Gender and Health systems strengthening

April 2022

Rationale for gender integration into health systems

Background

- Gender inequities within health systems are not merely a women's issue as they affect health outcomes for all (Hawkes, 2020).
- Gender within health systems continues to be neglected and often reinforces gender biases, stereotypes and norms that negatively impact system performance (Hay et al., 2020).
- Within health systems research, gender continues to be 'a tick-box' exercise that does not adequate analyse gender (Morgan et al., 2018).

Gender integration: key to achievement of Universal health care (UHC) and Sustainable (SDGs) Development Goals (Hay et al., 2020)

Decision-making roles: Enabling women to play a key role and have an equal say in the design and delivery of policies and programs, advances health systems functioning.

Health leadership: Increased representation of women enhances diversity in perspectives and inclusiveness of agendas that impact women and girls such as sexual and reproductive health

Service delivery: Empowering female providers to lead health services improves health outcomes, retention and greater innovation within health systems

Slide 2

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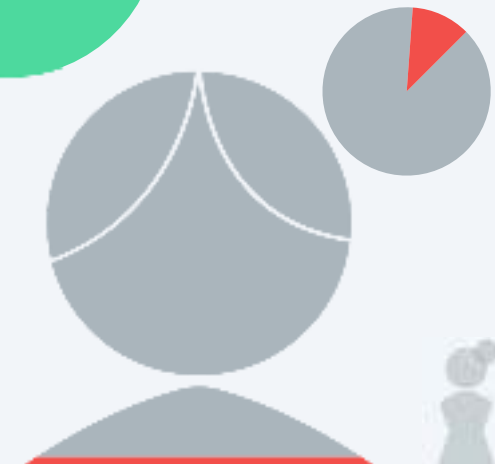
What do the statistics say?



25%

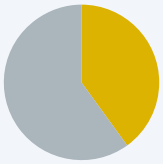
Women in health leadership roles

70%

of the health and social care workers, globally, are women

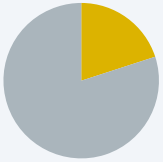
(WHO, 2019)

Among 140 global health organizations



40%

mention gender in their governance documents



20%

of global health organisations have gender parity on their governing boards

Two UN agencies related to health have female heads

(George et al., 2020)

59 countries

no laws prohibiting sexual harassment in the workplace

100 countries

no civil remedies for sexual harassment in the workplace

110

no criminal penalties for sexual harassments in the workplace.

(George et al., 2020)

Broad objectives

Strong rationale for integrating gender into health systems as a means of strengthening system, health outcomes and progress towards SDGs and UHC

The Bill and Melinda Gates Foundation has taken a strategic decision to ensure that the Foundation grant supports programs that are gender intentional and gender transformative. This study aims to enable state governments supported by the Foundation to integrate gender within their health system strengthening interventions focusing on healthcare providers. It was conducted as part of the Foundation's supplemental grant from October 2021-April 2022.

OPM's objectives are to study gender in relation to healthcare providers –

- **Understanding gender inequities faced by healthcare providers in their day to day functioning as well as at the leadership and management level**
- **Reviewing program interventions that directly/ indirectly integrate gender into health systems**
- **Reviewing existing tools, frameworks, benchmarks and indicators to assess gender integration into health systems**
- **Exploring the relevance of existing policies and directives with relation to gender equity and the lacunae within the policy space**
- **Providing key learnings to guide the thinking and interventions around gender integration**

Slide 4

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List of key outputs

1. Scoping review on gender constraints, barriers, and discrimination faced by facility based female healthcare providers
2. Review on benchmarks, frameworks, tools and indicators used to assess gender integration within health systems
3. Scoping Review of Programmes: Learnings and Opportunities Relating to Integrating Gender for Healthcare Providers in Health Systems
4. An overview of Policies on Gender Integration for Women Healthcare Providers in Health Systems in India
5. Learnings and opportunities: Gender integration for healthcare providers: What are experts saying ?

Slide 5

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Scoping review on

gender constraints, barriers, faced by facility based female healthcare providers

Introduction

The integration of gender within health systems is sparsely researched and focused mainly on 'client-centric' gender-sensitive behaviour among health providers (Celik et al., 2011). Few studies, however, focus on the role of health providers' agency towards the creation of gender-equitable health systems (Nanda et. al, 2020). **Empowering the healthcare workforce, which is predominantly female, is being increasingly recognized as one of the most critical pathways for transforming health systems.**

The few existing interventions conceptualized as 'gender transformative' for providers tend to be based on a limited understanding of the underlying drivers of inequalities. **Therefore, this scoping review aims to develop a deeper understanding of why, how, and where the inequities related to providers operate, and what their implications for health systems are, to help aid transformative programming.**

Research Method

Scoping review of literature using a set of a priori protocols

1. Key questions

- What are the key systemic gender barriers and constraints to the performance of female facility-based healthcare providers?
- What are the facility level gender constraints and discrimination faced by women in their day-to-day work?
- What are the key gender barriers faced by women within health systems in assuming leadership and management positions?
- What are the implications of this for service provision and in turn on health system performance?

2. Selection criteria

- Published in English, since 2000
- Explicit focus on gender inequities in relation to female healthcare providers

3. Key search terms

Gender or gender constraints or gender barriers AND health systems
AND nurses or female facility providers or auxiliary nurse midwives or human resources
AND leadership or leadership management
AND low- and middle-income countries or LMICs or low- and middle-income countries or India

4. Total citations included

Fifty-five citations

Adaption of frameworks for Synthesizing the Findings

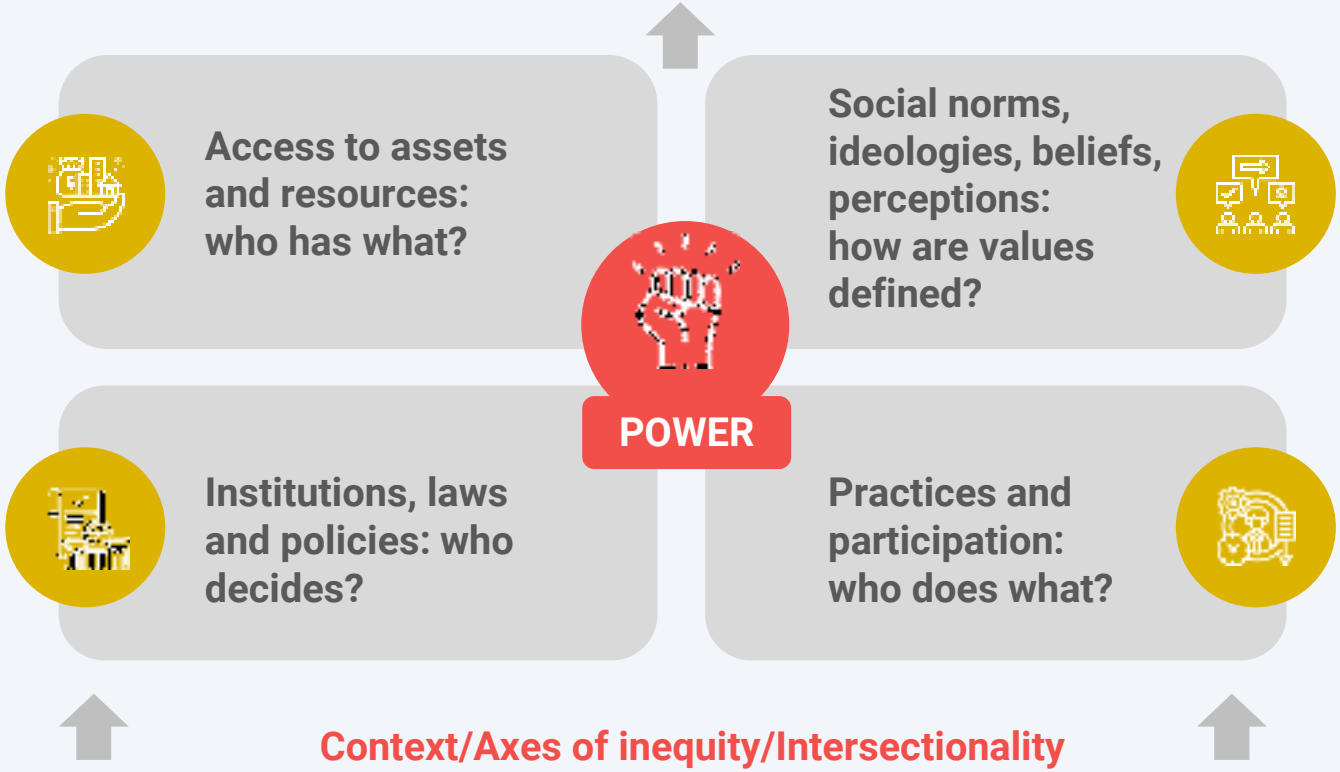
- Used **framework synthesis approach** to extract and present the findings.
- Framework for analysis draws on two key gender analysis frameworks:
  - **Jhpiego Gender Analysis Toolkit (2016)**
  - **Morgan et. al (2016)** that have been
- Both frameworks are broadly built around four key dimensions:
  - **Access to assets and resources**
  - **Participation and practices**
  - **Norms and values**
  - **Policies and Institutions**
- Central to both the frameworks is the **recognition of gender as a power relation**.

Based on learnings from literature, **we added 4 critical elements** to the existing dimensions borrowed from the two frameworks- JHPIEGO Gender Analysis Toolkit (2016) and Morgan et. al (2016).

1. **Multi-tier understanding of gender inequities** that operate at different levels : institutional, organisational, individual, and community (Steege et al., 2018).
2. **Intersectional lens** to understand gender-based constraints operate in tandem with other power relations such as caste, class, religion, age, education, etc., that advantage (or disadvantage) health system actors and influence health system functioning (George et al., 2020; Steege et al., 2020). The existing frameworks do not make this element visually explicit.
3. **Context-based understanding** of gender, gender inequities, and intersectionality. Health systems are fundamentally social systems and gender power relations vary across social, economic, and political contexts (Steege et al., 2018).
4. **Incorporate the element of implications** to show how gender inequities faced by providers can affect service delivery and quality of care, particularly to make a case for policymakers, donors, and governments to invest in integrating gender in health systems.

Adapted Framework

Implications on performance and delivery of healthcare



Context/Axes of inequity/Intersectionality

- Institutional level
- Organizational level
- Community level
- Individual level

Synthesis of Findings using WHO's Health System Building Blocks

We use

WHO's six building blocks

to structure our findings in conjunction with the four dimensions of the framework (discussed in slides 8-10).

- This approach adds value by creating a systemic perspective on gender-based issues within health systems.
- It enables an understanding of how the health system inputs (human resources, information and research, medical products/technologies, and health system financing) influence the outputs and in turn the outcomes (service delivery).

(Summary of findings are presented in the following slides)

Health System Financing

Leadership and Governance

Human Resources

Medicines and Technology

Health Information Systems

Service Delivery

Summary of key findings: Human Resources

Key issue	Access to assets and resources	Practices and participation	Norms, values, beliefs, and perceptions	Laws, institutions, and policies
Education, training and career growth	• Poor quality and unregulated pre-service education, lacking in practical training • In-service training and career growth opportunities limited • Absence of leadership, management, and soft skill training	• Limited uptake of skilling, advanced training, and career growth by women providers • Men more able to take up self-funded training • Selection bias against female providers in hiring, promotion, and deployment decisions	• Gendered roles and expectations especially related to dual burden work both inhibit their own participation as well as leads to biased decision making around selection and promotion	• Inadequate regulatory mechanism for pre- and in-service training and continued professional development • Eligibility criteria often exclude women • Non-gender-responsive training logistics and provisions • Limited provisions for advanced nursing roles
Occupational segregation	• Gender-based segregation of occupational roles with most of the women workforce in the lower rung of the hierarchy • Gendered barriers to clinical specializations • Limited access to leadership and decision-making roles	• Female providers more likely to opt for low status, low pay roles • Men opt for more technical, managerial, decision-making roles • Female-dominated professions like nursing accorded low value and subordinated status • High burden of work for women (including informal and unpaid) • Gendered division of roles and responsibilities drive other forms of gender inequalities • Gender pay gap	• Dominated by 'gender essentialism' and 'male primacy' • Care giving is perceived as essentially a female skill • Historical association of nursing as a vocation • Gender stereotyping of clinical specializations; undermining female providers' skills and expertise	• Limited opportunities for career advancement • Lack of gender parity policies in • highly paid positions and in leadership and decision-making roles
Resources and infrastructure	• Gendered discrimination in access to resources and infrastructure access • Limited availability of basic amenities and space • Inadequate security and safety measures	• Gendered discrimination in access to resources and infrastructure access • Limited availability of basic amenities and space • Inadequate security and safety measures	• Low status and negative stereotypes about female-dominated professions and female workers • Gender based stigma of shame and honour related to reporting sexual harassment and violence	• Poor regulation of working conditions for nurses and women workforce • Lack of provision and policy for childcare and other amenities • Increasing casualisation of female-dominated cadres • Poor or no implementation of laws and policies related to workplace safety • Inadequate implementation of grievance redressal platforms

Summary of key findings:
Leadership and Governance

1. Access to assets and resources

- Limited opportunities for women leadership and decision-making roles
- Lack of clear job description
- Inadequate and weak support and supervisory mechanisms
- No access to grievance redressal

2. Practices and participation

- Selection bias in appointments to leadership position
- Discrimination against female leaders
- Low participation in policy making about their work
- Higher burden of work & accountability
- Punitive & inadequate supervision and performance management
- Doctors' professional associations more powerful than nursing associations

3. Norms, values, beliefs, and perceptions

- Anon0ernalised gender roles and expectations inhibit from opting for leadership positions
- Gender-biased stereotypes and presumptions of women's professional abilities because of their maternal responsibilities and marital status
- Poor perceptions of female leaders' skills and competencies

4. Laws, institutions, and policies

- Inadequate provisions for women's leadership
- Absence of directorate-level positions for nurses
- Leadership positions for female cadres are male-dominated or remain vacant
- Regulatory bodies for nurses and midwives are male-dominated
- Committees for policymaking mainly comprise doctors, while nurse leaders have a limited say in decision making
- Lack of gender-sensitive HRH policies and organisational support for women's specific needs
- Gender-biased eligibility criteria for hiring and promotion
- Weak implementation of gender-equitable policies on healthcare leadership

Slide 13

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Summary of key findings: Health Information Systems

1. Access to assets and resources

- Inadequate support infrastructure for data reporting
- Lack of training for online data reporting
- Limited role in use of data for decision-making

2. Practices and participation

- Nurses burdened with mundane data collection and reporting
- Stringent data reporting requirements with compliance gaps attracting punishment
- Malpractices such as data manipulation, inflation, and tampering emerging from high accountability burden to demonstrate good performance

3. Norms, values, beliefs, and perceptions

- Gendered roles and expectations in the workplace with women seen as more suited for routine data collection work

4. Laws, institutions, and policies

- Policy gaps in leadership and decision-making roles preclude most female cadres in having formal roles on data use for decision-making
- In LMICs like India, absence of comprehensive gender-disaggregated data for providers, especially to assess their representation, participation and implementation of provisions that could be gender-responsive (like implementation of POSH, 2013)

Summary of key findings:
Medicines and Technology

1. Access to assets and resources

- Low and unequal remuneration
- Differentials between the contractual and permanent staff
- Occupational segregation

2. Practices and participation

- Gender bias in hiring and promotion
- Male-dominated professions more likely to take up private practice to supplement incomes
- Gender pay gap

3. Norms, values, beliefs, and perceptions

- Low status of female-dominated professions and female workers
- Gendered perceptions around women's naturalised caregiving, marital and maternal roles

4. Laws, institutions, and policies

- Casualisation of female-dominated healthcare cadres
- Low unionisation of nurses
- Lack of regulations for nursing remuneration

Health system Financing

1. Access to assets and resources

- Poor access to medicines and technology within facilities
- Lack of/ inadequate training on technology use and pharmacology
- Poor access to continued capacity building

2. Practices and participation

- Nurses find use of technology challenging
- Data documentation burden borne by nurses

3. Norms, values, beliefs, and perceptions

- Low social positioning of female cadres within medical hierarchy

4. Laws, institutions, and policies

- Lack of provisions for continued learning and capacity building

Slide 15

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Summary of findings:
Implications on service delivery

Poor technical capacity and skilling	Poor autonomy and decision-making	Demotivation, absenteeism and burnout	Poor resource availability for service delivery	Disrespectful maternity care

Human resources

- Occupational segregation
- Low access and poor quality education
- Limited career growth
- Poor working conditions
- Workplace violence and sexual harassment

Leadership & governance

- Gender deficit in healthcare leadership
- Policy lacuna and weak implementation of existing provisions
- Poor management and governance of female dominated cadres

Health system financing

- Low and unequal remuneration
- Casualisation of female dominated cadres
- Gender pay gap

Medicines and technology

- Poor access to clinical resources
- Inadequate access to technology
- Poor capacity building on technology and medicine administration

Health information systems

- Documentation burden on female cadres
- Inadequate digital infrastructure, training and support on data related work
- Data manipulation and fabrication

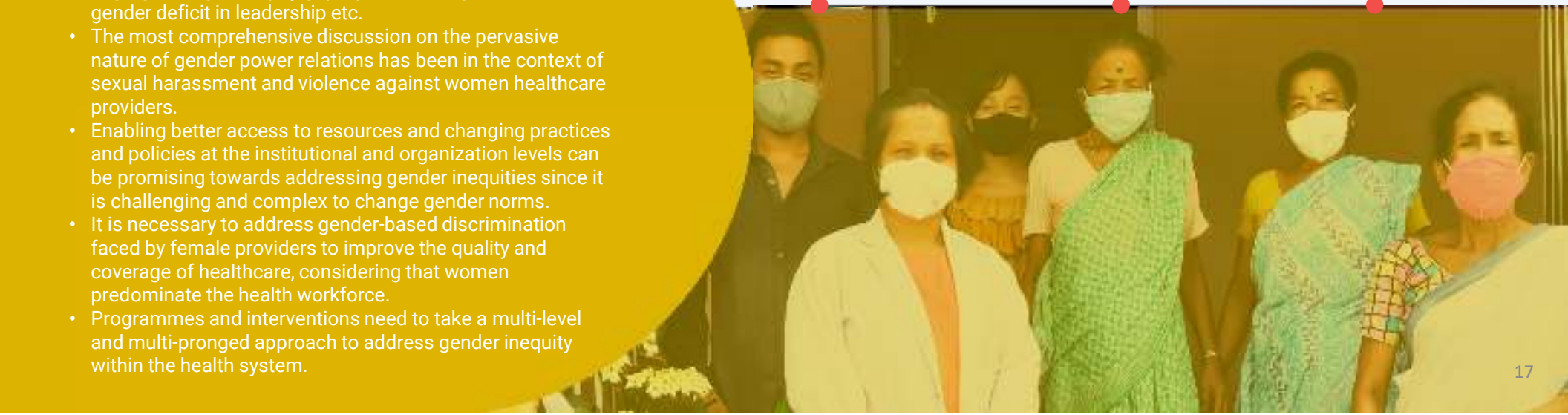
Key learnings from the scoping review of literature

Reflections

- Gender-based issues are essentially underpinned by social structures- gender norms, values and beliefs that influence how health systems are structured and organized. Deeply embedded gender inequalities are reflective in occupational segregation, gender pay gaps, poor working conditions, gender deficit in leadership etc.
- The most comprehensive discussion on the pervasive nature of gender power relations has been in the context of sexual harassment and violence against women healthcare providers.
- Enabling better access to resources and changing practices and policies at the institutional and organization levels can be promising towards addressing gender inequities since it is challenging and complex to change gender norms.
- It is necessary to address gender-based discrimination faced by female providers to improve the quality and coverage of healthcare, considering that women predominate the health workforce.
- Programmes and interventions need to take a multi-level and multi-pronged approach to address gender inequity within the health system.

Gaps in Literature

- Gender issues related to providers are not explicitly discussed within health systems; literature often focuses on the clinical and technical aspects of service provision, administration, and management.
- Most of the literature that is focused on gender, limits itself to acknowledging gender as a power relation, eschewing a deeper discussion of power.
- Issue of intersectionality is not adequately discussed and engaged with from a provider perspective.



Scoping review on

benchmarks, frameworks, toolkits and indicators used to assess gender within health systems

Introduction

- While there has been growing focus on gender transformative programs and policies within health systems, efforts towards improving gender equity have not quite been effective (Malhotra, 2021). Thus, measuring the performance and potential gaps of different strategies and programs becomes critical to inform evidence-based policy and programmatic decision-making.

- The aim of this review was to scope for measuring and monitoring tools and aids to assess the changes and shifts stimulated by such gender integrative interventions for women healthcare providers with a focus on 4 broad aspects: Gender equity benchmarks, MLE frameworks, Measurement toolkits, and Indicators

- Existing research on benchmarks and methods for assessing gender integration in relation to health systems is relatively sparse and mostly user focused. Literature on measures to assess gender integration from a provider perspective is limited. Thus, we also reviewed toolkits and scales focused on healthcare users to tease out the aspects that are relevant for providers

Research Method:

Scoping review of measurement frameworks using a set of a priori protocols

Key Questions

- What is the gender-equitable benchmark against which gender integration within health systems has been assessed?
- What are the MLE frameworks that have been developed to analyse gender within health systems?
- What are the measurement tools used to analyse gender within health systems?
- What are the indicators used to assess gender integration within health systems?

Selection Criteria

- Published in English, since 2000.
- Explicit focus on assessment methods in the context of female healthcare providers and healthcare leadership and management.

Key Search Terms

Gender or gender equity or gender mainstreaming or gender integration AND health systems or human resources for health AND framework or methods or indicators or benchmarks or measurement tools or tools.

Total citations included

Nine citations

What are Gender-Equitable **Benchmarks:**

against which gender integration within health systems can be assessed?

(an approach that compares health systems against an agreed-upon standard or realistic goal of health system performance and assesses if the health system meets that standard)

- Health system reforms have been historically devoid of considerations around social determinants like gender (PAHO, 2009).
- There exists no clear definition of what a gender equitable health system means and what its key attributes are (Percival et al, 2018).
- But gender is increasingly recognised as being a critical consideration in health systems strengthening (Morgan et al, 2018; Standing, 2000: Hay et al, 2019).

Importance of gender equity benchmarks for health systems

- To determine the degree of gender integration within a health system at the baseline
- Enable comparisons between different health systems in terms of gender-equity
- To assess the effectiveness of gender transformative strategies, programs, and policies to evaluate progress, gaps and challenges

Gender Equity Benchmarks

The review threw up only two citations on gender equitable benchmarks for health systems (PAHO is detailed in following slide)

Percival et al (2018)

- Provides benchmarks for WHO building blocks and offers a systemic perspective; but do not look at health systems software
- Also provides attributes of a gender equitable health system
- Developed for conflict affected settings with applicability across contexts
- Includes all genders, not just binary classification
- More aligned to integrating gender for healthcare users

PAHO (2009)

- Comprehensive list of benchmarks for analysing gender equity within healthcare policies
- Most useful set of for adequately analysing gender issues faced by healthcare providers (discussed in next slide)

Review of PAHO Benchmarks

Draw attention to the need for collecting sex-disaggregated information on the healthcare workforce and using it for informing gender equitable policy.

Unlike mainstream approaches, these benchmarks move away from only looking at the technical aspects of health system towards **considering factors such as working conditions**

Inclusion of a separate benchmark for the unpaid health workforce stresses the need to understand and assess gender inequities faced by them, an aspect often overlooked within health systems research

Key research questions accompanying each benchmark help clarify the specifics of what needs to be assessed and achieved under each benchmark in concrete terms. They can be reformulated as indicators.

The benchmarks and the questions also provide for undertaking a comprehensive assessment, including the 'what' of the gender equity measures and their evaluation

Provides a very comprehensive and detailed list of criteria for analysing the core gender issues faced by health workers. Including benchmarks on recruitment, training, career progression, work environment and decision-making which are adequately reflected in the benchmarks

Highlight the need to undertake an in-depth context analysis of the health sector as a prerequisite to gender analysis

LIMITATIONS

In applying these benchmarks is that they **may need to be contextualised** as they were originally developed for the Pan American region

Gender-equity benchmarks

for health system policies by PAHO

Oxford Policy Management

Key aspect around which gender issues exist	Policies and management information systems for the development of health human resources	Working conditions and employment patterns	Introduction of flexible labour practices and privatization	Training	Unpaid health workers
Benchmark	There is a policy in place that supports equal opportunity for women and men in recruitment, training, and promotion in employment. The information system that supports human resources management provides sex-disaggregated information, which facilitates timely decision-making and makes it possible to monitor compliance with the gender equality policy.	The participation of women in health sector decision-making is encouraged and supported, and affirmative action measures are envisaged for that purpose. Working conditions and terms of employment are "family-friendly" for personnel who have responsibilities for child and elder care, and these conditions apply to both female and male workers	Reforms take into account the differential effects that labour market flexibility policies may have, and are having, on women and men, and envisage measures to mitigate adverse effects	Processes are under way aimed at modifying university curricula and providing in-service training for health service personnel in order to include issues relating to gender inequalities and their impact on health and health care.	The unpaid health care provided (predominantly) by women in the community and the home is recognized and valued, and those who do this work are supported accordingly

Draw attention to the need for collecting sex-disaggregated information

Looks at affirmative action and measures

Focus on work environment

Draws attention to gender-related concerns of unpaid workers

What are the **Frameworks** that have been developed to analyse gender within health systems?

A gender analysis framework provides a structure for organizing information about gender roles and relations as well as differences across different domains of social life, and to examine how these differences affect the lives and health of men, women, boys, and girls

Most gender analysis frameworks are user-focused. We find several frameworks that look at gender in relation to healthcare providers broadly falling within three categories (shown below).

Focus on Gender Analysis Framework

Health Systems Perspective

Using a systems lens

Healthcare users and providers

Specific Gender Issues within the health system

Gender-based workplace violence

Gender barriers and constraints to health systems leadership

Specific Cadre of Healthcare Workers

Community healthcare workers

01 First Category

analyses gender from a systemic perspective focusing on healthcare users and providers (including nurses, doctors, community health workers etc) (Caro et al, 2013; Morgan et al, 2016).

02 Second Category

includes frameworks that look at a gender in relation to a specific aspect of health systems – leadership (Vong et al, 2019) and violence at the workplace (George et al, 2020).

03 Third Category

includes one framework that studies gender relations for a specific cadre of healthcare workers – close to-community providers (Steege et al, 2018).

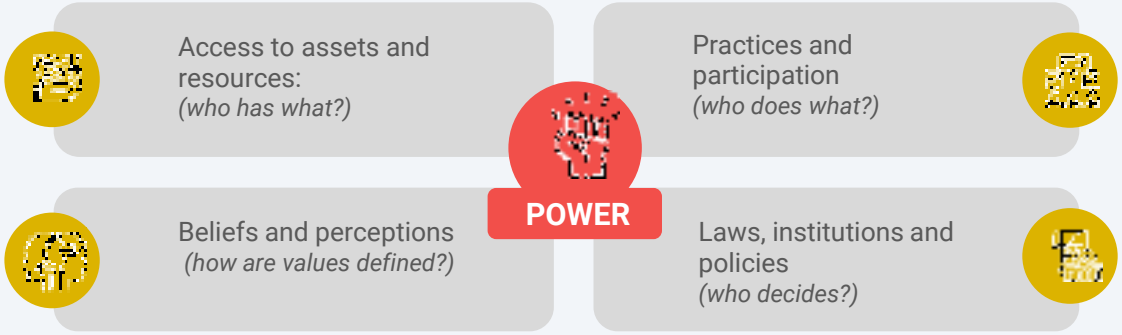
Pioneering frameworks for gender analysis

Most comprehensive gender analysis frameworks

- Jhpiego gender analysis framework by Caro et al (2013)
- Framework developed by and Morgan et al (2016)

Developed for gender analysis from a health systems perspective and are used for both healthcare providers and users

Key framework dimensions by Morgan et al, and Jhpiego gender analysis toolkit



ADVANTAGES

Four key dimensions

- Well aligned with literature on gender issues
- Morgan et al, also offers systemic perspective using WHO building blocks

Context and intersectionality

- Incorporates them as key elements to gender analysis

Centrality of power

- Recognition of gender as a power relation manifest across key dimensions

Tools for analysis

- Offers research questions to aid comprehensive analysis

LIMITATIONS

- Frameworks do not look at different levels at which gender inequities manifest, such as institutional, organisational, community and individual
- Centrality of gender norms as an overarching is not reflected in the visual representation and/or the description of both the frameworks

Brief review of other frameworks

01

Framework on workplace violence (George et al, 2020)

- Founded on gender power relations and feminist analysis of power
- Core dimensions offer a holistic and systemic approach to analysing workplace violence
- Illustrates how gender inequities across the different dimensions operate in interlinked ways, thereby eschewing any single point solution
- Good diagnostic tool but is essentially theoretical and broad-based in its approach
- Can be applied to a wide range of issues not just workplace violence

02

Framework on workplace violence (George et al, 2020)

- Possibly the only framework that looks at women leadership in health
- Useful as an analytical tool to map barriers and enablers to women's leadership operating at different levels- macro socio-cultural, meso organisational and micro individual levels
- Problematic in terms of how different levels are outlined

03

Framework on workplace violence (George et al, 2020)

- Assesses gender inequities exclusively in relation to community healthcare workers
- Disaggregates three levels at which gender inequities manifest- health system, community and individual that are cross-cutting; including national context and 'axes of inequity' (e.g. age, race); but excludes role of local contexts
- Including the organisational and institutional factors within health system level can limit its operationalisation

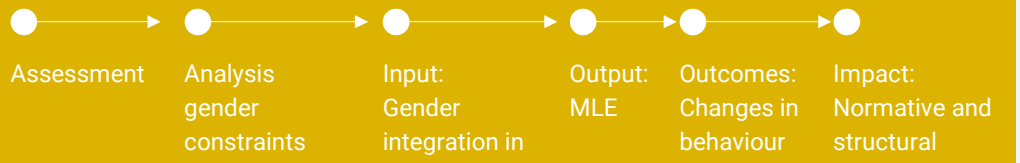
What are the **Toolkits*** used to analyse gender within health systems?

*A gender analysis toolkit provides a set of tools that offer practical guidance in integrating gender within health systems

- The Jhpiego gender analysis to the most comprehensive for gender analysis for healthcare providers
- Toolkit on Gender Equity and Social Inclusion (GESI) by THET is focussed on integrating a GESI approach across all aspects of the Health Partnerships to further FCDO's vision of gender equality with some insights relevant to healthcare providers

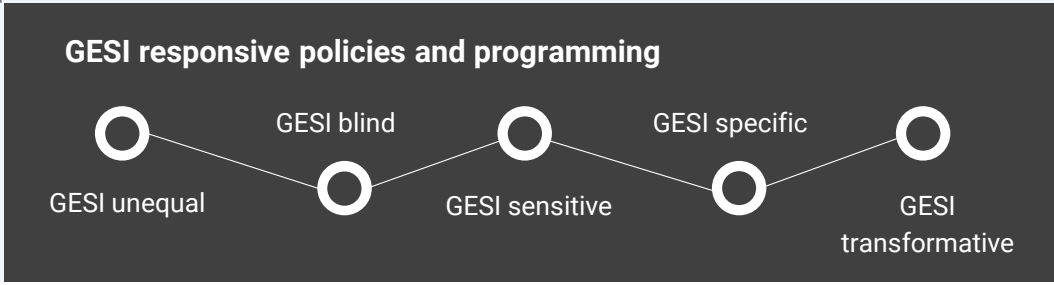
Jhpiego gender analysis toolkit provides -

- Gender analysis framework
- Research questions for each framework dimension
- Gender integration pathway for gender analysis (shown below)
  - Serves as logic model or log frame for designing interventions
  - Underscores the need to measure outcomes and impact in terms of behaviour change and shifts in norms and structures
  - Allows for disaggregated gender analysis at the individual, household, community, facility level and policy levels



GESI toolkit: insights for healthcare providers

- Resources for GESI needs assessment to identify constraints in project objectives and design.
- Ways to create an institutional buy-in to ensure feasibility, scalability as well as sustainability of gender integration projects
- Need for creating internal awareness on GESI within the teams of the Health Partnerships
- Ways to identify and support champions for advocating the GESI approach within the Partnerships
- Use of the GESI Gender-Responsive Assessment Scale for evaluation (shown below)



What are the **Indicators*** used to assess gender integration within health systems?

*Gender indicators are criteria used to assess gender-related change in a condition and to measure progress over time toward gender equality.

1.

In scoping for gender indicators in relation to health systems, we find substantial literature on healthcare users but there **is not much discussion around healthcare providers.**

2.

We find that most gender indicators for healthcare providers such as PAHO (2009) are-

- Look at specific aspects related to such as gender parity in decision-making and women's representation in various professional categories without including many of the core gender issues faced by female providers (e.g. safety at workplace)
- Most only measure change at the output level, and not at the outcome and impact levels, which are equally important aspects to gender-related change

3.

Key guiding questions provided as part of the benchmarks and gender analysis frameworks can be reformulated as indicators and are more useful for gender analysis for healthcare providers. These include-

- PAHO (2009)
- Morgan et al (2016)
- Jhpiego Gender analysis toolkit (Caro et al, 2013)

4.

Can serve as important tools to measurement as they are **adequately aligned to literature** and comprehensively cover the critical gender-based issues faced by healthcare providers

Illustrative questions reformulated as indicator

A robust set of gender indicators should be able to measure-

1. Gender indicators should measure both quantitative and qualitative aspects to assess the depth and scale of gender (in)equity

2. Should measure the gender differences in outputs (participation/ benefits), outcomes and impacts, that is, differences across the theory of change

Illustrative questions when reformulated as indicators serve to:

- Measure both quantitative as well as qualitative aspects
- Assess changes in output, outcome and impacts. Most focus on outputs.
- Serve to measure changes at different levels i.e. institutional/ policy, organisational (facility) as well individual levels at which gender inequities manifest
- Overall, we find list of questions by PAHO (2009) to be the most comprehensive and detailed, and thus the most useful for gender analysis (see next slide)

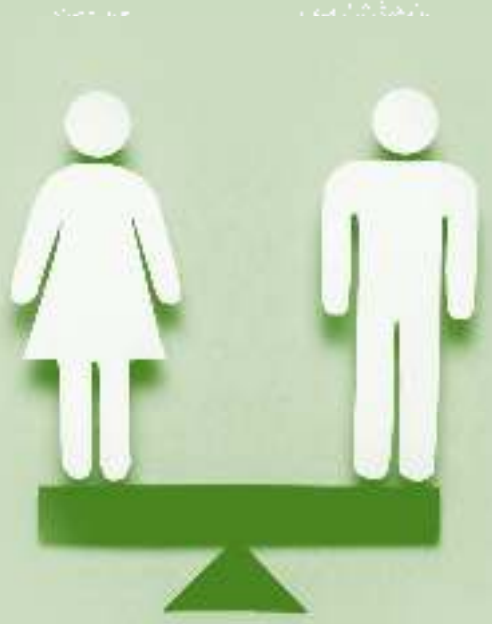
Examples of illustrative questions and indicators

Core gender issues from scoping review	Illustrative questions	Reformulated as an indicator	Source
Gender deficit in leadership and management	What is the representation of women and men in boards, panels, working groups and other decision-making bodies, or in supervisory and management positions?	Percentage of men and women in boards, panels, working groups and other decision-making bodies, or in supervisory and management positions	Morgan et al (2016)
Poor work environment	Are there female members and workers from across the health workforce hierarchy on committees that adjudicate over sexual harassment in the health workforce?	Proportion of women members and workers across the health workforce hierarchy on committees that adjudicate over sexual harassment in the health workforce	Morgan et al (2016)
Access to resources and amenities	Are there infrastructure conditions that favor breast-feeding by women who work in the health sector?	Proportion of healthcare facilities with infrastructure that favour breast-feeding by women who work in the health sector	PAHO (2009)
Poor access to training, education and career progression	What are supervisors and administrators' attitudes about sending male and female providers for training? In the district? Outside the district? Overseas?	Changes in attitudes of supervisors and administrators about sending male and female providers for training in the district/ outside the district/ overseas	Caro et al (2013)
Gender-based occupational segregation	To what extent are women more or less likely to work in frontline service delivery in poorly compensated (including volunteer) or less supported positions than men?	Percentage of men/ women in frontline service delivery in poorly compensated (including volunteer) or less supported positions	Morgan et al (2016)
Low and poor renumeration	What sex differences exist with respect to remuneration, job security, working hours and benefits?	Average remuneration, job security, working hours and benefits provided to women healthcare providers versus male healthcare providers	Caro et al (2013)
	Do performance-based incentives mean the same thing for female and male health workers across and within cadres?	Difference in the meaning of performance -based incentives between male and female healthcare workers across cadres	Morgan et al (2016)
Gender-biases and norms within health systems	What are providers' beliefs about gender differences and equality? In general? In the health care workplace?	Differences in male and female healthcare providers beliefs about gender equality in general and in workplaces	Caro et al (2013)

Look at both quantitative and qualitative aspects

Look at different levels - institutional, organisational and individual

Reflections on gender-related terminology and programming



- Most programmes use terminology developed by USAID or WHO which were originally conceptualised as practical tools that would enable gender to be integrated into the social sector, including health systems, and be measured across a continuum (Malhotra, 2021).
- Such terms and categorisations offer some clarity but the lack of standard terminology poses a key challenge Also, despite ubiquity of these terms in health systems programs, policies, and interventions for the past several decades, not much change has been affected in improving gender equity (ibid). Underlying issues highlighted by Malhotra, 2021 include-
    - Concepts around gender transformation are typically introduced at the conceptualisation of programs. However, they focus on intentionality, rather than articulating what will the programme achieve and how it will achieve it.
    - Most programs labelled as 'gender-transformative' are not strategically conceptualised to effect shifts in cultural norms, the key underpinning to transformative change. As shifting norms is a long-term project, it necessitates sustained investments for improving gender equity. Instead, in practice, gender programs are short-term projects with limited investment and often place the onus on individuals and communities to drive change.
    - Outcomes of programs can often eschew clear classification into one category along the responsiveness scale

If a program is intended to be gender transformative, its implementation should clearly articulate the pathways (such as financial investment, human resources etc.) needed to operationalise shifts in the direction (ibid)

Key Learnings

Existing measurements for healthcare providers, albeit limited, provide a good starting point for evaluation and assessment of gender-integration within health systems:

Benchmarks: PAHO (2009) Guide provides the most comprehensive and detailed benchmarks to assess how gender equitable health systems are.

MLE Gender Analysis Frameworks: Jhpiego gender analysis toolkit and Morgan et al (2016) are the most pertinent frameworks that can be used to map most of the gender issues faced by female healthcare providers against its four key dimensions. Power is central to the analysis of both frameworks provide illustrative research questions

Measurement Toolkits: Jhpiego toolkit is the most comprehensive for analysing gender inequities within health systems both for providers and users. It offers a gender integration pathway that can be operationalised at different levels of the health system. The toolkit delineates gender integrative change into inputs, outputs, outcomes, and impact, and serves as an effective logic model for designing interventions.

Indicators: Illustrated questions by Morgan et. al, PAHO and Jhpiego when reformulated as indicators can effectively serve as measurement tools.

Way forward:

- **Need for operationalizing existing tools and measures identified in the review, for application across contexts.**
- **Need to further develop gender indicators on behaviour (outcomes) and normative changes (impact),**
- **Measurements and frameworks need to provide information on how power as a dimension can be operationalised in gender analysis.**

Overview of

policies, provisions and directives in relation to gender equity within health systems

Policy overview

Introduction

- The policy overview attempts to assess the degree to which policies in the Indian health system provide equal opportunities to female healthcare providers and are responsive to their needs.
- We provide a broad (though not exhaustive) overview of the available policy provisions relating to women healthcare providers in India, focusing on the following areas:
  - remuneration and allowances
  - career progression
  - sexual harassment and violence, and grievance redressal
  - maternity and other benefits
  - staffing and working conditions and
  - retention of women healthcare providers in rural areas.

Research Method

The Policy Overview is based entirely on desk-based research and draws on issues highlighted in literature, and by experts interviewed on policies related to women healthcare providers in India.

1. Search terms

list of key words from the issues listed above like 'nurse remuneration' specific legal acts like 'Prevention of Sexual Harassment', and known provisions, such as 'maternity leave' etc.

2. Literature reviewed

policy documents, government reports, guidelines, circulars, legislation, and office orders/notifications; international conventions and polices, especially the ILO Convention for Decent Work, primarily as a guide to desirable standards and potential policy reform

3. Web search engines and electronic databases

Google, Google Scholar, and Lexis Advance.

Policy-related barriers that need to be addressed to build a more gender-equitable health system

Policy implementation–monitoring gap

- Provisions for maternity benefits have not been implemented by states
- Grievance redressal: Till date, no reports on the implementation of the POSH Act (2013) exist.
- Career progression policies are disparate across states

Policy development gaps

- Lack of integrated planning mechanisms in the form of HR development policies
- Lack of policy action on improving the working conditions of women providers.
- Absence of supportive structures regarding workplace violence and harassment

Gender deficit in policymaking

- Lack of prioritisation of women's needs in policies owing to exclusion of women in policymaking
- Absence of policies that mandate, incentivise women's leadership roles in decision-making
- Leadership roles lack consideration for women's reproductive roles, responsibilities

Need for short-term and long-term review mechanisms to understand issues and ensure implementation

- NHM's yearly Common Review Mission can be leveraged as a mechanism for assessing and addressing implementation-monitoring gaps.

Need to adopt provisions from international legislation for areas of concern that national policies don't address

- A comprehensive policy on Human resources in Health
- Adopt CEDAW's provision on modification of social and cultural norms
- Leverage ILO conventions on decent work

Need to include women across cadres in leadership and decision-making roles

- Impart leadership skills in pre-service, in-service education and training
- Formulate gender-responsive policy provisions for childcare benefits and support in the workplace

Learnings from Policy Overview

Key Takeaways:

- There is a lack of gender-responsive policies for women healthcare providers in India as most existing national and state provisions are not gender intentional.
- Existing policies that could afford better equity to women healthcare providers suffer from poor implementation.
- Poor representation of women in policymaking roles.
- Gender-responsive provisions are not legally binding and lack any form of accountability.

Need for decision-making bodies to move away from theoretical planning to actual implementation of the existing provisions, to ensure a more robust health system that caters to female healthcare providers.

Scoping Review of Programmes:

Learnings and Opportunities Relating to Integrating Gender for Healthcare Providers in Health Systems

Introduction

- Gender-intentional programmes and interventions can play an important role in addressing some of the gender inequities faced by female healthcare providers. In the long-term, gender-integrative programs can potentially shift the status quo and improve performance of providers, quality of care they deliver and ultimately health outcomes.
- We reviewed programmes that have directly or indirectly addressed gender issues to provide lessons about what works in terms of integrating gender into health system strengthening (HSS) for providers.
- The purpose of this scoping review is to provide learnings and opportunities that can be leveraged to initiate pilots, models and gender programming for healthcare providers in low- and middle-income country (LMIC) settings.

Research Method

1.

- **Interviews conducted with key experts** who were directly involved in the implementation of the programmes
- **Published articles and reports** on the programmes

2.

A total of eight programmes were selected: six from India and two from African countries

3.

The programmes that we identified through interviews with key informants were included based on the following criteria:

- Context: implemented in LMIC settings
- Addressed gender-based issues faced by providers: Whether the programme, primarily focused on improving quality of care for women, also addressed some gender issue faced by providers
- Inclusion of programmes: that aimed to improve quality of care, coverage, or the leadership function in health systems, and by default, addressed some of the issues faced by female healthcare providers

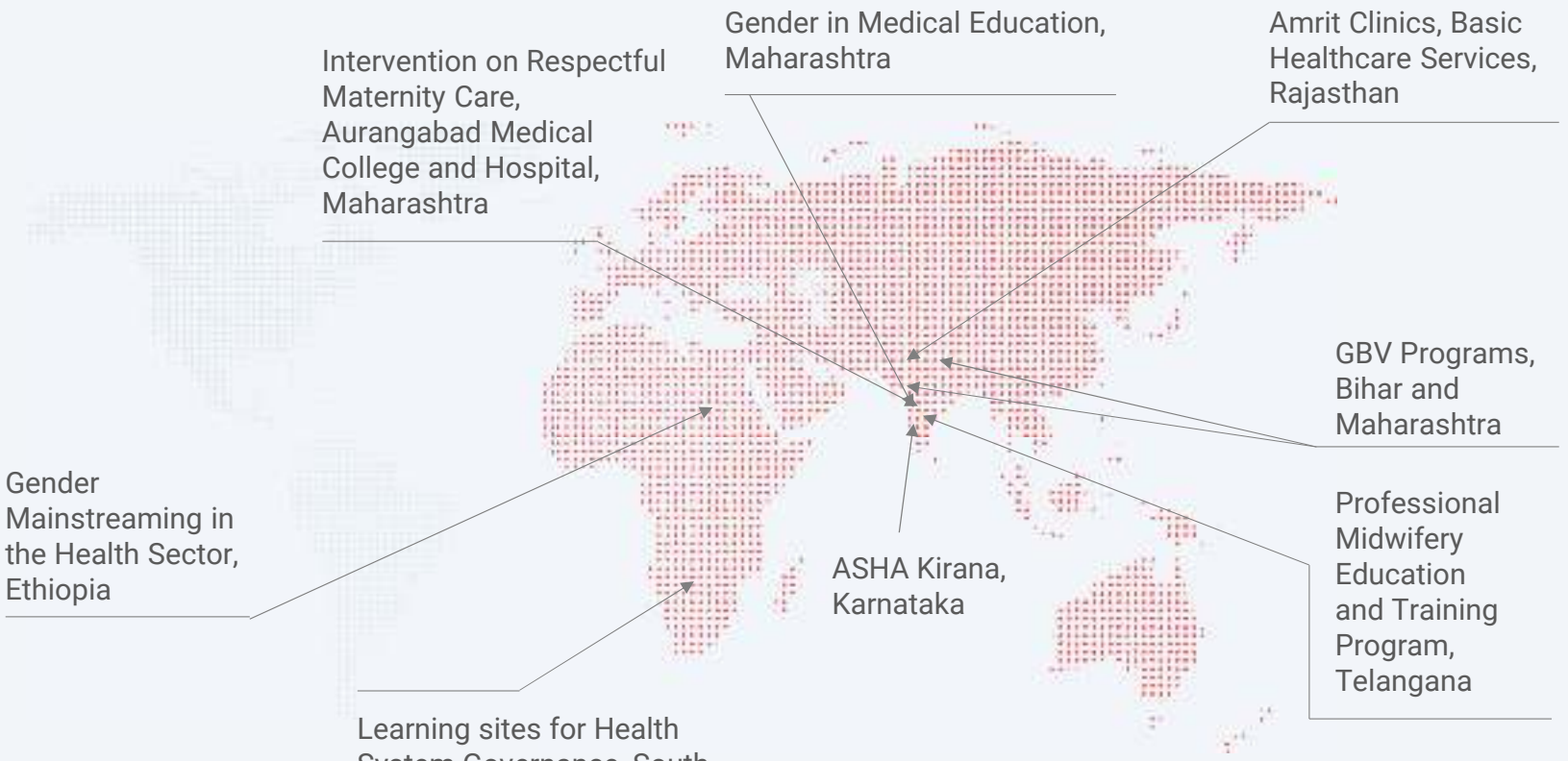
4.

The selected programmes were further categorised based on -

- Gender intentionality of the programme from a provider perspective: was it explicit or by default?
- Gender issues: The gender issue that the programme addressed for women healthcare providers
- Intervention setting: private or public health system

The programmes' assessment was not one of the criterion for selection because most of the relevant programmes are still in the process of being evaluated.

Programmes included in the review



Overview of programmes

Interventions on responding to gender-based violence (GBV) in Bihar and Maharashtra

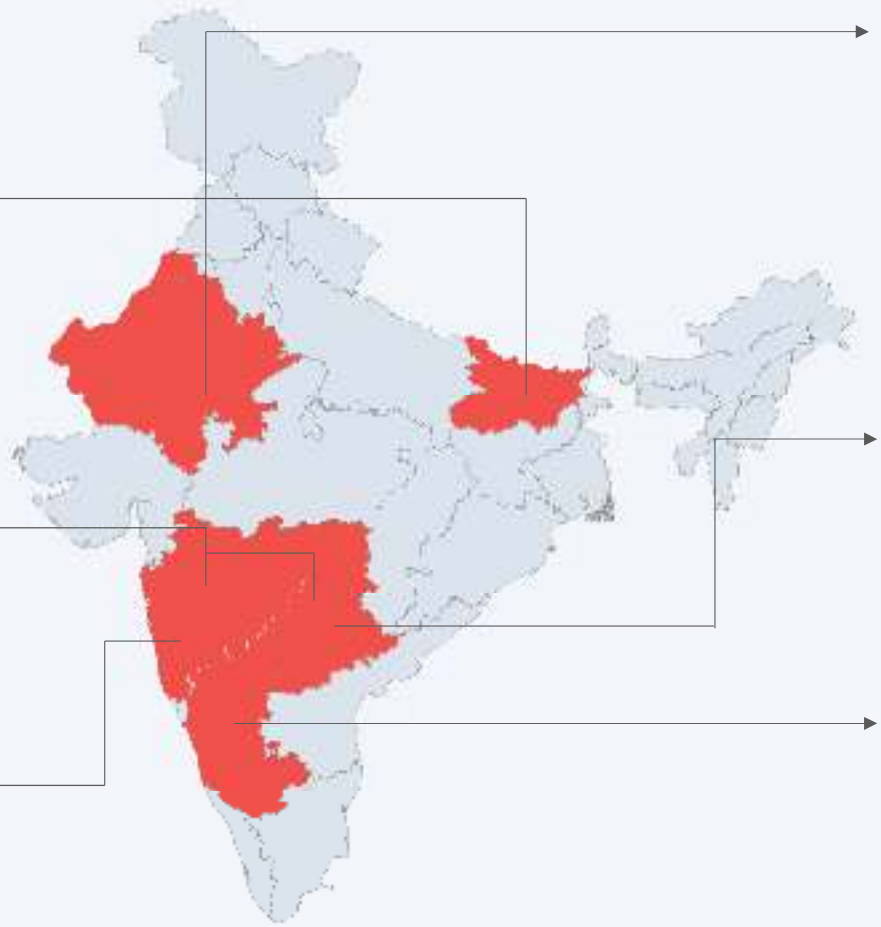
Building awareness of, and sensitization on GBV faced by providers themselves; also led to setting up complaints' committees and a helpline in some cases.

Changing health provider attitudes and increasing respectful maternity care, Aurangabad Medical College and Hospital, Maharashtra, and Fernandez Foundation, Hyderabad, Telangana.

Training healthcare providers to move toward respectful maternity care (RMC). Also led to reflection on the treatment of nurses and making some facilities more gender responsive.

The Gender in Medical Education (GME) project, CEHAT, Maharashtra

Aimed at integrating a gender perspective in the undergraduate medical curriculum of all government colleges in Maharashtra.



Enabling nurse-led primary healthcare centers in under-served areas with vulnerable population groups, Basic Health Services (BHS), Udaipur, Rajasthan

Established nurse-led primary health units ('AMRIT clinics') that reach the most vulnerable and under-served communities, with nurses having decision-making power.

Professional Midwifery Education and Training Programme

Through training, seeks to build a cadre of skilled and empowered NPMs who will enable and promote positive childbirth experiences and advance respectful maternity care.

Empowering frontline health workers through digital technology ASHA Kirana, Koppala, Karnataka

Enabled frontline workers to collect and use clinical assessment data using digital technologies during home visits, in a pilot project.

Overview of programmes

The Health Sector Transformation Plan (HSTP), Ethiopia

Operationalizing integration of gender for healthcare users and workers and empowering the female healthcare workforce.

Processes to build collaboration and distributive leadership Learning sites in Kenya and South Africa

Operationalizing integration of gender for healthcare users and workers and empowering the female healthcare workforce.

Learnings from the review of programmes

To improve coverage and quality of healthcare care, improve gender equity for providers	Aurangabad medical college's efforts to create a conducive, respectful work environment for nurses, and promotion of nurse leadership in Amrit Clinics, played a crucial role in empowering nurses to steer frontline delivery of healthcare services in low-resource settings.
Initiatives to shift gender inequities can begin small by changing practices at the organizational level	RMC and GBV Interventions in Maharashtra's government facility were housed within the government medical facility and college, steered by the administration of the department, and involvement of the college faculty and clinical staff.
Government buy-in is a must for scaling up and institutionalisation	Dilaasa, a GBV initiative was able to successfully scale up across states after it was integrated and supported within the National Health Mission.
Methods and processes are key to nudging power hierarchies and breaking silos	Joint training across cadres, using reflective, participatory, and experiential methods proved to be effective in disrupting professional power-based silos, instilling confidence in the lower cadres and building joint ownership of the programmes.
Invest in long-term programmes, modelling, and experimentation	Most experts shared that efforts to break down hierarchies among cadres, instil teamwork, and respectful attitudes toward women take time and patience and require long-term investment to understand what really works.

Learnings from the review of programmes

Assess shifts in behaviour differently- adopt descriptive, qualitative, and incremental measures	Measure small changes observed in day-to-day micro practices- whether lower cadres are comfortable to speak up in front of seniors (AMC), whether a team can take a decision to undertake a task (Amrit Clinics), whether doctors are willing to work in collaboration with nurses (Fernandez Hospital).
Create different and distributive leadership for gender equity and service efficacy	Building technical, leadership, soft skills of nurses is necessary to equip them to assert themselves, have bargaining skills, and be effective in their leadership roles. Capacity building of nurses in the Midwifery program, Aurangabad Medical College and Amrit Clinics (in tribal areas), fostered effective task-sharing and enabled nurses to be the backbone of service delivery.
Reward, validate, and build champions for gender-equitable practices	• Dilaasa created championships involving senior doctors, nurse supervisors and matrons who helped disseminate the programme's learnings in different forums. Their recognition and appreciation enabled more champions to emerge. • HODs of medical colleges in Maharashtra continue to champion and advocate for the need for gender-integrated curriculums.
Harness expertise through collaboration and partnerships	• GBV initiatives in Aurangabad and the Sajha programme in Bihar evolved by drawing on the support and expertise of CEHAT. • AMRIT clinics are working with IIM Udaipur to introduce its model to a public health facility and develop a metric for behaviour change.
Integrate skilling and learning to build a gender-responsive culture and gender-responsive practices	In Maharashtra, gender is integrated into the core curriculum of medical education instead of as standalone modules. In Amrit clinics, skills on leadership, communication, and management were aligned to the tasks that were expected of the nurses.

Opportunities for donor support

1.

Leverage government-supported programmes on GBV and RMC

Provide non-threatening entry point and gateway to address issues related to workplace violence and harassment faced by providers.

2.

Support current and ongoing initiatives to strengthen evidence and outcomes

Programs such as Amrit Clinics, that have enabled changes in work culture through gender-equitable practices can be adapted within public health systems with the support of external resources.

3.

Adapt existing programme models to ongoing initiatives in the public health system

Health and Wellness centres (Ayushman Bharat programme) can be an entry point for leveraging lessons on task sharing from Amrit Clinics. Learnings from Aurangabad Medical College can be integrated into the RMC initiative by Pronto in Muzaffarpur.

4.

Create a learning network around gender intentional practice including exchange visits to generate evidence and strengthen advocacy for gender programming

Creating a learning platform and network to exchange ideas and practices and build evidence - based advocacy can provide the necessary promote more gender-intentional programming by governments and development partners.

5.

Develop a deeper understanding of championship and champions

Document and collate pathways, processes related to creating championships and champions, hosting convenings, and building networks of gender champions (professors, clinicians, nurse leaders, senior bureaucrats), who can build a strong advocacy platform.

6.

Document effective micro-practices, processes, and methods used by gender-integrative programmes

Creating such an evidence base can increase understanding of the change and effectiveness achieved by such programmes from the perspectives of the women healthcare workforce

7.

Explore concepts and practices such as diverse and distributive leadership

Identify what gender-responsive leadership means, document what it looks like and what it takes to establish this kind of leadership.

8.

Develop and test a charter of respectful working conditions and a respectful environment

The charter should delineate responsibilities, provisions for career progression and women's specific needs, such as workplace safety, grievance redressal, access to decent working conditions, regular health check-ups (e.g. for breast cancer), etc

9.

Develop a comprehensive MLE framework for gender intentional, provider focused programs

Draw on learnings from current gender intentional programs to design and test a MLE framework, including methods and metrics for effective adaption across different settings.

Learnings and

opportunities for integrating gender within health systems

Learnings and Opportunities
for integrating gender within HSS initiatives

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Introduction

- Strong imperative to invest in making health systems gender equitable for women healthcare providers since it is well recognized that gender inequities directly influence their performance and adversely affect the provision of healthcare services.
- While research extensively documents the prevailing gender-based inequities at the healthcare provider level, little exists in the solution space for addressing these.
- To better understand some of the ways in which gender-related considerations can be integrated within health systems, we conducted key informant interviews with practitioners, program experts, academics and health system actors in the field of gender and health systems.
- We draw out key learnings and opportunities that can serve as effective entry points, pathways, strategies and enablers for improving gender equity for women providers.

Research Methods

- We conducted **key informant interviews** with select non-government experts in the field of gender and HSS, including international and national practitioners, academics and health system actors.
- The initial **selection of experts** was done based on consultation with BMGF and our own knowledge of having conducted the scoping review for literature and programmes. Additional selection of experts was done using the snowballing sampling method, through references provided by initial experts interviewed.
- Interviews were conducted remotely using the Microsoft Teams software. We **interviewed a total of 22 experts** from December 2021 to March 2022.
- Drafted a **general guiding tool** with questions, suggestions and recommendations related to (i) programme and evaluation (ii) healthcare leadership and management and (iii) policies & policymaking related to gender and health systems.
- The **transcripts** were coded manually, extracted using Microsoft excel and data was analysed using the thematic content analysis approach.
- We took measures to follow the **ethical procedures** of consent, safety, confidentiality, and privacy while conducting the interviews and in presenting the data as part of the study findings.

Unpacking Gender
in the Health System

01 The interviews generated interesting discussions on what gender and gender inequity might mean in the health system, how it manifests for providers and how it intersects with other sources of power. *Some of the key learnings are illustrated in the next slide.*

02 It is difficult to distinguish whether inequities faced by female providers are based in gender power relations or stem from low professional hierarchy since a majority of the female healthcare workforce is positioned in the lower rungs of the health system. **However, one should not even aim to disentangle gender from power hierarchy as both*"…go together really, really tightly and it's quite challenging to think about disentangling, when the identity of the occupation is so tightly, you know, wound in a gender way."*** *(as quoted in a KII)*

03 Lower status of a largely women cadre is a reflection of gender-based occupational segregation wherein nursing, midwifery etc. associated with care giving roles are considered more suited to women. As a result any occupation that is feminised tends to be accorded lower social value, devalued status, and lower pay-scales.

04 Certain issues are distinctly gender based that women across hierarchical cadres are susceptible to- such as sexual harassment and workplace violence.

Unpacking Gender in the Health System

Varied discussions emerging from key expert interviews

Health systems reflect and therefore normalize the gender norms, roles, and expectation of the socio-cultural context they operate in 01

Household gender social norms and country context are mirrored within health systems- male dominated professions treat female dominated professions in a gender discriminatory way (assuming caregiving roles are women's domain) and also, there is acceptance of these due to women's internalized gender roles

Medical profession can be gender blind and thus not always intentionally gender discriminatory 02

Health and health system tend to operate with a biomedical framework and tend to focus on the individual and therefore do not account so much for the social determinants of health and nor the health system as social systems.

Implications of gender and gender inequity may be considered from user perspective but rarely from a provider perspective 03

Overtime, given the growing importance given to quality of care, GBV and RMC, doctors and managers have become aware of gender issues related to users but they continue to remain unaware of the gender inequities that they continue to perpetuate vis-a -vis women healthcare providers

Women healthcare providers are not only at the receiving end of the gender inequity but also are perpetrator 04

Women as carriers of patriarchy and internalised gender norms around birthing and subordination of women tend perpetuate inequities through normalisation of disrespectful maternity care and obstetric violence

Unpacking gender within health system needs also to take men into account 05

Gender tends to get identified with women only. Gender being about power relations, needs to taken into account men. Its not just about scaling up women, but scaling down men. To enable gender equity, power will need to move and shift. Men in the health system may not even understand what gender issues for providers are and may not even acknowledge the existence of these issues

Health Systems still don't talk about other gender identities 06

Issues of gender continue to be discussed only in binary of men and women. Health system literature rarely focuses on other gender identities.

Intersectionality is central to understanding of gender inequities in the health system from a provider perspective 07

Gender inequities manifest in intersection with other forms of social inequities related to class, caste, age, education etc.

Women Leadership in Health Systems

01 The deficit in women leadership within the health system is amongst the most critical underpinning of the several gender issues faced by women health workforce, including that of working conditions, vulnerability to workplace violence and sexual harassment, gender pay gap.

02 Lack of adequate representation of women in leadership position precludes them from participating in policy and decision-making leaving them with little say in matters that affect their profession.

03 The issue of gender deficit in leadership lacks traction due to simplified and fixed understanding of what leadership may mean and essentializing leadership models that usually privilege the male norm of leadership. It emerges from multiple factors and is not single levered (See quote below).

> "The issue itself is complex and that it doesn't sit in one place... it's an issue that has a lot of different roots to it and that we need to be thinking about all those different roots. Some of those roots are in our family, some of them are in our culture and some of them are job roots and some of them are personal factors.

Specific reasons for the deficit of women leadership shared by experts:

Difficult to promote women's leadership: Limited understanding about what constitutes good leadership, its parameters and assessment in execution.

Current model of leadership typically promotes leadership models in line with male roles and expectations: dual or multiple responsibilities of women professionals are not accounted for

Lack of necessary supporting policy provisions in LMICs: little or no childcare facilities, little opportunity to join the workforce after career breaks so women often lose seniority and promotions when they take long breaks etc.

Self-imposed or internal barriers in uptake of leadership roles: Women step back owing to lack of lack of provisions within health systems to enable handling of dual responsibilities

Deeply entrenched, norm-based biases against accepting women leaders. Men considered superior to women, irrespective of seniority, are not receptive to women leadership

Lack of women leadership at higher levels tend to discourage women from taking on position at the lower levels of the health system. For e.g. Absence of women in senior administrative roles like Chief Medical Officers in districts in India, can impede women to take up the positions of Medical Officers In-Charge (MOICs) in block level facilities. (as shared by a key expert

Women Leadership in Health Systems

Attributes of Gender-responsive leadership

Decentralized and distributed form of leadership, comprising teamwork: Doctors must understand that they cannot function without nurses. Distributed leadership can also enable women to effectively manage their dual responsibilities

Collaborative and not embedded in subordination: A collaboration of equals with each leading their own areas of work and expertise.

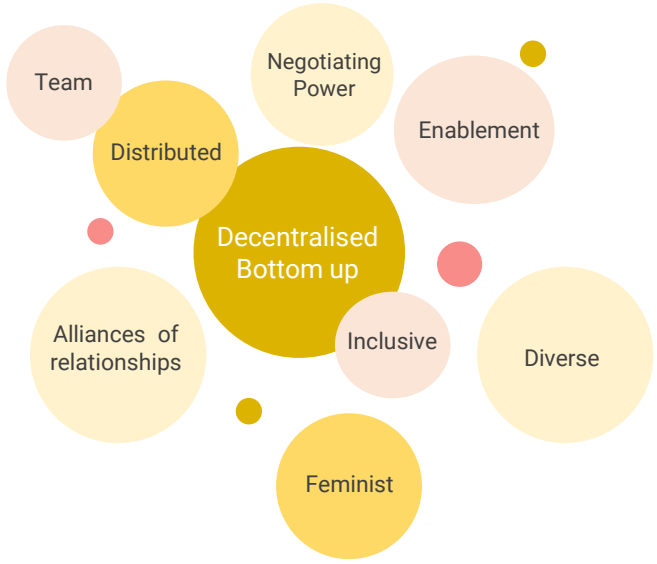
Gender responsive leadership is not the same as a gender responsive leader

Diverse leadership styles: shift from typical 'hard edged', 'masculine' practices to more equitable and different ways of leading.

Leadership that is enabling and nurturing: leaders allowing more leaders to emerge

Gender aware and transformative leadership: cognizant of the fact that policies affect men, women and other genders differently and thus factoring enablers in line with those differences to bring about transformative changes

Showcases/applies feminist principles of leadership: imbuing the spirit of transparency, equity, enablement, mentoring/nurturing and allowing for both men and women to be able balance their dual responsibilities. (See quote below)



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"

The discourse on gender-responsive leadership hasn't filtered its way in a practical way in the health sector but it looks like 'workplace issues that allow feminist approaches to be operationalized.' (Based on papers from Harvard Business Reviews). A leadership where a lot of thought is put into decision-making in a much more transparent and non-hierarchical way even if you are leading. Giving space to people in your teams to weigh in, to mentoring where a person kind of proactively supports mentoring the junior and the early career folk in your team and the organization. Really creating institutions that support the idea of flexible work hours, allowing both men and women to take time off for childcare or family leaves care. And exercising that leadership position that creates a workplace for some of these provisions.

Women Leadership in Health Systems

Enhancing representation of women's leadership roles in health systems is necessary but not sufficient

01 Enhancing numerical presentation of a women in leadership positions is necessary from an equity and rights perspective

02 Not numbers but the types of women who take on leadership role will make the difference in terms of whether leadership and health systems are gender responsive or not.

03 In the experience of experts, women leaders have been both as supportive and non-supportive of initiatives to promote gender equity as men.

Enabling Women Leadership in Health

> "We appoint 10 women in our cabinet, but what does that mean? Are you doing this as a token thing? Or are you really shifting your workplace policies to enable women to rise? To enable women to thrive? To enable the work-life balance. Are you really changing how workplaces operate in terms of not sending women out every time to bring coffee into the room? Are you doing those things? Are men in the workplace taking responsibility to change those gender norms?

Integrate leadership and technical trainings for leadership competencies at early, at the medical and pre-service education and orientation.

Citing the example from Bangladesh and India, some experts point out how when not having been trained or given an opportunity to exercise decision-making and autonomy, when women healthcare providers and administrators are elevated to leadership, they do not how to play those roles. They end up being subordinates and compliant, unable to advance the cause of their cadres.

Willingness of women to take on some of the leadership mandates:

One expert suggested that women too should be willing to take on some of the key responsibilities that come with the position. She cited the example of how women tend to avoid leadership roles as they are unwilling to taken on the medico-legal work that comes with the leadership positions.

Make policy provisions that enable women to get adequate support in their workplace so that they can have work life balance take on their dual responsibilities without having to compromise on either.:

Talking about women's hesitation to take up leadership roles because its time consuming and impinges on their ability to fulfill their care responsibilities at home, some experts spoke about supportive policy measures including childcare provisions, distributed leadership and providing work life balance for both men and women. Support for children was also discussed in connection to women taking on rural postings, often a steppingstone for leadership position. An expert suggested women taking on rural posting should have the government support their education in good institutions with boarding

Reservation with necessary policy provision and support:

One expert, citing those men will not make space women so easily, suggested that, like in the panchayats, there can be reservation for women leadership roles. She however cautioned that just reservation may not work if it is not accompanied by the policy provisions to enable her to fulfill the responsibilities of that role. The policy provisions could include childcare support, technical capacity building, work -life balance etc.

Financial and Non-financial incentive:

Some experts suggested that women's leadership could be encouraged with financial and non-financial incentives. Suggesting collective financial incentives, one expert suggested that governments could provide additional financial support to districts that have high percentage of women leaders at the different levels. On non-financial incentive, one expert suggested that women would be keen to take up rural postings, if it was assured that having served in rural areas, they would covet postings that would ensure their career growth.

Leadership roles at the lower levels.

Some of the experts pointed out women hesitate to take up leadership positions because of the absence of women leaders in most of the leadership roles in the higher levels or their reporting lines. One expert shared that women doctors would feel more comfortable taking up MOIC roles if the CMOs were also women. Thus, she suggested that it is important that sufficient representation of women leaders at all levels.

Fulfill the existing policy mandates and create new mandates.

Experts suggested that amongst the first step to encourage women leadership in health system would be to fulfill the existing policy mandates of establishing nurse leadership roles. This was stated in the context of nursing directorates (discussed in the next section). Some also pointed out that men continue to occupy leadership roles even in structures that serve women only cadres like the nursing associations (discussed in the following section). Additionally, leadership positions should be landed through streamlining provisions for career progression that leads to leadership positions.

Advancing nurse leadership

through institutional reforms, strategies, and organizational practices

01 Increase the representation and substantive participation of nurses in existing leadership roles

Establishment of nursing directorates at the central level and across states as recommended by the high powered committee on nursing

Fill key governance positions lying vacant across states

Existing key governance positions need to be vested with authority and power that allows nurses to exercise decision-making and autonomy.

02 Involve nurses in policymaking within the health sector that influence their practice and status and especially entrust the authority in decisions related to nursing

Expert committees formed to make decisions for nursing should constitute 50-70% nurses across different levels of seniority, including lower-positioned cadres.

03 Creating definite and favourable pathways for career progression to advance nurse leadership

While doctors have timely career advancement opportunities, avenues for promotion of nurses are limited and far apart (see difference in career progression on right). Limited opportunity for nurses to reach decision-making roles as they get closer to retirement age.

Need to establish conducive career pathways to avail the leadership opportunities.

Career advancement every 2-5 years of practice

Head of Department

Senior Resident

Junior Resident

Career trajectory for doctors

First promotion after 15 years of practice

Nursing Superintendent

Senior Nursing Officer

Nursing Officer

Career trajectory for nurses

Advancing nurse leadership

through institutional reforms, strategies, and organizational practices

04 Need to address the disparity in clinical practice and education-oriented professional growth opportunities for nurses

Establish flexible structures and career ladders that allow nurses to take up roles across clinical, research, education, leadership, and management.

05 Leadership and soft skills training, complemented with practical learning components can be effective in empowering nurses.

Build leadership capacities of nurses: development of communication skills, training on aspects of management and developing interpersonal relationships as well as training exercises wherein nurses learn about real-life problem-solving and responsibilities in which they would have to exercise their leadership skills.

For e.g. handling of facility inspections, effective management of staff teams and possessing the financial know-how of managing funds in order to make decisions on workings of the facility.

06 Operationalize nurse leadership through improvements in work culture- entrusting nurses with authority in the everyday functioning of facilities, power to make decisions and trust in their competence and clinical judgement

Create a conducive work environment for nurses- opportunity and confidence to exercise their skills and leadership roles, where they are supported and treated with respect.

Training and sensitizing other healthcare providers and the administration to build receptiveness towards nurse leaders.

> “That they are treated well, their opinion matters, there are ways to listen to them and act upon them, they are given autonomy. I mean, for example, in our clinics, the nurses have the autonomy to decide to waive off the fees for anyone that they feel is a poor person. It doesn’t have to come to anybody else. They can make that decision. It’s some of these decentralized practices.

Shifting work culture
towards greater respect and equality

Oxford Policy Management

Experts shared insights and strategies for improving the work culture within facilities which can potentially create an empowering environment for female healthcare providers.

Involving and engaging with the administration to institutionalize gender-responsive work culture. It is an important pre-requisite to shift the ways of working at the facility-level and can help in garnering support for gender-integration initiatives

Designing training methods that can help to break the notions and practices around hierarchical ways of working. Changing the processes of training that tend to have inbuilt power dynamics methods can establish a sense of equality between different cadres and create respectful workplaces

Facility-based collaborative practices to operationalize non-hierarchical culture of working. Ensuring greater transparency in communication between colleagues and seniors, collaboration in clinical and non-clinical tasks, all staff members including lower-positioned female providers having the liberty to take leaves.

Designing and constructing health facilities/systems that are responsive to women's specific needs. Access to amenities such as clean toilets with facility for menstrual hygiene management, designated private spaces for female providers (for rest, breast-feeding, etc). Provision for transport and security to ensure safety of women workers.

Cultivating respectful treatment and caring attitudes towards healthcare providers. This includes recognizing the barriers and constraints faced by female providers at the workplace, and be attentive to their needs as individuals and the specific issues they have (e.g. menstrual discomfort, pregnancy, etc.)

Task redistribution as a strategy to strengthen teamwork and build a sense of equality among facility staff. Sharing of tasks with clearly defined responsibilities, autonomy in clinical practice and supportive working relationships between physicians and nurses.

Create fair and equitable institutional mechanisms for performance management and appraisal. Performance assessment should be undertaken by a committee and not left to the discretion of the immediate supervisor- a single individual.

Develop an institutional Charter on rights and entitlements of healthcare providers to enable a respectful culture of work. This would include regulations and provisions around work shifts, leaves, rights and entitlements of staff, especially the women healthcare providers

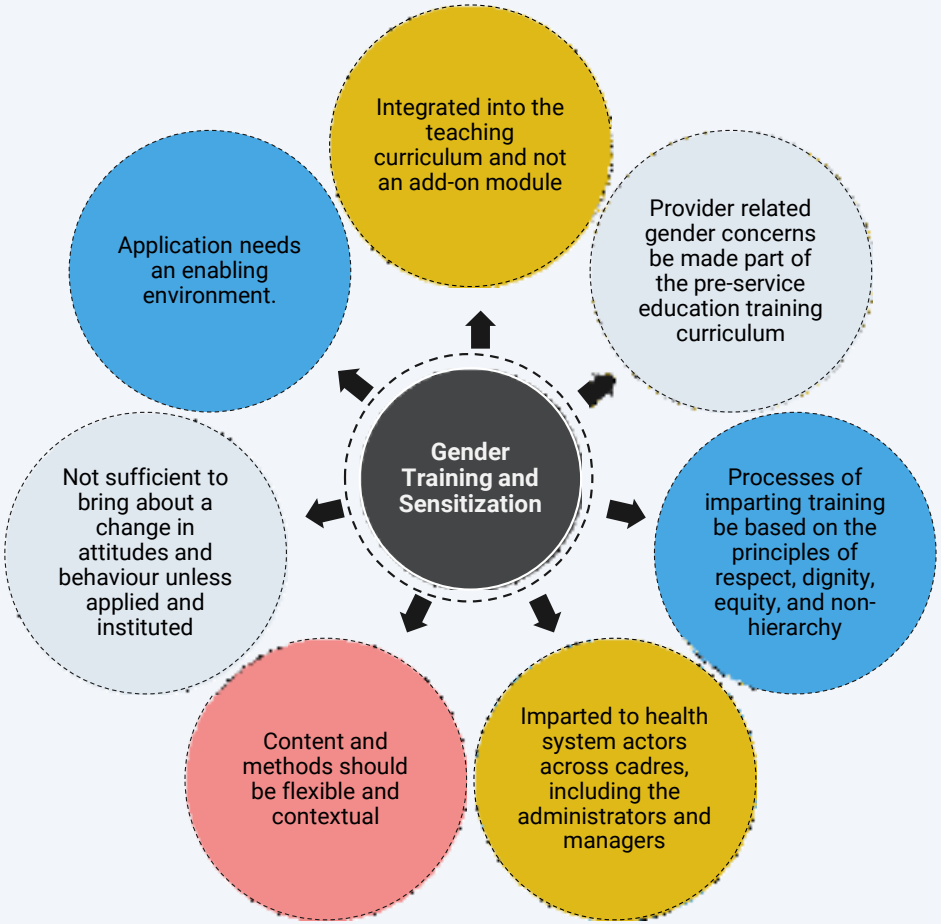
Key constituents of conducive work culture

- Non-hierarchical work environment
- Teamwork and collegiality
- Respectful work environment
- Autonomy
- Gender-responsive policies and institutional mechanisms

Gender training and sensitisation

We asked several of the experts on the efficacy of gender training and sensitization as an entry point to making healthcare actors, facilities and eventually the health system more gender responsive. The experts shared several insights on what, when and how gender training and sensitization interventions may work to achieve the desired results shown in diagram:

> It is really about how we teach and how our curriculum is designed. If you don't teach medicine, nursing, public health, midwifery, social work from a form of feminism, then a lot of it is undoing what they have been taught in certain way. So, in order to make some impact, you have to teach in a very different way. You have to get the people who we are producing as doctors, nurses, midwives and social workers, to really be oriented to these issues from the very beginning.



Assessing gender integrative interventions

Experts were asked to share their views related to MLE for assessing gender intentional programs for providers

They outlined some key principles and others the strategies that they have adopted.

Principles to guide measurement and assessment

- Gender integration is a long-term process. Outcomes and Impacts must be assessed over longer timelines
- Conventional assessments and measurements, which are predominantly quantitative and rely on rather linear theories of change may not work for assessing gender integrative change
- Measurements must be context-based and flexible

Approaches and strategies

01 **Focus on observing and monitoring incremental changes in micro-practices, processes, attitudes, and behaviours.** Measuring these may not directly reflect changes in the gender related changes in norms and practice but may serve as proxy variables to signal those changes are taking place in the right direction

02 **Developing and using standardised tools to measure attitudes and behaviour will be necessary for scaled interventions**

03 **Outcomes and impacts cannot be measured in the short term as doing so has the potential to distort processes.** Shifts in in behaviours, attitudes and practices need to be sustained over time bring about changes in the underlying values, beliefs and norms

04 **Descriptive indicators and checklists to assess gender responsiveness of health facilities and systems**. Some examples shared were related to the sense of respect that is accorded to the staff; the initiatives taken by staff to adopt new practices; the sense of wellbeing that nurses experience even when resources remain a constraint.

05 **The availability of data and sex-disaggregated data on providers can be the starting point** for gender analysis and can help inform evidence-based decision-making by the healthcare leadership and practitioners

Workplace violence and sexual harassment faced by women providers

- Experts shared on-ground knowledge on the prevalence of workplace harassment, reasons for under-reporting and strategies for prevention and redressal .
- Gender-based workplace violence and harassment is widely prevalent across the healthcare hierarchy, starting right from the time of medical education and is perpetrated by colleagues, peers, juniors, medical professors and others within the health system as well as patients and communities
- Under-reporting is driven by structural constraints such as poor access to redressal mechanisms, lack of confidentiality and restrictive gender norms that normalise workplace violence and discourage reporting. As a result, prevalence is much higher than what is reported

Strategies for prevention

Creating awareness by leveraging existing interventions for addressing gender-based violence to include a module for training women providers on provisions around sexual harassment at the workplace, the legal provisions, processes for reporting and redressal etc

Improving infrastructure and safety provisions. These include provision of adequate security and safety measures, safe resting places, access to separate toilets within the premises, and a safe accommodation.

Improving work culture through gradual shifts in the day-to-day micro-practices and behaviours in order to make them more respectful and equitable. Awareness creation through gender training and sensitization across healthcare cadres is also a complementary strategy to achieving this.

Community-based approaches such as community-based campaigns and advocacy to create awareness at the community level and bolster systems of social accountability related to workplace violence.

Strategies for redressal

Strengthening implementation of existing laws and provisions with a focus on:

- Improving on-ground implementation and access to redressal mechanisms, particularly at the local healthcare facility level. E.g. making POSH Act a mandate
- High levels of confidentiality in all processes related to reporting (see quote on right)
- Fair, safe and unbiased mechanisms for addressing cases of sexual harassment and violence
- Facilitating support to women providers in the reporting process

> **"What we had found over the years is nurses would not approach the centre. Because of not being identified. Even if the centre was keeping everything confidential, just visiting…people would know that you have gone to Dilasa. So, they chose to speak to some of us at CEHAT over phone and access services.**

‘What works’: Shifting gender norms within health system

Strategy I: Using the intermediary level as the entry point

- Directly attacking gender norms are likely to face strong resistance as it requires challenging the status quo and power hierarchies which are deeply entrenched
- Alternative pathway is to nudge shifts at the intermediary level, i.e. by addressing structural and subjective gender biases in access to resources, policies and practices (figure on right)

Strategy II: Do it without labelling it as gender

- Gender integration interventions have the potential to come across as threatening and tend to draw resistance, undermining efforts toward improving gender equity.
- So interventions should do so without explicitly labelling themselves as being gender-based.

Strategy III: Increasing access to resources

- Serves as a non-threatening pathway to shifting practices and enabling better healthcare provider performance (both clinical and non-clinical)
- In the longer-term, it be a powerful catalyst for shifting mindsets of women, who over time, become more confident and start performing better but also of those around women (see quote)
- Examples include improving access to basic amenities (e.g. washrooms), resources & infrastructure (e.g. diagnostics) and opportunities (e.g. career progression)

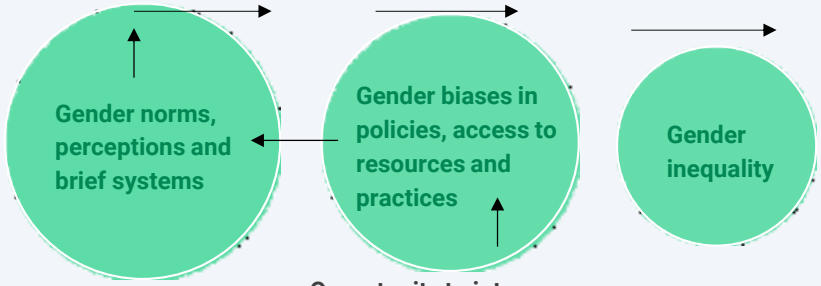
Strategy IV: Leverage policy instruments to promote norm change

- Provision of resources can drive shifts in practices but are insufficient for large-scale normative changes; simultaneous changes at the systemic level are necessary for sustained shifts
- One such pathway is to make policies gender-responsive (see box on the right)
- Examples include gender responsive infrastructure (e.g. creches), relaxing norms around promotion and career growth, increasing budgetary provisions.

Strategy V: Improving work culture

- Incremental shifts in micro-practices and behaviours have the potential to shift normative and value structures within the health system. This is discussed in detail in the slide on improving work culture (see quote on right)

Entry point for shifting gender norms



Source: Adapted from the framework by George et al (2020) and informed by the learnings from the key informant interviews

Addressing Gaps in policy and policy making

Key strategies suggested by experts to strengthen gender policy making in health systems

- Strengthen implementation, including grievance redressal mechanisms for women to access and use without fear.
- Make policies gender intentional/transformative in meaningful ways, aimed at ultimately shifting norms and informed by indicators to report on (See quote on the right)
- Collate and create data base that shows up the gender gaps in policy, implementation, and practices- generating discourse. For e.g. evidence on lack of women's leadership within health systems, prevalence of sexual harassment and workplace violence etc.
- Create visibility of gender issues faced by women healthcare through campaigns, convening and exchange platforms with key policy makers to share easily accessible evidence. For e.g. campaigns like White Ribbon Alliance Initiative 's (WRAI) 'What Women Want'.
- Create demand from within the system by including 'voices from the ground', 'enhancing leadership, creating networks and platforms for champions.
- Policies should be contextualised and adaptable. As cautioned by an expert, "There might be different answers coming for the same question in different countries and these differences have to be considered to ensure that we do not adopt the approach of one size fits all".

"

Certain indicators inform any policy and have a policy which talks to those issues. Unfortunately, gender is either reduced to just attending to women. Within policy such as how to improve maternal healthcare, we don't have gender components because we think it's anyway working with women. So, the understanding of gender is limited to just having, attending to biological females. But to understand how power dynamics works out, how norms work out, how stereotyping happens and to address those in the policy is something I had in mind when I meant 'gendering of a policy.'

"

We curated all the evidence. We worked with researchers to translate their evidence into language that's easily understood. It … meant, some amount of knowledge translation that we must do and to get… meaningful exchanges (with health system actors/policy makers) (brackets added)

Donors' role in promoting gender integration

in the health system for women healthcare providers.

Key principles for strategic investments in advancing gender integration within health systems

- All donor investments should incorporate a gender component and the same should be made a pre-condition for other organisations to obtain donor funding for any project.
- Gender should not be an add-on check-box exercise, it should be meaningfully integrated into interventions.
- Donors must commit to long-term investment in gender integration for providers and look at its potential long-term impact vis-a-vis opting for piece-meal short-term investments with a focus on short-term outputs.
- Involve women providers in investment decisions related to their cadre
- Internal dialogue and buy-in within the teams of donor organisations regarding taking up gender integration and infusing it in all aspects of their work

Strategies for gender integration that can leveraged by donors

- Donors need to be gender intentional from a provider perspective.
- Invest in experimenting, testing & demonstrating different models for improving gender equity. 3 areas identified by experts for long-term investment:

1. Invest in improving work culture- Fund initiatives related to team building, task redistribution and human resources to empower female providers.
2. Support model building in primary healthcare- especially in rural areas; demonstrate different models of nurse leadership, management of facilities.
3. Integrate gender into undergraduate medical curriculum- gender sensitization and training be built into pre-service medical education

- Investments in soft skills and leadership training complemented by practical, application-oriented exercises.
- Raise profile of issues, amplify voices by organizing convenings, special meetings and conferences focusing on provider gender-related issues.
- Support and/or fund evidence generation, research and MLE on gender inequities faced by providers within the health system
- Make investments in technology more enabling for women health workers

Way forward for gender integration:
multi-pronged and multi-level approach

- The expert interviews yielded useful insights around some of the key gender issues faced by women providers as well as strategies for making health systems more respectful, conducive and equitable towards women healthcare providers.
- The review very clearly bears out that no single strategy can in itself suffice in addressing gender-based constraints and barriers faced by providers since they are “complex,” “not unidimensional” and “very context specific.”
- Enabling gender integration in health systems for women healthcare providers will require a multi-pronged and multi-level approach (See figure in the next slide). It requires an interplay of elements across multiple levels of the health system, as is also corroborated by literature (Malhotra et al, 2002; Steege et al, 2018).

- To elaborate, there is a need for both formulating and reforming existing policies towards making the health systems more gender-responsive while including the voices of women healthcare providers who will be affected by these policies. Policy directives will need to be accompanied by allocation of resources and budgets. It will also require the instituting of requisite implementation and accountability mechanisms that enable these policies to translate into action at the organisational level. Further, there will be the need to build both capacity and readiness at the individual and organisational level to action policy directives.

- In addition to adopting a multi-pronged and multi-level approach, insights from experts make it clear that any intervention or strategies should be guided by certain set of principles related to the processes of implementation or realisation (see the left column of Figure on the next slide).

Principles for implementation

- Long timeframe
- Based on ground-up evidence
- Using enabling processes in the implementation- collaborative, non-hierarchical & respectful
- Contextualize
- Engagement across healthcare cadres
- Promoting more donor investments
- Promoting & building networks of gender champions
- Developing quantitative and qualitative indicators and measurements
- Empowering use of digital technologies

Strategies

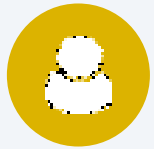
1. Building gender responsive leadership
2. Enhancing women's leadership in policymaking & administration across cadres
3. Filling data gaps and collecting sex- disaggregated data related to providers (e.g. incidence of gender-based workplace violence, leadership)
4. Filling policy lacuna and implementation gaps; making policies more inclusive and gender responsive - enabling, work-life balance, meeting specific gender-based needs, enhancing women's leadership, regulated, quality & gender integrated education and training etc.
5. Improving work culture and work environment- safe space, autonomy, teamwork, access to adequate resources and infrastructure
6. Gender awareness, sensitisation & training
7. Implementing existing provisions on prevention and redressal of sexual harassment and workplace violence
8. Strengthening accountability mechanisms for implementation of gender policies
9. Shifting gender norms by improving access to resources & opportunities
10. Promoting supportive supervision
11. Recognition, rewards and incentives for gender-responsive practices

Levels

Institutional

Organisational

Community

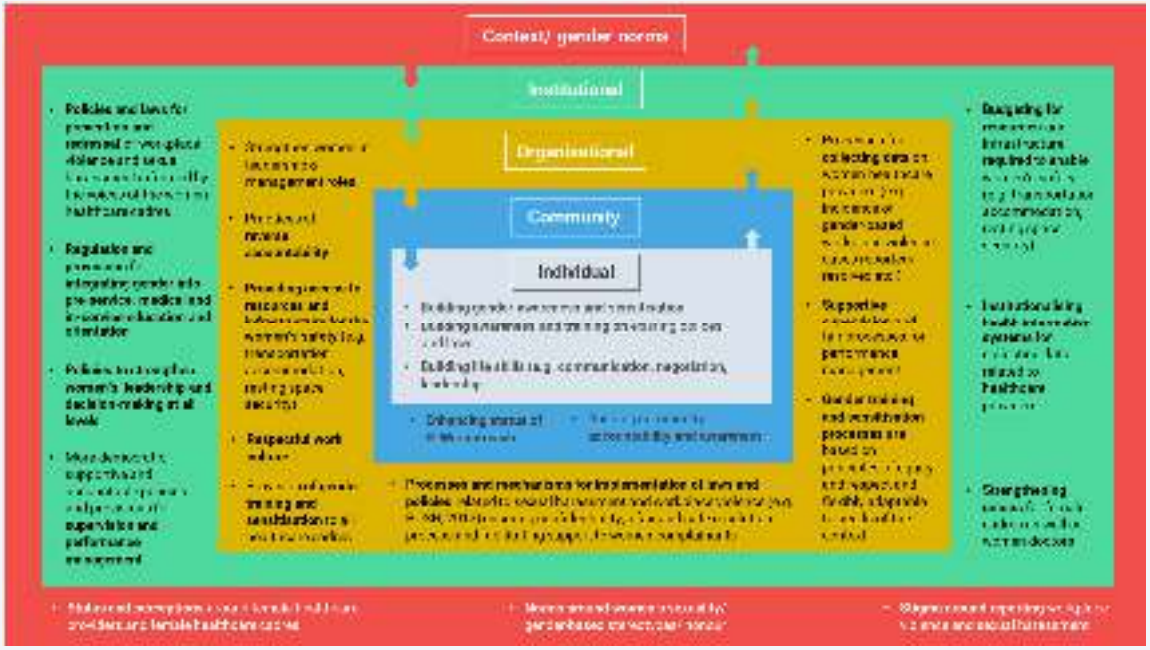


Individual

Gender Integration for Women Healthcare Providers:

A Multi-level and Multi Pronged Approach

- Enabling gender-related shifts in the health system for providers is not single levered.
- It requires an interplay of elements across multiple levels of the health system.
- To begin with there is a need for both formulating and reforming existing policies with including the voices of women healthcare providers who will be affected by these policies.
- Policy directives will need to be accompanied by allocation of resources and budgets.
- It will also require the instituting of requisite implementation and accountability mechanisms that enable these policies to translate into action at the organizational level.
- There will be the need to build both capacity and readiness at the individual and organizational level to action policy directives.



E.g. Addressing Sexual Harassment and Workplace Violence

References

- Caro, D., Nordehn, C., Betron, M. (2013). Gender analysis toolkit for health systems. JHIPEGO Consortium.
- Celik, H., Lagro-Janssen, T. A., Widdershoven, G. G., & Abma, T. A. (2011). Bringing gender sensitivity into healthcare practice: A systematic review. Patient Education and Counseling, 84(2), 143–149. https://doi.org/10.1016/j.pec.2010.07.016
- George, A., McConville, F., De Vries, S., Nigenda, G., Sarfraz, S., and McIsaac, M. (2020) 'Violence against female health workers is tip of iceberg of gender power imbalances', BMJ 371, m3546.
- Hawkes, S., Allotey, P., Elhadj, A. S., Clark, J., & Horton, R. (2020). The Lancet Commission on Gender and Global Health. The Lancet.
- Hay, K., McDougal, L., Percival, V., Henry, S., & Equality, N.A. (2019). Disrupting gender norms in health systems: making the case for change. The Lancet, 393, 2535-2549.
- Malhotra, A., Schuler, S.R. and Boender, C. (2002) Measuring Women's Empowerment as a Variable in International Development. The World Bank, Washington DC.
- Morgan, R., George, A., Ssali, S., Hawkins, K., Molyneux, S., and Theobald, S. (2016) 'How to do (or not to do) … gender analysis in health systems research', Health policy and planning 31(8), pp. 1069–78.
- PAHO. Guide for analysis and monitoring of gender equity in health policies. Washington, DC: 2009.
- Priya Nanda, Tom Newton Lewis, Priya Das & Suneeta Krishnan (2020) From the frontlines to centre stage: resilience of frontline health workers in the context of COVID-19, Sexual and Reproductive Health Matters, 28:1, 1837413, DOI: 10.1080/26410397.2020.1837413
- Steege, R., Taegtmeyer, M., McCollum, R., Hawkins, K., Ormel, H., Kok, M., Rashid, S., Otiso, L., Sidat, M., Chikaphupha, K., Datiko, D. G., Ahmed, R., Tolhurst, R., Gomez, W., & Theobald, S. (2018). How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework. Social science & medicine (1982), 209, 1–13. https://doi.org/10.1016/j.socscimed.2018.05.002
- Percival, V., Dusabe-Richards, E., Wurie, H., Namakula, J., Ssali, S., & Theobald, S. (2018). Are health systems interventions gender blind? examining health system reconstruction in conflict affected states. Globalization and health, 14(1), 90. https://doi.org/10.1186/s12992-018-0401-6Hay, K., McDougal, L., Percival, V., Henry, S., & Equality, N.A. (2019). Disrupting gender norms in health systems: making the case for change. The Lancet, 393, 2535-2549.
- Standing, H. (2000). "Gender – A Missing Dimension in Human Resource Policy and Planning for Health Reforms". Retrieved via URL: <https://www.who.int/hrh/en/HRDJ_4_1_04.pdf>
- Morgan, R. et al. (2018) 'Gendered health systems: evidence from low- and middle-income countries', Health Res Policy Sys 16, p. 58. https://doi.org/10.1186/s12961-018-0338-5
- Vong, S., Ros, B., Morgan, R. et al. Why are fewer women rising to the top? A life history gender analysis of Cambodia's health workforce. BMC Health Serv Res 19, 595 (2019). https://doi.org/10.1186/s12913-019-4424-3
- WHO (2019) Delivered by Women, Led by Men. A Gender and Equity Analysis of the Global Health Workforce produced by the Global Health Workforce Network's Gender Equity Hub
- Gender Equality and Social Inclusion (GESI) Toolkit for Health Partnerships. https://www.thet.org/wp-content/uploads/2020/09/22458_THET_-UKPHS-GESI-toolkit_V6-1.pdf