Gender equity and human resources for health in Fragile and Conflict-Affected States

Sally Theobald
https://doi.org/10.1093/heapol/czx102
Case studies

In focus (health workforce, methods)

Review of building blocks
Methods

Mixed method research on human resources for health in Sierra Leone, Zimbabwe, Northern Uganda and Cambodia

Life histories with male and female health workers to explore their lived experiences, but complement the analysis with evidence from surveys, document reviews, key informant interviews, human resource data and stakeholder mapping

We applied a gender analysis framework to explore access to resources, occupations, values, decision-making and power
Findings

Fragile and conflict-affected states typically face severe challenges recruiting health care workers - training institutions destroyed - staff killed/fled

Women predominate in nursing and midwifery cadres; under-represented in management; clustered in lower paying positions

Gendered power relations shaped by caring responsibilities shape opportunities and access to training

Coping strategies within conflict emerged as a key theme, with experiences here shaped by gender, poverty and household structure.

Most human resources for health regulatory frameworks did not sufficiently address gender concerns (some promising practice in Cambodia)
Women face challenges in combining motherhood and reproductive roles and health work during conflict.

‘In Adilang … I remember struggling to help a woman, kneeling with no bed but just on the floor, so that was the worst experience I had. I was also pregnant and I got a miscarriage’ (Female LH, Uganda)

In Cambodia male health workers train themselves to use weapons for protection, whereas female health workers found ways to escape.

In Sierra Leone health workers were targeted for kidnapping to provide health services behind rebel lines; female health workers also faced the additional risk of sexual violence if kidnapped by the rebels.

‘…the rebels came, abducted the in-charge and killed a nursing aide. I managed to escape but … I ran among the community members… I would not treat my hair… they [rebels] would follow you because you look different from other people. … That is why they [rebels] did not focus on me particularly because I was exactly like the community. And I used to buy simple clothes for my baby like for the community, even this one’ (Female LH, Uganda)
Implications

Gender needs addressing to promote recruitment, retention, distribution and gender equity and social justice within human resources for health.

Health workers who lived and served in conflict are very female-dominated. Women showed special resilience and courage, supported by links to families and communities.

Family-friendly working practices are important in all settings, but insecure areas need specific measures to ensure all staff can feel safe.

Career paths can be re-engineered to allow leadership development for a wider range of professionals.

Practical steps and gender analysis need to be taken to identify gender barriers proactively and engage staff and communities on best approaches for change.
With thanks

All participating health workers
Co-authors: Sophie Witter, Justine Namakula, Haja Wurie, Yotamu Chirwa, S. So, Sreytouch Vong, Bandeth Ros, Stephen Buzuzi

Building Back Better: Kate Hawkins, Valerie Percival