTC providers face because of their gender, perhaps by promoting the engagement of community leaders, husbands of CTC providers, and communities to help gain greater acceptance of and support for female CTC providers' roles and work duties. Empirical studies would be useful to provide deep understanding of the gendered experiences of CTC providers during the COVID-19 pandemic.

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7. Annexes

Annex 1: Data extraction tool

Data extraction tool can be viewed here

Annex 2: Code book

Who has what? **Access to resources (education, information, skills, income, employment and career opportunities, services, benefits, time, space, social capital, and support)**	**Working Conditions:** • Working environment- job descriptions, working hours, workload, and factors influenced the working environment, retention: the level of retention for female or male CTC providers during COVID-19 response, safety at the workplace –Gender differences in relation to promotion, job security, working hours and benefits across and within all types of health workers • the access that women and men have to education, training and other career opportunities **Remuneration/incentive** • Remuneration/incentive provided • Gender differences in relation to remuneration/incentive - reason for these differences • Performance-based incentives mean the same thing for female and male health workers across and within cadres **Support: (other than financial incentive)** What support do CTC providers receive during COVID-19 response? [at national and institutional levels: safety measures not to get infected, PPE, mental health first aid training, supervision and mentorship **Mental health issues** /mental health support
Who does what? **Division of labour within and beyond the household and everyday practices**	**Roles and responsibilities** What are the roles and responsibilities of CTC providers that they are actually performing during COVID-19 response? **Selection/recruitment**- Selection and recruitment process/policies and factors influencing the selection and recruitment process
How are values defined? **Social norms, ideologies, beliefs and perceptions**	**Family and Household dynamics:** family support and other household relations that influence or affect the CTC work How do social roles affect their roles and responsibilities as CTC providers? e.g. having family, kids, a carer for parents, fear of contracting the virus and infecting them **Influence of community:** community acceptability/trust, female and male health providers are recognised differently - Community support, (both barriers and motivation), acknowledgement/ lack of acknowledgement of the role of female providers during COVID-19 response

	Mobility: moving for their work, restrictions, difficulty in going to places during the lockdown and curfews **Safety and security** - e.g. restricted mobility at night, risk of sexual harassment at the community level in times of conflict
Who decides? **Policies and decision-making (both formal and informal)**	**Policies and guidelines:** • recruitment and re-deployment of CTC providers during COVID-19 response • safety policy e.g. against the virus, sexual harassment, violence against CTC providers • maternity, paternity and family leave policies for CTC providers • gender has been mainstreamed into human resource policy **Decision making power/authority at health system, community and individual (CTC provider) level:** Who decides? How is the decision made? Participation of the CTC providers in the decision making

Annex 3: Framework matrix (findings related to gender are highlighted in yellow)

Who has what?		
Working conditions	**Remuneration and incentives**	**Non-financial support**
Shortage of staff	Lack of incentives	**Supervision**
Workload	Salaries	Peer supervision
Exhaustion	Paid through incentives	Community supervision
Lack of PPE/supplies	Housing allowance	Supportive supervision
Occupational exposure to infection	Transportation allowance	**Training**
	Mobile payments (phone credit)	COVID-19 case definitions and protocols
Fear of infection	Supplemental hours (part-time or unpaid CHWs)	Infection control
Changes in work schedules		PPE
Females in lower cadres more work & less pay, incentives & PPE	Compensations to occupational threat	Develop low-literacy tools to provide the necessary to manage their tasks (female)
Work remotely	Performance-based incentives	Equal training opportunities
Poor support	Health insurance coverage	**Workplace**
Lack of power		Supporting routine CHW workflows
Lack of leadership		Enabling environment to reduce exposure
Income uncertainty		Community support for female CHWs' roles e.g. engagement of community leaders, husbands of CHWs
Gender biases - not considered for relief food (female)		
		Hand hygiene facilities and disinfection facilities
		Staff with co-morbidities are allocated to routine non-COVID-19 care
		Prioritise COVID-19 testing for CHWs
Mental health issues		Supply planning
Work		Mental health support

Psychological trauma		**Motivation**
Distress in workplace		Public recognition
Exhaustion		Appreciation by managers
High case fatality – increase attacks on health workers		Rehabilitation, and curative services for occupational infection
Community		Job security beyond the engagement for the current pandemic
Disrespected		
Socially isolated		**Security**
Stigma		Protections from acts of violence
Viewed as 'carriers of the disease'		Anti-stigma campaigns
Feeling alone		Gender-specific aspects of security (female)
Individual		**Digital technology**
Balancing work and family life (female)		Digital innovation - mobile technology
		Digital tools for real-time decision-support
Changes in personal and social lives		Digital community-based surveillance, and contact tracing during COVID-19
Fear of contracting the virus - passing it on to their loved ones		Digitally enabled training (video conferencing, PowerPoint decks, guidelines)
Separation from family/children to protect them (female)		Digital sharing of information (text messages, mobile applications, phone trees, 24-hour support phone number)

Who does what?	How are values defined?	Who decides?
Roles and responsibilities	**Family & household dynamics**	**Policies and guidelines**
COVID-19 cases		A basic package of PPE (5 supplies)
Case identification, reporting, referral	**Community factors**	No clear guidance about their role in the COVID-19 response
Safe collection of samples and transport to labs	Perceive CHWs as vectors spreading the virus	MOH recommendations for CHWs to stop home visits
Conduct COVID-19 rapid tests	Don't trust CHWs	Laws against attacks on CHWs
Management of died patients e.g. dead body preparation	Don't respect CHWs	
Assess returning migrants	Stigmatise CHWs	
Community awareness and sensitisation	**Mobility**	
Community surveillance and contact tracing	**Access challenges**	
	Transport ban – curfew (female)	
Dissemination of information on preventive measures	No vehicles (low cadre workers & female CHWs)	**Decision making power**
Help implement and monitor preventive measures	No staff accommodation or transportation provided by HFs	Lack of power and voice of female workforce
Identify risk populations to reduce their exposure	**Facilitator**	Limited power and positionality – gender considerations
Support self-isolation and monitor patients	Government provided stickers to enable CHWs to travel	Integrate CHWs in the design and implementation of the response
Support delivery of food, social and medical support		
Addressing misconceptions to mitigate stigma	**Safety and security**	
	Safety measures	
Risk communication and behaviour change promotion	Mobile technology for remote supervision to reduce travel	
	Pairing male and female CHWs	

Maintaining routine health service delivery (e.g. SRH)	Provide PPE and disinfectants	
	Security training	
	Safe working environment	
	Health insurance	
Selection and recruitment	**Risks**	
Shortage of staff	Lack of PPE and supplies	
Optimise staffing ratios	Community transmission	
Proportionate distribution	Risk of infection and death	
Additional capacity sourced	Passing the virus to family	
Recruit unemployed/retired CHWs	Female CHWs are at higher risk of exposure (no PPE)	
Mobilising networks of allied health professionals	**Community factors**	
Volunteers	Harassment and disrespect	
Professionals from other sectors (e.g. teachers)	Violence	
	Stigma	
	Physical assaults	
	Fear-based discrimination	
	Verbal assaults and threats	

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