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GENDER RELATIONS IN COMMUNITY HEALTH SYSTEMS IN WEST AND CENTRAL AFRICA

Community health systems are considered vital to accelerate progress towards some key Sustainable Development Goals (SDGs), e.g., the reduction in child mortality. But how exactly do community health interventions operate, and what does gender have to do with the achievement of more favourable, equal health outcomes? This brief summarizes findings from an anthropological study of community health practices in Côte d'Ivoire, Mali and Senegal in 2019.

WHY THIS STUDY: BACKGROUND

Community health-based approaches are widely used to supplement care provided in health care facilities, making it accessible to all populations, particularly poor populations with little access to professionalized care. Yet, recurring criticism points to community health producing two-tier medicine which leaves isolated populations to fend for themselves, that exploits often female labour, and that is likely to widen social and gender inequalities. Thus, community health has come to be regarded as a complementary effort to address immediate health vulnerabilities, with thematic strategies mostly focusing on child nutrition, integrated childcare (mostly malaria, pneumonia, and diarrhoea) or maternal and new-born health.

Community health workers are positioned at the interface between individuals, families, and health care facilities, and – as this research shows – their engagement is often driven by opportunity and availability of finances. The various kinds of health care options are often perceived as complementary rather than exclusive, and the 'best' treatment in many cases uncovered by trial and error.

A regional report on community health programmes in 20 countries in West and Central Africa in 2019 confirms the expansion of community health policies in the region, as well as the tendency to standardize and simplify national reference frameworks. It also shows that – **contrary to many regions in the world, most countries have male community health worker predominance** (UNICEF, 2019).

Relying on poorly trained and unpaid or poorly paid workers raises a series of questions related to their identity in relation with communities, the effectiveness and quality of care, as well as the impact of their engagement on inequalities in access. Do community health programmes play a role in narrowing the gender gap between women and men, or do they reinforce negative gender stereotypes and therefore limit equal opportunities for women, men and younger people to training, empowerment and potentially additional income? Investigating these dimensions with a particular view on gender dynamics, uncovers dissimilar challenges to becoming and being respected and effective community health workers, and that the gender of community health workers markedly informs the community health activities.

STUDY METHODOLOGY

In one region each in three countries – Korhogo in Côte d'Ivoire, Sikasso in Mali and Ziguinchor in Senegal – one study site with at least one community health programme was selected based on their distance to the formal care supply network.

Villages located more than 5 km from a health facility (health centre and health post) were favoured as this study was particularly interested in the curative role of the agents in the context of poor geographical accessibility of care.

The research deployed a qualitative methodology, where the researchers – accompanied as required by qualified interpreters – undertook field work over a period of five weeks each.

In addition to anthropological observations of community health interventions, 67 individual and small group interviews with 'beneficiaries' of the community health interventions were carried out, and 46 in-depth interviews with community health workers using the life story method.

A pilot study in close collaboration with the Community Health Department of Bambey University, allowed for a multi-disciplinary development, testing and adjustment of the necessary research tools – each of which could still be adjusted to the local context in which the researchers worked.

THE GENDER OF COMMUNITY HEALTH: SUMMARY OF FINDINGS


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WHO ARE THE COMMUNITY HEALTH WORKER?

The engagement of community health workers seems a form of mutual obligation, sometimes clientelism, over which community health workers themselves do not always have control. Neither women nor most men decide for themselves if and how to engage in community health work – usually, this decision is made based on the opinion of someone who rationalizes the individual and collective interests involved.

The pursuit of community health activities depends on the family's ability to accept and compensate for the periods of absence of the person leading them as community health activities remain secondary to mostly agricultural work, in addition to the domestic work carried out by female community health workers, and the costly and tiring constraint of needing to travel to meet 'beneficiaries'. Thus, community health workers perceive community health activities largely as an interference, a burden that can lead to a loss of income and make it difficult to cope with social obligations and running of households.

Frequently changing priorities set out by international organizations, uncertain and unreliable project implementation, late payments and a lack of supplies renders this 'volunteering' only an acceptable form of work in a context of mutual obligations, where everyone makes contributions in the common interest. Only where community health workers are gaining a more professional status and being paid for their work, particularly in Mali, is more significant time assigned to community health activities.

Literacy and proper conduct in accordance with local standards are the most important criteria for selection and assignment of legitimacy and trust. Being 'a child of the village' can then be both an advantage as personal ties are made and community health workers know local social codes, but also a disadvantage where the recognition of particular skills might be questioned. Furthermore, some health issues may be hidden where they are deemed too sensitive to discuss with a neighbour or relative, or – in the opposite case – relatives can be particularly demanding.

The criteria have clearly gendered implications in a region where **most male community health workers are 'sons of the villages' they work in, and female community health workers usually join – through marriage – from other villages or regions.** Another 'marker' signalling the ability to care and being reliable is parenthood - particularly important for women, whose general status is closely linked to motherhood and their role in providing food security.

The importance of social identity makes it extremely difficult for unmarried young people – perceived as both inexperienced and irresponsible at the same time – to build legitimacy as community health workers. The one potential compensation for these 'flaws' – higher education – is then also the one thing that makes their ambitions to go beyond badly or unpaid community health work. In addition, young girls are often not be perceived as a 'good investment', since they will most likely be married away.

The integration of young community health workers is also hindered by the shame caused by intergenerational relations, where e.g., discussions on sexuality are considered inappropriate between people of different generations.

HOW DO COMMUNITY HEALTH WORKERS ENGAGE?

Gender roles

Dependent on prevailing gender norms and roles, being a female or male community health worker can have significant impact on the ability to carry out certain activities. Often, **qualities expected of community health workers are related to stereotypical 'female qualities' such as sensitivity and patience, are in stark contrast to views of women with lower levels of education being incapable of carrying out community health activities.**

Maternal health activities appear to be carried out less frequently where community health workers are predominantly male as many **female beneficiaries are embarrassed to discuss or ask questions with male community health workers if they relate to issues concerning contraception, childbirth and illnesses involving the stomach and genitals.** As intimate experiences unknown to men, women are more credible when speaking e.g., about maternal health, having experienced the pain of childbirth first-hand.

Another limitation to maternal health and family planning lays in community health workers' subjection to husband's authority. Indeed, male community health workers have been found to avoid carrying out home visits when the head of the family is absent; and some community health workers refuse to provide women with contraceptives without first gaining their husbands' consent or refer them to health professionals as a way of supporting women and avoiding husbands' anger at the same time.

Women's 'inherent' good qualities relate not only to women's but also children's health and their way of engaging with them. Women are considered naturally more sensitive to children's health and more adept at 'coaxing' them when it comes to treatments and instilling good hygiene habits.

Knowledge and Intervention methods

As training is often short and focused on several specific health problems, **community health workers often have only fragments of the medical knowledge and their health messages are brief and one-dimensional.** With beneficiaries making various forms of logical associations between knowledge and health care and interpreting messages in different ways, the passing of 'educational talks' through word of mouth frequently distorts messages to extents where the shared knowledge has very little link to subsequent health care choices.

Furthermore, where workers are poorly equipped to articulate medical reasons for particular recommendations or in the wider aim of driving behaviour change, the use of other explanations or forms of persuasion – which they know would work with their specific clientele – range from pragmatic, e.g., laying out cost-benefits of early health expenditure, to coercive, infantilizing or even humiliating, at times enforcing gender roles and norms. In Senegal, members of the husbands' school warn that men who do not take care of their wives' health (i.e., accompany them to maternity clinics) will not be able to have a second wife.

GENDER ROLES AS BARRIERS FOR FEMALE ENGAGEMENT IN RURAL AREAS IN WEST AND CENTRAL AFRICA

- Lower levels of education
- Lesser socialization into public sphere
- Lesser encouragement of professional specialisation
- Joining husband's villages after marriage means unfamiliarity with communities
- Limited time due to reproductive 'demands' and related successive pregnancies, childbirths and breastfeeding; as well as domestic chores, care activities and agricultural or other income-generating activities
- Limited mobility due to social norms, access to transport and safety constraints

Whilst men also split their time between several activities and their obligation to be able to provide for their family practically rules out their engagement in voluntary activities, men have greater freedom to *choose* whether and how to allocate time to their community work - as long as the activities contribute to their families' incomes. Women remain responsible for taking care of their households, no matter what else.

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HOW DO COMMUNITY HEALTH WORKERS PERPETUATE OR CHALLENGE GENDER ROLES?

One of the methods used by community health workers to change health behaviours is the moralization of family and social health roles – often reconfirming and strengthening existing stereotypes as messages are passed on through the local approach of allocating tasks based on gender.

With regard to the promotion of hygiene measures and practices aimed at improving children's health, health messages tend to exacerbate the gendered allocation of health roles. Specifically, women's practices are directly questioned, and activities criticized through the promotion of health and hygiene measures; whereas when men are collectively engaged in hygiene issues, their work mainly involves coordinating women's work. Although shared responsibility is emphasized, the **sharing happens along the lines of men 'knowing better' and women 'doing the caring better'.**

The parental model of interdependence of care based on the acceptance of the husband's authority is perpetuated, and preventive messages can be used against mothers, since non-compliance with the advice provided is naturally interpreted as a denial of authority and a cause of illness, i.e., if the child is sick, the mother is blamed for not having taken care of her child, while the father is deemed guilty of not having maintained his authority.

Dialogues between people of the same gender continue to be favoured, with male community health workers preferring to address men, and female community health workers preferring to address women. When community health workers are male, there is the risk that women will be unable to express their views.

However, **the intervention of male community health workers in certain health issues, particularly maternal health, goes against the common division of prevailing gender roles.** In all three study countries, maternal health is one of the main areas targeted by community health workers, who promote antenatal care, a balanced diet during pregnancy, and delivery in a health care facility and family planning.

On the one hand, men's increasing engagement in maternal health issues as community health workers could be seen as the beginning of – hopefully – greater concern, understanding and support for maternal health problems. On the other hand, this area of health used to be dominated by older women and female healers, who are now losing a certain amount of female power. Women's reluctance to see men (who have received very little training) take credit for their knowledge of motherhood and to position themselves as spokespeople for female-specific health problems are creates additional barriers.

Community health workers can be allies of mothers demanding care for their child, for which many families prefer modern medicine – if they can afford to – in fear of doing harm by using traditional medicine, and for women's health and access to antenatal consultations and delivery in health care facilities. However, **the role of community health workers in family planning is socially risky,** exposing them to hostile reactions and potentially causing them to lose the trust of part of the local population, as family planning is generally not considered appropriate until several children have been born. Particularly unmarried young women, whose sexuality is mostly considered illegitimate, do not dare to consult community health workers; whereas young men – generally more mobile – can procure condoms in the anonymity of the city.

WHAT KIND OF COMMUNITY HEALTH DO WE NEED TO PROMOTE: RECOMMENDATIONS

Based on above reflections of the research in rural areas of Cote d'Ivoire, Mali and Senegal, more consideration with regards to gender in community health programmes can be given along several axes:

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1. TOWARDS A GENDER-BALANCED, RESPECTED COMMUNITY HEALTH WORKER WORKFORCE:

- Ensure that recruitment methods and criteria do not indirectly favour men. Support female candidates and/or enforce quotas where balance is not achieved.

- Strengthen the training and supervision of workers to build their legitimacy and skills. Ensure that women have access to the training, i.e. consider needs for transport, childcare, time constraints, level of literacy and numeracy, etc.

- Support local adaptations to places of service delivery to counter issues of restricted mobility and time constraints of women specifically.

- Encourage the involvement of community health workers in organizing care, rather than dividing them up into projects, which makes their activities more precarious. Ensure that this process of institutionalization risks does not entrench status inequalities between men's and women's contributions.

- Ensure equal remuneration for men and women remuneration that, at the minimum, compensates for the loss of income and costs associated with the activities.

- Ensure that gender analysis and data disaggregation (gender and age) are part of the routine monitoring & evaluation of community health programmes performances.

Related sources and further readings

Hélène Kane (2021). *Genre et santé communautaire*; UMIESS and United Nations Children's Fund, 2021. [English version: *Gender and community health]*

UMIESS (2020). *L'engagement dans la sante communautaire parcours de vie*, Document réalisé dans le cadre du programme «genre et santé communautaire» en partenariat avec l'UNICEF WCARO, 2020.

UNICEF (2019). *Community Health Policies and Programmes in West and Central Africa*; United Nations Children's Fund, 2019.

Further information and guidelines: World Health Organization's Community Health Workers (CHWs) *https://www.who.int/hrh/community/en/*

2. FACILITATING COMMUNITY HEALTH WORKER ROLES FOR TARGETED AND IMPROVED HEALTH OUTCOMES

- Engage in ethical reflection on community health modes of action, particularly in terms of confidentiality, respect and equity.
- Guide community health workers in analysing their practices and the gender norms that underpin them, questioning the moral categories differentially associated with female and male behaviour.
- Allow for discussion and adaptation of roles in line with local concerns, including via intersectoral approaches including the habitat, working conditions, nutrition, etc.
- Question the focus of community health on maternal and child health, and consider how programmes might integrate male health issues, as well as those affecting adolescents and older people.
- Enhance the mediation role played by workers, particularly regarding referral to different health care spaces. This 'mediation' should include the promotion of mixed-gender and intergenerational dialogue spaces prior to health care decisions being made.
- Enhance community health workers' role regarding health issues that are 'hidden' because of gender-related modesty: reproductive health, gynaecological problems, sexually transmitted infections, etc. Allow women and men to have access to workers of the same gender for this purpose.

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