

Handout 1.6.1

Country Strategies

Case #1: Bangladesh (Transformative)

A nongovernmental organization (NGO) in rural Bangladesh is formally committed to responding to gender inequalities in its programs and policies. Its anti-poverty programs offer credit and income-generating skills and inputs, with 70% of members and 85% of borrowers being women. The organization also strives to employ women and to pursue progressive and countercultural social goals through women's workforce participation. It increased women's presence in the organization, their participation in decision-making and retention by recruiting more women, adopting "fast-track" promotion policies for women and providing special training in management skills. It also facilitated their physical adjustment to the demands of the workplace and their role within it by addressing issues of mobility and safety, organizing essential health care and maternity leave and allowing two days per month "desk leave" for menstruation.

Female development agents still experience some problems: high degrees of mobility for young women and living away from the family in proximity with non-kin men call into question their personal integrity and may subject female workers to public hostility. All staff must sign a "movement register" when they leave the office, a security measure that is resented by female staff who claim that their movements are more strictly controlled than that of their male colleagues. As it is widely held that women's reluctance to ride bicycles account for high drop-out rates, riding motorcycles has provided protection for female staff since the speed and noise shield them from verbal and other attacks. Despite these difficulties, village women have expressed admiration for female field workers and see motorcycle riding as a way of improving women's status, and many female workers expressed a feeling of pride and accomplishment in their freedom of movement and skill.

Case #2: United Kingdom (Blind—contributing to or exacerbating gender equalities)

In Britain, the health service reforms of the 1970s changed the nursing field from a female matron-headed chain of command to a new career hierarchy of posts from ward level up through the hospital and through the newly constructed administrative tiers to the Regional Nursing Officer.

In the new system, rigid qualifying time periods were built into progression, such that time taken off (e.g., maternity leave) or periods of part-time work, sent a nurse back into a lower grade upon return.

As a result, nearly 50% of the senior nursing management positions were filled by men, even though men made up only 10% of the nursing field. While men took, on average, eight years to reach Nurse Officer grade, women who took career breaks had to put in an average of 23 years to reach the same level, while women who didn't take career breaks took an average of 15 years to reach Nurse Officer grade.

Case #3: Austria (Transformative, limited immediate impact)

Austria's parental leave policies prohibit the employment of women for a minimum of 16 weeks before and after childbirth and provide a state-subsidized income substitute. Legislation enables both mothers and fathers alike to take a job-protected, paid leave of absence for up to two years to care for each child. Benefits consist of one flat rate for a single mother or married mother whose husband has little or no income. Fathers have the right to paid paternal leave as long as the mother does not take it and remain employed.

Since these laws have passed, nearly all women (95-98%) who are entitled to parental leave benefits take them and the majority of them draw benefits for the entire period. However, only 1% of those taking parental leave are fathers. For men, parental leave tends to constitute a transitory phase in their formal careers, frequently connected with a change of jobs. For women, parental leave usually marks the beginning of a longer period of absence from the labor market for child care.

Case Study #4—Sudan (Blind)

A study conducted in the Sudan found that a requirement for overseas training for medical career progression created an obstacle for female doctors who were not able to leave husbands and family at that period of their lives. In the survey, female doctors described an assumption in the upper ranks of the medical establishment that women did not want or were not able to advance their careers because of family responsibilities, which resulted in pervasive discrimination against women in promotions and the award of scholarships for overseas study. The study found that nearly half of the postgraduates were not taking post-graduate training, mainly because of the pressures of family responsibilities while they were undertaking training. These graduates also believed they were discriminated against through common stereotypes of female doctors as “inefficient” and lacking motivation because they were more likely to work part time or to take career breaks. The study also identified a primary concern for women doctors moving to rural areas to be adequate housing and security, and not salary incentives. Ultimately, there was a high “rate of exit” from medicine by women graduates. (Standing, Missing Dimension)

Case Study #5—Yemen (Blind, switching to Transformative)

Seclusion of Yemeni girls and women is considered a sign of female respectability; respectability also requires that women travel in the company of a male family member. At the same time, considerable use is made of women as community level paramedical staff, in recognition of their frequently greater acceptability to local users and their ties to the locality.

There is anecdotal evidence that the cultural expectations of female respectability constrain the full range of community outreach activities and supervisory performance expected from trained community midwives (CMWs) in Yemen. For example, female supervisors were expected and made efforts to return home before nightfall, although this expectation was difficult to meet when visiting CMWs in remote locations. Some CMWs mentioned that they had arranged to be escorted by male family members in order to carry out community outreach activities. These expectations are not addressed in recruitment, training or deployment policies or practice. Recently, very directive measures were taken by the government to overcome the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, a system of compulsory health service for women was established. (Standing, 2000)

Case Study #6—India (Accommodating)

Managers in a health program in India found that poor men and women had differences in access to RTI treatment at hospitals. They concluded that the treatment of RTIs and minor gynecological and urologic problems provided at the primary level would reduce travel time and costs for clients. However, while most dispensaries and health posts operated from one facility, they were separated in the services they provided: Dispensaries were 50% staffed by male doctors who treated minor ailments while most health posts were staffed by female doctors providing MCH and FP services. To improve accessibility for women, they decided that they needed to ensure that all primary facilities had skilled female providers, reasoning further that access to both male and female doctors would improve chances for partner communication about STDS and contraceptives.

The program managers therefore decided to integrate the work of health posts and dispensaries so that the existing pool of male and female doctors could be used to provide care for both male and female clients at the primary level. Evening operating hours were established, but managers found that evening hours presented access problems for couples as well as differential availability of male and female service providers. Many auxiliary midwives and female doctors asked to work within municipal health services because the daytime hours and working conditions fit their role as wives and mothers. Male doctors were assigned to work the evening shifts.