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Review Article

The Role and Impact of Female Health Workers on the Well-Being of Global South Communities: A Call for Gender-Transformative Action

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Abstract

One of the cornerstones of a sustainable health system is the presence of a strong primary health care sector; it is important to recognize the central role that universal health coverage has in achieving the Sustainable Development Goals. The 2030 Agenda for Sustainable Development has set its vision to 'leave no one behind'. In particular, Sustainable Development Goal No. 3 and its targets (intended to ensure healthy lives and promote well-being for all people of all ages) will advance through substantial strategic investments in the global health workforce. There is, therefore, a need to address issues related to both the shortage and maldistribution of the health workforce and performance challenges in order to promote universal health care and improve all health-related goals. Many countries have adopted the concept of 'task-shifting', through the involvement of lay and community health workers as a rational strategy for addressing the shortage in human resources, impeding the roll-out of primary care programs in these countries. Anchored on the models of task-shifting and task-sharing, this paper explores the role and impact of female Community Health Workers (CHWs) to the well-being of communities in the 'Global South' (a term generally used to identify regions of Latin America, Asia, Africa, and Oceania. Findings revealed the well-known gaps that affect gender-transformative action for women, including occupational segregation, harassment, the gender pay-gap and leadership challenges in the health and social workforce, yet programmatic focus on maternal and newborn health and wellness in Global South communities are the most highly impacted by female CHWs.

Keywords: *Women, Health workers, Developing countries*

Introduction

In 1969, progressive social activist, Carl Oglesby, coined the term 'Global South', a broad term often referring to poor and/or socio-economically marginalized parts of the world and is generally understood to mean developing countries, underdeveloped countries, low-income economies or, the least-favored term, Third-World countries. It would include formerly colonized countries in Africa and Latin America, as well as the in the Middle East, Brazil, India, and parts of Asia.

The 2030 Agenda for Sustainable Development has set its vision to 'leave no one behind'. In particular, Sustainable Development Goal No. 3 and its targets (intended to ensure healthy lives and promote well-being for all people of all ages) will be advanced through substantial strategic investments in the global health workforce. To ensure a diverse mix of sustainable skillsets, interprofessional primary care teams of health workers would be trained and deployed as part of greater efforts to strengthen primary health care, supported by strong health systems that enable and empower the health workforce to deliver safe and high-quality care for all [1]. The WHO's General Director, Tedros Adhanom Ghebreyesus, emphasizes the "triple billion" targets of the new five-year strategic plan, which include: one billion more people benefiting from universal health coverage; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being [2].

Strengthening Primary Health in Universal Health Care

A strong primary health care sector is one of the cornerstones of a sustainable health system; it is important to recognize the vital role of universal health coverage as part of achieving the Sustainable Development Goals. The 2008 Alma-Ata Declaration on Primary Health Care (PHC) had eight essential components, including (a) health education, focusing on the prevailing health problems and methods of preventing and controlling them; (b) nutritional promotion, including food supply; (c) supplying adequate safe water and sanitation; (d) maternal and child health care; (e) immunization against major infectious diseases; (f) prevention and control of locally endemic diseases; (g) appropriate treatment for common diseases and injuries; and (h) provision of essential drugs [3]. Community Health Workers (CHWs) in primary care settings are integral to building strong, resilient, and safe primary health care systems that contribute to the achievement of the interrelated Sustainable Development Goals

and targets that include: nutrition (SDG 2), health (SDG 3), education (SDG 4), gender equality (SDG 5), employment (SDG 8), and reducing inequalities (SDG 10) [4].

There is, therefore, a need to address issues related to the shortage and maldistribution of the health workforce and performance challenges in order to promote universal health care and improve all health-related goals. The Global Strategy on Human Resources for Health: Workforce 2030 passed a resolution (WHA69.19) in 2016 identifying the opportunity to boost the performance, quality, and impact of CHWs for the achievement of universal health coverage and sustainable development goals [5]. Furthermore, many countries have adopted the concept of 'task-shifting', through the involvement of lay and community health workers as a rational strategy for addressing the shortage in human resources, impeding the roll-out of primary care programs in these countries [6]. Task-shifting makes use of already available human resources by delegating tasks requiring high skills to health workers with lower qualifications.

During the UN General Assembly in September 2015, the four pillars of the Decent Work Agenda - employment creation, social protection, rights at work, and social dialogue - became integral elements of the new 2030 Agenda for Sustainable Development [7,8]. The United Nations High-Level Commission on Health Employment and Economic Growth recognized the potential of the health sector to create opportunities for qualified employment, through job creation, that contributes to the economic development agenda [9]. This was reaffirmed in 2017 by the resolution on human resources for health (WHA70.6), which called to "stimulate investments in creating decent health and social jobs with the right skills, in the right numbers and in the right places, particularly in countries facing the greatest challenges in attaining universal health coverage." In 2018, the World Health Organization adopted the evidence-based *Guideline on health policy and system support to optimize community health worker programs* [10]. In 2019, the World Health Assembly passed a landmark resolution on CHWs (WHA72.3), highlighting their role "to assure that universal health coverage and comprehensive health services reach difficult-to-access areas and vulnerable populations" and their role in "advancing equitable access to safe, comprehensive health services [11].

Community Health Worker Programmes

By the year 2030, it is projected that there will be a global shortage of almost 18 million health workers [2]. Demographic changes and rising health care demands are expected to drive the creation of 40 million new jobs by 2030 in the global health and social sectors [7]. The key to reversing this trend and promoting health efforts is to invest in female CHWs through education, training, and employment [12]. However, before investing public resources in activities such as curriculum development and certification, documentation of the effectiveness of these workers making an impact on important health concerns is required [13,14]. CHWs are comprised of various community health aides who are not trained health professionals, albeit trusted and respected, and able to provide a link between people's homes and formal government Primary Health Care (PHC) clinics, thereby engaging in task-shifting and task-sharing [15,16]. These CHWs are usually trained to deliver basic health-related interventions and services within their own community; it is difficult to generalize one universal title for all CHWs, as their specific job responsibilities within their local cultures and health systems vary (e.g., traditional birth attendant, lay health advisor, community care coordinator, community health volunteer, lactation consultant, family service worker, *barangay* [village] health worker, village doctors, health advocates, *promotor de salud* [health promoter], *consejera/animadora* [counselor/organizer], maternal/infant health outreach specialist, patient navigator, peer educator, public health aide, neighborhood health advisor, *shasthya shebika*, etc.) [17-19]. The efficacy of CHWs in reducing the burden of care in under-staffed and under-resourced health systems remains a point of dialogue, with varying perceptions regarding their value.

National CHW programs comprise the foundational component for achieving universal access to primary healthcare [6]. In 2014, a group of experts produced a guide for developing and strengthening CHW programs, at scale, that drew heavily on previous experiences with CHW programs [20]. In 2017, this same group of experts produced 13 case studies of national CHW programs [21]. The compendium *Health for the People: National Community Health Worker Programs from Afghanistan to Zimbabwe* updated and broadened the 2017 case studies of national CHW programs to include the following 29 countries: Afghanistan, Bangladesh, Brazil, Ethiopia, Ghana, Guatemala, India, Indonesia, Iran, Kenya, Liberia, Madagascar, Malawi, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Rwanda, Sierra Leone, South Africa, Tanzania, Thailand, Uganda, Zambia, and Zimbabwe. Each case study has at least one author who has personal in-country experience with the program being described [22].

This expanding list of countries, with large-scale and stable CHW programs, provides growing evidence of the effectiveness of CHWs in achieving specific health outcomes and a renewed global confidence in CHWs [23-25]. A number of significant international consensus statements have recommended that CHW programs be integrated into health systems, increasingly linking these to the concept of Universal Health Coverage (UHC) [26-28].

CHWs and CHW programs encompass a broad concept and umbrella of practices that are driven by different imperatives to deliver a diverse array of programmatic priorities, roles, and forms of community involvement in health and healthcare delivery. CHW initiatives have taken a variety of regional- and country-specific forms. Some, such as the Brazilian Programa Saúde da Famiília [6,25,29], Ethiopia's health extension workers [16,30] and the Behvarzs of Iran [31], the BRAC's *Shasthya Shebika* Program of Bangladesh [16,19,32], the Lady Health Workers of Pakistan [33,34] and the Community Health Assistants of Liberia [20,22] have been part of broader social, political, and health sector changes, established in response to the public health challenge of high maternal, neonatal, and under-five mortality. The overwhelming care and social needs in southern African countries afflicted with HIV engendered home-based care and support that emerged organically through local community and non-governmental organizations. In other African countries, Global Health Initiatives and partnerships focused on malaria and childhood diseases.

There are several models for governance in CHW programmes, which may be either 1) integrated, 2) networked, or 3) detached from the formal health systems; each has its implications on how programmes obtain funding, select and train CHWs, support and supervise CHWs, pay CHWs, and how the programs involve communities.

The Brazil Programa Saúde da Família [PSF] and the Health Extension Worker [HEW] programmes in Ethiopia are integrated with the formal health system and obtain support from within the system. India's Accredited Social Health Activists [ASHA] CHW program and the Building Resources Across Communities (BRAC) CHW program in Bangladesh do not belong to any formal facility-based health system, however, they have networked structures that link to the system. Non-governmental organizations (NGOs) run the CHW programs in South Africa and are centrally driven within established parameters at the national level but are run through separate structures.

Female CHW at the Forefront in the Global South

The 'Shasthya Shebika' Program of Bangladesh

Bangladesh traces a long history of productive collaboration between the government and NGOs on CHW programs, and a strong community engagement in development programs. The Building Resources Across Communities (BRAC) CHW program, of national scope, consists of two cadres of female CHWs (*Shasthya Shebikas* [SSs] and *Shasthya Kormis* [SKs]) that complement the government's three CHW cadres, i.e., the Family Welfare Assistants, the Health Assistants, and the Community Health Care Providers.

The BRAC's *Shasthya Shebika* Program has been an integral part of the country's healthcare system for more than three decades and is widely seen as having made key contributions to Bangladesh's remarkable achievements in reducing maternal and child mortality and controlling tuberculosis [19]. During monthly household visits, SSs provide health promotion sessions, educating families on safe delivery, family planning, immunizations, hygiene, and water and sanitation. A referral system to government facilities or BRAC clinics has been established for patients with illnesses that the CHW cannot manage. Over 110 million people in Bangladesh have benefited from BRAC community-based integrated programs.

Bangladesh's experience is exemplary because of its record two-thirds decline between 1990 and 2015 in the mortality of children younger than five years of age. It has achieved a significantly high contraceptive prevalence rate of 62% and a fertility rate of only 2.1 births per woman, to which female CHWs have made major contributions. Home visits by female CHWs have, likewise, improved the distribution of Micronutrient Powder (MNP) within communities [32].

The Brazil Programa Saúde da Família

Officially launched in 1994, the Brazil Programa Saúde da Família (*Family Health Program*, now called the *Family Health Strategy* and abbreviated as PSF), builds upon several decades of experience in rural underserved areas with Community Health Agents (CHAs). CHAs are full-time government employees who engage in monthly home visits for health promotion, surveillance, and linkage to the facility-based health system. CHAs form Family Health Teams together with other CHAs, nurses, and a physician based at a nearby health center [22]. By 2002, CHAs were officially recognized as professionals by Law No. 10.507 [29].

Brazil's health status is one of the best in the world, and it is one of the few countries in the world that has eliminated socioeconomic disparities in the nutritional status of children that result in childhood stunting. Expanded access to services has also resulted in marked reductions in maternal, infant, and child mortality [22]. The country's CHAs are seen as critical to this achievement through their promotion of maternal and child health by educating families on appropriate household behaviors (including good nutrition) and linking families to needed health services [6].

The Community Health Extension Program of Ethiopia

Ethiopia began its current CHW program (HEP) in 2003, although the country's experimentation with CHW models dates back to the 1950s. Its dual cadre CHW program consists of professionalized Health Extension Workers (HEWs) and the Women's Health Development Army (HDA) volunteers. HEWs undergo twelve-month training before they are deployed as salaried government employees, with benefits, and serve a catchment of approximately 2,500 people. The HDA volunteers, on the other hand, each serve five to ten households and form health development teams (HDTs) that comprise up to thirty households residing in the same neighborhood. More than 42,000 government-salaried female HEWs are deployed in the country to provide key health services through outreach activities. They are expected to spend 25% of their working time conducting home visits and outreach activities, and the remaining 25% at health posts providing basic curative, promotive, and preventive services [22].

Ethiopia's advances in reproductive, maternal, and child health have been outstanding since the implementation of the HEP. Ethiopia's CHWs have been the foundation for these advances, leading to a rapid rise in the contraceptive prevalence rate from only 5% (when the HEWs were first introduced) to 40% at present. Ethiopia's CHWs impacted a two-thirds decline in the mortality of children younger than five years of age between 1990 and 2015. Ethiopia is also remarkable for the role of HEWs and HDA volunteers in the control of HIV/AIDS, malaria, and tuberculosis, all of which have improved remarkably since the introduction of HEWs [30].

The ASHA Programme in India

India's Accredited Social Health Activist (ASHA) programme was launched by the National Health Mission (NHM) in 2005 [formerly known as the National Rural Health Mission (NRHM)], in line with its policy of community engagement to ensure people's participation in health, especially among the marginalized communities. Women between 25 and 45 years are preferentially recruited as ASHAs, based on leadership and communication skills. Each ASHA functions as a 'health care facilitator, service provider, and health activist' and is deployed and expected to conduct health promotion activities for at least 1,000 people in a village [35].

ASHAs' activities in Reproductive, Maternal, Neonatal, and Child Health (RMNCH) include maintaining pregnancy registration records, holding village-level health meetings, motivating and escorting women to access Antenatal Care (ANC) and facility-based delivery, providing post-natal care, promoting and facilitating the use of birth spacing methods, immunizations, and counseling about pregnancy-related issues, including anemia management, and distributing iron tablets, sanitary napkins, contraceptives, and pregnancy kits. The ASHAs' efforts were strongly correlated with the utilization of maternity services, specifically with the improved utilization of at least one antenatal care visit, skilled birth attendance, and giving birth in a health facility [36].

The Female CHW of Afghanistan

The Village Health Council (VHC), or Health *Shu'ara*, nominates the Community Health Workers (CHWs) in Afghanistan as part of the country's national health care system. They make up the majority of the health workforce in the remote areas of this country and are often the first point of contact for most of the basic health needs of the communities. The Basic Package of Health Services for the Afghanistan (BPHS) initiative only requires the CHWs to undergo highly targeted, multi-phase training for a minimum period of eight weeks to learn about the management of basic illnesses [37]. Because of limited female mobility in Afghanistan, due to cultural and religious norms, the BPHS initiative employs CHW couples/partner groups, whereby female CHWs are often accompanied by a *Mahram* - usually their husband, brother, or father who acts as a male religious guardian, in order to ensure that health services are delivered efficiently [38].

The Lady Health Workers of Pakistan

The Pakistan Lady Health Worker (LHW) programme (The Pakistan National Program for Family Planning and Primary Health Care), was started in 1994 with a staff of nearly 30,000 women. Over the years, it has expanded to more than 125,000 employees, deployed in all districts of the country. Patriarchal normative proscriptions of seclusion forbid women's access to health care facilities, hence the LHWs need to provide door-step reproductive health services in a context where socio-cultural factors such as gendered norms and extended family relationships and *biradari*/caste-based hierarchies impact rural women's mobility patterns and LHWs' home-visit rates. Lady Health Workers have, likewise, successfully provided cognitive-behavioral interventions for postpartum depression. Approximately 60-70% of rural areas and urban slum populations are benefited by the programme [33,34].

Female Community Health Volunteers of Nepal

Some 53,000 female community health volunteer workers (FCHV), serving 125 households, comprise the Female Community Health Volunteers of Nepal since the commencement of the programme in 1988. The foci of their tasks are safe motherhood, child health, family planning and immunization. Their basic training course usually lasts for 18 days. After completion of training, FCHVs are provided a certificate from the Ministry of Health, and a medicine kit that includes oral rehydration solution packets and oral supplements such as vitamin A and iron. They are provided an identity card and a register with 30 to 40 indicators to be recorded, including maternal, infant, and child deaths, and details of vertical programmes in their areas [7,39].

The Community Health Workers in South Africa

In 2011, the South African (SA) National Department of Health (NDOH) launched 'The Re-engineering of Primary Health Care' policy, which relies heavily on CHWs, to reduce maternal and child mortality and improve access to health care [39,40]. Local communities and Non-Governmental Organizations (NGOs) responded to overwhelming care and social needs in the HIV-affected countries of southern Africa and provided home-based care and support that emerged organically. Global Health Initiatives and partnerships in other African countries, focused on malaria and the promotion of integrated Community Case Management (iCCM) of childhood illness. CHWs and CHW programmes in South Africa are, thus, a broad umbrella concept and practice under which a diverse array of programmatic priorities, roles, and forms of community involvement in health and health care delivery exist. The Philani Plus (+) Intervention Program builds upon the original Philani CHW home-visiting intervention program for maternal and child nutrition by integrating content and activities to address HIV, alcohol, and mental health [41].

The Barangay Health Workers in the Philippines

The Philippines was an early adopter of the CHW model for the delivery of PHC, launching the Barangay (village) Health Worker (BHW) programme in the early 1980s. Operating at the level of *barangays* or villages, the smallest unit of governance in the Philippines, volunteer Barangay Health Workers (BHWs) has evolved to become an essential component of the nation's healthcare workforce. In 1995, the Philippine Congress passed Republic Act 7883 (The BHWs' Benefits and Incentives Act) aimed to empower BHWs to self-organize, strengthen, and systematize their services to communities, and create a forum for sharing experiences and recommending policies and guidelines. In most areas of the country, BHWs are often exclusively female. This points to yet another symbolic factor that impacts and limits wider participation in the BHW programme, i.e., the persistent effect of cultural patriarchy on women's labor force participation in the Philippines. Despite the country's world-leading performance on several key indicators of gender equality, the most recent figures for 2019 indicate that just under half of all Filipinas above 15 years of age are actively employed, placing the Philippines in the bottom third of over 180 nations [18].

The Impact of Women in the Health Care Workforce

Women comprise a large part of the community healthcare workforce, with approximately 67% of the health workforce in 104 countries being female. Gender distribution by occupation across all regions exhibits systematic professional differences, with males comprising the majority of physicians, dentists, and pharmacists, while females comprise the majority in the nursing and midwifery workforce [42]. This is confirmed by the report "Delivered by women, led by men: A gender and equity analysis of the global health and social workforce," that female health workers are relegated to a lower status, with lower pay or, often, into unpaid roles, while facing harsh realities of gender bias and harassment [7].

For World Patient Safety Day, 17 September 2021, the WHO urged all stakeholders to "act now for safe and respectful childbirth!" with the theme "Safe maternal and newborn care" [43]. Approximately 810 women die every day from preventable causes related to pregnancy and childbirth. Aligned with this thrust are the programmatic foci on maternal and newborn health and wellness in communities that are the most highly impacted by female CHWs [1,44]. These include birth preparedness and distribution of misoprostol to prevent postpartum hemorrhage among mothers who deliver at home [45], postnatal home visiting, umbilical cord care, thermal care, promotion of exclusive breastfeeding, and prevention of neonatal sepsis through prompt treatment of neonatal infection [46-69] and support to mothers and infants for the prevention of mother to child transmission of HIV [50,51]. Promotion of child health, including uptake of immunization [52] nutrition, including breastfeeding, micronutrient supplementation and supplemental feeding [53], community management of malnutrition [54], and early childhood development [55]. The Integrated Community Case Management (iCCM) of childhood illness combines the diagnosis and treatment of malaria with Artemisinin Combination Therapy (ACT), pneumonia with oral antibiotics, and diarrhea with zinc and Oral Rehydration Salts (ORS) [56].

Gender-transformative Action for Female CHWs

There is no doubt about the role and significance of women in society. On the 8th of March, every year, the United Nations celebrates Women's Day around the world to honor the achievements of women in all areas of life-social, economic, and cultural. The main purpose of the day is to honor the accomplishments of women while also raising awareness about gender bias. Recognized gaps that affect gender-transformative action for women include occupational segregation, harassment, the gender pay gap, and leadership challenges in the health and social workforce.

Systemic issues in the health workforce workplace include: gender biases, discrimination, and inequities leading to occupational segregation by gender [7,42]. In many organizations, female health workers are not allowed maternity leave, because they expect women to fit into systems designed for male life patterns and gender roles. Many countries still lack legal and social protection for women on issues that underpin gender equality at work, such as gender discrimination, sexual harassment, and equal pay [12]. The theme for the 2022 United Nations International Women's Day is: "'Break the Bias' - #BreakTheBias"-calling for 'gender equality today for a sustainable tomorrow'.

The stigma and fear of retaliation inhibit female health workers from reporting workplace violence and sexual harassment. Violence and harassment - often from male colleagues, male patients, and even random members of the community - harm women physically and psychologically, cause attrition, low morale, and their ill-health impacts their ability to deliver the quality of care necessary for caring for others [38].

Occupational segregation drives a gender pay gap that is larger than in many other economic sectors, thus robbing women of decent work [8]. Women in the health care sector earn, on average, 28% less than men, with occupational segregation alone driving a 10% pay gap. When multiplied over a lifetime, this pay gap translates into poverty for many women during their older years. It is estimated that women in the health care workforce contribute 5% to the global Gross Domestic Product (GDP) - approximating US$ 3 trillion - annually, out of which almost 50% is unrecognized and unpaid. It is an unsettling fact that health systems are currently subsidized by the unpaid work done by women CHWs delivering care to families and others in their communities.

Occupational segregation by gender also means that health systems fail to take advantage of female talent and perspectives in particular specializations and in leadership. A significant challenge to gender-transformative change in the health workforce is women's relative absence from decision-making and leadership positions. Representation of women in decision-making positions in global health organizations remains low, with only 25% having gender parity at senior management levels and 20% of organizations having gender parity in their governing bodies [57,58]. Health systems are stronger when the women who deliver healthcare have an equal say in the design and delivery of the systems they know best. Investments in the health workforce lead to the economic empowerment of women with a projected 9:1 return on investments [5]. Highlighting the impact that girls and women, worldwide, have in their roles as healthcare workers, caregivers, innovators, and community organizers during the COVID-19 pandemic, the 2021 United Nations theme for International Women's Day was "Women in leadership: Achieving an equal future in a COVID-19 world" [59]. According to the International Labor Organization, or ILO's Decent Work Agenda, the four pillars of decent work are: promoting jobs and enterprise, guaranteeing rights at work, extending social protection and promoting social dialogue. Indeed, much still needs to be done to advocate for gender equity in the health workforce and advance the cause for Decent Work among female community health workers in the Global South.

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