



# Conceptual and Practical Foundations of Gender and Human Resources for Health

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*The views expressed in this document do not necessarily reflect the views of the United States Agency for International Development or the United States Government.*

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## I. Introduction

The desired outcomes of all gender-related actions in human resources for health (HRH) are improved service delivery and health—for health workers<sup>1</sup> and for the communities they serve. However, gender equality should be a primary goal in all areas of social and economic development<sup>2</sup>. Thus, gender inequalities and discrimination need to be addressed in HRH policy and planning, workforce development and performance support to ensure that women and men have equal opportunity and treatment in employment and occupation, whether it is in the formal or informal health sector.

As it worked to strengthen HRH systems to implement quality health programs in developing countries, the Capacity Project focused on how differences and inequalities affect women’s and men’s opportunities for education, training, occupational choice, employment and professional advancement. The Project promoted research and interventions that were *deliberate in addressing gender inequalities and discrimination* that act as barriers to workforce participation, within the following strategic framework:

- **Purpose:** Eliminate gender-related barriers to women’s and men’s participation in the health workforce that affect workforce entry, safety, professional satisfaction, rights at work and retention
- **Strategic objectives:** (1) Strengthen HRH policy and planning to promote gender equality; (2) increase gender integration in education, training and work; (3) create supportive, fair and safe work environments.

**Gender Discrimination:** Any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights (World Health Organization, 2001). Gender discrimination includes distinctions, exclusions or restrictions based on the biological characteristics and functions that differentiate women from men (e.g., pregnancy). Gender discrimination typically disadvantages women more than men. Discrimination against women has the “effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality, of human rights and fundamental freedoms in the political, economic, social, cultural civil or any other field” (Division for the Advancement of Women, 1979). In the world of work, gender discrimination has been directly or indirectly linked to pregnancy, marital status and family responsibilities and is manifested in occupational segregation, wage discrimination and sexual harassment.

The Capacity Project conducted extensive literature reviews in the areas of gender and HRH, workplace violence and gender discrimination. Two studies explored gender inequalities and discrimination in formal and informal health workforces:

- A study in Rwanda of workplace violence and gender discrimination as barriers to women’s workforce participation on an equal basis with men (*objectives 1 and 3*)

<sup>1</sup> The term “health worker” applies to all workers in formal and informal sectors, including those in the allied health occupations.

<sup>2</sup> International Labor Organization. In “Definition of Gender Mainstreaming” gender mainstreaming is defined in its original context of the UN Fourth World Conference on Women held in Beijing in 1995. Accessed 1 May 2009 at: [www.ilo.mirror.cornell.edu](http://www.ilo.mirror.cornell.edu)

- A study of men as providers of HIV/AIDS care and support to address shortages in the informal care workforce for HIV/AIDS in Lesotho and identify the dynamics of occupational gender segregation and stereotypes (*objectives 1 and 2*).

The studies drew on national policy commitments to gender equality and made use of a research-to-practice approach in design and dissemination to increase the likelihood that study results would be applied. This paper presents what the Capacity Project learned about various forms of gender discrimination and how they serve as barriers to health workforce participation, against the backdrop of the global gender and HRH literature. It points to the central roles played by *pregnancy discrimination* in weakening women's ties to the health workforce, and *occupational segregation* in limiting men's role in the development of a robust informal HIV/AIDS caregiving workforce. The paper also offers global recommendations for future action through health workforce policy, planning, development and support.

## II. Gender Discrimination and Unequal Opportunity as Core Barriers to Workforce Participation

The Capacity Project research studies in Rwanda and Lesotho built upon a growing body of knowledge regarding the gender issues in HRH. Recent reviews summarized the literature from various countries describing factors related to gender inequality in the health sector, including migration, gender dynamics in medicine and nursing, violence, the concentration of women in nonmanagement or stereotypically “female” jobs such as nursing, pay gaps or unremunerated care work and the difficulty faced by female community health workers (CHWs) whose jobs are not seen as legitimate *vis à vis* the formal health system, resulting in less access to support and training (George, 2007; Reichenbach, 2007; Sen et al., 2007). Women generally comprise the majority of workers in the health sector (between 65%-85%) but occupy lower-level cadres, predominate in the informal care economy and experience gender hierarchies in management, which result in differences in pay and promotion (Ogden et al., 2006). Gender inequalities are particularly acute in HIV/AIDS care (90% of which is provided in the home), with women and girls making up the informal care workforce (Ogden et al., 2006; Sen et al., 2007). Women and girls bear the greatest responsibility for family and community caregiving, resulting in lost income and educational opportunities and psychological and physical health impacts (Sen et al., 2007; Ogden et al., 2006; Lindsey et al., 2003). Women have less access to social protections such as insurance, social security, leave or pensions because these are typically tied to employment status. Their responsibility for caregiving at home and in the workforce limits their autonomy and opportunities to participate in paid labor, and relegates them to part-time, temporary or informal jobs that do not accrue social protections (Blau et al., 2006; Sen et al., 2007).

It is useful to analyze gender issues in HRH in the context of gender discrimination and unequal opportunity at work. These have been implicated as key factors that impact women's workforce entry, treatment at work, re-entry and retention, constrain career advancement and weaken women's ties to the paid workforce (International Labor Organization [ILO], 2000; Budig and England, 2001; Bisgrove and Viswanathan, 1997; Standing, 2000; Standing and Baume,

2001). Occupational segregation<sup>3</sup> is a widespread form of discrimination that is rationalized by gender stereotypes based on so-called essential traits of women and men that hold that they are better suited to some tasks rather than others (Ridgeway, 2006). In the marketplace, beliefs and stereotypes about what is appropriate work for men and women ultimately impede the crossover of women into male-identified occupations and men into female identified-occupations. Stereotypes in educational curricula and vocational counseling channel students into “male” or “female” jobs with unequal opportunities for being hired, promoted and compensated because there are differing values and compensation attached to “male” and “female” jobs (Dube, 2006). Occupational segregation usually reflects unequal opportunities; it is “strongly related to inequalities in pay, career prospects, and employment protection,” and has “proved to be one of the most profound dimensions of labour market inequality (compared with, say, race or class) and the most enduring” (Scott, 1994; Tzannatos, 2009).

HIV/AIDS caregiving is typically a gender-segregated job in which unpaid “women’s work” in family structures extends to care for others in the community (England, 2006; Sen et al., 2007; Marshall, 1998; Newman et al., 2009). Because “women’s jobs” are undervalued and undercompensated, men are less likely to want to enter this occupation (Careers Scotland, 2004; England, 2006; Anker et al., 2003). Although the role that men and boys actually play as providers of care in the context of the HIV/AIDS epidemic has been poorly documented and understood (Reichenbach, 2007), it is generally recognized that women and girls continue to bear the greatest responsibility for the psychosocial and physical care of family and community members (Ogden et al., 2006) as well as the greatest costs (Akintola, 2006; Lindsey et al., 2003). Occupational segregation, recognized worldwide as a major source of inequality, labor market rigidity and inefficiency (Anker, 1997), is extremely problematic—apart from considerations of fairness—in that it impedes the development of robust health workforces by creating barriers to health workforce entry and career progression.

Gender stereotypes reflect status beliefs that associate greater “status worthiness and competence” with men than with women and create “a network of constraining expectations and interpersonal reactions that is a major cause of ‘the glass ceiling’” (Ridgeway, 2001). The “glass ceiling” is a form of vertical occupational segregation wherein the advancement of a qualified worker within the hierarchy of an organization is blocked at a particular level because of some form of discrimination, most commonly sexism or racism (ibid.). The “ceiling” that limits upward advancement is “glass” (transparent or invisible) because the limitation is not immediately apparent and is typically an unwritten and unofficial policy.

Pregnancy discrimination refers to exclusions, restrictions or distinctions made on the basis of pregnancy, childbirth or related medical conditions, and occurs when expectant women or women of childbearing age are: not hired; fired; not promoted; demoted; not rehired after maternity leave; or have their pay docked; have working hours limited; or are otherwise discriminated against due to actual pregnancy, intention or potential to become pregnant (ibid.). An expectation to bear children and girls’ and women’s disproportionate responsibility in child care and household labor contribute to their own or their families’ unwillingness to invest in girls’ education and women’s careers, as well as constituting strong cultural barriers to health workforce participation (Hartmann et al., 2006). When a female health worker enters the

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<sup>3</sup> See Annex A: Definitions.

workforce, cultural barriers may be reinforced by employer discrimination in the form of management policies or practices that consider men as breadwinners and advantage them in terms of compensation and access to social protections, or by lack of specific policy (for example, policy that protects the right to work regardless of pregnancy status or potential, or that supports flexible work arrangements). Family responsibilities can result in female workers taking more flexible but insecure (part-time, temporary) occupationally segregated work that typically has lower status and compensation (Polachek, 2006). Part-time work has been associated with a “motherhood wage penalty” that may result from the effects of motherhood on productivity as well as from employers’ discrimination against female workers with children (Budig and England, 2001). There is evidence that while men with children get an earnings boost, women lose earnings (Longley, 2009), including a “baby tax” wherein each leave for childbearing has an effect on a woman’s subsequent earnings, type of position, job advancement, level of management autonomy and power and benefits (Bisgrove and Viswanathan, 1997).

Other forms of gender discrimination come into play in education and work. Sexual harassment, considered both a form of workplace violence and a form of gender discrimination, is a common experience for women at work (di Martino, 2002; Newman et al., 2008). Two forms have been generally recognized in more and less developed countries’ laws: *hostile environment harassment* in which sexual comments or behavior have the purpose or effect of interfering with an individual’s work performance or creating an intimidating, offensive, hostile, humiliating work environment; and *quid pro quo harassment*, when work-related decisions or tangible job benefits (such as salary raise or promotion) are granted or denied based on an individual’s rejection of or submission to unwelcome sexual advances (Diversity and Equal Opportunity Office, 2009). Sexual harassment that includes sexist remarks or innuendos that denigrate a person’s work or competence may be a manifestation of resistance or hostility to women’s entry into traditionally male-dominated occupations. In these cases, the hostile environment may impel a worker to transfer or drive her out of the health workplace entirely. One effect of hostile environment sexual harassment is that it suppresses competition for desirable jobs<sup>4</sup>.

Wage discrimination or inequalities in remuneration (including systematically paying lower wages to women than men) is a worldwide phenomenon that may be linked to women’s employment structures and wage-fixing mechanisms (ILO, n.d.). While wage discrimination has been tied to education, experience and seniority, there is considerable evidence documenting differences in pay between women and men who have the same job, education and qualifications in the workforce, as well as for female employees with more seniority and better performance than male employees (National Committee on Pay Equity, n.d.). Rationales for wage discrimination include the belief that men need higher wages because they have families to support (a breadwinner benefit) or that differences in pay are due to choice of work, rather than a belief that differences in experience, training and occupation reflect larger workplace and societal discrimination (Reed, 2001). Occupational segregation contributes to wage differences because more women than men may be represented in a particular occupation (ibid.).

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<sup>4</sup> See *Jenson vs. Eveleth Mines* (or *Jenson v. Eveleth Taconite*) as an example. Filed in 1984, settled in 1998 for \$3.5 million, this was the first sexual harassment lawsuit in US history to be given class action status. Female employees of Eveleth Mines endured extreme sexual harassment from the men who believed women should remain at home and not compete with men for scarce jobs. This type of sexual harassment is perhaps more clearly understood as “gender harassment”.

Specific forms of gender discrimination that affect equal opportunity and participation in the health workforce are defined in Table I with illustrative examples. (For full definitions, please see Annex A).

**Table I. Gender Discrimination that Affects Equal Opportunity and Treatment and Participation in the Workforce**

<b>Discrimination Based on Marital and Pregnancy Status and Family Responsibilities</b>
<p><i>Exclusions, restrictions or distinctions at school or work made on the basis of pregnancy, childbirth or related conditions, such as unwillingness to hire, promote or retain female students or workers who may get pregnant and leave the workforce or require maternity leave and benefits. Examples include mandatory pregnancy testing or questions regarding planned pregnancies during recruitment; women being forced to retire upon marriage or pregnancy, or jobs requiring women not to get pregnant or marry; restricting working time of women (e.g., overtime); not hiring women because health insurance will reduce profitability or efficiency; women's greater responsibilities at home preventing their being considered for training; perceived lack of separation between personal and professional caring responsibilities. Encouraging women to take insecure (part-time, temporary, nonmanagement) forms of employment that are unprotected by benefits or labor codes) to accommodate family responsibilities. Expelling students from school if pregnant. Discrimination based on marital and pregnancy status and family responsibilities is associated with pay gaps.</i></p>
<b>Occupational and Task Segregation</b>
<p><i>Pervasive and widely documented form of gender discrimination that concentrates women and men in different occupations, jobs and tasks. Women are typically confined to a narrower range of work, in insignificant, lower grade and less well-paid jobs ("horizontal segregation"), often hold caring occupations (nurses, social workers, teachers) and remain at lower grades of work ("vertical segregation" typified by the "glass ceiling") that are less likely to provide benefits, on-the-job training, opportunities for promotion or to exercise authority or control, while men are found in managerial, technical and higher-paid positions. Examples include job advertisements excluding applicants of a certain sex; career counseling or recruitment that channels men away from caring professions and women into it; restricting women's entry into certain occupations or positions; transfer of the family's gendered division of labor into the informal, volunteer caregiving workforce. Occupational segregation is associated with wage discrimination.</i></p>
<b>Wage/Remuneration Discrimination</b>
<p><i>Systematically paying lower wages to women or minorities. Difference in salary and any additional benefits whether in cash or in kind, paid by the employer to the worker and arising out of the worker's employment (e.g., retirement pensions and health insurance) based on gender and not on objective differences in the work performed, seniority, education, qualifications, experience or productivity. Associated with biased perceptions of women's capabilities and commitment to work, gender segregated jobs, stereotyped perceptions or the perceived labor costs associated with biological and social reproduction (the "wage penalty for motherhood"). Examples include lower hourly pay related to temporary or part-time work; compensation tied to vertical and horizontal occupational segregation in which jobs typically held by women are undervalued; salary raises based on subjective appraisal or quid pro quo sexual harassment; policies or practices whereby an employer provides extra compensation to employees who are believed to be the "head of household" or "breadwinners" (i.e., married with dependents and the primary financial contributor to the household). Usually favors men and has a negative impact on women.</i></p>
<b>Gender Stereotyping</b>
<p><i>A rigid, oversimplified, generalized idea or image that attributes certain essential characteristics to men or women based on the belief that there are attitudes, appearances or behaviors shared by all men or all women. Gender stereotypes sustain occupational and task segregation, such as when an idea that women are uncommitted to work excludes them from senior leadership positions or when positive stereotypes elevate men's status and opportunities vis à vis women and preserve men in management positions (men as strong, decisive, competent, "breadwinners"). Negative stereotypes may also keep men out of "female" jobs (men as untrustworthy, emotionally noncommunicative, inept at caregiving).</i></p>



### Sexual Harassment and Assault

Violence (and discrimination) consisting of comments or behavior of a sexual nature that are unwelcome, offensive and detrimental to the person's human dignity at work. Hostile environment sexual harassment refers to receiving unwanted attempts to establish a sexual relationship; displaying sexually offensive or pornographic material in the work setting; being exposed to a sexually explicit discussion or conversation; being subjected to sexist remarks that minimize competence or ridicule based on one's sex; receiving sexual notes or other correspondence; receiving repeated requests for dates or to establish a sexual relation despite rejection; witnessing someone make a sexually suggestive gesture. Quid pro quo sexual harassment occurs when deserved advancement or continuation in service is conditional on sexual receptivity; or where unwarranted advancement is offered in return for sexual favors. Examples include being sexually coerced, cajoled, blackmailed or threatened; being offered money, gifts or favorable job treatment in exchange for sexual favors. Assault refers to attempts to stroke, fondle or kiss, being threatened with sexual assault, being physically coerced, assaulted or raped.

## III. Insights from Capacity Project Research

Capacity Project research provided insights into the ways in which gender differences, disparities and discrimination described in the global literature actually operate in the formal and informal health workforces in Rwanda<sup>5</sup> and Lesotho. Key study findings appear in Table 2. Pregnancy discrimination emerged as an important (though not the sole) form of discrimination faced by female health workers in Rwanda. Occupational segregation lay at the core of HIV/AIDS caregiver shortages in Lesotho<sup>6</sup>.

**Table 2. Gender Discrimination in Formal and Informal Health Workforces**

Rwanda (formal workforce)	Lesotho (informal workforce)
Gender discrimination is related to health workers' experience of violence at work, consistent with ILO findings.	Caregiving is not gender-neutral. Men were extremely unrepresented in the unpaid, informal caregiving workforce. A nexus of gender stereotypes about essential "male" and "female" traits, status beliefs and perceptions of men and of caregiving kept women in unpaid, voluntary HIV/AIDS caregiving and kept men out of it. That is, gender beliefs and stereotypes sustained gender segregation of this job.
The perception of gender discrimination is related to increased odds of experiencing violence at work. Negative stereotypes of women at work seem to justify violence.	Male respondents emphasized the technical aspects of caregiving and identified with more powerful male tasks and groups (first aid, miners), representing this work as more "masculine" by using male-identified traits such as bravery, courage, dignity and discretion.
Forms of discrimination appear to occur together: hiring or promotion decisions and negative evaluations linked to pregnancy and family responsibilities; sexual harassment; negative stereotypes; vertical segregation ("glass ceiling"); and task segregation.	Men stand to lose respect from other men and discretionary time by engaging in community-based HIV/AIDS caregiving, but stand to gain economically by entering the now-remunerated CHW cadre. While
Gender discrimination may exist but not be perceived, as in the case of the "glass ceiling." Gender discrimination hinders equal treatment at	

<sup>5</sup> Wage discrimination was not studied in Rwanda.

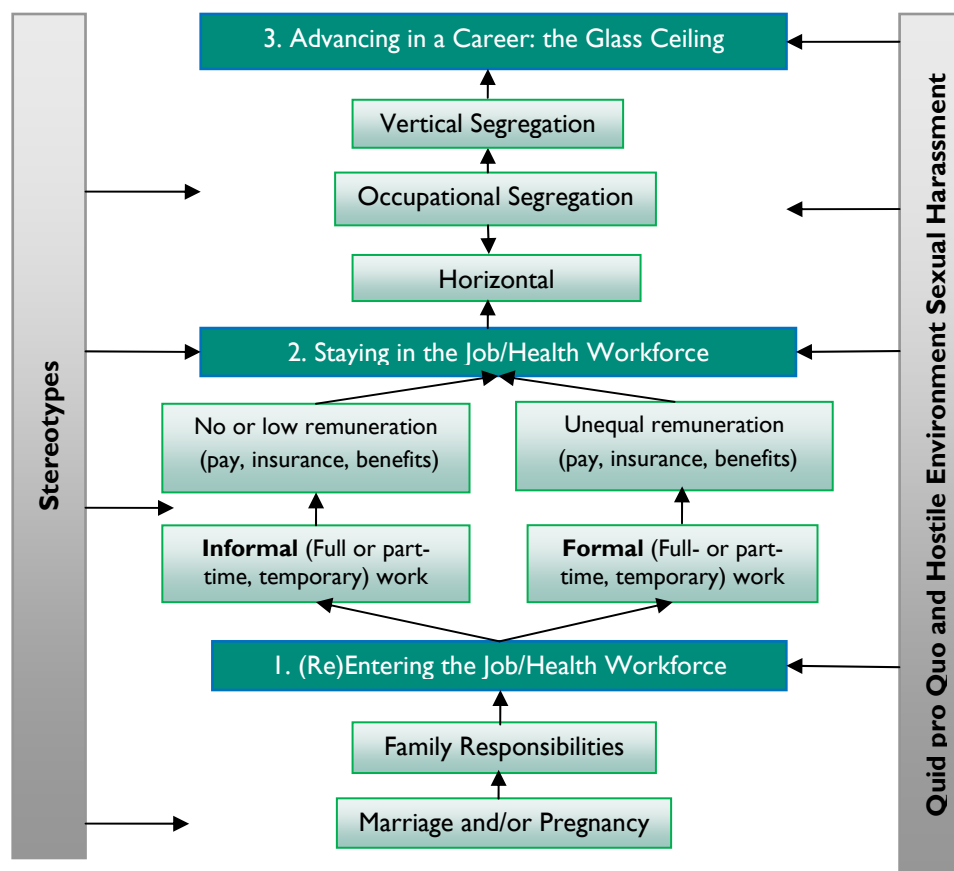
<sup>6</sup> The Capacity Project's gender research is described in separate documents: see Newman C. Workplace violence and gender discrimination in the health sector in Rwanda. Gender Research Brief No. 1. Chapel Hill, NC: Capacity Project, 2009. Available at: [http://www.capacityproject.org/images/stories/files/researchbrief\\_1.pdf](http://www.capacityproject.org/images/stories/files/researchbrief_1.pdf); and Newman C. Alleviating the burden of responsibility: men as providers of community-based HIV/AIDS care and support in Lesotho. Gender Research Brief No. 2. Chapel Hill, NC: Capacity Project, 2009. Available at: [http://www.capacityproject.org/images/stories/files/researchbrief\\_1.pdf](http://www.capacityproject.org/images/stories/files/researchbrief_1.pdf).

Rwanda (formal workforce)	Lesotho (informal workforce)
work and negatively impacts female health workers' career path.  De facto gender discrimination may exist in health workplaces in spite of a positive legal/policy environment and public rhetoric that strongly favors gender equality.	men's participation in HIV/AIDS caregiving can alleviate the disproportionate burden of HIV/AIDS care on women, they stand to lose the benefit of social recognition and may face competition from men in the CHW job.

## IV. Implications

The global literature of gender and HRH and the Capacity Project's gender research suggest that HRH leaders should view gender discrimination and unequal opportunity as key barriers to paid workforce entry, re-entry and retention, especially for female health workers, though occupational segregation acts as a source of labor market rigidity and inefficiency (Anker, 1997) that impedes men's fuller entry into caregiving and the development of robust, gender-integrated health workforces. With regard to women's experience in workforce participation, "gender discrimination" can be depicted as a system of related (for some forms, perhaps causally so) discriminations and unequal opportunities starting early in life<sup>7</sup> that affects entering and staying in a health job and advancing in a career. Figure 1 represents the most basic configuration of relationships.

**Figure 1: Gender Discrimination in the World of Health Work**



<sup>7</sup> For example, the foundations of occupational segregation are put in place when a worker enters a course of study as well as when (s)he enters the workforce.

The Capacity Project demonstrated that HRH policy research can be the platform for policy dialogue, development or change related to gender discrimination. The existence of these forms of discrimination and their relationships should therefore be documented by country workforce assessments and research as essential information to guide health workforce policy, planning, development and management. They should be targets of HRH policy and practice through equal opportunity legislation and policy and strong accountability systems. Attention must also be given to the cultural expectations that affect the entry and exit of potential (female) health workers, such as life cycle events (pregnancy, childbearing and care) that may result in female workers leaving or re-entering the workforce, foregoing training opportunities or scaling back work (sometimes permanently, if health systems remain unresponsive to life cycle needs). Gender stereotypes may militate against women's advancement in a career or against men's more active participation in caregiving occupations.

## V. Recommendations

Gender is a fundamental source of social stratification and status inequality across most societies. Women are typically disadvantaged by structural inequalities and discriminations embedded in laws, policies, sociocultural norms and roles that impinge on their health and work. When gender inequalities and discrimination operate in the workforce outside of the awareness of HRH policy-makers, planners, educators and managers, they may impede entry into health occupations or contribute to attrition, absences from work, lower productivity, poor health and low morale of health workers. The result is a limited pool of formal and informal health workers to deal with today's health and development challenges. It is likely, though, that HRH policies and programs that give attention to gender issues will more fully achieve their workforce coverage and productivity goals. Further, where women have greater opportunities to move into leadership positions, HRH programs are more likely to view health and human resources issues in more diverse ways, which in turn will improve health program effectiveness and health outcomes.

Given the negative impact of gender discrimination on the development and retention of health workforces—and pregnancy discrimination and occupational segregation as cases in point—national governments are called to think “upstream.” This involves putting in place systems to identify and monitor gender discrimination<sup>8</sup> in education and employment; translating the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and regional commitments to gender equality into national equal opportunity policies and law; vigorous implementation and enforcement of equal opportunity laws and policies through programs and accountability mechanisms; and finally, social education that valorizes caregiving and equal responsibility for it.

Access to and use of family planning, and women's confidence that they can control their fertility, will have beneficial long-term effects on women's abilities to participate more fully in the paid health workforce, since they are more likely to choose jobs with a greater degree of security, where they can work more hours, acquire more skills, earn more money and have more chances of job advancement (Bisgrove and Viswanathan, 1997).

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<sup>8</sup> Workplace violence should also be monitored.

Capacity Project research and the global gender and HRH literature suggest practical ways to address gender discrimination in health workforce policy, planning, development and support. Table 3 provides a summary of action items to eliminate or address gender discrimination, assure equal opportunity for education, occupation and employment and develop and manage more robust health workforces. Gender-aware HRH policy and planning, workforce development and workplace support must all be conceptually and practically integrated to eliminate gender discrimination over the long term and to realize both human rights and efficiencies in HRH at national policy and operational levels. (See Annex B for more detailed text on Gender and HRH Strategic and Practical Recommendations to Address Gender Discrimination.)

**Table 3: Gender and HRH Strategic and Practical Recommendations to Address Gender Discrimination**

<b>Policy/Planning:</b>	<b>Workforce Development:</b>	<b>Workplace Support:</b>
Strengthen HRH policy and planning to promote gender equality	Increase gender integration/ decrease segregation in education, training and work	Create supportive, fair and safe work environments
<p><i>Identify gender discrimination in HRH policy and workforce planning through workforce assessments that routinely gather information on gender discrimination at work, and on women's status relative to men's in policy and law</i></p> <p><i>Design human resources information systems (HRIS) to provide sex-disaggregated data for HRH policy and planning, including identification of discrimination in pay, promotion or training</i></p> <p><i>Translate international and national commitments to gender equality into national equal opportunity policies and laws</i></p> <p><i>Eliminate penalties for marriage and motherhood. Promote policies that respond to life cycle events linked to workforce entry/exit/re-entry, need for flexibility in hours/scheduling, pregnancy benefits and parental leave</i></p> <p><i>Document and address women's unpaid work and the unequal distribution of unpaid caregiving between women and men in the informal care economy. Create standardized protections and resources for volunteer health workers (e.g., financial incentives, health insurance/care, pensions)</i></p> <p><i>Government HIV/AIDS policy and implementers' programs should explicitly</i></p>	<p><i>Eliminate gender stereotypes in curricula that may serve as barriers to women's and men's entry into nontraditional health occupations or task-sharing</i></p> <p><i>Promote equality in educational recruitment, targeting boys'/men's entry into "female" health occupations and girls'/ women's entry into "male" health occupations</i></p> <p><i>Provide social support to boys and men who choose nontraditional health occupations</i></p> <p><i>Consider cultural factors and expectations in educational and certification requirements: create "bridging programs" to help girls meet entry requirements for professional schools</i></p> <p><i>Eliminate policies and practices that exclude girls and women from schooling if they become pregnant</i></p> <p><i>Make continuing education</i></p>	<p><i>Promote gender-aware human resources management (HRM) to effectively support both female and male health workers in equitable work environments</i></p> <p><i>Conduct "gender audits" of workplace policies and practices to identify gender discrimination in hiring, training, promotion, pay and sexual harassment</i></p> <p><i>Develop and enforce equal opportunity employment policies to eliminate discrimination on the basis of marriage, pregnancy and family responsibilities and promote equal remuneration and equal opportunity for career advancement</i></p> <p><i>Recruit men and women into nontraditional jobs and promote equitable task-sharing of health work among staff</i></p> <p><i>Implement health personnel training on workplace violence and gender discrimination</i></p> <p><i>Develop and enforce zero-tolerance codes of conduct for sexual harassment</i></p>

<b>Policy/Planning:</b> Strengthen HRH policy and planning to promote gender equality	<b>Workforce Development:</b> Increase gender integration/ decrease segregation in education, training and work	<b>Workplace Support:</b> Create supportive, fair and safe work environments
<p><i>promote an equal or more equitable division of responsibilities between women and men and continue to strengthen women's capacity to care for those affected by HIV/AIDS</i></p> <p><i>Develop national educational policies and strategies that valorize caregiving as a social good</i></p> <p><i>Address violence and discrimination at the same time</i></p> <p><i>Develop HRH policies and programs that ensure the safety and security of women at work</i></p> <p><i>Involve women in HR policy and strategy decision-making processes on an equal basis with men</i></p>	<p><i>accessible to help women return to work after prolonged maternity leave</i></p> <p><i>Ensure that women are equally represented in management and leadership skills training</i></p> <p><i>Strengthen associations as empowerment and leadership mechanisms for female health workers</i></p> <p><i>Add gender equality and gender-based violence content to professional school curricula to raise awareness of gender and health</i></p>	<p><i>Develop employee assistance programs that offer free family planning, voluntary counseling and testing, prevention of mother-to-child transmission services, post-exposure prophylaxis, counseling, child care and response to gender-based violence</i></p> <p><i>Make changes in the physical work setting or in housing to improve security; provide vehicles to enhance health workers' mobility</i></p>

## Annex A: Definitions

**Workplace violence:** Any incident of physical or psychological assault or abuse that occurs in work-related circumstances and challenges a victim's safety, well-being or health. It includes incidents in which employees are abused, threatened, attacked or in which they are subject to other kinds of aggressive or offensive behaviors or actions in circumstances related to their work (including on the way to and from the workplace).

### **Types of Workplace Violence**

**Physical violence:** The use of force to cause physical or psychological harm. It includes: hitting, biting, throwing objects at someone, strangling, pushing someone around, shoving, punching, kicking, dragging someone, pushing someone against the wall, beating someone with a stick, threatening an individual with a gun, a knife or any other kind of weapon.

**Verbal abuse:** Verbal behavior aimed at degrading or humiliating someone, as well as showing a lack of respect for someone's worth and dignity. This type of violence may include humiliating someone in front of patients or his/her coworkers. Humiliation is often based on insults or sarcasm.

**Bullying:** Psychological violence used to intimidate, marginalize or isolate another worker. Supervisor bullying involves repetitive abuse and oppression of a less powerful person (subordinate) by a more powerful person (hierarchical superior). Bullying may include verbal abuse, malicious allegations, blackmail aimed at making someone lose his/her job or face disciplinary actions, isolation and denigration of his/her work; giving someone an offensive nickname, onerous tasks, canceling earned days off, wrongfully punishing someone and slandering someone's reputation directly or indirectly. Bullying differs from verbal abuse and physical violence in that it is a *repetitive* behavior, occurring over time. Bullying may be perpetrated by an individual or a group of people. In the latter case, it is referred to as "mobbing."

**Sexual harassment:** A type of violence consisting of unwelcome comments or behavior of a sexual nature that are offensive and detrimental to the person's human dignity at work. Sexual harassment may include verbal, nonverbal and physical acts. It may take the form of attempting to establish or force sexual relations, sexual blackmail or offering money, gifts or privileges in exchange for sexual favors. Sexual harassment also includes sexist remarks or innuendos denigrating a person's work or competence, and may be a manifestation of resistance or hostility to women's entry into traditionally male-dominated occupations (i.e., it may serve to lessen competition for desirable jobs). Examples include: pornography in the workplace; forcing someone into having a conversation about sex; looking at someone in a lascivious way; frequent requests for dates after refusals. Two types of sexual harassment are recognized worldwide—"hostile environment" and "quid pro quo":

- **Hostile environment harassment:** Sexual comments that have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, offensive, hostile, humiliating work environment (Diversity and Equal Opportunity Office, 2009)

- **Quid pro quo harassment:** When work-related decisions or tangible job benefits (such as salary raise or promotion) are granted or denied based on an individual's rejection of or submission to unwelcome sexual advances (ibid.).

**Sexual assault:** An extreme type of sexual harassment to coerce sexual contact or relations without mutual consent between the two parties. It may consist of intimidating someone in order to have sexual relations, as well as caressing or kissing someone without his/her consent or forcing sexual relations (rape).

## **Gender Discrimination**

**Gender** refers to the social definition of what it means to be a man or a woman, including the social and cultural characteristics, and the economic, social, political and cultural opportunities (or lack thereof), associated with being female and male.

**Gender discrimination** refers to any distinction, exclusion or restriction based on socially constructed gender roles that prevent a person from enjoying full human rights (WHO, 2001), or based on the biological characteristics that differentiate women from men (e.g., pregnancy). Gender discrimination covers marital status, pregnancy, family responsibilities, occupational segregation and sexual harassment. In practical terms, it creates barriers to equal opportunity or treatment in employment, access to education, services or social benefits, including development. Gender-sensitive HR policy, planning and practice will eliminate gender discrimination as well as other forms of discrimination.

**Gender stereotype:** A rigid, oversimplified, generalized idea of the differences between women and men, their skills, psychological attitudes, ambitions and behavior (Johnson, 2000; ILO, 2008. See also Blau et al., 2006). Stereotypes are forms of social consensus rather than individual judgments (Online dictionary of the social sciences, n.d.; Wikipedia, 2009). Gender stereotypes contribute to ideologies and norms of what constitutes appropriate behavior or aspirations for men and women (Online dictionary of the social sciences, n.d.). Stereotypes can be negative and used to deny individuals respect or legitimacy, or positive, to maintain privilege, based on membership in that group. (The term “norm” is used to refer to a culturally established rule or standard of appropriate social behavior, as distinct from a stereotype, which is a socially constructed, oversimplified, generalized idea.)

**Glass ceiling (“vertical segregation”):** Situations where “the advancement of a qualified person within the hierarchy of an organization is halted at a particular level *because of some form of discrimination*, most commonly sexism or racism. This situation is referred to as a “ceiling” as there is a limitation blocking upward advancement, and “glass” (transparent or invisible) because the limitation is not immediately apparent and is normally an unwritten and unofficial policy. Although this phenomenon may be illegal, it is still prevalent in most countries.

**Occupational segregation by gender (“Gender segregation”):** Pervasive and widely documented form of gender discrimination that concentrates women and men in different occupations, jobs and tasks. Women are typically confined to a narrower range of work, in insignificant, lower grade and less well-paid jobs (“horizontal segregation”), often hold caring occupations (nurses, social workers, teachers) and remain at lower grades of work (“vertical

segregation” typified by the “glass ceiling”) that are less likely to provide benefits, on-the-job training, opportunities for promotion or to exercise authority or control, while men are found in managerial, technical and higher-paid positions. “This segregation has been shown to be strongly related to inequalities in pay, career prospects, and employment protection. It has proved to be one of the most profound dimensions of labour market inequality (compared with, say, race or class) and the most enduring” (Scott, 1994). Occupational segregation prevents women from accessing jobs other than the ones they are traditionally given and which do not pay as much, and effectively serves as a brake on competition in the labor market. Men and women may be given different tasks in the same job.

**Pregnancy (maternity) discrimination:** Exclusions, restrictions or distinctions at school or at work are made on the basis pregnancy, childbirth or related medical conditions. It occurs when expectant women or women of childbearing age are demoted, fired or are not hired, promoted or rehired after maternity leave, have their pay docked, have working hours limited or are otherwise discriminated against due to pregnancy or intention or potential to become pregnant. Typically, pregnancy discrimination excludes women from jobs because of stereotyped notions that women are incapable of doing their jobs, will leave their jobs after childbirth or because employers are unwilling to pay the costs of maternity leave or believe women will require too many accommodations after return from maternity leave.

**Wage/remuneration discrimination** (or systematically paying lower wages to women or minorities): A phenomenon that has been documented in countries with labor compliance mechanisms and information systems. Wage discrimination may be a part of discrimination related to broader *remuneration* that includes the ordinary, basic or minimum wage or salary and any additional benefits whether in cash or in kind, paid by the employer to the worker and arising out of the worker’s employment (e.g., retirement pensions and health insurance) (ILO, 1951). Wage discrimination has been tied to education, experience and seniority, but there is considerable evidence documenting differences in pay between women and men who have the same job, education and qualifications in the workforce, as well as for female employees with more seniority and better performance than male employees (National Committee on Pay Equity, n.d.). Reasons for wage discrimination include the belief that men need higher wages because they have families to support (a “breadwinner” benefit) or that differences in pay are due to choice of work, rather than the belief that differences in experience, training and occupation reflect larger workplace and societal discrimination (Reed, 2001).



## **Annex B: Gender and HRH Strategic and Practical Recommendations to Address Gender Discrimination**

### **Strengthening HRH Policy and Planning to Promote Gender Equality**

#### **Identify Gender Discrimination in HRH Policy and Workforce Planning**

Conduct workforce assessments that routinely gather information on gender discrimination at work, and women's status relative to men's in policy and law. Assess if policies and laws indicate which (gender, labor) rights are protected and what opportunities exist to promote gender equality through HRH policy and legislation. Determine if a country is signatory to the CEDAW, the Beijing Platform of Action, regional instruments such as the African Protocol on the Rights of Women and international labor standards that promote equal remuneration (ILO Convention 100), equality of opportunity and treatment (ILO Convention 111), protection against discrimination for workers with family responsibilities (ILO Convention 156) and maternity protection (ILO Convention 183).

#### **Use Sex Disaggregated Data to Inform HRH Policy and Planning**

Design human resources information systems (HRIS) to provide sex-disaggregated data for HRH policy and planning. Document numbers of men and women by (management) cadre, salary scales, promotion or training by gender and use reports to identify any pay, promotion and retention differentials. Reports generated with sex-disaggregated data in an information system that can link workers to jobs and salaries will demonstrate differences in salaries where men and women have the same job or difference in the numbers of men and women in top health management jobs.

#### **Translate International and Regional Commitments to Gender Equality into National Equal Opportunity Policies and Laws**

Integrate ILO Conventions C.100, C.111, C.156 and C.183 into the Labor Code. Do not codify “breadwinner” wages, bonus and benefits policies that assume that only men are the principal wage-earners in the family. Make job recruitment based on sex illegal. HRH policy and planning should also promote or reflect antidiscrimination legislation and special or temporary measures of protection. Equal opportunity laws and policies, targets, affirmative action<sup>9</sup> policies and monitoring and evaluation should be put in place and reinforced by organizational policies and procedures to provide guarantees of equal treatment for women and men at work.

#### **Eliminate Penalties for Marriage and Motherhood/Promote Policies that Respond to Life Cycle Events**

HRH policies and practices should ensure that women are not penalized for marriage and

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<sup>9</sup> Many people misunderstand the difference between discrimination (i.e., any distinction, exclusion or preference made on prohibited grounds, such as sex or race, that has a negative effect on equality of opportunity and treatment—whether or not intended) and affirmative or positive action, which is a special, temporary measure of protection made to redress historic inequities.

motherhood. Increase women's attachment to the health workforce through fair career progression policies and wage increases that do not penalize women for taking time out of careers for childbirth and family responsibilities. Girls and women are often perceived to be higher risks for skill investments and are sometimes excluded from educational and training opportunities, hiring or promotion. Policies must ensure that women are educated, hired and promoted regardless of the prospect that they may leave the workforce for marriage or maternity. Female health workers should not be demoted or lose seniority after maternity leave. Ensure that women who are or who plan to get pregnant enjoy equal opportunity and treatment at work, including measures such as: eliminating retirement plan or health insurance forfeitures for career interruptions; providing minimum paid sick leave days and leaves of absence with a guarantee of an equivalent job upon return; promoting female workers who work part-time; adopting work models and policies that are sensitive to life cycle events and workers who cannot work at night or travel for extended periods; develop workplace re-entry education programs after childbirth; create family-friendly leave legislation or policies, including paid parental leave for both men and women or government-provided child care.

### **Document and Address the Unequal Distribution of Unpaid Work**

Workforce policy and planning should document and address the unequal distribution of unpaid care work between women and men in the informal care economy. Make women's (unpaid) work visible in national accounts by calculating its worth in monetary terms. Document how unpaid caregiving between women and men is distributed. Develop policies, programs and budgets that recognize the value of women's unpaid caregiving and the support and compensation unpaid workers need. CHW programs should create standardized protections and resources for volunteer health workers (e.g., financial incentives, tax credits, cash benefits, child care subsidies, free medical care or health insurance contributions and/or pensions to home-based primary caregivers). Develop national educational policies and strategies that valorize caregiving as a social good. Government HIV/AIDS policy and implementers' programs should explicitly promote an equal or more equitable division of responsibilities between women and men and continue to strengthen women's capacity to care for those affected by HIV/AIDS.

### **Ensure Workplace Safety**

HRH policies and programs must assure the safety and security of women at work. Gender discrimination has been implicated in the high levels of violence to which health workers are exposed. Address violence and discrimination at the same time by developing national workplace safety and security policies that address gender discrimination. Deployment of female workers to remote rural areas or areas experiencing conflict should anticipate and prevent the possibility of sexual harassment and assault at work or on the way to work. Workplaces should have zero-tolerance codes of conduct sanctioning violence at work. Make changes in the physical work setting or in housing to improve security; provide vehicles to enhance health workers' mobility.

## **Involve Women in HR Policy and Strategy Decision-Making Processes on an Equal Basis with Men**

Make deliberate efforts to ensure that women are invited to or chair meetings where health workforce policy and planning take place. Include women in advocacy, leadership, management and public-speaking training.

### **Increasing Gender Integration in Education, Training and Work**

#### **Eliminate Stereotypes in Education and Training**

Educational policy-makers and planners should eliminate gender stereotypes in curricula that may limit the integration of men and women into health professions. Education and training for students crossing gender boundaries and entering occupations that have been traditionally considered female or male (e.g., men in nursing or social work) should include critical reflection and deliberate attention to “identity work” (i.e., coping strategies used to deal with challenges to sexuality or gender identity) (Lupton, 2006). Promote coeducational activities to increase exposure to women’s and men’s competence. Media recruitment campaigns should target gendered division of labor to promote gender integration of health occupations (e.g., depicting men and women caring for families, girls in conventionally male-identified roles).

#### **Promote Equality in Educational Recruitment**

Develop educational recruitment strategies that actively target boys’/men’s entry into “female” health occupations and girls’/women’s entry into “male” health occupations. Educate advisors and vocational guidance counselors who help boys choose alternate career paths. Support men who choose a female-identified occupation. Publicize male role models in the profession. Use man-to-man recruitment strategies. Target older men who are changing careers for recruitment into nursing and home-based care. Avoid using masculine stereotypes to attract and compensate men. Provide social support to boys and men who choose nontraditional health occupations.

#### **Consider Cultural Factors and Expectations**

Professional schools should consider educational and certification requirements that take into account cultural factors and expectations of girls and women that may hinder school entry, retention or completion of studies or qualification for a health profession (e.g., expectations that girls leave school for marriage or family caregiving; family preferences to financially support boys’ schooling; sexual harassment by other students or teachers). Girls may need mentoring, tutoring or remedial support to meet math or science entry requirements of some professional schools, tuition or licensing fee waivers and flexible scheduling to meet certification qualifications. Schools should also institute codes of conduct for teachers and students. Eliminate policies and practices that exclude girls and women from schooling if they become pregnant.

## **Ensure That Women Are Equally Represented in Management and Leadership Skills Training**

Female health workers are typically unrepresented in health workforce management (especially upper management). They may be in gender-segregated, temporary or part-time jobs or subject to stereotypes that hold that employment is of secondary importance to women. Because of this, female health workers may not be considered for promotion or selected for management or leadership training. In-service education program managers should therefore look for opportunities to invite promising female employees for such training. Strengthen associations as empowerment and leadership mechanisms for female health workers.

### ***Creating Supportive, Fair and Safe Work Environments***

#### **Foster Gender-Aware Human Resource Management**

Promote gender-aware human resource management (HRM) for facility managers and service supervisors so that they may effectively support both female and male health workers in fair work environments. HRM training at all levels should include orientation to forms of discrimination and violence, gender dynamics between supervisor and supervisee (including abuse of power and sexual harassment), how to respond constructively to maternity/paternity leave and workers' family responsibilities, equal opportunity policies or labor standards that protect workers' rights and how to challenge myths related to women's capabilities and dedication to work. Managers should make deliberate efforts to strengthen female health workers' long-term attachment to the workforce by developing or enforcing antidiscrimination measures in the workplace, ensuring equal remuneration and opportunity for promotion, flexible scheduling, parental leave benefits for men and women or on-site child care.

#### **Promote Equal Opportunity and Treatment**

Facility managers and supervisors should conduct "gender audits" of workplace policies and practices to identify gender discrimination in hiring, training, promotion, pay and sexual harassment. Develop and enforce equal opportunity employment policies to eliminate discrimination on the basis of marriage, pregnancy and family responsibilities and promote equal remuneration and equal opportunity for career advancement. Recruit men and women into nontraditional jobs and promote equitable task-sharing in similar jobs. Rectify working conditions for nursing and caregiving occupations to attract and retain both men and women. Work with unions to address pay inequalities between predominantly female and male jobs. Create a wage council. Ensure that pay and promotions for men in "female" jobs do not disadvantage women (e.g., men should not be paid more than women for the same work). Employers should monitor for the possibility that women are subject to greater and unfair competition from men for leadership positions even in jobs that are considered "women's work" (i.e., in nursing).

## **Address Workplace Violence**

Develop and enforce zero-tolerance codes of conduct and implement health personnel training on workplace violence and gender discrimination. Communicate regularly with health workers to monitor prevalence of sexual harassment and other forms of violence (including the threat of violence) at or around the workplace and the impact of violence on well-being and productivity. Give incentives and recognition to facilities that create mechanisms to report violence by health workers and to create a fair process to address grievances.

## **Develop Employee Assistance Programs**

Establish gender-aware workplace HIV/AIDS policies and programs that offer voluntary counseling and testing/prevention of mother-to-child transmission/antiretroviral therapy/PEP services, family planning, substance abuse counseling, child care and response to gender-based violence. These programs should address women's physical, social and economic vulnerability to HIV/AIDS, their vulnerability to violence and the need for men to be fully engaged in HIV/AIDS risk reduction.

## References

- Akintola O. Gendered home-based care in South Africa: more trouble for the troubled. *African Journal of AIDS Research*. 2006; 5(3): 237-247.
- Anker R. Theories of occupational segregation by sex: an overview. *International Labour Review*. 1997:36.
- Anker R, Malkas H, Korten A. Gender-based occupational segregation in the 1990s. Geneva, Switzerland: International Labor Organization, 2003. Available at: [http://www.ilo.org/wcmsp5/groups/public/---ed\\_norm/---declaration/documents/publication/wcms\\_decl\\_wp\\_18\\_en.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_decl_wp_18_en.pdf)
- Bisgrove E, Viswanathan M. A framework for the analysis of the impact of family planning on women's work and income. Research Triangle Park, NC: Family Health International, 1997.
- Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006.
- Budig MJ, England P. The wage penalty for motherhood. *American Sociological Review*. 2001;66:204-225.
- Careers Scotland. Gender stereotyping of career choice. Services to the Learning and Guidance Community. Glasgow, Scotland: Careers Scotland, 2004. Available at: <http://www.careers-scotland.org.uk/nmsruntime/saveasdialog.asp?IID=6719&SID=2346>
- di Martino V. Workplace violence in the health sector: country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study: a synthesis report. Working paper. Geneva, Switzerland: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, 2002.
- Division for the Advancement of Women, Department of Economic and Social Affairs. Convention on the Elimination of All Forms of Discrimination Against Women, 1979. Available at: <http://www.un.org/womenwatch/daw/cedaw/>
- Diversity and Equal Opportunity Office. Sex discrimination: what supervisors need to know [website]. Diversity and Equal Opportunity Office: University of South Florida, 2009. Accessed 30 Apr 2009 at: <http://usfweb2.usf.edu/eoa/sex>
- Dube B. Illustrations as vehicles of gender stereotyping: an analysis of selected primary school readers in Zimbabwe and South Africa. Paper presented at the Foundation of the Tertiary Institutions of the Northern Metropolis Gender Studies Conference; Jan 2006; Pretoria, South Africa. Available at: [http://www.fotim.ac.za/fotim\\_conferences/genderconf/papers/dube\\_paper.pdf](http://www.fotim.ac.za/fotim_conferences/genderconf/papers/dube_paper.pdf)

England P. Towards gender equality: progress and bottlenecks. In: Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006; pp. 245-264.

George A. Human resources for health: a gender analysis. Geneva, Switzerland: WHO Commission on Social Determinants of Health, 2007. Available at:  
[http://www.sarpn.org.za/documents/d0002790/HR\\_health\\_George\\_Jul2007.pdf](http://www.sarpn.org.za/documents/d0002790/HR_health_George_Jul2007.pdf)

Hartmann H, Rose SJ, Lovell V. How much progress in closing the long term earning gap? In: Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006; pp. 125-155.

International Labor Organization. Equality of opportunity and treatment [website]. Available at:  
[http://www.ilo.org/global/What\\_we\\_do/InternationalLabourStandards/Subjects/Equality/lang-en/index.htm](http://www.ilo.org/global/What_we_do/InternationalLabourStandards/Subjects/Equality/lang-en/index.htm)

International Labor Organization. Convention concerning equal remuneration for men and women workers for work of equal value. Geneva, Switzerland: International Labor Organization, 1951. Accessed 2 Apr 2009 at:  
[http://www.ilo.org/public/english/employment/skills/hrdr/instr/c\\_100.htm](http://www.ilo.org/public/english/employment/skills/hrdr/instr/c_100.htm)

International Labor Organization. Wages and income: wage discrimination. ILO instruments concerning wage discrimination are Convention No. 100 and Recommendation No. 90 on equal remuneration for men and women for work of equal value. Accessed 1 May 2009 at:  
<http://www.ilo.org>

International Labor Organization International Training Center. Break gender stereotypes, give talent a chance: toolkit for SME advisors and human resource managers. European Communities, 2008.

Johnson AG. *The Blackwell dictionary of sociology: a user's guide to sociological language*, 2<sup>nd</sup> ed. Malden, MA: Blackwell Publishers, 2000.

Lindsey E, Hirshfeld M, Tlou, S. Home-based care in Botswana: experiences of older women and young girls. *Health Care for Women International*. 2003;24;86-501.

Longley R. GAO report: why women still make less than men [website]. About.com; 2009. Accessed 5 Oct 2009 at:  
<http://usgovinfo.about.com/cs/censusstatistic/a/womenspay.htm>

Lupton B. Explaining men's entry into female-concentrated occupations: issues of masculinity and social class. *Gender, Work and Organization*. 2006;13(2):103-128.

Marshall G. Occupational segregation in employment. *A dictionary of sociology*. 1998. Accessed 25 Mar 2009 at:  
<http://www.encyclopedia.com/doc/1O88-occupationalsegregation.html>

National Committee on Pay Equity. Examining the “women’s choices” theory [website]. National Committee on Pay Equity, n.d. Accessed 30 Apr 2009 at: <http://www.pay-equity.org/info-choices.html>

Newman C, Kanakuze J, Fine A, Ngendahimana, G, De Vries DH. Study of workplace violence in the health sector of Rwanda: final report. Chapel Hill, NC: IntraHealth International, 2008. Available at: [http://www.capacityproject.org/images/stories/files/workplace\\_violence\\_health\\_sector\\_rwanda.pdf](http://www.capacityproject.org/images/stories/files/workplace_violence_health_sector_rwanda.pdf)

Newman C, Makoae N, Reavely E, Fogarty L. Alleviating the burden of responsibility: report on a study of men as providers of HIV/AIDS care and support in Lesotho. Chapel Hill, NC: IntraHealth International, 2009. Available at: [http://www.capacityproject.org/images/stories/files/study\\_of\\_men\\_as\\_providers\\_of\\_care\\_lesotho.pdf](http://www.capacityproject.org/images/stories/files/study_of_men_as_providers_of_care_lesotho.pdf)

Ogden J, Simel E, Grown C. Expanding the care continuum for HIV/AIDS: bringing careers into focus. *Health Policy and Planning*. 2006;21(5):333-342. Available at: <http://heapol.oxfordjournals.org/cgi/reprint/21/5/333>

Online dictionary of the social sciences [website]. Athabasca University and the International Consortium for the Advancement of Academic Publication, n.d. Accessed 3 Aug 2009 at: <http://bitbucket.icaap.org/>

Polachek S. How the life cycle human capital model explains why the gender wage gap narrowed. In: Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006; pp. 102-124.

Reed A. Whatever you call it, it’s still discrimination and it still affects women’s wages. *Federal Reserve Bank of St. Louis- Regional Economist*, 2001. Accessed 30 Apr 2009 at: [http://findarticles.com/p/articles/mi\\_qa3678/is\\_200104/ai\\_n8948449/](http://findarticles.com/p/articles/mi_qa3678/is_200104/ai_n8948449/)

Reichenbach L, ed. *Exploring the gender dimensions of the global health workforce*. Global Equity Initiative, Harvard University. 2007

Ridgeway C. Gender as an organizing force in social relations: implications for the future of inequality. In: Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006; pp. 265-283.

Ridgeway C. Gender, status and leadership. *Journal of Social Issues*. 2001;57:629-637.

Scott AM, ed. *Gender segregation and social change*. London, England: Oxford University Press, 1994.

Sen G, Östlin P, George A. Unequal, unfair, ineffective and inefficient gender inequity in health: why it exists and how we can change it. Geneva, Switzerland: WHO Commission on Social



Determinants of Health, 2007. Available at:  
[http://www.who.int/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf)

Standing H. Gender: a missing dimension in human resource policy and planning for health reforms. *Human Resources Development Journal*. 2000;4:27-42. Available at:  
<http://www.moph.go.th/ops/hrdj/hrdj9/pdf9/Gender4I.pdf>

Standing H, Baume E. Equity, equal opportunities, gender and organizational performance. Geneva, Switzerland: World Health Organization, 2001. Available at:  
<http://www.who.int/hrh/documents/en/Equity.pdf>

Stereotype. Wikipedia [website]. Accessed 1 May 2009 at:  
<http://en.wikipedia.org/wiki/Stereotype>

Tzannatos Z. Monitoring progress in gender equality in the labor market. In: Buvinic M, Morrison AR, Ofosu-Amaah AW, Sjöblom M, eds. *Equality for women: where do we stand on millennium development goal 3?* Washington, DC: World Bank, 2009.

World Health Organization. Transforming health systems: gender and rights in reproductive health. Geneva, Switzerland: World Health Organization, 2001. Available at:  
[http://www.who.int/reproductivehealth/publications/transforming\\_healthsystems\\_gender/text.pdf](http://www.who.int/reproductivehealth/publications/transforming_healthsystems_gender/text.pdf)

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