

Gender and health workforce statistics

Overview

Women make up about 42% of the estimated global paid working population. Within the health sector, in many countries women comprise over 75% of the workforce, making them indispensable as contributors to the delivery of health care services.

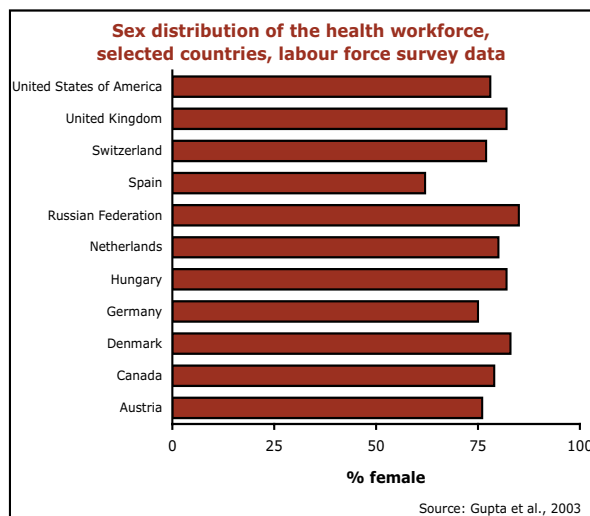
However, in many countries, women still tend to be concentrated in the lower-status health occupations, and to be a minority among more highly trained professionals. In particular, the distribution of women by occupational category tends to be skewed in favour of nursing and midwifery personnel and other 'caring' cadres such as community health workers. Women are often poorly represented in other categories, e.g. physicians, dentists, pharmacists and managers.

The under-representation of women in managerial and decision making positions may lead to less attention to and poorer understanding of both the particular features of working conditions that characterize much of women's employment, and the health care needs specific to women. In many contexts, access to female providers is an important determinant of women's health service utilization patterns. Omission of gender considerations may also lead to inadequate health system responsiveness to the needs of men: for example, reproductive health services are often not set up so as to encourage male involvement.

Gender analysis of the health workforce may reveal that health systems themselves can reflect or even exacerbate many of the social inequalities they are meant to address and be immune from. Participatory approaches in health workforce planning, development and management should be ensured, where both women and men health workers are given an active role to ensure that research being undertaken is relevant to their needs and interests. Research, policy and programme efforts to address gender equality in the health workforce should lead to strengthened health systems more broadly.

Gender analysis of the health workforce

The collection, processing, dissemination and use of sex-disaggregated data can help to plan, monitor and evaluate successful gender-sensitive interventions in the work place, bringing attention to the ways in which social and behavioural differences between women and men may lead to inequities in working conditions in the health sector and, ultimately, in inequities between women's and men's access to health care services and health outcomes. Access to reliable, timely information on gender and the



health workforce can inform the steps needed to achieve gender equity.

A strategy for gender analysis of the health workforce should include four key components:

- Building capacity at the international, national and sub-national levels for gender analysis in workforce policy and planning;
- Reflection of gender in national health workforce development budgets;
- Promoting the use of sex-disaggregated data in monitoring and evaluation activities at all levels; and
- Establishing accountability.

Existing tools, methods and approaches for health workforce analysis, originally developed in relation to predominantly male employment sectors, should be validated and extended for analyses of women's jobs. Analyses of working conditions should consider factors more specifically affecting women workers, such as physical work loads, reconciling work and family, relations with clients and sexual harassment. For example, some incentives for addressing worker productivity and retention may be more favourable to female than to male workers, such as flexible leave arrangements and career-break schemes. Monitoring, assessing and reporting country experiences of these indicators should be improved.

At the same time, caution should be taken to avoid over-emphasizing gender differences, in relation to other characteristics relevant to health workforce studies. Education and training, access to resources, client volume, supervision and age are among the many other explanatory variables involved in processes that characterize health worker productivity and retention.

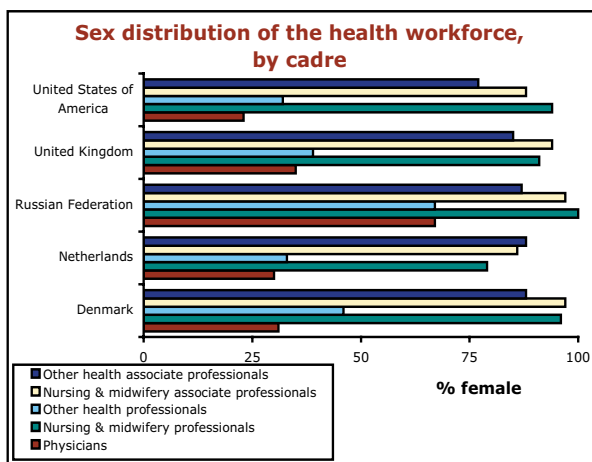


Selected statistics

Three main employment dimensions have been identified as the starting point for the study of gender equality in the labour force: occupation, working time and earnings. Occupational segregation by gender can correspond to either vertical clustering (differentials in the sex ratio according to relative job status) or horizontal clustering (sex differentials according to specialization). Working time can affect workers' economic position, especially when it results in lower monetary and non-monetary compensation among part-time workers compared to their full-time counterparts, as well as less job security and fewer opportunities for promotion. Because the labour conditions and opportunities vary markedly across occupations and countries, gender equity can be referred to as the absence of observed gender differences.

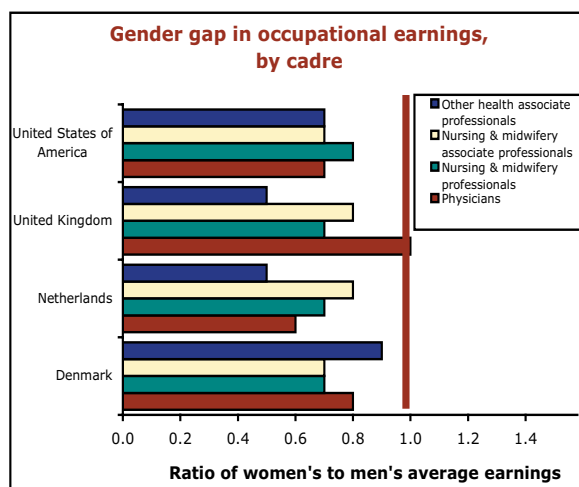
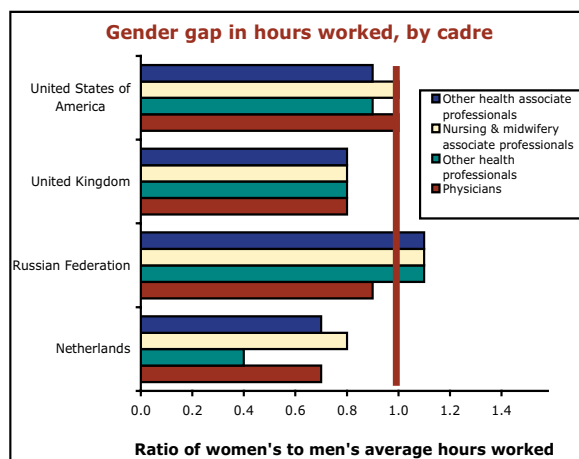
Presented here are some statistics relevant to gender analysis of the health workforce for selected countries with developed market economies and economies in transition, as compiled drawing on data from national labour force and employment surveys archived by the Luxembourg Income Study [<http://www.lisproject.org>]. Labour force surveys offer an advantage for conducting analyses on gender and work because they provide nationally representative data on a number of labour market variables that can be disaggregated by sex.

In general among the selected countries, health occupations were found to be subject to both vertical and horizontal gender imbalances. The proportion of women was considerably higher for occupations at the associate professional level compared to the professional level, and also for nursing and midwifery professionals compared to physicians and other health professionals. In some countries, women represented over 90% of nursing and midwifery personnel.



Important gender differences were observed in some countries in working time, measured as the usual number of hours worked per week, including overtime and second jobs. Women tended to average fewer hours than men.

Marked differences were found in average wages by gender. Women of all cadres tended to earn significantly less than their male counterparts. Exceptions were found for certain occupations in the Russian Federation. Given the longer history of high female labour force participation in transitional countries, along with social policies emphasizing equality and supporting working women and their families, gender imbalances may be expected to be less pronounced compared to countries with developed market economies.



Source: Gupta et al., 2003

References and suggested readings

- Sen G, Ostlin P, George A, *Gender Inequality in Health: Why it exists and how we can change it*. Report prepared for the WHO Commission on the Social Determinants of Health, September 2007. [www.who.int/social_determinants/resources/latest_publications]
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- Gupta N, Diallo K, Zurn P, Dal Poz MR, Assessing human resources for health: what can be learned from labour force surveys? *Human Resources for Health* 2003, 1:5. [<http://www.human-resources-health.com/content/1/1/5>]
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Next issue: Monitoring education and training for health workers