

Advancing Gender Equality in Health Systems

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CapacityPlus developed learning tools to address the challenges of gender inequalities and discrimination in the health workforce and health professional education systems and promote gender-transformative principles in advocacy, policy-making, and program implementation.

Background

Gender equality and nondiscrimination promote the achievement of health workers' greatest potential, which can have a positive impact on the provision of high-quality health care. When all health workers, whether male or female, can access education, training, and leadership opportunities, the quantity and quality of the health workforce improves. Giving all health workers an equal chance of being employed, fairly paid, and supported through life events such as childbearing may contribute to improved morale, productivity, and retention—in turn contributing to high-quality health services and the achievement of national and international health goals. Further, promoting gender equality within the health workforce has potential to transform gender norms within the populations health workers serve, by promoting nondiscrimination, nonviolence, and equality through the health services they provide.

Gender equality in health systems also requires that health workers be able and willing to provide high-quality care for victims of gender-based violence (GBV). In many countries and communities, GBV is not recognized as a health problem. Health workers who encounter clients who have experienced GBV may dismiss their injuries, may not ask appropriate questions in a sensitive way about the origin of their injuries, and may not refer clients to available GBV services. Further, all clients, men and women, should be able to receive care for every health problem in a way that is gender-appropriate.

Strategy and Approaches

CapacityPlus addressed the challenges of gender inequalities and discrimination in the health workforce and health systems by 1) developing learning tools to promote gender-transformative principles among health workers and health system leaders; 2) building the capacity of stakeholders to use these tools for advocacy, policy-making, and the implementation of gender-transformative interventions to promote equal opportunity and nondiscrimination in the workplace, health professional education systems, and clinical care; and 3) training health workers to better recognize, treat, and refer



clients who have experienced GBV. The tools include:

- A gender and health systems strengthening (HSS) eLearning course that supports learners to understand how gender norms drive health behavior and decision-making and the provision and utilization of care, and presents evidence-based ways to improve health and social outcomes by addressing gender barriers. The course contributes to the aims of the USAID *Gender Equality and Female Empowerment Policy* and is designed to build the capacity of USAID field-based health officers, foreign-service nationals, and US government partners to promote gender equality and women’s empowerment in health systems strengthening efforts in order to improve health and social outcomes. The course is also a mechanism to disseminate some of the USAID Interagency Gender Working Group’s core gender analysis and integration concepts.
- An advocacy tool to address gender discrimination in health workforce development that outlines

recommended combinations of gender-transformative interventions to counter various forms of gender discrimination in learning environments, and provides advocacy strategies for stakeholders to develop plans to create, implement, and enforce conducive environments, equal opportunity, and nondiscrimination policies. The tool draws from a technical report and brief published earlier in the project on strengthening the health worker pipeline through gender-transformative strategies.

- A companion advocacy tool to promote gender equality in the health workforce (see Figure 1) that provides users with approaches to understand and examine common gender discrimination types—pregnancy and family responsibilities discrimination, occupational segregation, wage and responsibility discrimination, and sexual harassment—along with recommended gender-transformative interventions and strategies for the health workforce and within health systems.

Figure 1: Screenshot of Gender Equality in the Health Workforce Advocacy Tool

Promoting Gender Equality in the Health Workforce: An Advocacy Tool

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Pregnancy & family responsibilities discrimination

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Overview Purpose How To Use This Tool

"Gender equality and female empowerment are core development objectives, fundamental for the realization of human rights and key to effective and sustainable development outcomes. No society can develop successfully without providing equitable opportunities, resources, and life prospects for males and females so that they can shape their own lives and contribute to their families and communities."

[USAID Gender Equality and Female Empowerment Policy, 2012](#)

Health workers improve and save lives by providing family planning, maternal and child health, HIV/AIDS, and other essential health care services to communities in need. Country stakeholders recognize the importance of their public health workforce and are striving to ensure health workers’ job satisfaction and safety. They also want to strengthen human resources management so that health workers can reach their greatest potential and fulfill their rights at the workplace.

However, health workforce leaders may not be aware of the ways in which unequal opportunities and [gender discrimination](#) impede efforts to develop, efficiently deploy, and fairly compensate their health workforces. This can result in [health worker maldistribution, workplace absenteeism, and a limited pool of motivated health workers](#), all of which can negatively impact the provision of quality health care.

However, consider the effects of promoting equal opportunity and nondiscrimination and, ultimately, gender equality in the health workforce:

- When all health workers, whether male or female, have equal access to opportunities for professional education and skills-building, the

In addition, the project updated sexual and gender-based violence (SGBV) curricula for health workers and trainers in Kenya and Mali. The curricula mainstreamed gender-transformative approaches, identified and filled health workforce skills gaps, and integrated new SGBV policy and service protocols to help these countries' health systems to better respond to children, adolescents, and women who have experienced sexual violence.

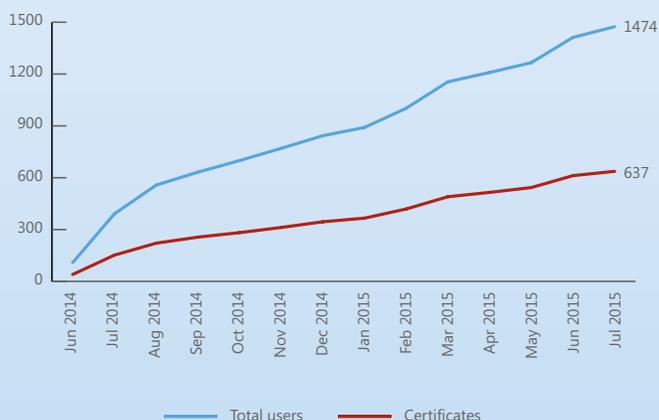


Highlights of Results

Global Participation in Gender HSS eLearning Course

Since its June 2014 release, 1,474 learners from 57 countries have used the course and 637 (43%) have earned a certificate of course completion (see Figure 2), of whom 54% are female. In 2014, the project also led 22 participants from 10 countries in a two-week study group to enhance learners' understanding of the course content through moderated discussions. The first study group of its kind for the Global Health eLearning Center, the course had more than 98% of participants coming from outside the US.

Figure 2: Gender and HSS eLearning Course Users and Certificates Earned Over Time



Gender and HSS course learners from international nongovernmental organizations (INGOs) and government expressed how they planned to apply what they learned in their respective academic, programmatic, and clinical settings:

- "I will use the knowledge acquired [from the course] to empower women in rural communities to raise their voice toward demanding reproductive health right[s]." ~ Male INGO worker, Tanzania
- "I intend to advocate for gender equality in regards to health-related issues like signing consent for cesarean section, family planning, and even hospital-seeking services." ~ Female INGO worker, Somalia
- "I will engage my colleagues in a conversation that addresses the issues of gender and reproductive health as they affect the victims of trafficking, so that [they] receive psychosocial supports from our shelter, and gender is streamlined in the policy." ~ Female national government employee, Nigeria
- "[I will] undertake a retrospective analysis of reported data on activities based on sex disaggregation, and share the analysis with the project team." ~ Male INGO worker, Burundi

Fostering Action through Pilot Application of Advocacy Tools at the Country Level

CapacityPlus field-tested the gender equality advocacy tools through a capacity-building workshop with 51 health workforce, gender, and preservice education stakeholders in Cross River State, Nigeria in 2014. The workshop discussions enabled the stakeholders to identify and prioritize gender-related challenges—including learning and working environments that may promote sexual harassment and GBV, caregiver responsibilities discrimination affecting midwife deployment and retention, and occupational segregation and wage discrimination—while working on a draft advocacy action plan. Workshop participants then nominated representatives to form a state-level Gender Human Resources for Health (HRH) Working Group, which

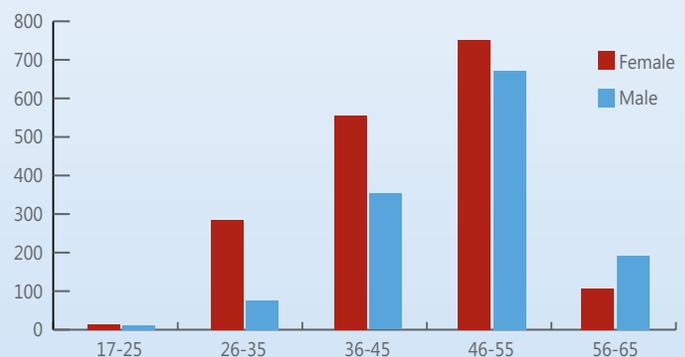


met in May 2015 to further refine and pursue advocacy goals to advance gender equality in the health workforce and at health professional education institutions, including promoting efforts alongside the state's forthcoming gender policy.

In August 2015, a sex-disaggregated analysis of the CapacityPlus-supported Cross River State Ministry of Health workforce registry (customized from the project-supported iHRIS Manage software) was undertaken to develop a more robust evidence base on gender issues in the health workforce and better inform decision-making for how to promote and achieve gender equality. Preliminary results indicated that of the 3,626 health worker records that had a sex variable, 64% of health workers were female and 36% were male. Analyzing the age distribution of the Cross River State health workforce and disaggregating the results by sex revealed an important aspect of the female and male health worker life cycles. Figure 3 shows the number of men and women in the health workforce by age category. The proportion of females to males is 3.7 to 1 in the 26-35 age category, but 1.6:1 for health workers aged 36 to 45, and 1:1 for health workers aged 46 to 55. For those aged 56 to 65, this ratio is reversed, with almost twice as many male health workers (1.8) as females. This finding may imply that while many women start off their careers as health workers, there is attrition, with fewer women likely to remain in the

profession until retirement. Alternatively, as these data represent only the current health workforce, this finding may imply that in recent decades there has been an influx of female health workers to the labor market, which would represent great potential in terms of achieving Nigeria's health goals.

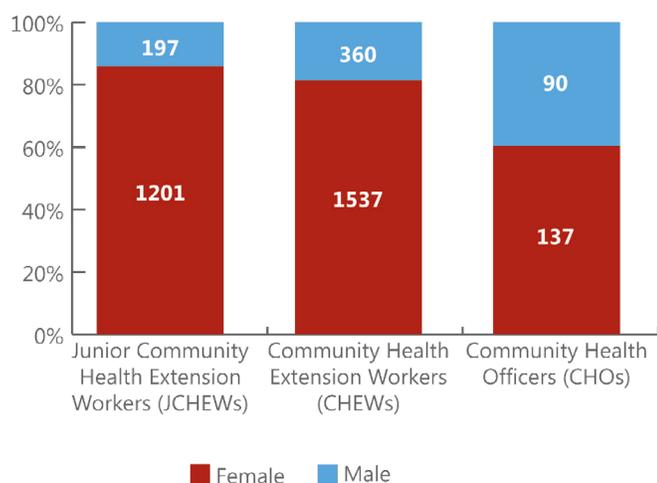
Figure 3: Distribution of the Health Workforce in Cross River State, Nigeria by Sex and Age, 2015 (N=3,020)



An analysis of data from the Community Health Practitioners Registration Board of Nigeria showed the sex distribution of Cross River State's three types of community health practitioners. As displayed in Figure 4, from left to right in order of the amount of training time that is required, it can

be noted that while all professions have a majority of female health workers, the community health officer position that requires the longest period of study and practica has the largest proportion of men, indicating that there may be challenges that women face to complete additional training within the community health practitioner profession.

Figure 4: Distribution of Community Health Practitioners in Cross River State, Nigeria by Sex and Title, 2015 (N=3,558)



Source: Community Health Practitioners Registration Board of Nigeria. Data as of July 15, 2015. National health workforce registry.

Improving Training on and Management of Sexual and Gender-Based Violence

Kenya: With approximately 160,000 children and youth living with HIV in Kenya and an estimated adult prevalence of 5.3%, the government is seeking to reduce HIV risk factors, including those associated with SGBV. At the request of the USAID Office of HIV/AIDS Gender Technical Working Group and in collaboration with the USAID FUNZOKenya project, CapacityPlus integrated PEPFAR's technical considerations for clinical management of children and adolescents who have experienced sexual violence into USAID's APHIAplus service delivery project in Kamili zone. The projects worked with the Ministry of Health (MOH)'s Reproductive and Maternal Health Services Unit (RMHSU) to develop a new module focused on children and adolescents for the revised national curriculum on SGBV, including supplemental training and performance support

materials. Sections in the module and wider curriculum address HIV counseling and testing (as well as pregnancy testing and counseling), plus post-exposure prophylaxis, referrals, and forensic examinations. The revised national SGBV curriculum (2015) seeks to advance the MOH's mandate to train health workers on management of survivors of sexual violence.

Additionally, a training needs assessment conducted before testing of the new children and adolescents-focused module among trainers and providers identified shortages of key equipment (e.g., forensic kits), deficiencies in performance support mechanisms for staff, and the existence of inherent biases against adolescents by a number of providers. Findings from this assessment assisted the Ministry in incorporating health workers' attitudinal aspects into the curriculum as well as taking corrective actions to ensure that appropriate equipment to address SGBV exists in health facilities.

Mali: The armed conflict in northern Mali has displaced about 180,000 people; the United Nations' working group on violence found 2,383 cases of violence against women in 2012 and 3,330 in 2013 (UNFPA Mali 2015). In response to the crisis, in collaboration with USAID/Mali, CapacityPlus provided technical leadership to draft national health worker training materials in SGBV. National stakeholders from the Ministry of Health and Public Hygiene; Ministry for the Promotion of Women, Children, and the Family; Ministry of Solidarity, Humanitarian Affairs and Reconstruction in the North; health facilities; and NGOs validated and finalized training materials, including a reference manual, facilitator guide, and participant workbook and job aids. To further support victims of SGBV in Gao region, CapacityPlus supported local NGO *Groupe de Recherche d'Etude de Formation Femme-Action* (GREFFA) to conduct informational sessions on SGBV and identify victims of SGBV. In June 2015, the Ministry of Health and Public Hygiene, with technical and financial assistance from CapacityPlus, organized a national training of 18 trainers in case management of SGBV and targeted regional participants from the health directorates and hospitals. In collaboration with the Gao Nursing School, the project also organized an orientation session on SGBV case management for 30 teachers

and trainers. This intervention constitutes the first step in the introduction of these national curricula into preservice education institutions in Mali.

Lessons Learned and Recommendations

- The gender and health systems strengthening eLearning course proved an effective way to introduce a complex topic to a broad audience. Because gender discrimination and inequalities are context-specific, providing learners with case studies and examples is essential to illustrate gender dynamics. Additional course study groups could be offered—for example, in East and Southern Africa or among francophone countries—to create virtual communities of practice that can share experiences and support each other to promote gender equality.
- A functional, robust human resources information system (HRIS), such as the iHRIS-supported Cross River State health workforce registry, is key to monitor health workers longitudinally and promote sex-disaggregated analyses by cadre, location, and age to reveal where attention can be focused to address discrimination and promote equal opportunity. Similarly, student, graduate, and faculty tracking systems are important to identify where there may be gender challenges in health professional education systems.
- Gender advocacy action plans may need to differ from traditional development approaches. For example, many small “quick win” steps may need to be adapted as the strategy evolves. Further support is needed to develop compelling and timely data-driven gender advocacy messages, link them to specific “asks” to policy-makers, and hold policy-makers accountable for implementation.
- In countries with cultural and societal challenges to addressing SGBV (e.g., Mali) the rollout of SGBV curricula should be accompanied by community mobilization to include political leaders, traditional and religious leaders, health systems leaders, women’s groups, youth groups, and a pool of health worker champions who are trained and identified as being supportive of SGBV victims and can motivate and inspire other health workers.

References

UNFPA Mali. 2015. Journée internationale pour l'élimination des violences faites aux femmes : Les temps ont été durs pour les maliennes. <http://www.unfpa-mali.org/journ%C3%A9e-internationale-pour-l%E2%80%99%C3%A9limination-des-violences-faites-aux-femmes-les-temps-ont-%C3%A9t%C3%A9-durs-pou> (accessed August 23, 2015).

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