



# Equity| Exploring Gender Equity in Health Partnerships

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**Speakers:**

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# How can Health Partnerships become a vehicle for gender transformation?

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# Overview

- The challenge
- Potential solutions – The toolkit
  - *Needs assessment*
  - *Policy development*
  - *Gender transformative interventions*
  - *Monitoring, Evaluation and Learning*

# GENDER ANALYSIS

**Aim:** to gain insights into concerns of health partnership staff and health providers.

**Methodology:** Qualitative study using focus group discussions (FGD); key informant interviews (KII).

**Respondents:** 71 participants in Uganda (doctors, nurses, lecturers, policy makers within the public, private)



# Context: Uganda



# YET...

- Yet gender wage gap is at 35%
- Inequalities are particularly prevalent in health-related indicators: (adolescent pregnancy; MMR at 343 per 100,000 deaths; HIV prevalence of women at 7.5% compared to men at 5%.)
- Social norms continue to reinforce gender inequality.

# KEY MESSAGE 1: GENDER DISCRIMINATION

- Prevalence of gender discrimination:

*“It happens all the time. People may not openly discuss it.”*

- Structural discrimination

- Male dominate top leadership deputized by women.

- Women dominate non-core positions.

- Increase in female medical students not reflected within leadership.

- The bar for women set too high.

- Discouragement for female interns especially from female doctors:

*“ladies doing medicine can never be good wives, mothers and good doctors at the same time. You have to choose one.”*

# KEY MESSAGE 1: GENDER DISCRIMINATION

- Male advantage/ “Patriarchal dividend” (Connell, 2008).  
*“I have had to shelve a scholarship for my PhD to first raise my children”.*  
*“As a woman every child you have is about ten publications lost.”*
- Disrespect for female doctors—about dressing, high heels:  
*“Some will go the extent of saying if she dare makes noise for me when am in labor, she will see me!”*
- Undermining women’s authority and/or passive aggression.  
*“some patients did not want to be attended to by female doctors feeling they are inferior.”*



## KEY MESSAGE 2: GENDER STEREOTYPING

- Doctors as inherently male and nurses female:

*Some patients referred to our female teachers as nurses and we the male students as doctors, stating: “wama doctor oli nurse abade angamba nkole bwenti, naye gwe olaba otya?”*

- Internalization of stereotypes

*“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. It is then that I changed to my dream career.”*

*“I had never seen a female doctor. I did not know friends whose mothers were doctors. All the doctors I saw were men and all the nurses female.”*

## KEY MESSAGE 2: GENDER STEREOTYPING

- Gender stereotypes are problematic for males too:
- Specializations largely reproduce traditional gender-stereotypic roles.

*“So women are softer and kids are calmer around them so we encourage them to do pediatrics...that comes naturally to females.”*

*“if I had been a male doctor, I would have pursued surgery given the flexibility with which men are privileged.”*

## KEY MESSAGE 3: GENDER-BASED VIOLENCE

- The silencing around gender-based violence was highlighted:

*"It is not easy to address because people tend not to open up... It is a setting where home issues may not be broadcast."*

*"It was more visible among nurses...they complain about spouses harassing them when they come for night duty, suspecting affairs with doctors."*

*"So the person is always money-less and always in crisis because their pay has to go through the man's account."*

*"They feel like if a woman has power, she will threaten his kingdom."*

- The valorization of marriage compounds silencing around GBV.

*"One time she claimed robbers at home had attacked her...I advised her to cancel her wedding, she insisted that all the shopping had already been done."*

*"so you're crying because of just an HIV test? Do you think you are the first person to get it?"*

*"You end up not following your passion because you are afraid of what a third party is going to do with your life."*

## KEY MESSAGE 4: VOICE AND LEADERSHIP

- Silenced by fear of branding as ‘the talkative one’; losing jobs, or transfer to remote locations.
- Women in power face passive aggression and sexism.
- Women’s voice heeded more in leadership.  
*“We were totally in their faces...So they provided a pumping space...a fridge...a shelf for breast milk.”*
- “Queen bee syndrome” (Derks, Ellemers, & Laar (2011)).

## KEY MESSAGE 5: GENDER TRAINING

- Absence of gender training within medical school.
- Gender training at the work places was online and optional.
- The training was useful nonetheless given its impact.
- The proposed gendered training needs summarized:

*“Women should be empowered to disrupt their marginalization...compete fairly...”*

*“Women should only be included if they can add value to the team.”*

*“Passive aggression which is “modern” gender abuse should be addressed.”*

*“Women in leadership should be prepared to embrace other women” .(Derks, Ellemers, Laar, 2011)*

*“Mentorship programs as a primary method of developing leadership.”*

## KEY MESSAGE 6: GENDER POLICIES

- Paucity of institutional gender based policy frameworks.
- Ignorance regarding gender-based policies in their institutions.
- Nevertheless, some of the doctors took gender into consideration:

*“I always look for structural barriers to ensure no one is left behind...So I basically do a gender analysis in order to involve the different stake holders.”*

- Leverage (inter)national gender laws to inform gender policies.
- Donors should attach gender equity as a condition for to funding.

# INTERVENTIONS

- Interventions right from childhood to attain a good education
- Child care facilities near women's work places and/or therein
- Flexible working hours
- Women encouraged to speak up
- Female doctors should be made visible
- Gender audits to inform recruitment
- Gender awareness days where gender rights are re-affirmed
- Sensitization of communities to empower both victims and perpetrators of GBV.
- Continuous training to empower women
- Institutionalize the mainstreaming of gender and promoting women.

## Summing up

*“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.”*

(Dr. Molly, Lecturer/Researcher, Medical School)



## References

Brody, A., Namatende-Sakwa, L. & Ahmed, R. A. (2019). Exploring gender equality in the health workforce: A study in Uganda and Somalia  
<https://www.thet.org/wp-content/uploads/2019/08/Exploring-Gender-Equality-in-the-Health-Workforce-1.pdf>

Connell, R. W. (2008). Gender. Cambridge: Polity Press.

Derks, B., Ellemers, N., & Laar, V. C. (2011). Do sexist organisational cultures create the queen bee? *British Journal of Social Psychology*, 50, 519-535.

# Gender Equality Toolkit for Health Partnerships



# Toolkit key elements

## This toolkit



This toolkit provides a set of guidance, tools and resources to support Health Partnerships to consider how they can improve gender equality in their projects, partnerships and institutions. The toolkit

provides a step by step guide to considering how gender equality can be incorporated and promoted at different stages in partnership and project development and delivery.

### 1. Needs assessment

How to conduct a baseline assessment through a gender lens.

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### 2. Development of partnership and project plans and policies

How to ensure projects, partnerships and organisations have gender sensitive measures in place.

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### 3. Implementation of activities

How to design interventions which advance and are mindful of gender equality considerations.

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### 4. Monitoring effectiveness of interventions

How to measure the impact of your activities.



# Gender in International Health Partnership Projects

**THET Conference 2019- Transforming Global Health**  
**26<sup>th</sup> & 27<sup>th</sup> September**

Dr Linda Gibson (Nottingham Trent University)

Dr David Musoke (Makerere University School of Public Health)

# MakSPH-NTU Partnership

- Higher Education Partnership
- MoU's
- Research
- Staff / student exchange
- Staff development
- Knowledge creations
- Collaborative projects
- Conferences
- Joint PhD supervision
- High level strategic commitment

Shared  
ownership



# MakSPH-NTU Partnership MoUs

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- First MOU 2012 – 2015
- Second MOU 2015 – 2018
- Third MOU 2018\* – 2023

# Principles of our partnership

Partnership is not just funding!

- Trust
- Reciprocity
- Sustaining activity
- Capacity building
- Empowerment
- Investment (people , communities & institutions)



# Strengthening the Community Health Worker programme for health improvement in Wakiso District, Uganda

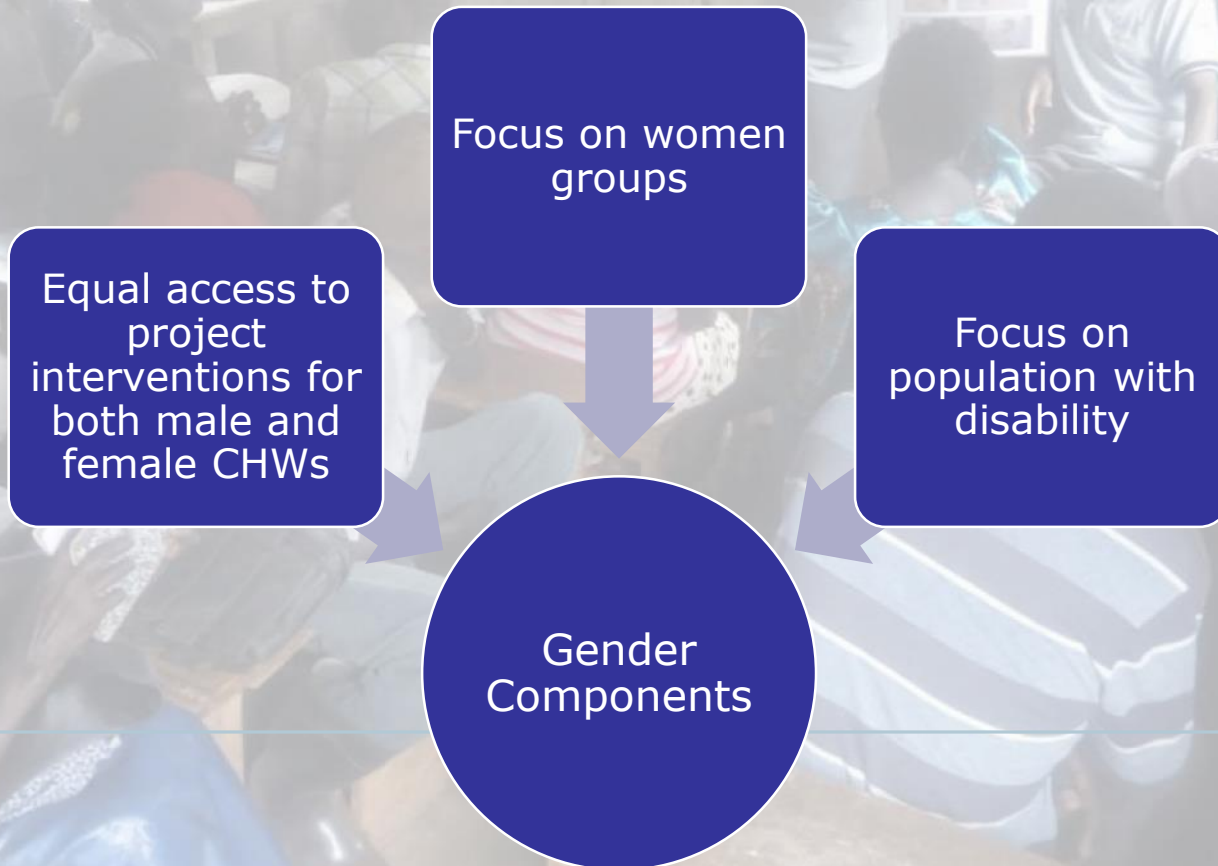
- THET / DFID HPS grant  
(Sustainability, Scale Up and Access)
- December 2017 to November 2018
- 3 sub-counties: Kasanje, Katabi and Bussi sub-counties
- Trained 34 CHWs supervisors on leadership
- Trained 200 CHWs on health promotion approach
- Provided motivational incentives: 3 motorcycles, t-shirts and certificates.





# Gender Component

- Enhance access to primary health care services around key health issues: communicable and non-communicable disease prevention, child health including immunisation, maternal health including antenatal and postnatal care, and family planning.



# Gender Components

Gender Components	Total	Male	Female
No. of CHW supervisors trained on leadership and management.	34	18	16
No. of CHWs in the 3 sub-counties trained and demonstrating improved knowledge and skills in their encounters with community members	200		
No of women sensitised by CHWs in the women groups	412	-	412
Number of people with disabilities involved in the study	313		



# Gender Indicators

1. How has this project specifically increased uptake of or access to healthcare services for marginalised or vulnerable populations?
2. How was gender considered within this project? Did the project increase uptake of or access to services for women and girls?
3. Have more women been able to upgrade their skills as a result of this project?
4. Has this project improved opportunities for career advancement for women?



# Indicator 1: How we targeted marginalised/vulnerable populations

- Collaborated with local leaders to identify people with disabilities.
  - In some project parishes, people with disabilities were able to formalise the groups and elected leaders which will continue to support them beyond the project.
  - These newly formed groups will serve as platform to support with other issues such as income generating ideas.
- *I am so happy for the training we received as people with disabilities as it has never happened to have someone gathering us together for health issues. We are only remembered by politicians during election time and that is all. Yet we are also human who need to know about how to live in good and healthy conditions. Long live Makerere University School of Public Health and your partners and never stop organising such good programs. Nakawungu Jane, person with disability, Katabi sub-county*







## Indicator 2: How gender was considered within our project



- Providing equal access to the project interventions for both female and male CHWs
- Women were also specifically targeted through existing women groups for wider reach
- 20 women groups engaged

# Indicator 3: Number of women who were able to upgrade their skills

- The female CHWs who were trained:
- The number of women who were health educated on key health issues: 412 women (through existing women groups)





## **Indicator 4: How the project improved opportunities for career advancement in women**

- Knowledge enhancement of these female CHWs improved their economic empowerment
- Capacity building of our female volunteers
  - Deborah Ikhile
  - Edwinah Atusingwize
- Investing in women as future global leaders



# Lessons Learned

- Gender equity means 'Leaving no one behind': that is, equal opportunities for both female and male
- Gender equity requires collaborative efforts
- Gender intersects with other social stratifiers such as income level, physical/mental disability
- Gender equity as a process not an outcome





# Challenges

- Gender equity is a debatable concept
- Difficulty of talking about and doing gender in different settings
- Having generic indicators around gender [not context specific]



# Lessons from our other projects

Ongoing PhD Study by Deborah Ikhile: How to Strengthen Primary Health Care Capacity for Early Detection of Breast Cancer Using a Socioecological Approach

- How gender norms affect access to health services
- Intersection of gender and culture
- Importance of gendered approach to primary health care delivery



# Lessons from our other projects

- Ikhile, Deborah, Gibson L and Wahidin A. 2019. "‘I Cannot Know That Now I Have Cancer!’ A Structural Violence Perspective on Breast Cancer Detection in Uganda." In *Gender, Global Health and Violence: Feminist Perspectives on Peace and Disease*, edited by Tiina Vaittinen and Catia Confortini. London and New York: Rowman and Littlefield (forthcoming in Autumn 2019).
- Gender as a structural determinant of health



# Lessons from our other projects

- Musoke. D, Ssemugabo. C, Ndejjo. R, Ekirapa-Kiracho. E and George. A. 2018. Reflecting strategic and conforming gendered experiences of community health workers using photovoice in rural Wakiso district, Uganda. *Human Resources for Health*, 16(41). <https://doi.org/10.1186/s12960-018-0306-8>
- Gendered roles of CHWs
- In partnership with RinGs (Research in Gender and Ethics: Building Stronger Health Systems)



# Contribution of Health Partnerships to Gender Equity

- Develop teaching and research capacities in gender practices
- Build & sustain longer term collaborations with global South HEIs: N-S; S-S; N-S-S to deliver context appropriate and gender interventions
- Facilitate future research and development projects opportunities around gender and global health



# How our partnership is contributing to career advancement for women

- NTU-MakSPH supported the visit of a CHW to the UK between June and July 2019 - Mariam
- CHW voice on her visit to NTU and work with women's groups to increase their empowerment [[Mariam's Video](#)]



Mariam presenting at the International Health Congress in Oxford, June 2019



Mariam with Dr Linda Gibson at NTU



# Next Steps

Reconceptualization of gender in global health through creative approaches to research:

- Participatory approach
- Visual approach e.g. photovoice
- Story-telling



THANK YOU!

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