Policy Brief

Strategies to Overcome Gender-Based Constraints Impacting Community Health Worker Performance

Sub-Saharan Africa faces shortages in trained medical personnel. World Health Organization (WHO) estimates place the average ratio of doctor to patients at 2:10,000 in Africa[1]against a global average of 12:10,000. The coverage of nurses and midwives is 11:10,000 in Africa against a global average of 18:10,000, according to 2013 data.[2]

To fill the gaps in service provision in communities, countries are increasingly turning to community health workers (CHWs). Research shows that when CHW programs are managed and supported adequately, they can reduce maternal and child mortality (MCH) when compared to facility-based services alone. In Uganda, CHWs are known as Village Health Teams (VHTs). VHTs provide essential services such as community sensitization, awareness and distribution campaigns, nutrition, and family planning counseling, among other essential services.

The adoption of the Sustainable Development Goals (SDGs) has intensified the search for workable solutions to development challenges. Uganda and Kenya are using social enterprise models to demonstrate sustainable solutions to engage CHWs. A social enterprise is an organization that addresses a basic unmet need or problem through a market-driven approach. For instance, social enterprises like BRAC Uganda, Healthy Entrepreneurs and Living Goods offer a way for CHWs to generate some additional income from the sale of non-prescription medicines and health products.

About 70% of CHWs globally are women. CHW work is highly influenced by gender and sociocultural norms, which impacts their role as health workers and the achievement of health outcomes. Integrating gender means understanding the gender inequalities that CHWs face and taking steps to address them. In this policy brief, we demonstrate how integrating gender equality into CHW programs facilitates CHW's work; and, ultimately, improves their economic empowerment and the health outcomes of communities.

About the Research

BRAC Uganda and Cape Breton University, Canada, partnered with Healthy Entrepreneurs and LifeNet International in Uganda and Access Afya in Kenya to understand gender-based constraints faced by CHWs. This was the first study of its kind. The study used qualitative methods and adapted key gender analysis frameworks to inform the analysis. [3]The study ran from 2016 to 2020 in Uganda and Kenya and included 30 key informant interviews and 21 focus groups (a total of 175 individuals: 106 women and 69 men).[4]

[1] World Health Organization, (2016). Global Health Observatory Data Repository.

[2] World Health Organization, (2015). Global strategy on human resources for health: Workforce 2030 Draft.

[3] The frameworks and tools adapted included: International Labour Union (ILO). (1998). A Conceptual Framework for Gender Analysis and Planning. The Harvard Analytical Framework; Jhpiego. (2016). Gender Analysis Toolkit for Health Systems; Research in Gender and Ethics (RinGs). (2016). How do gender analysis in health systems research: A guide; and Population Reference Bureau (PRB). (2009). A Manual for Integrating Gender into Reproductive Health and HIV Programs. Commitment to Action (2nd Edition).

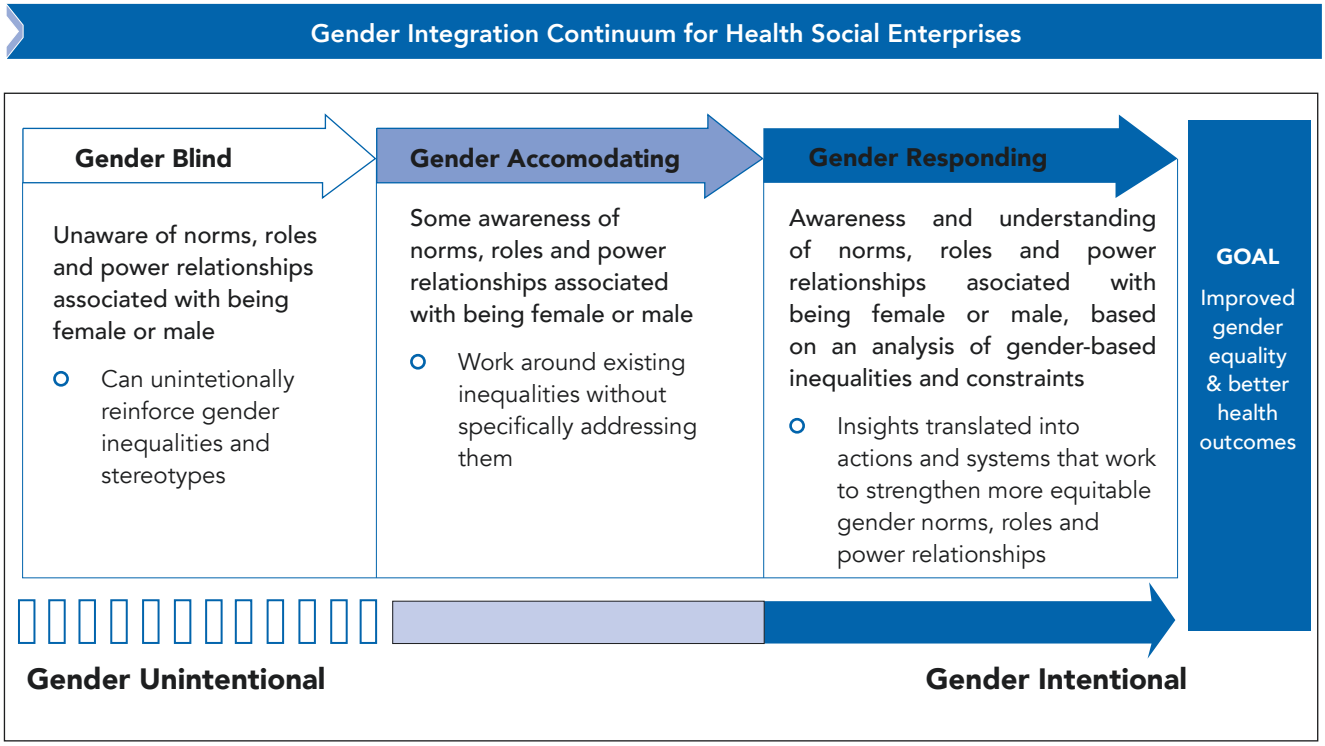
[4] For the focus group discussions, seven were with female CHWs, two with male CHWs and seven with the male partners of female CHWs and five with patients of CHWs (mixed gender).

Key Findings

1. CHW programs can be more gender-responsive

Most CHWs programs, even those that utilize only female CHWs, are not gender-responsive (across all their efforts). Through feedback from some of the Village Health Teams (VHTs), we learned that CHW work, particularly female CHWs' work, is highly influenced by gender norms. CHWs' work is also limited by gender-based constraints, which impacts both their role as health workers and the achievement of health outcomes at the community level.

As a part of this research, a **Gender Integration Continuum for Health Social Enterprises** was developed, which can be a useful tool for guiding gender-equality efforts with Uganda's VHTs and other CHW programs (see figure below).[5]



According to the figure above, when CHW programs are unresponsive or "gender blind" to gender-based constraints (left side of the figure), there is an increased potential for adverse outcomes, which consequently affect health outcomes.[6] However, when CHW programs are intentional and "gender-responsive" (right side of the figure), there is an awareness and understanding of the critical gender-based constraints impacting CHWs (particularly, female CHWs). As a result, insights are translated into strategies and actions that either reduce inequalities or strengthen equitable gender norms in order to reduce barriers and close gender equality gaps.

2. Female CHWs face unique gender-based constraints

In CHWs programs, we found that female CHWs experience unique challenges (when compared to men or male CHWs) including:

High time burden and lack of economic empowerment: Female CHWs face many demands on their time and have to balance their household and family responsibilities along with their CHW work and other income-generating activities.

[5] *The Gender Integration Continuum for Health Social Enterprises* has been adapted from two sources: IGWG. (n.d.). Gender Integration Continuum. Training Materials and Gates, M., (2014). Putting women and girls at the centre of development. Perspective. Bill & Melinda Gates Foundation. SCIENCE. Vol 345. Issue 6202. Page 1273.

[6] Gates, M., (2014). Putting women and girls at the centre of development. Perspective. Bill & Melinda Gates Foundation. SCIENCE. Vol 345. Issue 6202. Page 1273.

Risks to personal safety: The work of a CHW often requires women to travel alone and at night, particularly in the case of health emergencies. In addition, CHWs often have to deal with difficult or aggressive patients. In such instances, female CHWs are more vulnerable to harm, as they do their work. Unfortunately, during programming, these aspects are often not considered carefully.

Lack of career advancement and leadership opportunities: Female CHWs often face limited opportunities to advance their careers and to take additional leadership roles. This also links to the fact that female CHWs often have only basic levels of education, literacy and training.

Lack of access to needed equipment, medicines and transport: Access to proper equipment and non-prescription medicines allow CHWs to do their job effectively and assist in being perceived as legitimate health providers in the eyes of their community. CHW work often requires transport for home visits, especially if patients need to travel to a clinic.

Lack of access to capital: For CHWs that generate some income from the sale of medicines and health products, purchasing inventories is essential. Women often are more constrained in their access to capital than men.

Lack of access to social support and networking opportunities: Female CHWs can feel isolated in their roles. They are often situated "outside" of the health systems with no/minimal support and often have limited opportunities to connect with others including other CHWs.

Insufficient financial and non-financial incentives: Both financial and non-financial incentives motivate CHWs. For all CHWs, serving their community is one of the most important motivators. This confers status, respect and visibility for the health worker.

It is important to note that different contexts may generate varying gender-based constraints that require distinct gender-responsive strategies.

3. Appropriately engaging husbands provides a significant opportunity to improve the gender responsiveness of CHW programs

The relationship between the CHWs and their male spouse[7] is an important (but often invisible) influence that can either enable or constrain success. Female CHWs often face challenges with balancing gender roles and responsibilities (such as cooking, cleaning, childcare, etc.) and the expectations of their husbands with their volunteer or income-generating work (including CHW work). By examining the gender division of labour, husbands often support CHWs in a range of ways. Some of the support includes: paying for the purchase of medicines for inventory, escorting women at night to visit patients, selling or providing information/medicines to patients when the CHW is not home and helping to manage the home. Alternatively, in contexts where the husband maintains strong control and decision-making power at the household level, husbands can also be a limiting factor for a CHW's work.

[7] A spouse or partner may be a husband, wife or cohabitating partner. In addition, depending on the context and existing gender dynamics and/or the gender and sociocultural norms, another family member (i.e. mother-in-law, sister, brother, etc.) may play an important influencing role, especially in the case where there is no partner or where the context dictates strong family influence.

Recommendations and Policy Implications

Improving maternal and child health in Uganda requires a coordinated effort among all parts of the health system to **implement gender-responsive strategies** to support CHWs. At the community level, the empowerment of female CHWs facilitates the effective implementation of community health programs. To achieve this, we recommend the following strategies:

1. **Promote gender equality and women's economic empowerment** by ensuring appropriate remuneration for CHWs' time. This measure will support CHWs work-life balance and enable them to be more efficient and motivated. Further, it is important to create and support opportunities for income generation, such as selling health products.

2. **Appropriately engage husbands** by communicating directly to inform and educate them on the role of CHWs and their importance in community health, while also acknowledging and recognizing the opportunities to play a supportive role.

3. **Promote opportunities for leadership and career advancement** by providing CHWs with relevant training. Female CHWs cited the need to be trained in communication skills, conflict management, business, financial literacy and leadership. Such skills would enable them to serve their communities better. It is also essential to define clear job descriptions with the number of hours they are expected to work per week, along with providing a clear pathway for career advancement, promotion and leadership. Also, providing mentoring or coaching opportunities among CHWs, with an emphasis on supporting female-to-female connections.

4. **Promote CHW safety** by encouraging support from husbands when they need to accompany female CHWs to attend to a patient at night. Another strategy is to pair CHWs together or to pair male and female CHWs if appropriate for the context.

5. **Ensure adequate access to medicines and proper supply of health products, needed medical equipment and wet season gear** (e.g. umbrellas, boots). It is also essential to facilitate their CHWs' transport needs (especially for female CHWs), such as the provision of travel allowances or access to bicycles or motorcycles, where appropriate.

6. **Provide sufficient non-financial and financial incentives** by creating opportunities for income generation, facilitating access to loans and savings platforms, appropriate remuneration, appropriate monetary compensation for attending events like monthly meetings and proper supervisory support. It is also necessary to provide symbols of role and status such as t-shirts, which affirm the CHW's expertise to communities.

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