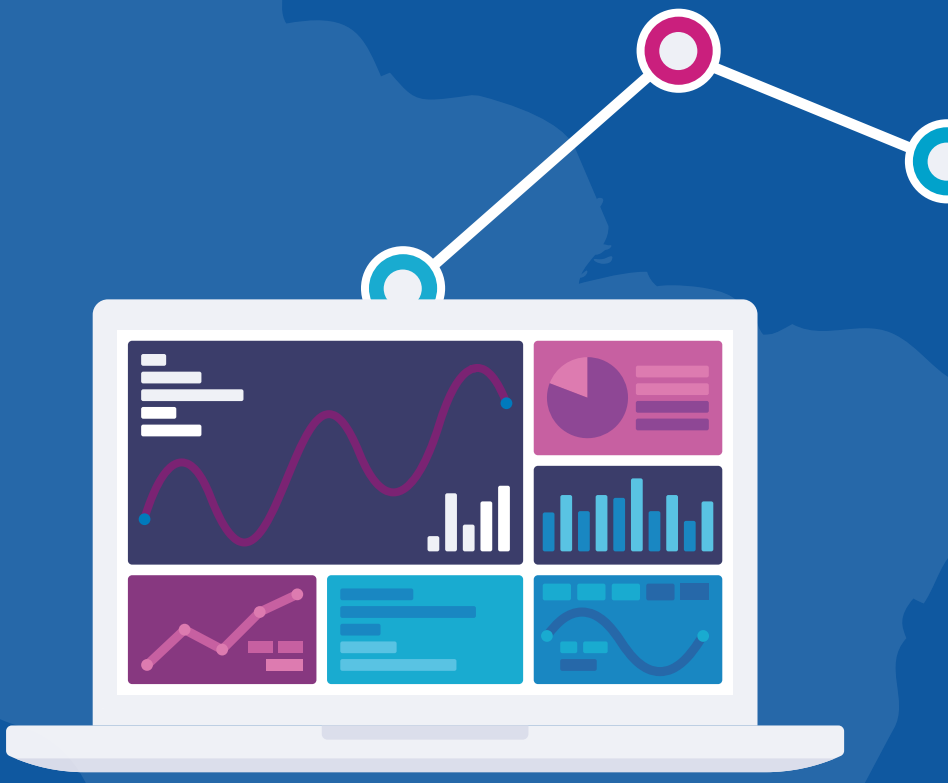
MAGE
Monitoring and Action for Gender and Equity

Gender and maternal and newborn health workforce: Key issues for monitoring and evaluation (M&E)



JOHNS HOPKINS
BLOOMBERG SCHOOL of PUBLIC HEALTH

GLOBAL FINANCING FACILITY

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Introduction

Improving maternal and newborn health within health systems entails ensuring that a woman and her unborn child reach their full potential for health and well-being during pregnancy, labor, childbirth, and postpartum. This brief explores key gender issues related to maternal and newborn health workforce and how they might impact maternal and newborn health outcomes. It includes examples of indicators that can be adapted for monitoring and evaluation (M&E) to increasingly achieve gender-responsiveness within the health workforce and contribute to increased retention of maternal and newborn health providers.

In the context of maternal and newborn health, gender-responsive M&E integrates women's needs, rights, and preferences, and the ways in which gender power relations and systems manifest as inequities (at all levels) to impact health and well-being. This can include through inequitable: access to resources; roles and practices; norms, values, and beliefs; and decision-making power and autonomy[1], into M&E of projects, interventions, and reforms. It further ensures that target groups are involved and represented in the whole project cycle (development, implementation, and evaluation processes)[1]. Including gender responsive indicators within health workforce M&E is important as the performance of the health workforce, and subseqent health outcomes, can be disproportionately affected by gender inequities. [1]

This brief addresses gender inequities that health workers who provide maternal and newborn health services experience. Key issues faced by providers include long working hours, poor remuneration, lack of training opportunities, violence, and restrictions on mobility. These can negatively impact provider motivation and satisfaction to do their job, as well as the quality of services provided.

Working hours

Nurses and midwives, the majority of whom are women[3], are more likely than men to undergo job stress because of long hours of paid and unpaid work and trying to balance their paid job responsibilities and unpaid home responsibilities, such as domestic work and child care[4]. For instance, nurses and midwives in Yemen and the West Bank Strip reported that they and their children suffered socially due to little or no help from their husbands for home responsibilities and childcare when they were at work[5]. Another study in Norway showed that despite the existence of policies and cultural attitudes that support work-life balance and an equal opportunity for medical training, fewer female graduates completed specialty training and instead switched to more flexible fields that could accommodate the balance between work, household responsibilities, and child care.[6]

Example indicators

Examples of the types of gender-responsive indicators that could be used to address the issues above[7,8]:

- The proportion of female health workers in active workforce by occupation, disaggregated to the health sector.
- The proportion of female and male staff at the health facility who reported being "highly satisfied" with their job.
- The proportion of time spent on paid work compared to unpaid work by women and men (time-use surveys).

Poor remuneration

Poor remuneration of health occupations mostly occupied by women

Globally, women in the health workforce are paid 19.2% less than men per hour[9]. There are occupational segregations where some roles are regarded as feminine and others as masculine. The feminine roles are often of lower status, low paying, with minimal or no benefits. The biggest percentage of health occupations are nurses and midwives, a highly feminized occupation, and frequently underpaid[10,11]. Community health workers, the majority of whom are women in many contexts, are often undertrained, under-resourced, and underpaid or unpaid[10,12]. According to the International Labor Organization, globally 43% of community health workers receive non-monetary incentives and 23% receive stipends[10]. Community health workers oftentimes incur indirect costs such as transportation that are not compensated, and in many cases, they do not have a clear job description, remuneration, or a job benefits structure[13]. Lack of benefits affects women more as they might find it difficult to take time off for maternity leave and child care[14]. This is especially true for underprivileged or poor women, such as immigrant women or single mothers. In countries such as the United States, women make up 75% of the population of immigrant healthcare workers, who often face additional barriers to fair remuneration and benefits[15].

Example indicators

Examples of the types of gender-responsive indicators that could be used to measure the issues above[8]:

- The proportion of skilled birth female and male staff at the health facility who received a written job description on deployment to the facility.
- The proportion of female and male staff at the health facility who reported being "highly satisfied" with their job.

Fewer opportunities

Fewer opportunities for training and decision-making for female health workers

Career advancement is an important motivator for health workers and can facilitate recruitment and retention of talent. Evidence shows that priority for career advancement in healthcare is often given to men first[3]. Associated training costs are sometimes unaffordable for women with reduced access to financial resources. The timing of training and location might in some contexts conflict with a woman's household responsibilities and freedom of mobility[16]. For instance, even though 90% of the nursing and midwifery workforce are women, there are few leadership positions held by nurses, more so women

nurses[17]. Further, women in healthcare are less likely to be placed in decision-making positions within the health system[16]. A study in the United Kingdom showed that the lack of women doctor leaders in medicine was attributed to rigid career paths and reliance on hierarchical systems that do not recognize the modern need for work-life balance[3]. Another study in Zimbabwe showed that men were more likely to be placed in rural and remote areas during their medical training which helped them to build their careers faster than women in the form of promotions[3].

Nurses and midwives sometimes do not have the ability to make decisions because their capacities and skills are less recognized or valued by medical and institutional hierarchies[5,18]. A study in South and Central Asia showed that nursing was seen as a low-status profession that was directly managed by doctors as key decision-makers, thus limiting nurses' exposure to opportunities for career advancement and leadership[3]. In contexts where women are disadvantaged by social gender norms that attach lower value to them and their professions[3], it is not enough to put women in leadership positions if their organizations do not support them in building their leadership skills[18].

Example indicators

Examples of the types of gender-responsive indicators that could be used to address the issues above include[8,19]:

- % of female and male staff with professional mentors to ensure clinical competence and improve performance.
- % of available posts that are filled by female staff in decision-making positions.
- % of female and male staff in the maternity unit who receive in-service training and regular refresher sessions at least once every 12 months in the identification and management of obstetric emergencies, routine care, and detection of obstetric complications during labor and childbirth, and essential newborn care, postnatal and breastfeeding support.
- % of female and male staff with recent training on respectful care.

Violence

Violence against women healthcare workers

Nurses, especially young and female nurses, are three times more likely than other occupations to experience gender-based violence (abuse, threats, or assault) in the workplace, and these events are even accepted as part of their job[20]. Research showed that 43.15% of female nurses experience verbal, nonverbal, psychological, and physical sexual violence from patients, mainly patients' families, physicians and coworkers[21]. In Pakistan, Lady Health Workers have reported being subjected to sexual harassment from both the upper management and lower-level male staff[13]. In Yemen, female midwives reported that they were disrespected because they worked at night and were subject to sexual harassment in homes, health facilities and within communities[5]. Research shows that female sexual harassment results in poor mental health such as anxiety and depression, poor physical health such as headaches, exhaustion, dizziness, loss of and increase in appetite, sleep difficulties, poor menstrual health, increased anger and nervousness, feeling sad, and loss of self-confidence[21].

In areas affected by conflict and complex emergencies, nurses and other health workers are at risk of attack. A WHO report showed that between January 2019 and January 2020, there were 10,054 attacks on health workers that resulted in 198 deaths and 626 injuries[17]. These insecure conditions disproportionately affect female health workers because they are more likely to be given lower social value and status[3]. For instance, a study in Yemen and Afghanistan reported that 58% of midwives were afraid to attend births at night in certain neighborhoods due to poor security conditions[5]. Violence against female health workers undermines their confidence in the workplace and affects their ability to progress in their careers or be promoted to leadership positions. In extreme cases there could be increased job stress and demotivation leading to frequent absenteeism, attrition, and decreased willingness to join the occupation, contributing to a shortage in the health workforce[18].

Example indicators

Examples of the types of gender-responsive indicators that could be used to address the issues above include[22]:

- Availability of violence against women programs for healthcare providers.
- Availability of a national health policy that includes responses to violence against women.

Mobility restrictions

Restrictions in the mobility of women health workers

In some settings, it is socially unacceptable, especially for women who are not married, to be seen moving alone and at night[13,18]. Female health workers might find it challenging to conduct home visits and outreach. In Cambodia, female health providers reported being unable to work night shifts due to disapproval from the community[3]. In Yemen, nurses and midwives reported low status in communities because they performed night shift duties which were contrary to their social norms that disapproved of women moving at night[5]. Another study in Afghanistan showed incidences of intimate partner violence where some female community health workers reported being humiliated and harassed for attending to calls for emergency deliveries at night because their husbands thought that they were being promiscuous[23].

Example indicator

An example of the type of gender-responsive indicator that could be used to address the issues above is[24]:

- Availability of measures to protect female health workers from disrespectful treatment, gender-based violence, and other security threats.

About the MAGE Project

The Monitoring & Action for Gender & Equity (MAGE) project is a partnership between Johns Hopkins University (JHU) and the Global Financing Facility for Women, Children and Adolescents (GFF), a multi-stakeholder global partnership housed at the World Bank that is committed to ensuring that all women, children and adolescents can survive and thrive. Supported by the Bill and Melinda Gates Foundation, MAGE aims to advance and strengthen the capacity and execution of gender- and equity-intentional monitoring and evaluation and build sustainable systems and capacity for the use of data to improve gender equality and RMNCAH-N outcomes for women, children, and adolescents in GFF partner countries and beyond.

Suggested Citation

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