PROMOTING GENDER RESPONSIVE POLICIES AND PROGRAMMES FOR COMMUNITY HEALTH WORKERS:

PROMOTING GENDER RESPONSIVE POLICIES AND PROGRAMMES FOR COMMUNITY HEALTH WORKERS: A GENDER ANALYSIS FRAMEWORK

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Cover image: Mercy Adori - CHV in Nairobi outside free maternal health clinic in Kibera, © R.Steege

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INTRODUCTION

BACKGROUND

Health systems are not gender neutral (Morgan et al. 2018; Hay et al. 2019). Within the health workforce, occupational roles are highly gendered; women remain vertically segregated to informal health jobs with the lowest pay and the least power (Newman et al., 2011). This is evident with the large proportion of women undertaking community health work. Recent findings from Afghanistan where community health workers (CHWs) who were men were praised for their volunteer work, but it was seen to be expected of women (Najafizada et al. 2019), illustrate how women health workers' roles are devalued and assumed to be an extension of the role of women in the household.

COVID-19 has further highlighted the gendered nature of the workforce; women healthcare workers are being infected by COVID-19 at a disproportionate rate (Global Health 50/50 2020), and a higher proportion of women assume caregiving roles for the sick, and this may also put them at higher risk of exposure. While more research is needed to understand why, reasons may include the types of work that women healthcare workers engage in which increases their direct contact with patients, in addition to potentially ill-fitting personal protective equipment (PPE) (Miyamoto 2020). Reliance on CHWs in the COVID-19 response has placed a new spotlight on CHWs, who are often asked to carry out their work with limited PPE and with little to no compensation (Nanda et al. 2020).

Though the importance of gender equity in the community health workforce is becoming increasingly acknowledged – as reflected in the 2018 WHO's Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes - understanding of gender with regard to CHWs is often limited to demand-side issues (Jackson et al., 2019). A growing body of literature highlights the ways in which gender roles, norms and relations influence CHWs' working lives and how CHW policies are often adjusted on the ground and negotiated by gender norms and relations at the community level (Steege et al. 2018). This evidence base, albeit limited, needs to be leveraged by CHW programmes. Without a comprehensive understanding of the gender and power relations from both the demand and supply side, CHWs programmes may reinforce, rather than transform, inequitable gender relations.

REFERENCE TO THE WHO GUIDELINES

In a positive shift to incorporate gender considerations into CHW guidelines, the WHO's Guideline on CHW Programmes adopted a gender and decent work lens (WHO, 2018). The guidelines were developed based on an extensive review of the current evidence base. Despite the explicit gender lens taken in developing these guidelines, a lack of robust evidence that concretely examines how gender norms, roles and relations impact CHWs limited the provision of recommendations beyond selection criteria. Of note, the recommendations are also largely based on the evidence surrounding the acceptability of services provided, rather than the gendered experiences of CHWs in recruitment and selection.

Box 1: WHO CHW Guidelines Goal, Objectives & Audiences (WHO, 2018)*

GOAL: Assist stakeholders to improve the design, implementation, performance and evaluation of CHW programmes, contributing to the progressive realization of UHC.

OBJECTIVES

- Provide gender-sensitive recommendations on CHW selection, training, management and integration.
- Identify implementation and evaluation considerations at policy and system levels.
- Suggest tools to support national uptake of recommendations in planning and operations.
- Identify priority evidence gaps.

TARGET AUDIENCES

- Policy-makers, planners and managers responsible for health workforce policy at national and local levels.
- Development partners, donors, global health initiatives, researchers, activists and civil society organizations.

CHW organisations and community health workers themselves.

*Source: World Health Organization, 2018. WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO

WHY THIS CHW GENDER ANALYSIS FRAMEWORK WAS DEVELOPED

The majority of the recommendations that feature in the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes are made acknowledging the 'weak evidence' base, indicating that few examples of what gender equitable CHW programming looks like exists in practice. This tool was developed based on current evidence and in consultation with key stakeholders in this area. It was designed to help practitioners add to the evidence base on gender equitable CHW programming, while ensuring that the implementation of the guidelines is gender-sensitive. In the absence of robust evidence-based recommendations, we ask CHW policy makers and programme implementers to take appropriate actions to ensure that all CHW programming is gender-equitable. Gender equitable programming leads to an empowering and supportive work environment, helping CHWs to fulfil their role as agents of social change.

HOW TO USE THE CHW GENDER ANALYSIS FRAMEWORK

The WHO guidelines present 15 recommendations across three key areas:

- Selecting, certifying & training CHWs (recommendations 1-5)
- Managing & supervising CHWs (recommendations 6-9)
- Community embeddedness and system support (recommendations 10-15)

The tool below uses a gender analysis matrix to interrogate the ways in which gender inequities or power relations manifest to affect each of the 15 recommendations. A gender analysis matrix is a way of organising information for gender analysis and can be used to identify key gender-related considerations, including barriers and opportunities, relevant for a specific topic. Gender analysis matrixes facilitate the creation of gender responsive interventions by allowing us to develop and implement gender analysis with new or existing research to identify and address key gender-related considerations for programmes or policies (WHO 2020).

This matrix uses a gender framework which presents key gender relations domains recognised as common ways in which gender inequities manifest. These include inequities in: access to resources, roles and practices, norms and beliefs, decision-making power or autonomy, or institutions, laws and policies (see Morgan et al. 2016; JHPIEGO 2016 for examples of gender frameworks). The gender domains are explored against the 15 recommendations within the CHW guidelines. At the bottom of each recommendation there are community and health systems level actions and recommendations. These are based on the gender analysis questions presented alongside each of the 15 recommendations. The actions/recommendations presented below are the result of a consultative process and based on inputs from a broad range of experts, researchers, policy-makers, and health workers involved in CHW programmes.

Policymakers and programmers can use the tool to: conduct research with CHWs on specific aspects of CHW work related to gender (e.g. interviews, focus group discussion or surveys); develop CHW and gender related indicators; develop gender responsive CHW interventions or programmes; and/or engage with CHWs, CHW supervisors and policy makers on the gendered nature of their work. This can also be used to engage with communities around these topics.

Note that the matrix is meant also to act as a tool to help generate evidence and data to inform CHW programmes and policies. The questions or actions/recommendations presented within the matrix may not be relevant for all contexts and it will be up to those utilising the tool to assess which questions and actions/recommendations are most relevant. You may wish to focus on select CHW recommendations. Those who read through multiple recommendations may notice that many of the gender analysis questions are similar; this is because we wanted to ensure we captured different ways in which gender inequities manifest across each of the 15 recommendations.

HOW THE TOOL WAS CREATED

This tool was developed through several processes of consultation with practitioners, academics and policy-makers, from diverse global contexts, including a number of CHWs. Initially, we developed a template framework, based on the WHO CHW Guidelines (WHO, 2018), and populated it through a participatory activity during a session held at Women Deliver in 2019 in Vancouver, Canada with approximately 80 participants. All notes were collected and synthesised by the session facilitators. A draft of the tool was then distributed to gender and CHW experts for online inputs and received an additional 25 contributions. The tool was further revised based on this input and presented at the 2nd International Symposium for Community Health Care Workers in Bangladesh in 2019 with approximately 80 participants from a broad range of practitioners including policy-makers, NGOs, health workers, and CHWs to further consider the suggestions across multiple contexts. Participants were asked to review, discuss, and provide feedback on a draft of the matrix. Participants were advised that the objective of the activity was to add to the WHO CHW recommendations to make them more gender considerate, and ultimately more gender transformative. The matrix was then further revised by the project team, developed into the tool presented below, and opened online for a further round of comments with previous contributors.

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CONCLUSIONS

We advocate that policy makers and programme planners should aim to design and implement programmes in consultation with CHWs themselves, enabling opportunities for CHWs' needs to be heard and considered. CHW programme decision-making and policy development often happens without their direct input, raising issues around accountability. Throughout this tool, we refer to a platform through which CHWs' needs and rights can be elevated, through community health committee structures, and local governance. Such platforms do exist in some locations but are not widespread and often focussed on identifying community needs rather than those of CHWs themselves. The framework can help guide dialogue between CHWs, communities, and policy makers. Consultation with local gender advocates (women and men), advisors and focal persons working within the policy environment is also encouraged. The creation of spaces for the voices of women and men with differing views and positionalities is key to challenging existing power structures.

We suggest that qualitative and quantitative indicators for policies are co-created with CHWs and health systems governance actors. Implementation of this framework would minimally require that indicators are monitored and corrective action is taken. Further disaggregation of indicators by socio-economic status and age would also be helpful to understand the needs of distinct groups of CHWs – considering women and men as individuals, rather than a homogenous group.

Finally, whilst this document focuses on the distinctions between men and women we encourage consideration to all genders to be part of CHW programming, and especially for the purpose of promotion of men's specific contributions to community and family health, and for provision of services for men's health.

Table 1 : Gender Analysis Framework for Community Health Worker Programmes and Policies

R1: Selection for Pre-Service Training

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R1: SELECTION FOR PRE-SERVICE TRAINING Criteria for selection: Membership of and acceptance by the target community • Specify minimum educational levels; • Require community membership and acceptance; • Consider personal capacities and skills; • Apply appropriate gender equity to context.	Are there differences between boys/girls and men/women in the following: • Investment in education? • Access to employment opportunities? • Leisure time for education and volunteering? • Access to application methods e.g. internet?	To what extent are girls/women able to achieve education standards and/or complete education due to early marriage, childbearing, household chores, stigma? To what extent are women encouraged to apply for CHW positions due to household pressures, childbearing, security, agricultural roles, stigma?	To what extent do gender and social norms influence: • Girls' education, including in literacy, maths, sciences? • Childbearing years? • Access to childcare support? • Access to paid employment? • Expected role in household earning (breadwinning)? • Societal perceptions on care-based roles? • Perception of value for CHW work perception and value within (e.g. is it seen as women's work)? • Perceived aptitudes for CHW work (counselling/empathy)? • Acceptance of women working outside the home or entering homes unescorted? • Restrictions imposed by partners/lack of freedom to decide • Religious beliefs around gender roles?	To what extent are eligible candidates able to self-select or are influenced by: • Need for permission from household heads or husbands • Nomination by traditional leadership To what extent do girls/women have power to decide if financial resources will be used for education and/or participating in program?	What gender preferences do the target beneficiaries have for the CHWs? How will this be determined? E.g. via consultation process with community members that allows for equal participation taking into account gender and power dynamics How are women, men, and community gatekeepers consulted in the development of selection criteria and processes? What gender-based barriers do eligible CHWs perceive in selection and participation? Do men/husbands approve of their partners accessing these opportunities? What is the average education level of suitable women and men? In selection, are accommodations made to overcome gender-related barriers? e.g. selection based on education level may need to be relaxed to encourage women to participate. Where is the training done (in community or residential)? Does the location present barriers to men or women accessing it? Can adjustments be made to ensure equal participation? Is it safe for women to engage this opportunity?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS (individual/people level)	1. Consult eligible women and men in the community about barrier to selection as CHWs 2. Ensure equitable gender composition of those developing selection criteria and processes with consideration to power dynamics that allow men and women to speak freely 3. Ensure community sensitisation especially of CHW families and community gatekeepers to enable support for CHW role, travel, education and employment 4. Engage community gatekeeper to promote the value of and support for CHW work 5. Sensitise communities on the negative impacts of harmful gender norms and work to transform attitudes 6. If financial barriers exist, ensure project addresses these in a gender equitable manner				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS (specify minimum educational levels)	7. Ensure that proactive policies seek to have equal gender representation be established by the Ministry of Health or government authorities in national CHW plans/strategies, and are effectively communicated and enforced at all levels. 8. Ensure that health system actors communicate with communities to encourage women to apply and be selected. This may require community dialogue with women and men and creation of spaces where women are listened to and feel comfortable to talk. It may also require literacy support for women/young people. 9. Ensure that during the pre-service training recruitment process, the health services communicate clearly that the training budget takes into account needs specific to individuals and covers the cost as opposed to a flat per diem for women and men, and clearly identifies who that budget holder is. This would include a strategy to provide a stipend upfront to men and women who are in training to compensate for diminished productivity at home and to cover additional costs that may be incurred.				

R2: Duration of Pre-Service Training

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R2: DURATION OF PRE-SERVICE TRAINING • Base on CHW roles and responsibilities; • Consider pre-existing knowledge; • Factor in institutional and operational requirements.	To what extend do men and women have equal access to: • Financial resources required to participate in training? • Time to participate in training? (duration, hours per day, assignments or readings? Are trainings held in locations reasonable for women to access? Is there access to safe, gender appropriate hygiene facilities?	To what extent do the following roles/ responsibilities affect women's/men's ability to participate in and complete training as trainers or trainees: • Employment outside the home? • Reproductive, caretaking, and household chores? To what extent does training location and modality (e.g. localised or residential) affect men/women's ability to stay in training throughout the day/week?	To what extent do gender and social norms influence: • Men/women's ability to absent from household overnight or for extended periods? • Men's/women's ability to task-share during training • Women's ability to assume non-household professional work?	To what extent do women require the permission of a gatekeeper to be absent from household, daily, overnight or for extended periods? To what extent do girls/ women have power to decide if financial resources are used for participating in program?	Are CHWs consulted in training design? Have communities and families been sensitized on the training location, time-commitment, costs etc.? What training locations are feasible and most accessible to both men and women considering household and financial responsibilities? What is the maximum amount of time CHWs can be away from homes to attend training? For face-to-face training, are accommodations made to overcome gender-related barriers to training? If residential training, would one long training or shorter modular training be more appropriate? Can childcare needs be met in training venues? Is there access to safe, appropriate hygiene facilities, including disposal facilities for menstruation supplies, and showering facilities? Consider gender-related and disability related access to facilities.
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS (individual/people level)	1. Engage communities in the discussion of how to support men and women CHWs who have childcare responsibilities and/or income generating responsibilities. 2. Ensure that the timing of training is flexible. 3. Sensitise those with decision-making power (e.g. men, older women) to encourage women's participation in training (initial or ongoing). 4. Conduct community sensitisation to challenge the notion that household and child caring are women's work and paid employment is for men.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS (specify minimum educational levels)	5. Consult men and women CHWs to inform gender sensitive training design and needs. 6. Ensure training facilities provide space and resources for breastfeeding mothers and those with children and for their accompanying care providers. 7. Take gender and local cultural contexts into consideration when defining training structure and duration to enable maximum participation. This may mean flexible, modular offsite training, or localising training to accommodate additional responsibilities. 8. Ensure gender parity among MoH decision makers who design CHW training courses where possible. Ensure active consultation with relevant ministries and local women's organisations to take into account social and cultural norms that affect the ability of women and men to equally participate. 9. Ensure gender parity in amongst training facilitators. 10. Design training to reduce the number of consecutive days individuals are absent from their household responsibilities. 11. Ensure that sustainable funding is available for appropriate accommodations during training. 12. Ensure adequate bathroom facilities, with adequate lighting at training site, proper disposal facilities for menstruation supplies, and wash room facilities separate genders. 13. Consider gender of trainer depending on context e.g. if CHWS are all women it may be is it more appropriate to have a women trainer. 14. Ensure that pre-service trainings consider and address gender and GBV issues.				

R3: Competencies in curriculum for pre-service training

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R3: COMPETENCIES IN CURRICULUM FOR PRE-SERVICE TRAINING • Train on expected preventive, promotive, diagnostic, treatment and care services; • Emphasize role and link with health system; • Include cross-cutting and interpersonal skills	Do men and women CHWs have equal access, experience and training with all technologies used for health services and for training? Do men and women CHWs have the same 'baseline' competencies prior to any new training introduced? Do men and women CHWs have equitable access to their professional equipment?	To what extent does the gender of CHWs affect: • Prior experience and key skills • Preconceived notions of task roles in promotion, counselling and treatment • Perceived suitability or competency for certain tasks • Personal experience in determining competency or for the task?(E.g. child nutrition, breastfeeding, childbirth) • Targeting of the client group or key population, especially for gendered health complaints	To what extent do social and gender norms influence: • Competencies related to communication, caring or listening skills • Competencies which may be considered more transformational • Competencies related to understanding the role of gender, such as awareness and discussion of gender roles, norms and relations as well as sexual gender-based violence. • Whether men and women CHW's advice is perceived as equally legitimate and followed to the same extent by men and women care-seekers?	To what extent is the design of policies, curricula and competencies influenced by: • Gender and gender perspectives of the decision-makers • Consultation with men and women CHWs • Consultation or gender analysis with key/ target populations • Gender power relations in communities and households	How does the beneficiary community perceive men and women in terms of their competencies or suitability for tasks? How acceptable is it to the target communities for men and women to perform specific tasks? Do men and women need the same types of training for specific skills?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS (individual/people level)	1. Assess gender norms and beliefs about specific roles, task and competencies with target and key populations. 2. If CHW programming is to be transformational, type of training to be offered is of relevance and can be tailored to address specific norms and relations. 3. Make training content and competencies context-specific to account for gender norms, roles, and relations. 4. Ensure both women and men CHWs are supported to be able to challenge gender norms that promote vulnerability and limit health care access.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS (specify minimum educational levels)	5. Ensure both men and women health professionals and/or gender specialists contribute to curricula development. Ensure that policies, curricula and competency frameworks capture: • Awareness and discussion of gender roles, norms and relations in households and communities • Skills for negotiating gender-based conflict and violence in community and households. • Adequate attention to soft skills training, not based on preconceived beliefs about gender and suitability • Additional support for CHWs carrying out tasks they have no prior or personal experience of				

R4: Modalities of pre-service training

<table>
<tr><th rowspan="2">CHW GUIDELINES</th><th colspan="4">GENDER ANALYSIS DOMAINS</th><th rowspan="2">PROGRAMMATIC GENDER ANALYSIS QUESTIONS</th></tr>
<tr><th>ACCESS TO RESOURCES (financial, social, time, etc.)</th><th>DISTRIBUTION OF LABOUR, ROLES, PRACTICES</th><th>NORMS, VALUES, BELIEFS, PERCEPTIONS</th><th>RULES AND DECISION-MAKING POWER</th></tr>
<tr><td>R4: MODALITIES OF PRE-SERVICE TRAINING
• Balance theory and practice;
• Use face-to-face and e-learning;
• Conduct training in or near the community</td><td>To what extent does gender influence:
• Familiarity with and access to learning technologies
• Ability to attend face to face trainings for longer periods of time
• Financial resources to attend training and cover related personal costs e.g. childcare
• Space to complete assigned work at home with limited distraction?
• Supportive social networks? (family, friends, mentors or role models), advocates in the community

How do pregnancy and breastfeeding affect access to training?</td><td>To what extent does gender of the CHWs determine:
• Work burden and roles within the family/ household that prohibit participation
• Availability for training participation in remote locations</td><td>Does gender composition of CHWs in the classroom setting influence willingness or openness to participate and engage?

How does gender of instructors influence CHWs' comfort with training, and on which topics?

Do instructors have gender-based beliefs of values that influence their approach?

Do cultural beliefs or norms dictate a need to separate sexes for certain topics or issues?

Are there sensitivities on use of video or images showing nudity/partial nudity, childbirth or family planning use?

Preconceived notions on intelligence or ability between gender</td><td>How does the gender of decision-makers influence their willingness to design flexible learning to accommodate gender needs?</td><td>Are men and women CHWs consulted in the design of training modalities?

Where distance learning is included, is adequate support given to overcome gender barriers to technologies?

In in-person training design, are accommodations made to overcome gender-related barriers to training?

Is there diversity in trainers able to provide different gender perspectives?</td></tr>
<tr><td>COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">1. When planning and implementing training events for CHWs:
• Ensure consultation of men and women CHWs in the design of training, looking specifically at learning technologies, duration, location, flexibility and accommodation required for women who are pregnant, breastfeeding or caring for small children
• Residential training can provide a supportive environment free from distractions – but short, modular and flexible training options should be considered (with provision of on-site childcare)
• Allow option to have separate training by sex in non-permissive contexts as appropriate
• Ensure durations of face to face training components allow for both genders to master skills, and overcome any individual level barriers to learning</td></tr>
<tr><td>HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">2. Develop national-level curricula and training guidance, which is informed by gender analysis of the CHW group, and ensuring gender representation in design decisions.
3. Review training guidelines to ensure inclusion of the following considerations:
• A pedagogical approach to ensure a positive, safe and dignified teaching environment where gender equity is promoted
• Guidance on selecting and preparing men and women instructors
• Advice on the implementation of gender assessments to inform local training delivery
• Use of technologies and overcoming gender-specific barriers to technology access
• Bias training for policy makers, planners, supervisors, facilitators</td></tr>
</table>

R5: Competency-based certification

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	**DISTRIBUTION OF LABOUR, ROLES, PRACTICES**	**NORMS, VALUES, BELIEFS, PERCEPTIONS**	**RULES AND DECISION-MAKING POWER**	
R5: COMPETENCY-BASED CERTIFICATION • Competency-based formal certification for CHWs who have successfully completed pre-service training	Are there differences between boys/girls and men/ women in the following which affect their ability to perform at the same level: • Investment in education? • Access to relevant work related information? • Time to engage in education? • Access to technology to be able to undertake work?	To what extent are the workload required to meet competencies reasonable for men and women? To what extent do employment and caretaking; responsibilities affect men and women's ability to meet competencies within a certain period? How might gendered roles responsibilities influence achievement on written or practical tests? Might alternatives for assessment be preferred?	To what extent do gender and social norms influence: • Men /women's ability to communicate with the opposite sex to meet competencies? • Perceptions of men/ women CHWs by established health workforce? • Perceptions of men/ women who have academic achievement?	To what extent do women need permission from a gatekeeper to engage in activities required to meet competencies?	Are accommodations made to overcome gender-related barriers to participation in assessments? Are there methods for detecting and eliminating unconscious gender-biases in assessment and certification?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Ensure community investment in and support for women CHWs when negotiating community contributions. 2. Ensure that CHW strategies reflect the reality that many CHWs, primarily women, working in both rural and urban settings, have low literacy rates that are challenging to their successful fulfilment of their mandate, as well as to their advancement.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	3. Ensure that required competencies are in alignment with reasonable workload analysis for CHWs per context. 4. Identify and address gender barriers to CHW performance and ensure adequate skills building and coping strategies are included in competencies (e.g. literacy training). 5. Establish a CHW training certification equivalent to other academic qualifications, rather than dependent on them. 6. Ensure that if formal certification is to be used for people who complete training, there are no requirements that may lead to gender imbalance in certification.				

R6: Supportive supervision

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R6: SUPPORTIVE SUPERVISION • Establish appropriate supervisor-CHW ratios; • Train and resource supervisors to provide meaningful, regular performance evaluation and feedback; • Use supervision tools, data and feedback to improve quality	To what extent does the gender of CHWs influence: • Availability to participate in individual supervision? • Participation in monthly or group meetings and travel outside the community? How does a CHW supervisor's gender affect: • Travel to visit supervisees? • Access to supervision related trainings and promotion? • Approachability to ask for help or support? Are there women supervisors to serve as role models for women CHW?	Are men and women supervisors allocated different tasks or roles in management with different levels of decision-making power and wage? Do gendered roles of men and women in the HH and community affect their selection as supervisors?	To what extent do gender norms and values influence: • Selection of supervisors? • Mind-set and approach to supportive supervision? • How men and women CHWs and are supervised? • How CHWs might perceive the support they get? • How CHW work is valued within health teams? • How incentives are distributed • Outcome of assessments? • How certain issues are raised or discussed by supervisors? Unconscious gender biases may influence all domains of supervision	To what extent does gender composition of CHW and supervisor groups influence CHW-supervisor dynamics and relationship including: • Decision-making power on participation in supervision or becoming a supervisor • Outcomes of assessments? • Workplace harassment? • Selection of supervisors? Do gender dynamics in teams affect CHWs' participation or opportunities for promotion? What powers are given to supervisors? Is there scope for that power to be abused?	Considering the gender composition of the CHWs and supervisors group, does gender affect methods or attitudes to supervision? How do CHWs self-organise? Do they have platforms for collaboration support and advocacy outside of the line of power? How are supervisors being supervised? Are processes in place to prevent abuse of power? Are both men and women supervisors given adequate support for travel and security in the course of their duties? How can women be empowered to become supervisors? Are there process/policies in place to detect gender discrimination in supervision? How are financial incentives distributed, and are they done so equally?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. When planning and implementing supportive supervision strategies at the community level: • Consult CHWs and supervisors to assess gender-related needs at individual and group levels and identify barriers including money, transport, and family-related issues • Conduct sensitisation to transform harmful gender norms in communities where barriers to women becoming supervisors exist • Ensure training and sensitisation for supervisors and community leaders involved in selection to support gender equitable processes • Ensure men and women supervisors are available to act as role models and to work within the realities of current cultural norms in some contexts • Group supervision should occur close to communities limiting need for long travel/relocation • Proactively promote opportunities for women to become supervisors and give preferential selection of qualified women candidates until gender parity is achieved, e.g. mentorship • Assess supervision data for gender differences and gender biases in supervision outcomes, coverage and participation • Ensure adequate supervision of supervisors to prevent gender biases, power abuse or harassment • Ensure CHWs have a line of communication outside of their supervisor to communicate problems 2. Within CHW collectives and unions: Encourage CHWs to be self-empowered and self-organising to advocate for their needs amongst power structures and facilitate the building of networks of CHWs for information flow, modelling successful CHWs of both genders and strengthening CHW communities (legitimization?) 3. During supervision: Promote the role of CHWs and supervisors with community leadership and sensitise them on gender-related matters, and sensitise families of CHWs on the importance of supervision activity participation. Allow for presence of chaperones in non-permissive settings or where one-to-one supervision might be uncomfortable OR conduct supervision in groups or pairs OR ensure CHWs have supervisors of the same se 4. It is recommended that as part of the supervision process the families of individual CHWs are also recognized for their contribution to the community (if they are supporting their time through childcare, agriculture or household tasks) to draw attention to the additional support women may need to complete their responsibilities				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	5. National level policies guidance and training documents should: • Include ways to ensure no gender biases emerge within the manner in which supervision occurs • Include training on gender and how this may impact power dynamics for supervisors • Specify gender parity within the criteria of the supervision team and give preferential hiring priority to qualified women until parity is achieved • Include methods to supervise supervisors, prevent abuse of power and enable grievance processes, codes of conduct to address harassment in the workplace • Ensure salary equity for supervisors 6. Health management teams need to: • Ensure gender power relations between supervisor and CHW are recognised and supervisors coached on proper, safe and dignified supervision. • Aim to ensure supervision teams rather than individuals, and include women supervisors where possible • Socialise the code of conduct and implement policies related to grievance handling • Create opportunities for CHW representatives and collectives to be heard • Track performance levels of women and men CHWs and; analyse/address apparent trends across genders				

R7. Remuneration

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R7. REMUNERATION • Include resources for incentives in health system resource planning; • Provide a financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake.	To what extent does remuneration place expectations on number and type of hours worked, and how does this affect men and women's willingness to apply? Are there differences between men and women in the following: • Financial compensation received • Workload of volunteer roles • Access to transport to allow them to cover more areas, thereby increasing financing compensation • Access to transport to collect earnings? • Time available to conduct unremunerated CHW work?	To what extent are men and women remunerated differently for similar or different roles? Is there equity in allocation of tasks/roles? Does a voluntary CHW role assume or reinforce the notion that women are less entitled to pay?	To what extent do gender To what extent do gender and social norms affect if men or women: • Are more likely to apply or be nominated by communities for a paid CHW position? • Are more likely to advocate for remuneration? • Require support to collect earnings? • Receive the same level of remuneration? To what extent do gender and social norms affect: • Whether CHW work is considered feminised labour? • The value placed on CHW work? • Whether CHW work is paid? • Stigmatisation of professional women	Are there differences between men and women in the following: • Knowledge of labour rights? • Ability and willingness to advocate for their rights, or take action (e.g. strike, petition, protest) to receive financial compensation? • Willingness to complain when payment is delayed? • Representation in collectives, unions, professional associations? • Control over earnings received? To what extent are Ministries: • Willing to invest equally in men or women CHW programs? • Assuming availability of women for unpaid work? To what extent might women's unpaid/paid work affect household power dynamics, cause conflict/ GBV?	Are their methods for detecting and eliminating unconscious gender-biases in remuneration? Are there differences in pay levels of men and women CHWs? Are pay levels determined by roles? Do CHWs have adequate representation in financial decision making bodies/platform (DHMT/ local gov or Health committees? Do CHWs have avenues for grievance re pay? Are CHWs given equal opportunity to advance their career and be eligible for promotions? Are there structures in place for maternity/ paternity pay or health/life insurance for CHWs? How are non-financial incentives distributed among CHWs – could this create/exacerbate power dynamics?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. For remunerated CHW jobs, ensure that women and men have equal chance to be selected. 2. For remunerated CHW jobs, ensure that men and women CHWs are remunerated equally, commensurate with workload. 3. Ensure communities commit to providing commodities to ease the financial burden/output of CHW (housing, food, provision of water/firewood, childcare, etc.). 4. Ensure that programme's budget for salaries if the work required exceeds what can be expected of volunteers. 5. Ensure that in addition to financial remuneration different types of remuneration are considered, such as training and career opportunities, childcare (community care centre or community food), loans for mothers, benefits e.g. family health insurance and life insurance. 6. For non-financial incentives, ensure that CHWs retain resources allocated to them (phone, animals, land, equipment)				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	7. Ensure that equal remuneration is offered for men and women working as CHWs. 8. Ministry of Health should provide supplementary wages to cover childcare and insurance costs. 9. Governments should adequately and appropriately budget for CHW programmes as they would for other health providers. 10. Ensure the roles and responsibilities of paid CHWs and volunteers who support them are clearly defined, and that the gender composition of paid vs. volunteers is considered and not exploitative of women's labour. 11. Ensure that remuneration for work is based on equal pay for equal work. Conduct periodic reviews of the CHW financial packages look for differences in packages. 12. Include social security packages such as health and life insurance, maternity and paternity pay alongside remuneration. 13. For non-financial remuneration ensure women are represented in planning to ensure suitable and equitable resource allocation				

R8. Contracting agreements

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R8. CONTRACTING AGREEMENTS *Provide paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights.	Are there differences between men and women in the following: • Ability to read and understand written contract? • Experience with contracting agreements? • Equal explanation of agreement clauses to ensure informed consent of commitment made	To what extent do contracting agreements include: • Maternity and paternity leave. • Flexible working approaches that support CHWs to balance community health work with domestic responsibilities. • Benefits: health insurance, payment of school fees	To what extent do contracting agreements: • Consider women's safety? • Formalize policies around sexual harassment? • Consider women's domestic responsibilities? • Allow for flexibility when children are sick or other unanticipated events occur?	To what extent do CHW unions or membership organisations: • Exist? • Have leadership and representation by men or women? • Consider issues affecting both men and women? • Ensure gender differences are accounted for in deliberations? To what extent do men and women require approval from a family member to accept a contract?	Do contracts with CHWs articulate their rights and expectations regarding their work, pay, leave allowances and maternity/paternity arrangements? Do contracts articulate what CHWs can expect in terms of support and gender-specific needs? Do contracts prohibit gender based violence and harassment in the workplace and articulate grievance processes for dealing with this? Do contracts clearly set out roles and responsibilities required of both paid and voluntary CHWs, and supervisors? Do contracts allow for flexible working arrangements?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Inform communities about contracting agreements, especially if this may enhance the perceived value placed on women CHWs and their work. 2. Consider formalised pathways to express grievances and come to mutual agreement 3. Promote a zero tolerance for sexual/gender based harassment culture. This would include training on sexual harassment for all workers in health system, provision of guidelines and option to anonymously report any sexual misconduct.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	4. Ensure written agreements are standardized, not based on personal negotiation where power relations and gender roles could risk influencing on contract content etc. 5. Ensure that contracts are issued to formalise labour rights for CHWs, such as maternity and paternity leave and holiday and sick pay. 6. Ensure that contracts recognise flexible working approaches that support CHWs to balance community health work with domestic responsibilities. 7. Ensure that templates for the agreements ensure equal terms for both women and men. 8. Ensure that contracting agreements consider the following: 9. Creation of safe spaces in health centres and delivery suites for women CHWs who work at night. 10. Option to conduct work in men-women pairs or women-women pairs depending on context to promote safety of women CHWs. 11. Clear job descriptions provided for all CHWs. 12. Creation of a dedicated health post to work out of to ensure women and men have a safe space to conduct their work. 13. Termination of employment for perpetrators of sexual/gender based violence or abuse of power.				

R9: Career ladder

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R9: CAREER LADDER • Create pathways to other health qualifications or CHW role progression; • Retain and motivate CHWs by linking performance with opportunities; • Address regulatory & legal barriers.	Are there differences between men and women in the following: • Access to transport? • Level of education? • Awareness of opportunities to move up career ladder? • Ability to take up opportunities? • Access to additional training? • Financial resources to take up education opportunities? • Time to focus on career due to family or other responsibilities? • Availability of childcare to take up opportunities?	Are there differences between men and women in the following: • Ability to take up training opportunities due to family or other responsibilities? • Ability to travel to take up opportunities due to family or other responsibilities? • Representation in managerial or supervisory roles?	To what extent do gender and social norms affect: • Whether men or women are promoted due to perceptions of leadership and/or competency? • Assumptions regarding men and women's availability for work? • Stigma as a result of hours spent travelling for work. • Compensation received by men and women for the same job roles. • Expectations regarding career progression for men and women? • Expectations regarding motivations for work?	Are there differences between men and women in the following: • Support from partners or family to progress careers? • Representation within decision-making and recruitment? • Support from supervisors to take up career enhancing opportunities	Is there any formal career pathway for CHWs? Are opportunities for further training and education captured in a manner that is conducive to recorded professional development? Are opportunities for further development accommodating of gender-barriers to prerequisite education? Is the experience and performance as a CHW being tracked and recorded in a manner conducive to fair promotion? Are there systems in place for transparent selection of CHWs for promotion or advancement Are there methods for detecting and eliminating unconscious gender-biases in promotion and opportunities for advancement? Are there quotas in place to secure places for eligible women and men to progress their careers/ undertake further training opportunities? Are actions for gender-equitable promotion articulated in policy and guidance?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Ensure there are sufficient educational opportunities to improve literacy for women/girls who want to become CHWs, and for CHWs who want to go on to further education. 2. Sensitise community gatekeepers and supervisors on the importance of gender-equitable career opportunities, and how this contributes to the broader development of the community.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	3. Ensure that the career pathway be known to all CHWs, with clear steps that are not changed based on an individual supervisor or connections. 4. Ensure pro-active policies be applied if there is a need to promote more women CHWs 5. Ensure that CHW policies ensure equal opportunities for career progression for men and women. 6. Ensure there are sufficient sponsored courses for women CHWs to undertake further training or education to enter into the health system, and that the health system has capacity to absorb new trainees.				

R10: Target population size

<table>
<tr><th rowspan="2">CHW GUIDELINES</th><th colspan="4">GENDER ANALYSIS DOMAINS</th><th rowspan="2">PROGRAMMATIC GENDER ANALYSIS QUESTIONS</th></tr>
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<tr><td>R10: TARGET POPULATION SIZE

WHO suggests using the following criteria in determining a target population size in the context of CHW programmes.
Criteria to be adopted in most settings:
• expected workload based on epidemiology and anticipated demand for services; • frequency of contact required; nature and time requirements of the services provided; expected weekly time commitment of CHWs (factoring in time away from service provision for training, administrative duties, & other requirements); local geography (including proximity of households, distance to clinic and population density).
Criteria that might be of relevance in some settings:
weather and climate; transport availability and cost; health worker safety; mobility of population; available human & financial resources</td><td>To what extent do men and women CHW differ in terms of:
• Mobility and acceptability of travel to remote locations, insecure locations, neighbouring villages?
• Working with other ethnicities
• Working with men/women target groups or key populations or gender-related health issues?
• Personal security in carrying out duties in households and communities?
• Access to transport?
• Ability to work alone or after dark or times required to reach target groups e.g. delivering mothers?
• Spending time at work to complete needed tasks?</td><td>How might gender roles in the household impact a CHW's:
• Total work burden in home and community
• Number of available hours for carrying out tasks and travelling
• Ability to meet the needs of target populations, case load, coverage or performance of tasks
• Overall wellbeing, stress and health
• Level of practical and psychosocial support enabling them to carry out duties?
How might gender roles influence:
• Access to target groups
• Ability to mobilise groups/populations
• Access to data and information about target populations</td><td>To what extent do gender norms, values, belief and perceptions influence a CHW's:
• Freedom to act
• Requirement for chaperoning
• Acceptability to clients to provide services
• The type of services they can provide to men and women.</td><td>To what extent are women and men represented in the identification of catchment areas and target groups?

Do decision-makers and managers have a way of tracking catchment and coverage?

What assumptions are being made at district and national political levels about the availability of men and women to receive CHW services?

Do CHWs have a voice or safe platform where their issues related to workload and population size or barriers to accessing populations can be heard and addressed?</td><td>Has a workload analysis been conducted to inform target population sizes factoring in gender-related roles e.g. care of children?

What restrictions imposed on women's freedom to act, make decisions or travel influence their ability to do CHW work?

What is a reasonable workload that can be expected of volunteers/part time CHWs?

What travel provisions are available?

What threats to personal safety, comfort or reputation might women and men CHWs experience?

What gender/s are the key populations and their gender-related health needs? Do sensitivities exist in terms services that can be provided by men or women CHWs?

What would make it easier, safer or more acceptable for women/men CHWs to work, especially reaching underserved areas?

How supportive are families: in-laws, husbands or elders towards women CHWs?

What community based structures can be leveraged to mobilize target populations, and overcome any gender barriers?</td></tr>
<tr><td>COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">1. Create platforms for CHW voices to be heard. Ensuring representation of both genders in these platforms goes beyond tokenistic inclusion, but considers power dynamics and allows for women to feel comfortable to voice their opinions.
2. Create fora for CHWs to interact with community leadership and health authorities to improve working conditions that are considerate of gender-power dynamics
3. Ensure equitable and appropriate access to transportation for men/women CHW to reach the target population. Consideration to provision of transport options acceptable to all genders e.g. quadbikes over motorbikes may be more appropriate.
4. Take all additional context-specific measures to ensure personal safety of CHWs, especially women, which may include provision of transport funds or means, provision of health posts for work and safe spaces next to delivery centres, providing mobile phones, deploying in pairs or teams, or with chaperone if needed.
5. In potentially dangerous or insecure settings ensure CHWs have emergency communication and back up support for any incidents
6. Encourage or support CHWs to identify childcare options within the community to free them up to carry out their work.
7. When mapping and identifying the catchment areas of each CHW in the area, ensure these are equitable, balancing our time in households and travel times.</td></tr>
<tr><td>HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">8. Assess and adjust catchment areas (target population site) to make sure they are equitable.
9. Transport should be budgeted adequately in programme financing
10. Creation of safe spaces in health centres and delivery suites for women CHWs who work at night should be budgeted
11. Bicycles or motorbikes, if distributed as part of CHW programmes, provided equally to men and women and training should be factored in
12. Ensure community structures are strengthened which facilitate CHWs voices to be heard and mobilise support to CHWs</td></tr>
</table>

R11: Data collection and use

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R11: DATA COLLECTION AND USE WHO suggests that practising CHWs document the services they are providing and that they collect, collate and use health data on routine activities, including through relevant mobile health solutions. Enablers for success include minimizing the reporting burden and harmonizing data requirements; ensuring data confidentiality and security; equipping CHWs with the required competencies through training; and providing them with feedback on performance based on data collected.	Are there differences between men and women in: • Access to and familiarity with technology, affecting speed and accuracy of digital reporting and caseload attribution? • Educational opportunities that affect ability to report if multiple and complicated reporting systems are required? • Access to transportation to collect data over a large area? • Access to financial resources to travel to collect data? • Acceptance/access into homes to collect data	Are there differences between men and women in the following: • Whether family or other responsibilities affect ability to participate in data collection, both as data collector and respondent? • Variations in caseloads and performances due to different socio-demographic characteristics? • Experiences of harassment while collecting data.	To what extent do gender and social norms affect: • If men or women can collect data from someone of the opposite gender? • Types of questions that can be asked to men or women? • Whether men or women can use different forms of transportation to collect data? • When women need to be accompanied when travelling to collect data? • Acceptability of harassment received by men and women CHWs while collecting data. • The observation or detection of sensitive issues (SGBV, child protection, HIV) • Ability to detect 'subtle' cues e.g. mental health • Client trust and disclosure	Are there differences between men and women in the following: • Permission required from family members to participate in data collection. • Safety and security needed while collecting data. To what extent are there policies in place to protect CHWs from experiencing harassment while collecting data?	Are the design of data collection systems co-created with CHWs? Are CHWs consulted on accompanying technologies? Are gender-related barriers to data input and utilisation identified and addressed in the programme? Are CHWs at any risk in collecting or reporting certain types of data (e.g. violence) and if so, are they adequately supported and protected? Are gender biases in the reporting rates of certain issues or conditions being identified (e.g. gender related issues, SGBV, MHPSS etc.)? Are men and women equally able and accepted to collect data?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Ensure that monitoring and evaluation activities include CHWs. 2. Ensure quality supervision systems are in place which identify any issues related to data quality and literacy 3. Ensure that data used for annual or regular performance appraisals are assessed for gender biases 4. Where significant differences in literacy levels between genders exist, ensure additional support to improve data collection and quality on data methods, or simplification of data reporting structures				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	5. Ensure that equal access for all CHWs to devices and training for data collections be ensured, as this will contribute to advancing skills, which are relevant for other jobs and for recognition and status. 6. Co-design data collection tools with CHWs and community insights 7. Ensure that socio and demographic data of CHWs is collected – and used in decision-making at the policy level. Collection of socio and demographic data on CHWs can help triangulate performance data and explain variations in caseloads and performances by CHWs. 8. Are there methods for detecting and eliminating unconscious gender-biases in data evaluation such as they relate to performance appraisals? 9. Consider existing difference in gender and education, literacy and use of technologies: design data systems which enable equal effective reporting by men and women				

R12: Types of CHWs

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R12: TYPES OF CHWS WHO guidelines recommend that polyvalent cadres are applied with specialized cadres to deal with specific target groups or issues as determined by epidemiology examples include HIV/TB, SGBV, MHPSS and NCDs, NTD eradication	See recommendations for selection of CHWs and target populations Do men and women CHWs differ in terms of: • Working with key populations or gender-related health issues • Access to means to travel to work with key populations or carry out specialized roles. • The types of services required, such as counselling, diagnosis, treatment, surveillance, assessment	How do gender roles in the home or community influence: • Suitability to provide specialized services • Availability of men and women CHWs to take up polyvalent or specialized roles • Exposure to risk factors in the course of their work?	To what extent do gender and social norms influence: • Assumptions about CHW roles • Suitability for voluntary or paid work or specific services? • How they are valued by community and by other health providers • Levels of influence on specialized health issues e.g. SGBV, HIV, NCDs • Perceptions regarding service competence and quality	What assumptions are being made at district and national political levels about the aptitude of men and women to provide generalised or specialised CHW roles?	See recommendations for selection of CHWs and target populations What barriers or gender-biases exist which might prevent one or other gender from taking on generalised or specialised roles? What specialised services are needed? Do these services have gender dimensions? What training might specialised cadres require in terms of gender-related issues (e.g. mental health and psychosocial support, HIV/AIDS, sexual health, TB, NCDs)? How do the health issues addressed by specialised CHW cadres differ by gender? What gender-related issues might arise in the course of carrying out specialised duties? Does specific protective equipment need to be issued based on specialised duties?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Ensure polyvalent cadres of CHWs are equally trained and supported to engage both men and women in the communities and households 2. When introducing a specialized cadre, if appropriate to conduct a local gender assessment around the health issue with men and boys or women and girls 3. Community sensitisation on elimination gender bias in relation to specific services				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	4. Prior to expanding the scope of CHWs, it is recommended that a gender assessment is conducted to explore extent to which views align with tasks required by CHWs. 5. If layperson is training as a CHW, it is recommended that a specialized pathway be implemented to encourage empowerment, appropriate supervision, and clinical governance				

R13: Community Engagement

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R13: COMMUNITY ENGAGEMENT WHO recommends the adoption of the following community engagement strategies in the context of practising CHW programmes: • pre-programme consultation with community leaders; • community participation in CHW selection; • monitoring of CHWs; • selection and priority setting of CHW activities; • support to community-based structures; • involvement of community representatives in decision-making, problem solving, planning and budgeting processes	To what extent does gender affect: • Men and women CHWs participation and influence in groups and community activities? • Ability to convene certain groups and populations for activities? • CHWs social capital? • Access to influential community members and leaders • Access to transport and communication channels?	To what extent do roles of men and women in the home or community impact time and availability for community engagement?	How do gender and social norms affect: • Community perception and trust • Credibility and influence over men and women's health choices • Freedom to speak openly in community places about certain issues (child marriage FGM, SGBV, IPV, and ASRH) without consequence. • Risk to personal safety or reputation • Perceived value in involving different stakeholders	To what extent do existing power relations impact: • Which community leaders are engaged to support mobilisation • How faith communities engage populations • How CHW activities are managed? • How men and women engage in community activities? • A CHW's influence over traditional power structures and faith-based communities • Access to research, data or guidelines on gender norms or gender-sensitive engagement	What are the gender dimensions of the issues CHWs are tasked to address? Do men, women, girls and boys have equal opportunities to be engaged in CHW activities (e.g. home visits, meetings)? If not, why not? What gender-related security issues may affect CHWs working in communities? What local government, services and local groups can be mobilised to support CHWs in engaging both men and women? What support structures are most influential over men and women community members? What community structures or leaders can be leveraged to promote equal participation of men and women? Do positive role models exist for men and boys and women and girls? How do educational materials reflect gender roles? How can these be adapted to promote family-inclusive/ gender-transformative concepts?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. During programme design and planning: • Conduct a gender analysis looking at traditional roles, norms and values. • Sensitise public services, local government and police on roles in protecting health workers, including women, ensure they respond where CHWs are victims of abuse. • Establish safe and confidential channels through which CHWs may report violence to the police or community leaders. • Identify all community groups, leadership and structures and engage them in gender-transformative program design, guided by analysis of the target community. 2. During community engagement and mobilisation: • Conduct a sensitisation session on power or gender, norms and values analysis be held with community and women's leaders • Consider targeting activities to ensure inclusion of the most vulnerable women and girls. • Both men and boys and women and girls are targeted during engagement activities and participation rates are disaggregated by these groups. • The value of the role of CHWs in community is elevated to counteract gender bias that reduce uptake, access to services. • Include sensitisation on sexual harassment and violence with community members, and give adequate attention to the personal security of CHWs in their deployment. • Safeguarding training for CHWs, including training on how to safely manage cases of SGBV and child abuse in communities. • The participation of men and boys in routine CHW activities including home visits is promoted. 3. When forming or mobilising community groups, committees and leadership structures ensure that: • Safe spaces are created for women to engage in community dialogue. • Community leadership committee composition is gender diverse, with clear gender parity, with representation of men and women CHWs at all levels • Role models for men and boys are identified and elevated to promote participation in CHWs activities, and ensure these roles are promoted by community and faith leaders • Disseminate information about services that a CHW can provide with respect to SRH sexual and reproductive health and gender-based violence.				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	4. During policy planning and financing ensure that: • Cell phones and credit are budgeted adequately for all CHWs • Security measures are in place for protection of CHWs if they experience any violence or threat in the course of their duties, including adequately sensitized police. • Pre-program consultation includes a participative vulnerability assessment with the community (i.e. Formative research). • Household and family engagement activities are men-inclusive • Gender norms and gender awareness be considered in programme design • Clear guidelines and tools for the conduct of Gender Analysis in community/CHW programmes is available • Data monitoring systems are able to measure the participation of different groups in CHW activities e.g. men participation in home visits • Ensure training materials are gender sensitive and promote gender equality to the extent possible • Design IEC materials and messages that depict a positive role for men and boys and promote gender-equity in caring for family health and nutrition				

R14: Mobilization of Community Resources

CHW GUIDELINES	GENDER ANALYSIS DOMAINS				PROGRAMMATIC GENDER ANALYSIS QUESTIONS
	ACCESS TO RESOURCES (financial, social, time, etc.)	DISTRIBUTION OF LABOUR, ROLES, PRACTICES	NORMS, VALUES, BELIEFS, PERCEPTIONS	RULES AND DECISION-MAKING POWER	
R14: MOBILIZATION OF COMMUNITY RESOURCES WHO suggests that CHWs contribute to mobilizing wider community resources for health by: • identifying priority health and social problems and developing and implementing corresponding action plans with the communities; • mobilizing and helping coordinate relevant local resources representing different stakeholders, sectors and civil society organizations to addresspriority health problems; • facilitating community participation in transparent evaluation and dissemination of routine community data and outcomes of interventions; • strengthening linkages between the community and health facilities	Are there differences between men and women in the following: • Access to and use of community resources? • Access to financial resources associated with community resources? • Ability to influence community resource allocation? • Are the professional needs of both men and women considered in determination of community resource mobilization?	Are there differences between men and women in the following: • Ability to engage in decision-making around mobilization of community resources due to family or other responsibilities?	To what extent do gender and social norms affect: • What is considered a community resource? • Who gets to decide, including activities or resources typically used by men or women?	To what extent do power relations within communities affect who is consulted? And to what extent the input if put into action. To what extent do men and women have equal decision-making power regarding the mobilization and utilization of community resources?	What community resources exist i.e.: • Financial resources and funds for support • Water sanitation and hygiene and infrastructures • Human resources: Volunteers and community groups, faith communities, care groups, microfinance, savings groups etc. Are there methods for detecting and eliminating unconscious gender-biases in use of resources?
COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS	1. Ensure that women in the community are consulted and part of decisions making. Try to get a broad participative consultation of women and men, young and old. Considering power relations, create and safe spaces for everyone to speak without fear of consequence. Try to uncover other diversity issues in the community. 2. Consider biases in the value put on different opinions and if all viewpoints are considered equally? Is input from certain groups being prematurely dismissed?				
HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS	3. Health systems should encourage community partnership in local level resource contribution.				

R15: Availability of supplies

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<tr><td>R15: AVAILABILITY OF SUPPLIES

WHO suggests using the following strategies for ensuring adequate availability of commodities and consumable supplies, quality assurance, and appropriate storage, stocking and waste management in the context of CHW programmes:
• integration in the overall health supply chain;
• adequate reporting, supervision, compensation, work environment management, appropriate training and feedback, and team quality improvement meetings;
• availability of mHealth to support different supply chain functions</td><td>To what extent are women's health-related drugs/medical supplies in stock? i.e. supplies specific to women's heath, such as menstrual hygiene products often not included within content.</td><td>To what extent does the availability of men or women CHWs affect the distribution of certain supplies?
To what extent are men and women CHWs expected to distribute certain supplies?</td><td>To what extent do gender and social norms affect:
• Whether men or women CHWs can distribute female or male related health supplies, including condoms, menstrual hygiene products, etc.?
• Availability and appropriateness of supplies?</td><td>To what extent do men and women have equal decision-making regarding what supplies are procured and distributed?</td><td>What types of medical commodities and supplies are required to meet the health needs of men and women?
Does the gender of CHWs affect acceptability by the target population? e.g. condoms, family planning commodities, menstrual hygiene kits etc.</td></tr>
<tr><td>COMMUNITY-LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">1. Ensure that CHWs are equipped with adequate supplies that meet the needs of their populations: men, women and youth, in line with their training and role expectations.
2. Ensure that women-related drugs/medical supplies are prioritized to be in stock.
3. Ensure that norms around which supplies may be distributed to and by whom are addressed.
4. Ensure that a gender assessment of a community content is conducted to see which supplies are appropriate and accepted by the community.</td></tr>
<tr><td>HEALTH-SYSTEM LEVEL ACTIONS/ RECOMMENDATIONS</td><td colspan="5">5. Include policies for the distribution of materials and supplies that detect and prevent gender biases in distribution</td></tr>
</table>

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