

## Addressing Gender Inequality in Human Resources for Health

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### Introduction

The public health workforce in developing countries is predominantly female. Addressing gender discrimination and inequality in human resources for health (HRH) policy and planning, workforce development and workplace support is essential in tackling the complex challenges of improving access to services, by positively influencing HRH recruitment, retention and productivity.

This brief reviews how the Capacity Project addressed gender discrimination and inequality in HRH through its institutional mechanisms, approaches and tools as well as in country-level implementation.

### Approaches and Activities: 2004–2009

#### Phase 1: Developing the Project's Gender Strategy, Tools and Staff Capacity

Initial activities focused on developing the Capacity Project's strategy to address gender-related barriers to women's and men's participation in the health workforce that affect health worker entry, safety, professional satisfaction, rights at work, productivity and retention. The Project's gender advisor worked with "country point people" (e.g., technical staff at headquarters overseeing country programs) to integrate gender analyses and training in country proposal and evaluation plans and in the Project's performance monitoring plan, and created guidelines for gender analysis in country situational analyses and workforce assessments. The Project's intermediate results areas provided the entry point for the gender strategy.

During the Project's start-up phase, the USAID Interagency Gender Working Group (IGWG) Training Team provided technical expertise and support. IGWG members helped the Project's gender advisor develop a gender and HRH orientation module for headquarters staff and adapt existing IGWG gender integration training materials for reproductive health programs to the area of HRH, including an advocacy module. This collaboration resulted in the implementation of these modules, raising staff awareness about gender and HRH, providing a common language and identifying potential entry points in country projects under development<sup>1</sup>.

Gender-based violence became a focus of the Project's attention because it was a priority area for the IGWG and because it represented a concrete issue that can be addressed by health workers

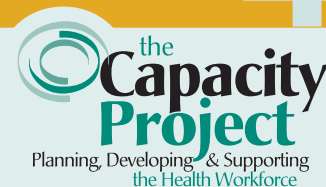
through pre-service education and in-service training. Project staff conducted a literature review on workplace violence<sup>2</sup> in health and other sectors, drawing on developed and developing country data. Other activities included sensitizing Project staff to gender-based violence to facilitate integration in key technical areas; preparing a resource paper on best practice training modules for addressing gender-based violence; developing a gender-based violence sensitization module for HRH leaders; and producing a compendium of gender-sensitive HR policies that could be adapted to country settings<sup>3</sup>.

#### Phase II: Moving to the Field

In one of the earliest efforts to begin moving gender activities to the field, the gender advisor worked with the manager of the Project's study on health worker retention in Uganda to integrate questions about violence and sexual harassment into the survey questionnaire. Twenty-four percent of health workers, most of them female nurses, reported that they had been abused sexually, physically, verbally or emotionally by a supervisor or others. These findings were subsequently addressed in Uganda's occupational health and safety policy guidelines.

Also in the first phase of the Project, the gender advisor and other technical staff had established strong working relationships with field leaders in Rwanda and Lesotho, which resulted in the development of two seminal research studies exploring gender discrimination in HRH and the hiring of a dedicated Gender Focal Point staff member in Rwanda who had extensive local networks for mobilization. The gender advisor provided a gender orientation to the Rwanda country office and partnered with the nursing school team leader to assess the gender sensitivity of the national nursing school curriculum. The nursing team leader then developed and disseminated a reference document on gender and health, including gender-based violence, for nursing school tutors to use across curriculum content areas. Concurrently, the Project assisted the Rwandan ministries of health and labor to conduct a study on workplace violence and gender discrimination.

*Workplace violence:* The Project's study focused on determining the contributors to, and HRH consequences of, workplace violence in the Rwandan health sector; examining the role played by gender discrimination; and assisting government ministries and other stakeholders to plan improvements to safety, security, equity,



### The Capacity Project's gender strategy objectives:

- 1) Strengthen HRH policy and planning to promote gender equality
- 2) Increase gender integration in education, training and work
- 3) Create supportive, fair and safe work environments.

## Workplace Violence in the Health Sector of Rwanda

*The study produced sobering results: 39% of Rwandan health workers surveyed had been subject to at least one form of workplace violence in the last year. Sexual harassment, while not the most prevalent at 7% of respondents, was the most frequent form of violence experienced.*

*Evidence showed discrimination because of pregnancy and other forms of gender discrimination such as negative stereotypes of female health workers (e.g., a perceived unwillingness to speak up, weakness, indecisiveness and incompetence) and vertical segregation of the health facility director's job ("the glass ceiling").*

*The study showed workplace violence impacted mainly on workers' psychological health, followed by absenteeism, poor interpersonal/work relations and resignation by female workers following bullying and sexual harassment. Gender equality was associated with lower odds of experiencing violence.*

productivity, job satisfaction and retention at work. The Project used a multisectoral, participatory and capacity-building approach to conduct the study. It identified ministry partners and focal institutions, oriented these future users of the study results to workplace violence and gender discrimination and solicited their input on the study tools and data analysis. The focal institutions were also involved in results validation and dissemination to their institutions and nationally.

*Men as providers of HIV/AIDS care:* During the third year, the Project collaborated with the Lesotho Ministry of Health and Social Welfare on a study to develop, implement and evaluate strategies to attract men into the HIV community health worker cadre in order to increase men's participation in a "female identified" job and, in so doing, address the critical shortage of health workers. A Project literature review on gender segregation in health occupations identified potential barriers to men's involvement in HIV/AIDS caregiving.

The study reinforced the Ministry's capacity to plan for a larger, less gender-segregated HIV/AIDS workforce by applying Lesotho's Gender and Development Policy within the context of the national HIV/AIDS strategy, which promotes men's sharing the burden of HIV/AIDS care through gender redistributive actions at national, district and community levels. A Capacity Project team interviewed potential results users and conducted formative research to develop the tools, which reflected gender analysis domains, and implemented the study through the University of Lesotho. The study found that caregiving is not gender-neutral. Men were extremely underrepresented in the unpaid, largely invisible caregiving workforce because of a nexus of gender stereotypes about essential "male" and "female" traits and status beliefs that kept women in the job and men out of it. Female community health workers reported feeling crushed by the burdens of community caregiving and their own household responsibilities, and younger recruits were unwilling to enter this job. The Project trained study stakeholders in gender and HRH at the time of results dissemination. Recommendations for policies and programs included that they needed to explicitly promote an equal or more equitable division of responsibilities between women and men; provide standardized resources, incentives and protections, meet health worker shortages; and continue to strengthen women's capacity to care for those affected by HIV/AIDS.

*Data for decision-making:* Sex disaggregated data and gender-related policy issues are referenced in the Project's human resources information system (HRIS) Toolkit<sup>4</sup> and figure in lists of policy questions and data collection tools. The standard HRIS workshop presentation included among the top five policy questions to be answered by data: "What is the gender distribution of staff? What are the relative average salaries and promotion rates? A key example in data for

decision-making training included discussion of the sex differential in students entering nursing training in the north and south of Uganda.

At the country level, sex-disaggregated data can answer HRH leaders' questions about men's and women's participation in education, training and the health labor market; gender inequalities in wages, promotions and health system management; and graduations and licensure by sex and age. With this information, HRH leaders can make policy decisions or take action to redress imbalances or inequalities. The Capacity Project's HRIS strengthening program—implemented in Botswana, Kenya, Lesotho, Namibia, Rwanda, Southern Sudan, Swaziland, Tanzania/Zanzibar and Uganda—drew on a literature search on the requirements of gender-sensitive HRIS and promoted sex-disaggregation in the data collection process at all levels. In Uganda, Kenya, Swaziland, Rwanda, and at a regional data-driven decision-making workshop, we used actual sex-disaggregated data from represented countries to illustrate gender issues for policy improvement. Even if countries may not yet be using sex-disaggregated data regularly, this work laid the foundation for use of such data and we know there is interest in the field in doing so.

*Empowering leaders:* The Project also intensified efforts to strengthen professional associations in Uganda, Kenya and Ukraine. Professional associations have been noted as an empowerment mechanism for allowing female health workers such as nurses and midwives to "take on leadership roles that might otherwise be unavailable to them" (McQuide et al., 2007), represent the interests of their profession, influence national and local health policy, engage in collective bargaining, ensure the highest possible standards of care and improve working conditions. As one example, Project activities in Uganda strengthened the primarily female nursing association's capacity to interact with the media and policy-makers through advocacy, communication and leadership skills development. Nursing leaders held a press conference to communicate messages about an Ebola outbreak and used data to make a stronger case at the Ministry of Health for supplies and other resources, so that a strike was avoided.

*Enhancing the constructive engagement of men:* The Project undertook a new initiative in the fourth year to develop health workers' capacity to engage men in family planning, antenatal care, prevention of mother-to-child transmission of HIV and antiretroviral therapy services through improved couples counseling in Rwanda. The Project partnered with the Rwanda Ministry of Health and the USAID HIV/AIDS Clinical Services Project in four districts, and drew on gender-related components of Rwanda's National Reproductive Health, Family Planning and Violence against Women and Children policies to identify gender-equitable messages that service providers can communicate through couples counseling.

Baseline results, serving as a gender analysis, showed that while men's health service use is

very low, almost all health-related decision-making rests with the man in the couple while responsibility for implementing decisions lies mainly with the woman. Couples counseling is almost nonexistent and violence against women is common, considered normative and perceived to result from family planning use, men's infidelity and polygamy, alcoholism, greediness and refusal of voluntary counseling and testing and treatment. Information, education and communications (IEC) messages were formulated to address these issues through a provider flipchart and client booklet. Follow-up assessments showed that clients perceived the couples counseling and IEC materials in a positive light, and suggested that family planning utilization by men had increased. The IEC materials were used in additional service sites, but lack of performance support subsequently resulted in diminished use of materials.

### Phase III: Sustaining Country Efforts

Based on the findings of the Rwanda workplace violence study, the Ministry of Health recommended conducting an in-depth study on pregnancy discrimination, developing a workplace violence policy for the health sector and implementing a training program on workplace violence for health providers and managers. The Ministry of Labor asked the Project to provide technical assistance to apply study results in the formulation of a national Workplace Safety and Security Policy that addressed gender discrimination. The Project continued to advocate for funding to implement these activities, which have the potential to make an impact where it matters—in health workplaces. Study results were channeled through the Rwanda Medical and Nurses Associations, which increased support for a health sector policy for the prevention and management of violence at work. Later, the results contributed to the revision of the national "Law (No 13/2009 of 27/05/2009) Regulating Labor in Rwanda," with specific articles prohibiting gender-based violence (article 9) and gender discrimination (article 24) in the workplace. The law outlines definitions, prevention requirements, penalties and rights of victims to claim damages.

In Lesotho, the Project later disseminated study results to the UN Theme Group on Gender, which subsequently influenced proposed revisions of Lesotho's 2003 Gender and Development Policy. Revisions will address HIV/AIDS care and support as an area of priority under "Gender and Health," serve as a basis for advocacy programs to promote the value of caregiving and set the stage for educational or capacity-building programs to educate men and boys on sharing of care responsibilities as well as promoting positive images of men and boys engaged in care work. The results also contributed to discussions between the Ministry of Gender, Youth, Sports and Recreation and the National Curriculum Development Centre on the need to improve the gender transformativeness of health provider training curricula. The study report recommends ways to translate research results and policy into programmatic practice in

the community—the ultimate site of increased gender equity in HIV/AIDS caregiving.

### Conclusions

Gender is a key factor in planning, developing and supporting the (largely female) health workforce in limited resource settings. The Capacity Project contributed new research methodologies, new knowledge about the impact of gender in the health workforce, practical gender and HRH mainstreaming tools and lessons learned about how to address gender in global and country HRH projects in concrete and effective ways. The Project built gender capacity, used gender data, worked with country stakeholders to improve national approaches to gender and HR, responded to USAID's Office of Population and Reproductive Health's cross-cutting priority areas of gender, poverty and equity, and Repositioning Family Planning, and applied PEPFAR's five gender strategies to local HRH problems (e.g., reducing violence, addressing male norms and behaviors, increasing equity in HIV/AIDS services, increasing women's legal protection and access to income [Ashburn et al., 2009]). The Project linked gender inequities and inequality to workforce entry, retention and productivity and contributed to policy changes in Lesotho and Rwanda.

Keys to success included having champions—the headquarters gender advisor, the Rwanda Gender Focal Point, and technical advisors who are willing to take leadership in integrating gender (e.g., in HRIS and e-learning)—in place at innovation and implementation points. It was also important to identify other leadership champions at Project headquarters and in the field, provide accountability mechanisms (e.g., indicators in the performance monitoring plan) for taking gender equality seriously and leverage funding. The Project successfully leveraged political will exerted by field leaders, which can be particularly effective in furthering gender equity and equality in projects and country programs.

The Project also demonstrated how to move gender out of a minimalist conception of the "cross-cutting issue" into the realm of an essential promising HRH practice. The initial focus on internal mainstreaming shifted to in-country gender equality interventions in diverse HRH settings at various levels: in field offices, with research stakeholders, in ministries, with professional associations and at health service sites.

### Recommendations

Looking ahead and based on the Project's experience, we recommend the following:

- Make gender analysis an essential part of program design and HRH and health curricula development and revision. Gender analysis should focus on norms, roles, stereotypes and power issues associated with men and women and how these are manifested in workforce policy and planning, development and support.
- Identify gender champions in the field to work with technical and management

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Visit the HRH Global Resource Center to find, share and contribute human resources for health knowledge and tools. For those working at the country or global level, the HRH Global Resource Center provides information to:

- Improve strategic planning and decision making
- Strengthen reports and presentations
- Support HRH advocacy
- Enhance professional development
- Save time.

- staff in various ways to address gender inequities and inequalities in HRH.
- Through such champions, establish working relationships with donors, in-country project leaders and national stakeholders *as early as possible* to ensure that gender analyses guide HRH agendas and result in country strategies with gender equality objectives and indicators for HRH policy and planning, development and support. Designate in-country champions to ensure use of gender analysis results and mobilization through local networks.
- Ensure that the development and strengthening of HRIS includes the capacity to disaggregate data by gender to contribute to strategic, data-driven decision-making. Promote the collection of sex-disaggregated data and its use to monitor gender issues related to health occupation education/training, licensing, continuing professional development, promotions, wage equity and retention.

- Ensure that HRH skills development includes leadership opportunities for women. For example, replicate the Capacity Project's professional association work in other settings, with other HRH groups, and assure that actions around gender equality and discrimination are deliberately included in capacity-building and action plans.
- Include gender-related indicators in project and country HRH performance monitoring plans as an effective accountability mechanism for action on gender equality in HRH.

Investments in gender data and capacity-building are key to developing gender transformative, multisectoral HRH strategies, policies and interventions that address gender inequality as it impacts workforce recruitment, productivity and retention. This in turn will contribute to the development and retention of the more robust workforces essential to deal with today's health challenges. Much more can be achieved with much greater impact where it matters, in policy, education and workplace programs, with greater investments.

1 The gender integration training modules are available on the Capacity Project's website ([http://www.capacityproject.org/index.php?option=com\\_content&task=view&id=100&Itemid=118](http://www.capacityproject.org/index.php?option=com_content&task=view&id=100&Itemid=118))

2 The Project defined workplace violence as "Any incident of physical or psychological assault or abuse that occurs in work-related circumstances and challenges a victim's safety, well-being or health. It includes incidents in which employees are abused, threatened, attacked or in which they are subject to other kinds of aggressive or offensive behaviors or actions in circumstances related to their work (including on the way to and from the workplace)."

3 In the last year, the Project also integrated workplace violence and gender discrimination in an HRH e-learning module.

4 Sex disaggregation is a standard part of the interactive data navigation in the iHRIS Suite. All standard charts and reports can be easily broken down for analysis by age and sex.



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