THET
PARTNERSHIPS FOR GLOBAL HEALTH

EXPLORING GENDER EQUALITY IN THE HEALTH WORKFORCE:

A STUDY IN UGANDA AND SOMALILAND

Acknowledgements

We would like to thank the Fraxinus Trust whose funding has allowed THET to research, document and develop tools which will transform our approach to gender equality and that of the Health Partnerships we work with. Following this study, a gender and social inclusion toolkit is in development which will be used by Health Partnerships, offering practical guidance and resources to incorporate and consider gender at all stages of their programmes, supporting them to maximise opportunities to tackle gender inequality in health and ultimately to strengthen the quality and impact of their work.

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Confidentiatlity

Some names and identifying details have been changed to protect the privacy of individuals.

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Recommendation Icon Key:

- Advocacy
- Policy
- Programme

UG Uganda

SM Somaliland

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Executive summary

Restrictive gender norms affect everybody. As a shared determinant of health for men, women, boys, girls, and gender-diverse people, gender inequalities drive large-scale excesses in mortality and morbidity globally. Gender inequality is transformed into health risk through the following: discriminatory values, norms, beliefs, and practices; differential exposures and susceptibilities to disease, disability, and injuries; biases in health systems; and biases in health research. Gender discrimination at any of these levels detrimentally affects health and social outcomes.
The Lancet, 2019

The Tropical Health and Education Trust (THET) has a vision of a world where everyone has access to quality healthcare. On a global scale, gender inequality negatively affects access to healthcare, particularly for women. In consequence, women experience the burden of morbidity and mortality disproportionately. This burden is compounded by a lack of female representation in global health leadership. In the global health sector, women make up more than 70% of the workforce, delivering care to over five billion people and contributing $3 trillion to global healthcare annually. Despite this, women remain critically underrepresented in health leadership, with only 25% holding leadership positions.

Ensuring the equal participation of women in the global health workforce – as in all spheres of public life – is an essential prerequisite to building more inclusive and equitable societies. In a health context, leadership teams that are representative of the patient populations they serve are better placed to identify effective ways to deliver quality healthcare. Systemic gender biases and inequities result in system inefficiencies, bottlenecks in health worker education and recruitment, and worker distribution imbalances across formal and informal health workforces. These challenges are undermining our progress towards achieving Universal Health Coverage (UHC), particularly in low- and middle-income countries (LMICs).

In 2019, THET conducted a qualitative participatory study in Uganda and Somaliland to deepen its organisational understanding of the main enabling factors and barriers posed to gender equality and women's empowerment for health professionals in low- and middle-income countries (LMICs). This study identifies and explores the main enabling factors and barriers posed to gender equality for health professionals in LMICs, taking Uganda and Somaliland as case studies. The study will serve as a basis to identify a series of workable gender transformative approaches, in the form of tools and resources, that will support health partnerships to integrate gender equality across their programmes.

By taking a holistic approach which brings together an understanding of best practice in the field of gender mainstreaming, with the lived experience of people involved in our health partnerships, we want to transform our partners' programmes into powerful activities which play a significant role in advancing women's development both as individuals and as health professionals.

Led by gender advocates from Uganda and Somaliland, the research approach was both diagnostic – in that it sought to identify how gender discrimination manifests, how it is experienced, and who it affects – and solution-oriented – in that it sought to identify trajectories of positive change and practical measures that can be introduced to address gender disparity. Through key informant interviews (KIIs) and focus group discussions (FGDs) with male and female health facility mangers and clinical staff, academics and policy-makers, a number of key themes were explored, including: gender discrimination and stereotypes, access to opportunities, flexible working and the impact of unpaid care work, Gender Based Violence (GBV) and sexual harassment, voice and leadership, knowledge and awareness of gender-based issues, and policies relating to gender. As the research took a peer-to-peer approach and was led by gender

advocates who are known to and are active within their communities, an advanced level of access and insight was achieved.

Drawing on personal accounts and analytical explorations at the institutional and system levels, the research identifies a number of key insights. It sheds light on the barriers posed to women in accessing health leadership opportunities, and how this intersects with gender discrimination derived from normative perceptions of male and female roles, obligations and qualities. Related to this, the research suggests that gendered specialisations within the medical profession often reproduce traditional gender roles, and that the implicit hierarchy of these ascribed gender roles is reflected in patient biases towards male and female medical staff. Further, women are found to suffer disproportionately from the dual burden of domestic unpaid care obligations and professional responsibilities – a reality emanating from gendered cultural norms in both Uganda and Somaliland. Unconscious gender biases are also found to play a role in hiring and recruitment practices, with favouritism and nepotism along gender and clan lines affording greater opportunities for training, scholarships and promotions to males, particularly in Somaliland. The issue of class and income level are found to compound the extent to which women struggle to balance these conflicting demands.

Of similar significance, the research touches on the hidden nature of GBV, which is a source of significant stigmatisation for many female survivors. As such, while the occurrence of sexual harassment, verbal abuse and intimidation in the workplace is acknowledged, there exists a notable lack of openness around the topic, and respondents are found to be hesitant towards sharing their experiences. As such, the researchers conclude that it is likely that the true extent of GBV will remain hidden across Uganda and Somaliland until further research is undertaken.

Finally, the research makes clear that a notable gap exists in gender awareness across all categories of health facilities in both Uganda and Somaliland – a problem compounded by shortcomings in the quality and frequency of gender training. The limited scope of gender knowledge among the participants of this study demonstrates the need to transform the institutions, structures, systems, and norms that facilitate and compound gender inequality and inequity. To this end, several recommendations are put forward in relation to each of the key themes explored in this study. A key focus is placed on gender awareness raising and sensitisation, and on the standardisation of gendered approaches to policy and practice at the institutional and national level.

Introduction

A Gender Study commissioned by THET in 2017 found that gender inequity is widely recognised as an obstacle for women working in the health sector in LMICs. The study identified three key issues:

- Discrimination against women, including hierarchical barriers with regards to promotion and opportunities for training and advancement.
- Stereotyping of the type of activities women should undertake, for instance, patients will often mistake female doctors for nurses or prefer being seen by a male doctor.
- Imbalances in the proportion of men and women in jobs. i.e men as doctors and senior administrators and women as domestic staff, secretaries and nurses.

Led by gender advocates and researchers in Uganda and Somaliland, this report reflects and expands upon the 2017 study, investigating and renewing our understanding of the gendered context in which we are working, aiming to bridge gaps in knowledge and ensure our work is delivering relevant responses to local problems.

The first section of this report presents key messages, critical questions and emerging recommendations drawn from an initial gender study commissioned by THET in 2017, and from wider literature on gender equality in the health workforce in LMICs.

The report then highlights gender-relevant contextual information on Uganda and Somaliland. The main body of the report explores the key findings of the research accompanied by a series of emerging recommendations intended to form the basis for further discussion and to inform the development of workable gender transformative tools and resources..

To facilitate conceptual clarity, initial definitions of terms used in the paper are included below:

Gender equality
'Gender equality in the health workforce describes a condition where men and women can enter the health occupation of their choice, develop the requisite skills and knowledge, be fairly paid, enjoy fair and safe working environments, and advance in a career without reference to gender; implies that workplaces are structured to integrate family and work to reflect the value of caregiving for men and women.'

Gender equity
'Gender equity is the process of being fair to men and women. To ensure fairness, measures must often be put in place to compensate for the historical and social disadvantages that prevent women and men from operating on a level playing field. Equity is a means. Equality is the result.'

Gender transformative approaches
'Gender-transformative approaches are programmes and interventions that create opportunities for men and women to challenge gender norms, promote positions of political and social influence for women in communities, and address gender inequities between persons of different genders.'

1. Qualitative research | Methodology

Research Framework

A qualitative participatory study was conducted in Uganda and Somaliland to deepen THET's organisational understanding of the context in which women and men operate at various levels in the health workforce. The study paid particular attention to the main enabling factors and barriers posed to gender equality for health professionals in LMICs. Through this, THET aimed to identify a series of workable gender transformative approaches to be incorporated into its tools and resources to support and promote quality health partnerships.

Aim

To gain a better understanding of the constraining and enabling factors for gender equality in the health workforce in LMICs.

Scope

Uganda and Somaliland were chosen as the focus of this study as representative examples of geographies with differing socio-political contexts and varying levels of health partnership activity. The sample countries allow us to explore cross-cutting inequalities and cleavages which shape the barriers and enablers women face at a structural level. Uganda was chosen as one of the main hubs of health partnership activity, with a view to develop tools that would serve a significant number of health partnerships. Moreover, this was an opportunity to delve deeper into the results of the aforementioned 2017 THET study. Somaliland represents a further key strand of THET's work: country programmes. Our longstanding footprint in-country, along with high levels of health system strengthening programme activity, mean that this study provides an opportunity for THET to transform its integration of gender from a programmatic perspective too.

Methodology

THET conducted a literature review of women's role in health system strengthening with a focus on the enabling factors and barriers faced. The key themes identified through this literature review informed the development of the research framework.

The process which followed was highly collaborative and participatory. The THET team and a gender specialist worked with gender-focused academics (Advocacy Leads) and researchers (Advocacy Assistants) in Uganda and Somaliland. The research framework and data collection tools were also developed collaboratively to ensure that the questions posed were relevant to each context and that the study addressed a balance of structural and agency-related factors. THET's in-country teams worked to identify target groups and to develop appropriate structures for the discussions.

The data collection methods employed were key informant interviews (KIIs) and focus group discussions (FGDs). The key themes explored included: gender discrimination and stereotypes, access to opportunities, gender based violence (GBV) and sexual harassment, representation and leadership, and awareness of gender-based issues (for a detailed set of research questions see Annex 1). The KIIs were one-to-one interviews led by the Advocacy Leads. Interviewees included senior policy makers, clinicians, managers and academics. The KIIs sought to gain detailed insights into the experiences of senior officials and individuals. A total of 10 were carried out in Uganda and 9 in Somaliland. The FGDs were facilitated by the Advocacy Assistants, who led discussions on the key themes identified in the research framework. FGDs ranged from 6-15 people and were separated by sex to encourage open and honest discussions on sensitive topics and to account for cultural norms in the two countries. A total of 61 individuals participated in the FGDs in Uganda, and 48 in Somaliland (See details in Annex 2).

Rationale

The collaborative approach to research design and the use of local teams for data collection were introduced as a quality and relevance mechanism to ensure that appropriate people were asking relevant questions, framed in the right way, to a representative group of participants. Because the research process was led by women and men active and well-connected in their communities, THET was able to gain a level of access and insight which is not often available.

The main limitation of this study was the sample size. Due to time and resource constraints, the total number of participants was limited, however the composition of the participants was carefully assessed to ensure that various aspects and levels of the health system were represented. We are confident that the sample is representative enough to provide relevant and useful insight which will serve as a robust evidence base for the development of tools.

2. THET's 2017 Gender Study | Summary of findings

In 2017, a gender analysis was conducted on behalf of THET to gain a greater understanding of the challenges posed to gender mainstreaming, gender equality and women's empowerment in Ugandan and Tanzanian institutions and partnerships participating in the Health Partnerships Scheme (HPS). The study's inormants included male and female health professionals, managers, volunteers and healthcare service users. Through FGDs and KIIs several key findings came to light, including:

2.1. A gender imbalance exists in employment and pay in many health institutions.

Men predominate in higher-paid, higher-status roles, while women are overrepresented in lower-paid positions.

Evidence:

- In Uganda, only 24% of doctors are women, compared to 80% of nurses.
- 45% of female and 28% of male health workers felt that unequal opportunities exist for each gender in the workplace.
- 70% of respondents (male and female) agreed that there is a need for better gender balance among staff in health institutions.

2.2. The voices of women are not being heard within health institutions.

The majority of decision-makers in health institutions are male, hence women's concerns are being overlooked and are often not vocalised due to women being afraid of jeopardising their job security. This challenge is compounded by a lack of technical and administrative support through which concerns can be raised.

Evidence:

- Amongst clinical staff surveyed, 40% of men and 50% of women felt that there was not equal technical and administrative support available for staff of all genders in their workplace.
- One female respondent expressed "there is no-one to advocate for women's rights" while another stated, "We are powerless. If you criticise, you are chased from work."

2.3. Normative gendered ideas which ascribe appropriate roles to women and men pose significant barriers to the health workforce.

Normative gender roles affect both women and men, having a restrictive impact on the positions held by and available to each gender.

Evidence:

- In Uganda and Tanzania, 77% of female and 83% of male community residents agreed that men make better doctors than women.
- While the majority of nurses and midwives trained under the HPS were female, only 2,200 of 5,600 doctors trained were women.
- In Uganda, of the 20% of nurses who are male, many are subject to ridicule and discrimination.

2.4. A gender-sensitive approach to health service provision is essential because women and men use healthcare services differently.

Men and women have different health needs and different health seeking behaviours. It is vital for male and female health professionals to understand these gendered barriers and to identify appropriate measures to encourage men and women to seek medical care when necessary.

Evidence:

- 72% of men and 70% of women agreed or strongly agreed that men in their community did not like to visit the doctor.

2.5. Gender training is needed for health workers across the board.
Individuals have varying degrees of knowledge on gender issues. Hence, institutional capacity building is required to provide health workers with the knowledge and skills necessary to develop and apply gender-responsive practices.

Evidence:
- 70% of participants stated that past seminars and training on gender in healthcare had been extremely useful in helping them to deal with gender issues in the workplace.
- 90% of female and 100% of male clinical workers responded that more training is needed so that health care workers can better understand gender issues affecting health care delivery.

2.6. There is a clear need to create gender-responsive work environments.
Institutions must build work environments which respect gender equality and equity, and which are free from discrimination, bias or harassment.

Evidence:
- 75% of female and 65% of male respondents agreed that there was a lot more room for gender sensitive behaviour among staff.

2.7. Health institutions must take a zero-tolerance attitude to sexual harassment and other forms of Gender-Based Violence (GBV).
Sexual harassment and GBV are often normalised in heath workplaces, both in the recruitment process and throughout employment.

Evidence:
- A recent study conducted on behalf of the Uganda Ministry of Health (MOH) found that sexual harassment in government health workplaces has become 'normalized'.

These findings raised some important questions relating to the different dimensions of gender inequality that THET and health partnerships more broadly must consider and address. The present study takes these findings as its starting point and seeks to expand, test and build on these to improve our contextual understanding of gender equality in the health workforce in Uganda and Somaliland.

UGANDA & SOMALILAND

NATIONAL STATISTICS

The barriers posed to women in the health workforce cannot be understood in isolation. Many of these barriers stem from the cultural, social, political and economic context in which women are situated.

As such, it is necessary to explore key statistics at the national level, including poverty rates and employment rates, before we can analyse progress towards gender equality and women's empowerment.

SOMALILAND

Education

Gender disparity exists at all levels of education, increasing at secondary and tertiary level.

Health

Somaliland has one of the worst Maternal Mortality Rates (MMR) in the world, estimated to be between 1000-1400 per 100,000 live births.

Political representation

Men make up 97% of top officials in government offices.

27%

of women are active in the labour force, compared to 48% of men.

60%

of women inactive in the labour force are unable to participate due to household duties.

UGANDA

22%

of women have no formal education. However, Uganda has achieved gender parity in primary education.

66%

of women are active in the labour force, compared to 74.9% of men.

39%

gender pay gap in the private sector. On average, women spend 7.5 hours on unpaid care work.

Political representation

Almost 35% of parliamentary seats are held by women, above the 30% target set by the Beijing Platform of Action, well ahead of many other LMICs.

Health

Adolescent pregnancy is among the highest in sub-Saharan Africa, at 106.5 per 1,000 women aged 15-19. The Maternal Mortality Rate (MMR) is extremely high, at 343 deaths per 100,000 Live births.

5. Qualitative research | Findings

The findings of the qualitative research process are summarised below, illustrated with relevant examples from the participant countries. The findings are accompanied by a set of recommendations based on evidence gathered in the 2017 THET analysis, relevant literature, and the present qualitative study. The recommendations are intended to provide an overarching guide for action, with the proviso that further research and consultation would be needed in partner countries to ensure any measures are adapted and developed in line with the specific country context.

5.1. Gender discrimination and stereotypes

Latent and explicit discrimination | Despite the existence of national and institutional regulations which promote equality between men and women, many female respondents in Uganda and Somaliland cited examples of latent and explicit gender discrimination. This reveals a dissonance between accepted codes of conduct and gendered practices in health institutions. The majority of male respondents claimed that discrimination was not a prevalent issue in their institution, suggesting that men and women experience and perceive discrimination differently.

Socially engrained perceptions | In many instances, biases and discriminatory attitudes derive from socially engrained normative perceptions of male and female qualities, roles, capacities and obligations. In both Uganda and Somaliland a common assumption exists – reinforced through media representations and social narratives – that women entering the medical profession will pursue nursing and men will become doctors. These associations are underpinned by gendered narratives (men as logical and capable, women as emotional and nurturing) that often go unquestioned. These narratives can affect women and girls at all stages of life. Dr Harriet*, a Ugandan senior academic and doctor, explained that as a child she had planned to become a nurse until her parents opened her eyes to the possibility of becoming a doctor: *"My dad questioned why I wanted to be a nurse when I could become a doctor. I did not know that women could be doctors then. It is when I found this out, that I changed my dream career."*

Further to this, a number of the male doctors interviewed in Uganda argued that paediatrics is more suitable for women than men. A male Ugandan ophthalmologist, Dr Alfred*, noted that "*Women are softer, and kids are calmer around them, so we encourage them to do paediatrics.*" A female senior academic and doctor from Uganda expounded this assumption, explaining that she had altered her aspiration of being a surgeon to become a paediatrician based on advice she received from a male supervisor during her third year of medical school: *"The supervisor told me 'I know you are married and honestly is not fair for you to be a woman and surgeon."* Such instances are common and are based on normative assumptions that women are nurturing and men have more flexibility to respond to emergency calls and to spend long hours operating on patients. Within specialisations, the allocation of tasks is also gendered. In Uganda, for example, respondents noted that male nurses sometimes avoid certain tasks and procedures such as wound dressing and drug dispensing due to a perception that they are 'feminine.'

Patient biases | The implicit hierarchy of these ascribed gender roles within the medical profession is evidenced in patient biases towards male and female medical staff. In both Somaliland and Uganda, several examples were highlighted in which nurses were assumed to be significantly less knowledgeable than doctors, and of instances in which female doctors had been exposed to the mistrust and abuse of patients. Several respondents reported occasions in which older male patients had been unwilling to accept the professional credibility of a female doctor, undermining their ability to examine and treat patients (see Box 1).

Box 1: Case study involving female doctors in Somaliland

"Some time ago an old man came to the hospital, his problem was tuberculosis. The old man brought his X-ray document, and when I met the old man and tried to listen to his issue, from the first instance he said; 'are you doctor? How you can be a doctor, you little girl?' He refused to give me his X-ray document. I persuaded him to tell his story to me, he started with, "a long time ago, someone hit me on my body, and that problem caused tuberculosis to my body." When he finished his story and I informed him that the wound and tuberculosis are two different things, he laughed at me and said "I knew already the female doctor cannot tackle my health problems."

Co-worker biases | Perceptions of women's limited capabilities extend beyond patients to colleagues within the medical establishment. In both private and public sector hospitals in Uganda, respondents cited incidents in which male doctors or trainees had explicitly insisted on being assigned a male supervisor – a request revealing explicit gender biases. Respondents also reported that female colleagues were failing to support or mentor young female interns. Dr Abbo*, a policy-maker for a private company in Uganda, stated that female senior doctors were harsher in their treatment of female medical students, noting that senior female staff sometimes discriminated against other women both at the clinical and administrative level. Young women were found to experience particularly harsh judgement by colleagues, with a young female medical professional from Somaliland recounting: *"the men underestimate me and ignore me, and I am still struggling to prove that I can successfully do this work."* She stressed that this made her feel obliged to constantly demonstrate her ability and resilience.

Male discrimination | While male medical staff acknowledge that gender biases largely work in their favour, men are not unaffected by discrimination. The majority of male respondents stated that they had not personally experienced any negative gender discrimination in terms of career progression or in their daily work. However, in cases where men had disrupted gender stereotypes, predominantly by working as nurses, some respondents stated that they had faced implicit or explicit discrimination. Male nurses in Somaliland noted that they often face disrespect from patients who believe that nursing is a 'female profession.' Male nurses in Somaliland also noted that they are not permitted to take a midwifery course – something that they feel is unjust and discriminatory. According to respondents, the occurrence of gender discrimination in the workplace has led some male nurses to retrain or leave the medical profession all together, confirming findings in THET's 2017 study.

UG Resentment of affirmative action | Gender discrimination is reflected in the resentment of males towards affirmative action schemes for young women in Uganda. Both the initial gender analysis and the present qualitative study make clear that while women predominate in the lower levels of health institutions, significantly few occupy decision-making positions. Despite this, a male Ugandan doctor argued that due to affirmative action, recruitment in the medical profession often worked in women's favour, to the detriment of male applicants. Several male doctors also stated that it was discriminatory for their female counterparts to be given 1.5 additional academic points to increase their chances of accessing university education as they felt that this policy led to male students missing out on government sponsorship. This suggests that there is a need to address the misperceptions surrounding affirmative action and to sensitise health professionals in Uganda about the gender inequalities that underpin affirmative measures.

"The men underestimate me and ignore me, and I am still struggling to prove that I can successfully do this work."

Recommended measures for mitigating and addressing gender discrimination in medical institutions

In both Uganda and Somaliland a series of common features were identified in relation to gender discriminatory practices which ultimately underpin a range of other aspects of gender inequality. While there is no single solution, health institutions, development agencies and government actors can support efforts to overcome gender discrimination by recognising the scope of the issue and by creating an enabling environment for change. Strategies could include:

- Launching gender awareness activities for male and female health professionals, patients, and members of local communities. This could take place through radio and television programmes and social media; posters and other forms of publicity; mandatory gender training for all staff; or a gender awareness raising day.
- Introducing formal, discrete channels for staff to raise complaints about discriminatory behaviour and for appropriate action to be taken.
- Running campaigns encouraging girls to consider pursuing a career in STEM subjects, while also promoting nurse/care positions as suitable for both males and females.
- Introducing gender in school and university curricula.

5.2. Equal access to opportunities, wages and promotion

SM Hiring processes | Equal access to employment opportunities in the medical profession is limited by a lack of transparency and consistency in hiring practices. This is particularly prevalent in Somaliland, where vacancies are shared informally through networks and private contacts, rather than through public advertisements, rendering 'who you know' more important than qualifications or experience. Men are more likely to benefit from these processes because the networks in which vacancies are circulated tend to be male-dominated. Women's predominance in the private spheres of home and community, dictated by religious and social norms, play a role in limiting their exposure to informal networks. As stated by a female respondent from Somaliland: *"Usually, jobs availability is passed on secretly, and women have no access to them."* A Somaliland female nurse said: *"people get employment opportunities because they know senior managers, or if you have someone who have links with them. The knowledge you have and whatever experience you retained is not relevant."* In Uganda, women were found to have greater access to vacancy information than their counterparts in Somaliland, with respondents stating that jobs are frequently advertised through agencies and the media.

Interview and training processes | There are indications that some employers are allowing gender biases to influence the interview and selection process at the recruitment stage and access to further opportunities for on-the-job training and promotion once in position. While women in Uganda have access to vacancy information, they are less likely than their male counterparts to be invited to interview. A respondent based at a private hospital in Uganda stated that their institution implements an unofficial policy of not hiring female laboratory staff based on the assumption that women cannot withstand the demands of the role and the long hours incurred. However, further research is needed to identify the extent to which gendered assumptions affect the transparency and fairness of hiring decisions in LMICs.

Accessing further training or scholarships once in position also arose as a key challenge to progression for women. Female tutors in Somaliland noted that opportunities are often shared by male managers with male doctors in informal situations such as tea breaks or social events after work. This informal system places women at a disadvantage; since they tend to have less free time than men due to the additional responsibility of unpaid care-work. In Somaliland, KII and FGD participants stated that in both public and private institutions, men are more likely to be promoted, even when they are competing against women with more experience and higher qualifications. Several female respondents stated that they had been discouraged from progressing or seeking promotions due to gendered cultural norms that assign unpaid care responsibilities to women. They are precluded from working the long, unsociable hours – including night shifts – that are expected of junior doctors, placing their male counterparts at an advantage.

Wages | Due to the sensitive nature of the topic, limited conclusions can be drawn from the research regarding equitable wages. While a number of respondents claimed that men and women are paid the same for equal work, there is a distinct lack of transparent data, necessitating further quantitative research to ascertain levels of gender inequality in wages.

Leadership | Gender equality in leadership is an area in which progress is being made. While there was a consensus among the majority of respondents in Uganda and Somaliland that leadership is male dominated, there are a number of positive exceptions to this rule. Dr Miremba*, a senior doctor based in Uganda, stated that women occupied four out of ten management positions in her institution. Similarly, the leadership of a Somaliland midwifery association involved in this study is made up largely of women, reflecting the growing number of leadership positions available to women in the countries studied. This said, women continue to face gendered barriers to leadership opportunities, and those who occupy

positions of power face both passive and overt aggression and sexism from male colleagues. Dr Abbo*, a Ugandan doctor, reflected on her experience as a woman in leadership within a government ministry. While men in the organisation did not directly challenge her seniority, they undermined her authority as a decision-maker through their reluctance to take timely action on policies that required their feedback and/or implementation. She was also subject to sexist jokes which undermined her reputation.

Recommended measures for ensuring gender equitable opportunities and treatment in employment

In both Uganda and Somaliland, there is a clear need for medical institutions to review and revise their current hiring practices to ensure the equal participation and professional development of female staff. In Somaliland, the lack of transparency surrounding health-related vacancies is a particular concern, while in Uganda the ineffectiveness of existing gender policies and regulations is indicative of the need for reform. To begin addressing these issues, employment practices can be improved by:

- Setting transparent recruitment criteria and developing written guidelines in medical facilities.
- Widely advertising vacancy information e.g. in medical schools and through the media.
- Using a wide range of channels to disseminate promotional opportunities to all relevant staff members.
- Establishing selection processes that are objective (based on the comparative knowledge and experience of candidates rather than on personal connections, gender, age etc.).
- Offering flexible working hours to ensure unpaid care work does not prevent women from accessing opportunities.
- Setting quotas to ensure women are represented in middle and top-level management to offset any internal gender biases. Research has shown that quotas can provide a useful starting point for ensuring that an initial critical mass of women are represented in leadership, helping to normalise gender equality in health leadership.
- Undertaking a gender audit to map progress against female leadership targets.
- Providing leadership training to students, young medical professionals and those in decision-making positions.

5.3. Flexible working and impact of unpaid care work

Care and profession | The dual burden posed by domestic care obligations and professional responsibilities is a well-articulated challenge for women with families in both Uganda and Somaliland. The majority of respondents agreed that due to gendered cultural norms, unpaid care obligations are the responsibility of female health workers, with little or no shared responsibility. In both countries, female respondents stressed that this burden restricted the possibilities and opportunities available to them, especially in relation to their choice of specialisation, their ability to progress to more senior positions, and their ability to undertake further medical training. Dr Dembe*, a female doctor, explained that many women accept employment opportunities at medical institutions that offer low salaries to be closer to their families. A female medical academic from Uganda suggested that: *"as a lady, every child you have is about ten publications that are lost."* The dual burden is compounded by a lack of flexibility – with only the occasional exception, health employers were found to implement no flexible working policies that would allow women to work part time or to limit the number of unsociable hours that they are expected to work.

Box 2: Female Ugandan doctor explains that managing multiple demands leaves her feeling conflicted:

"I rarely get home before 9pm. There is so much to attend to, so you end up doing pending or personal work after five and you have to pray that when you probably get home you leave the work aside to attend to the children. The only time one has is a weekend, especially Sunday when I take the kids to church then for an outing. I also try to make it to my children's school activities, although it is very hard. One has to sacrifice and find the time depending on the importance attached to the school event and this is what the children will remember that their father used to attend their school activities. It's about building memories."

Compromises | In response to financial demands, women are making significant compromises. In some cases, female health workers work in multiple institutions at a time, sacrificing the time they had to spend with family. As one nurse in Somaliland stated: *"the salary is poor – only USD$70 per month and it's not enough to support our families, so we end up working in more than one place or overtime to earn extra money. We end up losing time that we would love to spend with our children."*

Maternity provision | The majority of respondents commented on the inadequacy of maternity provision and the variation of provision between private and public institutions. Despite the existence of legislation and policies for maternity leave, provision was found to be inconsistent, with the length of leave varying greatly between institutions. In Somaliland, labour laws state that women working in public hospitals are allowed up to four months maternity leave, but in the private hospitals involved in this study, women are permitted only 40 days. In the public sector, the maximum length of leave varied from six weeks in a university context to three months plus one month's annual leave in government ministries. Female doctors in Somaliland stated that: *"We tried many times to convince our management team for this law, but they will not accept it, if you insist more you will lose your work, so that its compulsory to us to obey."* In Uganda, labour laws stipulate that employees are entitled to paid maternity leave for 60 working days. However, these laws are often poorly implemented. Female doctors in a private-for-profit institution in Uganda noted that maternity leave was unpaid, so most new mothers return to work within a month for financial reasons and for fear of losing their job.

Maternity facilities | In Somaliland, female employees in private institutions have no allowance for breastfeeding time upon their return to work, while in government institutions women were entitled to up

to two hours' breastfeeding time per day. In reality however, many women are unable to benefit from this policy because their homes are located too far away from the hospital to enable them to return, and there are no childcare facilities in or near their workplace. In instances where women reported having positive maternity experiences, particularly in relation to flexible working hours, this was usually dependent on favourable circumstances – such as having a supportive manager – rather than on standardised practice.

Paternity Leave | Prescriptive gender norms have a negative impact on men with childcare obligations. In both Uganda and Somaliland, paternity leave options were either unavailable or very minimal, with three days being the maximum in Somaliland. Single fathers with young children and no childcare support were found to face many of the same difficulties as women, but gendered cultural norms mean that their needs are not always accounted for.

Recommended measures to ensure flexibility for employees with childcare obligations

Female respondents in Uganda and Somaliland were clear about the changes they thought necessary in health institutions to create a more flexible working environment, to promote a better work-life balance for women, and to increase the opportunities available to parents in the workplace. Strategies to address these changes could include:

- Introducing strict guidelines limiting doctors' working hours so they can spend time with their families. The doctor-patient ratio could be improved by training more medicapersonnel to reduce the heavy work burden, optimising productivity.
- Facilitating flexible working arrangements (part-time or flexible working hours to accommodate child-care obligations).
- Standardising maternity and paternity leave within all medical institutions, in accordance with national labour laws. This practice should be formalised through institution-level gender equality policies which all staff should be made aware of. Staff should receive a level of remuneration throughout the leave period to enable them to benefit from this opportunity.
- Informing new fathers of their right to take paternity leave.
- Standardising the provision of affordable childcare facilities near or in health workspaces to account for the care responsibilites of men and for the double burden faced by women.
- Providing nursing mothers with adequate time and facilities for breastfeeding. Where possible, female staff should be provided with a clean and safe private room for nursing their babies.
- Introducing gender awareness in school and university curricula.

5.4. Gender-based violence (GBV) and abuse

Abuse | Female respondents reflected on the different types of abuse that constitute GBV in their community. Doctors in Uganda noted that a normative focus on physical violence overshadows the more potent nonphysical violence which remains widespread and unaddressed in workspaces and in society as a whole. As such, psychological abuse is often normalised or disregarded. Dr Abbo*, a senior manager at a private company, drew attention to the subtlety of indirect gender-based abuse: *"You can't put a finger to it but sometimes there is some sort of sexual harassment, not that someone will touch you but through some comments and attitudes."* Moreover, female respondents who had reached positions of power stated that they face passive or overt aggression and sexism from their male colleagues, especially if they are young.

Complexity of GBV | Known cases of GBV were limited among respondents. The health professionals who participated in FGDs in Uganda did not highlight GBV as a major issue, stating that the ethical code of conduct in public health facilities – particularly in faith-based institutions – helped to prevent GBV. While GBV was not recognised as a common concern, a limited number of examples of sexual coercion were provided by Ugandan health professionals, in which senior males in the medical profession had used their power to coerce young female staff and students into providing sexual favours. An example of this was provided by a female respondent who stated that some of her university professors had expected sex from female students in exchange for university certificates, and had subjected female students to bullying and intimidation if they refused. In Somaliland, few respondents acknowledged the occurrence of sexual harassment directed at female staff. However, there was a common recognition that women are more likely to be verbally abused by managers than their male counterparts. It was also suggested that female nurses working nightshifts are susceptible to intimidation from patients' relatives who assume that females are "*weak and unqualified health workers.*" No respondents in either Uganda or Somaliland were aware of any institutional policies promoting a zero-tolerance attitude to any form of violence, nor were they aware of any mechanisms for dealing with cases of GBV in their workplace.

Box 3: Personal accounts of gender-based abuse from Uganda

Dr Abbo* explained how she had experienced non-physical violence in her marriage. She said it stemmed from the ways in which society privileges men whose power is threatened by a woman's progress: *"They feel like if a woman has some sort of power, she will threaten his kingdom."* She explained that violence can often be emotional, rather than physical. In her case, violence was deployed through the withdrawal of financial support, putting a strain on her own finances as she fended for the family on her own.

SM Violence | Respondents in Somaliland identified violence against both women and men as a cultural phenomenon, stemming from issues that include clan-based rivalries and financial disputes. For example, according to a female Somali nurse: *"one of our female staff was beaten up badly by patient's relatives, she had a serious eye injury and broken maxilla bone. The management didn't do much to help her and the issue was solved outside the hospital in clan based traditional method."* In this instance, due to the specific cultural manifestation of violence, the issue was not seen as gender-related. Therefore, additional research which applies a gender lens to clan-based violence is necessary before further conclusions can be drawn.

UG Stigmatisation | Female respondents in Uganda noted that the hidden nature of GBV and the stigmatisation experienced by female survivors means that many are unable or unwilling to talk about it openly. In recognition of the growing body of evidence on the prevalence of GBV in the workplace in both high-income and low-income countries, it is likely that the true extent of GBV will remain hidden across Uganda and Somaliland until further research is undertaken. A carefully designed and culturally appropriate qualitative participatory study – grounded in a broad definition of GBV that includes psychological, physical and sexual abuse and coercion – is required to gain a better understanding of the scale and scope of the issue.

Recommended measures to prevent and address GBV in medical institutions

In both Uganda and Somaliland, GBV is an area where considerable work is required, both in terms of awareness raising at the community level, and in terms of standardising GBV policies and procedures at the institutional and national level. The following recommendations incorporate important steps to facilitate this change:

- Institutionalising a national GBV policy that is mandatory for all medical institutions promoting a zero-tolerance attitude to any form of violence or abuse.
- Implementing awareness-raising and training on GBV for all members of staff in order to mitigate its occurrence and to encourage staff to speak up about abuse. This should include targeted training for managers and other relevant members of staff on how to recognise and respond to cases of GBV in the workplace.
- Sensitising the wider community through media campaigns, radio programmes, community training, and other strategies. For example, one of the participating female doctors' institution in Uganda set up GBV Prevention Committees in local communities to encourage dialogue within communities, churches, and the family arena to open perpetrators' eyes to the consequences of GBV for families and communities.

5.5. Voice

Gendered staff representation | Many male respondents felt that there were adequate processes in place for staff to raise grievances, although they conceded that there is a lack of staff unions, councils and representatives. By contrast, many female respondents in both public and private institutions in Uganda and Somaliland expressed a view that speaking up about their concerns was generally discouraged. A number of nurses in Somaliland stated that in public institutions, women's complaints are not listened to, and in some instances individuals have been threatened by members of management for speaking out. Female members of a doctors' association in Somaliland highlighted that their concerns were not acknowledged because the majority of members are male and the men take responsibility for decision making, *"So most of the time they [men] don't consult us [women] and don't consider our decisions."* This reality is mirrored at the government level, with a representative from a Somaliland government ministry stating the ministry's overwhelmingly male leadership means that women have very little formal voice within the establishment – an inequity that is further compounded by the absence of a national gender policy. A similar situation exists in Uganda, where FGD participants noted that despite the existence of staff representatives through whom grievances can be raised, female staff are reluctant to vocalise concerns through fear of being reprimanded.

This said, a number of the doctors and policy-makers interviewed in Uganda acknowledged their ability to use their position of seniority to make specific demands. Dr Miremba*, for example, lobbied management for the installation of a permanent breastfeeding room for new mothers. Another positive example of women using their voice to affect change was provided by respondents in Uganda in relation to the use of motorcycles during fieldwork and community outreach to support HIV patients. Respondents stated that in the past, the motorcycles provided were often large, powerful ('macho') models better suited to men. Following complaints made by female staff, the issue was later addressed by the leadership of the institution who purchased smaller, user-friendly motorcycles suitable for all to use, making it easier for women to participate in fieldwork.

Recommended measures to build women's voices in medical institutions

Methods to improve staff representation in the workplace could include:

- Facilitating awareness-raising courses which help colleagues to recognise and mitigate inherent sexism in attitudes and behaviours. A Ugandan doctor noted that behaviour change is necessary because: *"we don't want the women to take on these [leadership] positions and again they are scared to speak out"* because they are concerned they will be seen as aggressive.

5.6. Knowledge of Gender Issues

Gender knowledge |There is a notable gap in gender awareness in both Uganda and Somaliland across health institutions. At the time of research, none of the participating health institutions or ministries provided any gender training. Of the health professionals involved in the study, only a limited number had received any gender training, predominantly from development partners. Respondents stated that any training they had received was inadequate and any learning had not been implemented.

Recommendations for improving gender knowledge and awareness in health institutions

Acknowledging the lack of gender awareness in their institutions, respondents suggested onsite training as a primary solution, stressing the ineffectiveness of external workshops where only a few can benefit, or online training as a limited number of people possess smart phones.

Additional recommendations include:

- Designing and displaying posters in health centres to improve awareness of gender issues among health workers and the public.
- Holding on-site training sessions and talks on gender for female and male health workers on specific issues such as GBV.
- Encouraging a 'trainer of trainers' approach to gender training and nominating 'gender champions' within health institutions.
- Conducting gender training through participatory workshops to enable female and male health workers to interact and discuss their own gender-related experiences, and to develop collaborative strategies for change.
- Offering online gender training as a supplement to workshops.
- Sensitising the community so they can recognise their own gender biases.
- Establishing a gender awareness day in hospitals and/or at the national level.

4.2.7. Gender policies and legislation

Progress on introducing gender-sensitive legislation varies between the countries studied. In Uganda, a national gender policy and other relevant legislation are already in place, while in Somaliland no relevant policies or legislations have been implemented. However, as the many cases of covert and explicit gender-based discrimination outlined above demonstrate, the existence of gender-sensitive laws and policies does not guarantee their implementation.

Importantly, no gender equality policies are currently in place in any of the health institutions contributing to this research. The introduction of such policies is vital to provide gender-responsive regulations such as paid maternity and paternity leave, transparent and gender-equitable hiring and promotion practices, and zero tolerance to any forms of GBV. Policies are also critical for establishing accountability processes within health institutions on the part of management and other members of staff. As such, it is important to ensure that staff codes of conduct include gender equality principals.

5. Conclusion

The purpose of this study has been to identify the main enabling factors and barriers posed to gender equality for health professionals in LMICs. The participatory methodology which underpinned this study sought to provide nuanced insights into the multifaceted nature of gender inequality in two very disparate contexts: Uganda and Somaliland. The expertise of the researchers, who were all gender-focussed academics active in their communities as advocates for equality, enabled THET to gain a contextualised and analytical insight into gender equality within the health workforce.

This report covers a range of structural and agency related factors which affect gender equality at various levels of the health system, from governmental departments, to health facilities and academic institutions. The main factors identified in the course of the research included: gender discrimination and stereotyping, equal access to opportunities, flexible working and unpaid care work, GBV, representation and leadership, knowledge of gender issues and gender policies and legislation. These dimensions of gender equality manifest at various levels of the health system and are visible in national and institutional policies, and the attitudes and behaviours of patients and health professionals.

While researchers identified some positive cases of men and women disrupting gender stereotypes, these are still in the minority, and the day-to-day reality of discrimination and imbalance is unfortunately still the norm in Uganda and Somaliland. In order to overcome the different obstacles identified, we need targeted and tailored interventions. Each of the challenges highlighted in this report require a different type of response; in some cases a top-down approach where management takes the lead in implementing facility-wide policies may be more appropriate, while in other cases community-wide participatory and consultative awareness raising is necessary.

The range of overlapping research findings identified in Uganda and Somaliland, and the global relevance of some of these issues – such as the burden of unpaid care responsibilities for women – necessitates a systemic yet context-specific response. This report has sought to highlight the cross-cutting nature of the inequalities experienced by health professionals. Inequality and discrimination experienced on the basis of gender is often compounded by other factors such as age, socioeconomic status, access to education, and clan-associations in the case of Somaliland. Such nuances and overlapping cleavages need to be given appropriate consideration when approaching the gender equality.

The findings put forward in this report seek to contribute to the existing evidence base on gender equality in LMICs with the aim to stimulate gender awareness across the healthcare and international development communities and to support the advancement of gender equality in all spheres of work.

"Until we get to a point where it is normal to see 50% or more of women on the board or at senior management, women are still not going to aspire for these positions and men will not accept that women can take these roles...You know how they say equality is giving everyone the same size of ladder to climb, but sometimes you need to give the shorter person the taller ladder to climb to be able to see overboard." Female Ugandan Doctor.

Annex 1: Detailed list of research questions

1. Gender discrimination and stereotypes

- What barriers and enablers did female and male healthcare workers encounter in their journey to employment? (family attitudes, school, college, application for jobs).
- Have they been able to fulfil their ambitions/interests?
- How do they experience discrimination in their daily work (attitudes, assumptions, roles and gendered division of labour, things people say etc - from other staff members, patients, managers?).
- Has there been any attempt to address discrimination and if so, is it successful? (e.g. non-discrimination policy, flexible working hours). Examples?
- What needs to change?
- Have there been any positive changes in terms of gender equality, attitudes and awareness? What factors have led to the changes?
- How are women, men and gender relations portrayed in the media and other forms of representation (training manuals, health leaflets etc).

2. Equal access to opportunities, wages and promotion

- How did the health workers get information about their job? Was it easy to access?
- How do employers make decisions about applicants? What are their criteria?
- Is there any positive discrimination/quota system to support inclusion of women and other traditionally marginalized people?
- Do health workers feel supported by colleagues and management (in terms of their daily work and aspirations?).
- What are some examples of support given?
- Are there examples where they did not feel supported?
- What kind of support would be useful?
- What opportunities are there for further training as part of the job?
- Are men and women given the same or different opportunities?
- What opportunities would they like to see?
- What opportunities are there for promotion?
- What are the criteria for promotion and how are decisions made?
- How do people learn about promotion opportunities? How do they apply?
- Are there any (successful) attempts to ensure women and men have equal opportunities for promotion?
- Do women and men receive the same pay for the same or similar work? If not, why not?
- Is there any transparency around wages? (for example, can details be easily accessed?)
- How could the gender wage gap be addressed? What policies or measures could be put in place?

3. Flexible working and impact of unpaid care work

- How do women (and men) manage home-life and professional life?
- Have caring responsibilities affected their choice of job or prevented them from taking up opportunities?
- Does their workplace have a flexible working policy? Is this implemented?
- What is the workplace policy on maternity and paternity leave? Is this implemented?
- What measures would help them create a better work-life balance?
- What accountability is there for implementation of the labour law?

4. GBV/ sexual harassment

- Have staff experienced sexual harassment, bullying or other forms of violence at work or know someone else who has?
- Did they speak out? If not, why not?

- What are the channels for raising the issue?
- What can healthcare institutions do to prevent and address GBV?
- Are there any measures that have been introduced in their institution? Are they successful? (why/why not?).

5. Voice and leadership

- What happens if they have a grievance at work (e.g, another colleague, manager, patient, unfair practices or something else)?
- Have they ever spoken out about a grievance or know someone else who has? What happened as a result?
- How does gender affect ability to speak out and chances of being listened to?
- What should be put in place to create transparency and accountability for all staff?
- Who are the staff representatives? Are there male and female representatives?
- Is there a women's rights/gender equality champion?
- Who are the decision-makers and how do they achieve those positions?
- What would enable female and male staff to be more involved in decision-making?

6. Knowledge of gender issues

- What is the level of awareness of gender issues and women's rights for all staff in the institution?
- What are the gaps?
- What type of gender training is available currently?
- Is it mandatory for all staff?
- What forms of training have been most successful?
- What could make training more useful and accessible?
- What forms of training and what types of content would be most appropriate and useful for staff? (e.g. online, face to face, workshops).
- What are some other ways to raise awareness of gender issues more generally in hospitals, clinics, local communities (e.g. posters, leaflets, workshops, radio programmes)? What would work best? Any examples of existing good practices?

7. Policies and commitments

- What polices or measures are in place to promote gender equality and prevent discrimination?
- How are these enforced?
- Is there an adequate budget for implementing labour laws and any gender-specific legislation (such as GBV law, anti-discrimination law etc)?
- Does anyone have responsibility for ensuring accountability on gender equality and women's rights?

In Somaliland a total of nine key KIIs were conducted, targeting policy makers, training institutions and health association, in addition to health services delivery staff and management. A total of eight FGDs were also conducted with female and male doctors from public and private hospitals; female and male nurses from public and private hospitals, male and female tutors from three teaching hospitals, and male and female staff from the Ministry of Health.

In Uganda 10 KIIs were conducted with seven female and three male health professionals. All the informants held senior positions in hospitals and other health-focused institutions and networks. A total of eight FGDs were held with separate groups of men and women in four types of institutions:

1. Government Hospital
2. Private Health Facility (Private for Profit)
3. Faith Based Health Facility (Private Not for profit)
4. Government Lower Health Facility

Annex 2: Research participants in Uganda and Somaliland

Uganda Focus Group Discussions by Type of Facility

Level	Type	Number of Participants		
		Female	**Male**	**Total**
Hospital	Government	11	12	23
Health Centre IV	Private for Profit (PFP)	06	03	09
Health Centre III	Private not for Profit (PNFP) - Faith Based	06	03	09
Health Centre IV	Government	16	04	20
		39	**22**	**61**

Somaliland Focus Group Discussions by Type of Facility

Target Group	Type of Facility	Number of Participants		Total
Nurses		Female	Male	
	Government Hospital	6	3	9
	Private Not for Profit Hospital	0	2	2
	Private Not for Profit Hospital	1	1	2
	Private Hospital	0	2	2
Doctors	Government Hospital	1	3	4
	Private Not for Profit Hospital	2	1	3
	Private Not for Profit Hospital	1	1	2
Tutors	Private Not for Profit Hospital	3	2	5
	University	1	2	3
Ministry of Health & Development Staff	MOH	8	8	16
Total FGD participants				**48**

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