Human Resources for Health: A Gender Analysis

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Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO's Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore and the Karolinska Institute in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise.   The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.

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Executive Summary

Background

In this paper I discuss gender issues manifested within health occupations and across them. In particular, I examine gender dynamics in medicine, nursing, community health workers and home carers. I also explore from a gender perspective issues concerning delegation, migration and violence, which cut across these categories of health workers. These occupational categories and themes reflect priorities identified by the terms of reference for this review paper and also the themes that emerged from the accessed literature.

This paper is based on a desk review of literature accessed through the internet, search engines, correspondence with other experts and reviewing bibliographies of existing material. These efforts resulted in a list of 534 articles, chapters, books and reports. Although most of the literature reviewed was in English, some of it was also in Spanish and Portuguese. Material related to training and interpersonal patient-provider relations that highlights how occupational inequalities affect the availability and quality of health care is covered by other review papers commissioned by the Women and Gender Equity Knowledge Network.

Main Arguments

The World Health Report 2006 puts forward an inclusive definition of health workers, which is "consistent with the WHO definition of health systems as comprising all activities with the primary goal of improving health –inclusive of family caregivers, patient-provider partners, part-time workers (especially women), health volunteers and community workers" (WHO 2006: xvi). The plurality of health workers mentioned reflects the broad and diverse nature of health care tasks that exist, integrated by the division of medical labour specific to each country's health system. The hierarchies that mark and coordinate such a diverse health work force are determined by technical needs, but also reflect power relations that structure health systems, often mirroring and sometimes even exacerbating inequalities in society.

Gender[1], among other power relations, plays a critical role in determining the structural location of women and men in the health labour force and their subjective experience of that location. The resulting gender biases influence how work is recognised, valued and supported with differential consequences at the professional level (career trajectories, pay, training and other technical resources, professional networks) and at the personal level (personal safety, stress, autonomy, self-esteem, family and other social relationships). The resulting health system outcomes are inequitable, but also unproductive as they restrain the true capacity of individuals working in the health sector.

The first form of gender bias that must be addressed pertains to describing who does health work and how it is done. The omission of sex-disaggregated data and the biases involved in conceptualising and measuring health work either hide the presence of women entirely or misrepresent their work. Health work is often categorised by stylised oppositional categories, whether curative or caring, formal or informal, full or part-time, skilled or unskilled, paid or unpaid work. Not only are women over-represented in caring, informal, part-time, unskilled and unpaid work, elements of work that are routinely not measured, but women's contributions also span a range of activities that blur some of these stylised

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[1] Gender is understood here as the learned social characteristics that distinguishes males and females in society. By reflecting normative power relations it can sustain social inequalities between women and men. Other normative power relations that create social inequalities include those relating to social class, race, age, sexual orientation, etc.

distinctions. By failing to accurately describe the gendered nature of health work, women's contributions to health systems continue to be unsupported as they are under-valued or not recognised at all. Despite increased attention to human resources in health, the lack of research dedicated to documenting its gendered nature and in assessing interventions that redress gender inequalities must urgently be rectified.

As mentioned gender bias exists across as well as within health occupations. As a result, measures like substitution and delegation, which affect the professional ordering of health systems, cannot be seen as technical interventions alone. The gender dynamics of these measures need to be considered on a contextual basis, with an assessment of how gender hierarchies among health occupations are formally and informally sustained or subverted, in order to eliminate rather than exacerbate current inequalities across health occupations. It is essential that delegation be seen as part of long term planning and investment efforts that skillfully restructures health systems to do more in different ways, rather than as a means to stretch farther on a cheaper basis, often falling back on unsupported female labour.

Gender also influences the structural location of women and men within health occupations, resulting in significant gender differences in terms of employment security, promotion, remuneration, etc. It is important to not perceive these differences as either static or universal. They need to be analysed and monitored within changing national contexts, specific health system circumstances and by other social determinants. Nonetheless, research has shown that in several contexts even when organisational location, productivity and family leave are adjusted for, significant levels of gender difference remain, indicating unadulterated gender bias.

This explains why although focused mentoring, professional assessment and guidance programmes can quantitatively increase the number of women at key levels and in certain positions, such affirmative action efforts cannot single handedly improve gender equity among health professionals. By focusing solely on the advancement of individual women, without addressing the gender biases that constrain women's potential as a group, these efforts may paradoxically reinforce gender biases by raising false expectations.

Participatory gender training that focuses on values, is based on health workers' own experiences and is also action oriented can succeed in raising individual health worker awareness of their own biases, empowering them to identify programmatic changes that can be made at their level of service delivery. Nonetheless gender training by itself cannot address the multiple forms of gender bias that exist simultaneously to constrain the capacity of women and men working in health systems. Such biases require holistic approaches that address the personal and professional struggles of health workers at both local level and higher levels of health systems management.

In order to succeed, affirmative action and training measures must be coupled with efforts that qualitatively transform how health work is conceived of and organised, so that the multiple forms of gender bias that act to obscure, devalue and constrain women's contributions to health care are addressed. This means sustaining a range of efforts spanning concrete and diffuse actions, including improving access to family leave or child care provisions in a gender equitable manner; resolving gender differences in access to strategic resources like mentoring and supervision, administrative and infrastructural support, secure funding sources and employment contracts, formal and informal networking; addressing gendered vulnerabilities to sexual harassment and other forms of violence experienced by health workers; addressing gender biases in measuring, rewarding and supporting work; and neutralising stereotypical work models.

Stereotypical work models either assume women are the same as men and thus expect them to conform to male work models that ignore their specific needs or swing to the other extreme and naturalise women's difference so they are seen as inherent to individual women

rather than as differences structured by the social environment. For instance, women are more likely to be stereotyped as caring health personnel than men. This not only excludes, or even worse excuses men, but also presents a homogenised, static expectation of women's capacities that absolves managerial responsibility from addressing their less autonomous and under-resourced roles in health systems. At the same time, the specific needs of women health workers are often not addressed, whether it is childcare or protection from violence. These problems are seen as caused by women, rather than by how health services are organised. By stereotyping women as being more caring in health work or conversely as being problematic for health care organisations due to their sexuality and childcare needs, gendered ideologies obscure important structural elements of disadvantage and bias. Although the consequences of these biases are blunted by women's individual private adjustments, they are not 'women's problems' alone and require collective, public efforts to resolve.

With respect to female community health workers, they negotiate gender biases at various levels, starting from their own homes, the communities they work in and the health systems they belong to. Strategies that most successfully address the gender biases that question the legitimacy of female health workers deployed at community level address both elements of personal and professional prestige. Successful programmes provide them with avenues for growth by questioning and reinterpreting gender norms in a constructive manner; allowing them to assume broader roles than the original simple health care tasks they were encharged with; guide them with continuous training and supervision; back them up with functioning referral systems; and support them through positive relationships with peer groups, community members, other health professionals and managers. Although these system wide improvements will benefit all health workers at the community level, it is notable how these systemic improvements are often undertaken in a gender blind manner, if at all. Too often community based health workers are expected to improve health outcomes, despite the lack of functioning health systems, reflecting false expectations that are themselves gendered.

Similar broad measures that strengthen the health systems that health workers are located in are required to address the gender dimensions of care work that is currently undertaken primarily by women in ways that are unsupported, poorly paid or unpaid at great cost to their own health and livelihoods. Significant effort must urgently address the biases in health services that work against recognising the value, difficulties and rewards of care work. Care work goes beyond assisting curative or palliative health care service provision to include basic services of a broad variety, it requires constant attendance since it cannot be regularly scheduled and entails substantial emotional involvement. In addressing these challenging realities, it is no longer acceptable for home-based care efforts to remain blind to who in the household shoulders the burden of home care in terms of gender and age. Support needs to integrate various kinds of social services beyond the formal health care sector to encompass social protection, employment, water, sanitation, agriculture, nutrition and housing, keeping in mind the perspectives of women as primary home carers, without stereotyping them as the only ones who can undertake care work.

The structural characteristics of increasingly globalised and under-resourced health systems also have gendered impacts through the migration of health workers. Not only are more female health workers migrating than before, but as skilled labour is drawn to more formal, better financed and functioning health systems, lower level health workers, who are more likely to be women, whether paid or not, are expected to shoulder the burden of sustaining crumbling health systems in source countries. Although pull factors play a critical role in sparking the current crisis of the global migration of health workers, this phenomena also draws its force from the significant numbers of unemployed or unproductive local health

workers that form a pool of latent discontent within health systems. More must be done in both source and recipient countries to retain local nursing staff, who in the absence of support either quit or migrate to better work environments.

While migration opens up new opportunities, it is also associated with new vulnerabilities and challenges that have gender dimensions. Female health workers are more likely that their male counterparts to face immigration or licensing systems that use gender blind criteria; have more difficulties reestablishing their careers in mid-life or even being recognised as a worker if termed as secondary migrants or dependent wives; unequally shoulder the responsibility of integrating their families into new communities, while maintaining family ties across farther distances; and are more likely to face sexual harassment and other forms of gender discrimination that may be heightened by the isolation and other insecurities specific to the migration process. Although some organisations and policies have responded to addressing these multiple forms of cumulative disadvantage faced by migrant female health workers, more research is needed to understand the gendered needs of migrant health workers and to assess the effectiveness of efforts to address their needs.

A gender analysis of the health labour force also reveals significant levels of violence experienced by health workers in the health sector. Women health workers are disproportionately victimised by such violence due to gendered ideologies that subjectively sanction such violence or due to their structurally disadvantaged position within the health labour force. As female health workers contravene conservative gender norms in their homes, in public spaces and through their health work, they risk attacks on their intimate selves, endangering their sexuality and personal safety, despite being educated and economically viable. Interventions must address both the normative values that naturalise and sanction such violence, as well as the structural biases that place female health workers at greater risk through poor working conditions and gender blind management practices.

In conclusion, a gender analysis of human resources in health reveals that although health systems are themselves meant to provide a source of healing and a social safety net for society, it can replicate and exacerbate many of the social inequalities it is meant to address and itself be immune from. Health systems rely on a foundation of health workers that are often informal, poorly paid or not paid at all, poorly supported and disproportionately female. Even among formally recognised sections of the health labour force, significant forms of gender bias exists across and within health occupations. Despite the prevalence of such structural and subjective biases, they are neither static nor universal, but actively contested, negotiated and adjusted to at the individual level. These individual efforts by women and men must be constructively and collectively amplified through policy and programme efforts at higher and broader levels in health systems. The results of such policy and programme efforts would result not only in more gender equality in the health labour force, but also improved health system functioning more broadly.

Key Policy Messages

1. Sex-disaggregated data and analysis along with more accurate measurement of the diverse range of health care tasks that make up health work must be supported so that women's contributions to health work can more accurately be represented and recognised.

2. Delegation must be seen as part of long term planning and investment efforts that skillfully restructures health systems to do more in different ways, rather than as a means to stretch farther on a cheaper basis, often falling back on unsupported female labour. The

gender effects of delegation must be analysed on a contextual basis so as to avoid exacerbating gender inequalities.

3. Individual strategies to address gender inequalities based on affirmative action and training must couple with broader measures that address how health work is conceptualised and organised. This means:
   - improving access to family leave or child care provisions in a gender equitable manner;
   - resolving gender differences in access to strategic resources like mentoring and supervision, administrative and infrastructural support, secure funding sources and employment contracts, networking;
   - reviewing gender biases in measuring, rewarding and supporting work;
   - addressing gendered vulnerabilities to sexual harrassment and other forms of violence experienced by health workers;
   - and neutralising gender stereotypes that assume that women are more nurturing or sexually provocative and thus serve to distract attention from important structural and social inequalities.

4. Addressing the gender biases that question the legitimacy of female health workers deployed at community level require attention to *personal and professional prestige* by
   - supporting the questioning and reinterpretation of gender norms in a constructive manner;
   - allowing them to assume broader roles than the original simple health care tasks they were encharged with;
   - guide them with continuous training and supervision;
   - link them with functioning referral systems;
   - and support them through positive relationships with peer groups, community members, other health professionals and managers.

5. Home-based care efforts must recognise who in the household shoulders the burden of home care in terms of gender and age. Support needs to integrate various kinds of social services beyond the formal health care sector to encompass social protection, employment, water, sanitation, agriculture, nutrition and housing, keeping in mind the perspectives of women as primary home carers, without stereotyping women as the only ones who can undertake care work.

6. As skilled labour is drawn to more formal, better financed and functioning health systems, lower level health workers, who are more likely to be women, whether paid or not, cannot be expected to shoulder the burden of sustaining crumbling health systems in source countries. More must be done in both source and recipient countries to retain local nursing staff, who in the absence of support either quit or migrate to better work environments. More research is also required to understand the specific opportunities and vulnerabilities faced by migrating health workers from a gender perspective.

7. Violence in the health work place must be recognised as an important priority. Interventions must address both the normative values that naturalise and sanction such violence, as well as the structural biases that place female health workers at greater risk through poor working conditions and gender blind management practices.

8. Despite the widespread prevalence of structural and subjective gender biases, they are neither static nor universal, but actively contested, negotiated and adjusted to at the individual level. These individual efforts by women and men must be constructively and collectively amplified through policy and programme efforts at higher and broader levels in health systems.

Introduction

The World Health Report 2006 puts forward an inclusive definition of health workers:
> "All of us at some stage work for health –a mother caring for her child, a son escorting his parents to a hospital or a healer drawing on ancient wisdom to offer care and solace. This report considers that 'Health workers are all people primarily engaged in actions with the primary intent of enhancing health.' This is consistent with the WHO definition of health systems as comprising all activities with the primary goal of improving health –inclusive of family caregivers, patient-provider partners, part-time workers (especially women), health volunteers and community workers" (WHO 2006: xvi).

The plurality of health workers mentioned reflects the broad and diverse nature of health care tasks that exist, integrated by the division of medical labour specific to each country's health system. The hierarchies that mark and coordinate such a diverse health work force are determined by technical needs, but also reflect power relations that structure health systems, often mirroring and sometimes even exacerbating inequalities in society.

Gender[2], among other power relations, plays a critical role in determining the structural location of women and men in the health labour force and their subjective experience of that location. The resulting gender biases influence how work is recognised, valued and supported with differential consequences at the professional level (career trajectories, pay, training and other technical resources, professional networks) and at the personal level (personal safety, stress, autonomy, self-esteem, family and other social relationships).

Nonetheless the gendered nature of human resources for health has not figured largely in health research or policy, despite current attention to the crisis in human resources for health. This lack of attention is significant considering the dominant role that women play in

Figure 1: % Female Health Workers in 11 Luxembourg Income Study countries, 1993-1997
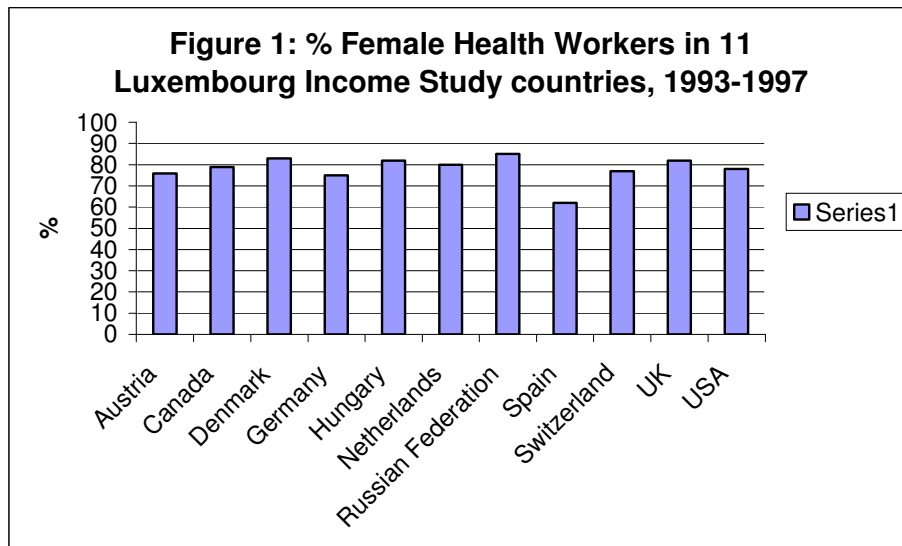
Source: Gupta et al. 2003: 8

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[2] Gender is understood here as the learned social characteristics that distinguishes males and females in society. By reflecting normative power relations it can sustain social inequalities between women and men. Other normative power relations that create social inequalities include those relating to social class, race, age, sexual orientation, etc.

service delivery at multiple levels. In 10 OECD countries and the Russian Federation during 1993-1997, women made up between 62-85% of the health labour force (Gupta et al. 2003: 7). If the frontline production of health is viewed as a pyramid with families at the base linked to informal workers and community workers and with health professionals at the apex (JLI 2004: 43), the base and most of the body of this pyramid would be female. In the USA, frontline[3] health workers are 79% female and are the fastest growing segment of all health care occupations and of all occupations in the economy in 2003 (Schindel et al. 2006:11, 13). Yet despite women's numerical presence in the health labour force, sex as a variable, is often not reported in health labour force surveys or in human resources studies, making a gender analysis impossible.

Distribution of women in health service professions, by WHO region

Data source: (3).
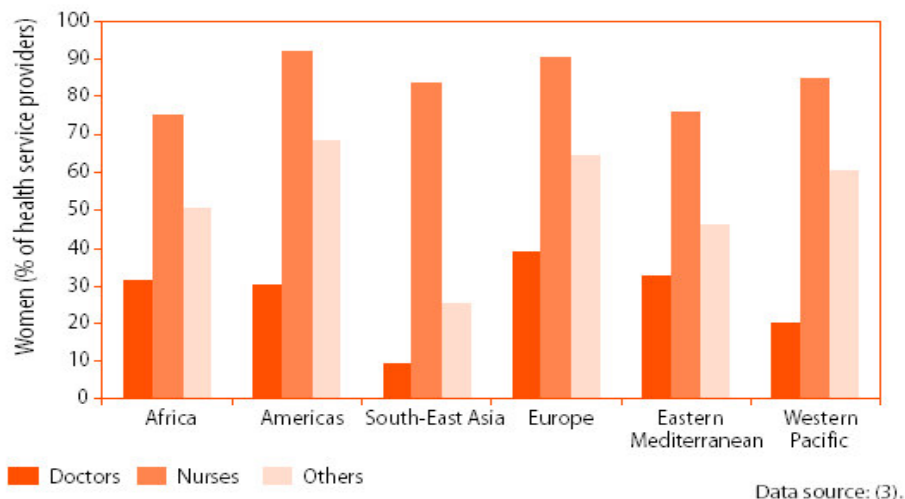
Source: WHO 2006: 6, Global Atlas of the Health Workforce
(http:///www.who.int/globalatlas/default.asp, accessed 19 January 2006)

In addition to recognising the numbers of women who participate in the health labour force, attention to the gendered nature of human resources for health requires examining how health work is conceptualised and valued. Health labour force statistics rarely incorporate part-time work, paid work that is informally arranged or unpaid work; spheres of work where women are over-represented. These gender biases in terms of the omission of sex-disaggregated data and the undercounting of women's health work fundamentally conceal how health systems function on the basis of female labour, allowing for women's contributions to health systems to continue to be under-valued or not recognised at all.

In addition to hiding women's contribution to health work, gender bias also stratifies their location in the health labour force. Health occupations that require fewer years of education, earn lower earnings and face more insecurities during health sector reform processes, also have higher proportions of women working in them (Standing 1997) (Table 1 and 2). In contrast, male occupations are generally more precisely defined, with better

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[3] A frontline worker was defined by the authors as work that entails a high level of direct patient care or care delivery support services, median annual wages of approximately USD $ 40,000 or less and work that required educational training of a bachelor's degree or below (Schindel et al. 2006: 3).

financial rewards and room for promotion, than female occupations (Messing & Östlin 2006). In Canada, the range of possible earnings for general duty nurses who are primarily female has not expanded beyond 15% in a decade (Kazanjian 1993).

Table 1: Health Professions in British Columbia, Canada

Category	Female	Post-Secondary Education in Years	Approximate Average Annual Earnings 1986	Total Number 1989-1990
Certified dental assistants	99.8%	0.85	CAN 21,000	3,606
Registered nurses	97.6%	2-4	CAN 25,000	30,140
Dental hygienists	97.3%	2	CAN 21,000	880
Occupational therapists	96.7%	4	CAN 23,000	448
Licensed practical nurses	93.8%	0.85	CAN 20,000	6,387
Physiotherapists	86.9%	4	CAN 28,000	1,575
Registered psychiatric nurses	73.7%	2		2,087
Pharmacists	44.9%	5	CAN 34,000	2,379
Psychologists	43.1%	7-9		788
Physicians	19.0%	8+	CAN 90,000	6,421
Optometrists	17.6%	5-6		227
Dentists	10.9%	7-8	CAN 73,000	2,002
Podiatrists	3.7%	6+		54

Source: Kazanjian 1993 citing data from Job Futures British Columbia, Employment and Immigration Canada and the Cooperative Database, Health Human Resources Unit, University of British Columbia.

Table 2: Health Professions in Nicaragua

	Female	Unemployed	Earning less than 300 USD	Rely on single employment	In public sector
Nurses	95%	6%	52%	95%	95%
Pharmacists	79%	2%	14%	70%	24%
Technicians	73%	8%	29%	82%	90%
Dentists	65%	4%	16%	71%	56%
Doctors	41%	1%	19%	60%	81%

Adapted from Nigenda & Machado 2000 citing data from Labour Market of Health Workforce in Nicaragua 1996. Ministry of Health/World Bank/Funsalud

Even within the same occupation, gender bias results in women earning less than men. Although the WHR 2006 suggests that there are few differences in male and female pay in the health sector (WHO 2006), other research based on 1996 ILO data differs with this assessment. When women's average monthly earnings were compared with their male colleagues, it was found that for physicians it was 32% less, for dentists 28% less, for professional nurses 16%, for auxiliary nurses 8% less and for X-ray technicians 7% less (Robinson 2001: 169 cited by Di Martino 2003: 26).

Gender as a power relation, apart from determining the structural location of women and men in the health labour force, also defines the subjective evaluation and experience of that location. Women are more likely to be stereotyped as caring health personnel than men. This not only excludes, or even worse excuses men, but also presents a homogenised, static understanding of women's capacities. At the same time, the specific needs of women health workers are often not addressed, whether it is childcare or protection from violence. These

problems are seen as caused by women, rather than by how health services are organised. By stereotyping women as being more caring in health work or conversely as being problematic for health care organisations due to their sexuality and childcare needs, gendered ideologies obscure important structural elements of disadvantage and bias.

The consequences are expectations for female health staff, that are unrealistic and unfair by themselves, but also more so when considering their unequal position in the health labour force. Although the availability of female health professionals is an important demand from female patients, particularly in gender conservative contexts, a gendered division of labour that places women in work situations where they have little authority or control over the nature of their work, makes it less likely for them to exert the discretion required to improve service delivery and champion patient's interests.

Through this review paper I further detail the gender analysis presented in this introduction through an examination of gender dynamics in medicine, nursing, community health workers and home carers. I also examine from a gender perspective issues concerning delegation, migration and violence, which cut across these categories of health workers. These occupational categories and themes reflect priorities identified by the terms of reference for this review paper and also the themes that emerged from the literature currently available at a global level. Material related to training and interpersonal patient-provider relations that highlights how occupational inequalities affect the availability and quality of health care is covered by other review papers commissioned by the Women and Gender Equity Knowledge Network.

Evidence Base for this Review

Process of Literature Review

Two months were spent during the final quarter of 2006 intensively compiling journal articles and Internet reports into an Endnote database. These references were initially categorised into a rough annotated bibliography. Internet based search engines used included: PubMed, Web of Science, J-Stor, Scielo. The terms used to carry out the literature search included a combination of the following: gender and human resources, women and medicine, gender and medicine, women and community health workers, women and health professions, gender and fieldworkers, gender and health care workers, gender and midwifery, gender and nursing, gender and violence and health worker, informal care, gender and training, gender and medical education, gender and trade unions, sexual harassment, gender and migration, nurse burnout, gender and job satisfaction. Articles were also found by following links created by the search engines.

Bibliographies of articles read were also checked for useful leads to more literature. Websites visited include: Equinet, PAHO, Human Resources for Health web-based journal, two Latin American and Caribbean health sector reform websites and the USAID funded Human Resources Clearing House. Correspondence was established with Laura Reichenbach, in charge of the Gender Task Force for the Joint Learning Initiative on Human Resources for Health. Correspondence with Sonia Correa and Sharon Fonn enabled access to literature not available through the Internet. Linda Rydberg at the Karolinska Institute also helped to access journal articles that were not accessible via Sussex University's electronic library. These efforts resulted in a list of 534 articles, chapters, books and reports. Although most of the literature reviewed was in English, some of it was also in Spanish and Portuguese.

The rough annotated bibliography and database was shared with colleagues within the Women and Gender Equity Knowledge Network in charge of writing complementary review

papers on interpersonal provider-patient relations (Loveday Penn-Kekana and Veloshnee Govender) and on gender mainstreaming (Sundari Ravindran). An outline was also shared with Ronald Labonte and his co-authors in charge of writing the review paper on globalisation and human resources for health.

Limitations of Literature Review

Despite the large amount of literature compiled, the information generated does not adequately address the original terms of reference defined for the review. The great majority of research on gender aspects of human resources for health at this stage is descriptive with little documentation of interventions, programmes or policies aimed at addressing gender issues in human resources for health.

OECD countries generate most of the available research on gender and human resources for health, with the USA being the most prolific. Research in the USA even explores gender dynamics in various sub-specialities of medicine. In contrast, for many non-OECD countries information on gender issues in human resources for health is derived from a single article. Most of the non-OECD literature comes from a few countries that have health research communities with links to English language dominated international health arenas: e.g. Thailand, South Africa and India.

No cross-national research efforts were found, except for one study on women and migration undertaken by Public Services International and one study undertaken by the Joint Programme on Workplace Violence in the Health Sector undertaken by the International Labour Office, the International Council of Nurses, the World Health Organisation and Public Services International.

The literature search also faced methodological limitations. Many research articles did not provide sex-disaggregated data and instead presented data by health worker category, which does not necessarily reflect gender realities. In addition, search engines do not consistently classify health workers. Health care personnel can be classified as professions, occupations, workers and volunteers. They include doctors, nurses, midwives, physician assistants, community health workers, field workers, pharmacists, lab technicians, etc. Each established profession has many sub-divisions with elite sections commensurate with other professional categories, e.g. some nurses are commensurate with physician assistants. The nature of the division of labour in health care that supports such different health roles is also nationally specific. This complicates efforts to systematically compile information across human resources for health.

Finally, the content of research articles also followed regional biases. While OECD material focused on established dominant professions (mainly doctors and their many specialties; nursing; with emerging work on dentistry and pharmacists), non-OECD material focused on less recognised health worker categories (community health workers, birth attendants, family planning volunteers) with much less sociological exploration of its dominant professions. For example, most of the literature on human resources in health in South Asia, financed through donor supported operations research, focused on family planning volunteers and traditional birth attendants. OECD material focused on professional struggles, while non-OECD material about similar issues is categorised as 'motivation'.

Gendered Experiences in Human Resources for Health

This section applies a gender analysis to a few occupational groups like medicine, nursing, community health workers and home carers. As mentioned earlier, health sectors vary

dramatically across nations, as such the occupational meaning of a doctor or a nurse cannot be assumed to be universally valid. While this review cannot detail the contextual details of every national health system mentioned, it does mention the national contexts from which examples are drawn from.

As not all health professions are covered (e.g. midwifery, dentistry, pharmacists, technicians, etc), this review will not provide a comprehensive gender analysis of the diverse forms of work that the health labour force undertakes. While the literature on gender dimensions of certain health occupations, like dentistry, pharmacists and other technicians, is not available at a global level, the literature on midwifery is already well represented in international health debates and too heterogenous to summarise within the space constraints of this review.

Medicine

Medicine is the premier health occupation that rules the division of labour within health care. In this section, I briefly review how medicine is feminising, before discussing various kinds of occupational biases that work against women in medicine, with reference largely to doctors but not exclusively so. As discussed in the introduction, more details are provided with respect to how the position of women in medicine is structurally disadvantaged, as well as subjectively biased through stereotypical assumptions.

How is Medicine Feminising?

Although overall female representation in medicine is only just beginning to reach 50%[4] in some countries, projections for the future are optimistic given that female medical students currently equal or surpass male medical students in some countries. The increasing female representation among doctors has sparked numerous articles and debates about the consequences of medicine feminising (Lorber 1984, 2000, Riska & Wegar 1993, Riska 2001, Carr et al. 1993, Hoff 1998, Knaul et al. 2000, Wright et al. 2003, Levinson & Lurie 2004, Reichenbach & Brown 2004). Reactions range from concerns about a consequent decline in the status of the medical profession, as well as hopes that women will promote a more humane workplace resulting in improved quality of care for patients. The concerns expressed are likely to be over-reactions and the hopes premature (Riska 2001), with the attention paid reflecting anxiety about women beginning to approach parity in medicine, the most elite health profession dominating the clinical hierarchy of health systems.

The empirical reality indicates that women are far from taking over the reigns of power within medicine as a profession. Female doctors are less likely to specialise and more likely to be under and unemployed in comparison to their male colleagues. In Lebanon, 69% of female doctors had no speciality in contrast to 39% of male doctors in 1998 (Kassak et al. 2006). In Nicaragua, female doctors were unemployed 3.5 times more than their male colleagues in 1996 (Nigenda & Machado 2000). In Mexico, female doctors were 4 times more unemployed and 3 times more underemployed than their male colleagues, with 60% of women not having a speciality in contrast to 34% of their male colleagues in 1993 (Frenk et al. 1999).

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[4] The exceptions are Mongolia, Russia, the former Soviet republics and Sudan (WHO 2006).

Table 3: Percentages of female doctors in different countries

Country	% of female doctors	Year	Source
India	40%	1992-3	Baru 2005
Egypt	35%		Nasser et al. 2000
Lebanon	16%	1998	Kassak et al. 2006
Chile, Costa Rica, Uruguay	30-50%	1995	Knaul et al. 2000
Nicaragua	41%	1996	Nigenda & Machado 2000
USA	23%	1997	Gupta et al. 2003
Canada	33%	2001	Adams 2005
UK	35%	1997	Gupta et al. 2003
Denmark	31%	1997	Gupta et al. 2003
Netherlands	30%	1994	Gupta et al. 2003
Russian Federation	67%	1995	Gupta et al. 2003

Although women are increasingly entering medicine, they do so on terms that are not equal with their male colleagues. This is not exclusively related to gender discrimination. It is also due to the contradictory forces of specialisation and cost-rationalisation that are internally dividing medicine and other health professions (Friedson 1986, Mullan 2002, Annandale et al. 2004). Adams concurs with findings by Williams (1999) that "While gender differences in practice are apparent, women are not so much changing the profession, as they are taking part in a profession that is, for other reasons, undergoing change" (Adams 2005: 90).

Nonetheless, the challenges faced by women entering medicine remain substantial. Apart from their less specialised roles and less secure employment basis, women are in extremely few positions of leadership in medicine. In 1999, only 6 out of 125 medical schools had female deans in the USA (Tesch et al. 1995). In 2005, only 15% of full professors and 11% of department chairs in medicine were women in the USA (Magrane et al. 2005). In 2004 in leading USA medical journals, while 29% of women were first authors, only 19% of women were senior authors, with 11% of guest editorials in the New England Journal of Medicine and 19% in the Journal of the American Medical Association done by women (Jagsi et al. 2006).

The contrast between women forming the base of the health sector, but not being represented in policy or other leadership positions is also found in low-income countries. Although 54% of all employees in the health sector in Zimbabwe are women, only 9% of women hold senior posts in the civil service (UNIDO 1989 cited by Standing 2000). In Indonesia, the health sector depends on a widespread female volunteer base, but only about 10% of the top two levels of all posts in government, legislative and judiciary bodies are female (Dwisetyani Utomo et al. 2006).

Occupational Gender Biases in Medicine

One form of gender bias is expressed through how work is assessed and supported leading to differences in working hours between female and male doctors. In Lebanon, female doctors spent less time waiting for patients than male doctors did (7% vs. 12%) and more time in their private life (42% vs. 34%) in 1998 (Kassak et al. 2006: 4). In Mexico, the average work week for women in medicine whether full or part-time was 38 hours compared to 43 for men in 1996 (Knaul et al. 2000). In the UK, women worked 80% of the hours worked by men across various health occupations (Gupta et al. 2003). However, these differences are neither static (Dedobbeleer et al. 1995) nor universal. In the USA and Russia, some groups of female health professionals worked more than their male counterparts.

From a gender lens, the small difference in working hours between women and men that seem to favour women, might in fact disfavour women once domestic responsibilities are considered. "Behind the story of 'equality' for male and female dentists, maybe a lack of opportunities for women to reduce their hours and take more leave for child-bearing and child-rearing" (Adams 2005: 90). In Canada, female doctors were more likely to put in 6 hours or more per week in domestic chores (82% vs. 42%) and more likely to undertake 16 hours or more of child care per week (59% vs. 12%) than male doctors (De Koninck et al. 1993). While 34% of women surgical specialists spent 21-40 hours per week on household management, only 7% of men surgical specialists did so (Grandis et al. 2004).

Indeed some of the gender differences in working hours are more apparent between single and married medical professionals, with the brunt being borne by married females. In Canada, single female dentists worked more than their male counterparts, while both married male and female dentists put in fewer hours (Adams 2005). In the USA, Carr et al. (1998) found significant differences between female and male medical faculty members with children resulting in females with children receiving less research funding and less secretarial support, resulting in fewer publications, lower self-perceived career progress and career satisfaction, but no gender differences among medical faculty members without children.

In the absence of adequate support, women strain to balance their professional and personal lives, planning their pregnancies, childcare, their own careers and supporting their spouse's careers. Some female doctors consequently actively select specialisations that enable them to have a family life, rather than specialisations in 'urgentology'(De Koninck et al. 1997). Their decisions are based on informed evaluations about the obstacles and opportunities available to them in their personal and professional lives (Elston 1993). These efforts remain invisible to management, contributing to statements from male colleagues like "You, women do not plan your career adequately" (De Koninck et al. 1997: 1829). Female doctors may themselves internalise such biases, as they describe domestic responsibilities and childcare as a 'personal choice', and not as work that contributes to their families, society and the productive economy (De Koninck et al. 1997).

In balancing these double work burdens, offering part-time working hours may not necessarily resolve gender inequities. When part-time work is granted, female and male doctors avail of it for different reasons. Several studies found that while women in medicine chose part-time work or consider leaving full-time work due to family responsibilities, men do so due to private practice or higher salaries elsewhere (Levinson 1993, Foster et al. 2000, Mayorova et al. 2005, Fox et al. 2006). Some of these dynamics may be changing across generations. A retrospective study in the USA found that 85% of female physicians made career changes for the benefit of their children and family, while only 35% of male physicians did so. However, younger male physicians were more likely than their older peers to have made a career change for marriage (49% vs 28%) or children (51% vs 25%) (Warde et al. 1996).

In Switzerland, although part-time specialist training was more readily taken up by women (33%) than men (6%), these part-time training opportunities were more likely to be found in female dominated specialities than in male dominated specialities, 10 years after the recommendation to initiate part-time training had been passed for all specialities (Heuss & Hanggeli 2003). This suggests that it is not enough to ensure that part-time or family leave is more available within medical practice, but that it is also done in ways that doesn't retrench gender stereotypes in medicine. In Sweden, although parents can decide who takes the majority of parental leave, in light of research that showed that women mostly did this, a certain proportion of it is now reserved exclusively for fathers (Bergman & Hobson 2002).

The good news is that supporting doctors who have children in ways that are gender equitable is not only amenable (Foster et al. 2000), but also effective. Investing in childcare

and allowing for flexible working hours reduced absenteeism, improved retention of staff and thus led to savings on training costs for new staff for various organisations in the USA and UK. For example, a pharmaceutical retail chain found that the number of shop assistants returning from maternity leave increased from 4% in 1989 to 49% in 1993 due to the introduction of various flexible working options (Cox and Blake 1991 cited by Standing and Baume 2001: 4).

Another important gender difference in medicine are the inequalities in pay usually favouring men. Again the data needs to be treated cautiously as different trends are apparent across countries. In general women on average earn less than men, except for in the Russian federation. In some areas these inequalities are decreasing, e.g. with physicians in the UK, while in other places it is increasing, e.g. in Denmark and USA (Gupta et al. 2003).

Some studies note that differences between women and men in the same profession are linked to their organisational location within the profession. In Ontario, Canada, women dentists earned 58.3% of male dentists in 2000. This is attributed to men moving out of associate practice and into solo practices sooner than women dentists (Adams 2005). Female doctors in Mexico were similarly more likely to depend on a single salaried position than men, who were more likely to enjoy more professional autonomy and higher salaries through independent practices or multiple contracts (Frenk et al. 1999).

Nonetheless after adjusting for differential occupational locations due to rank, track, degree, speciality, years in rank and administrative positions, female doctors at one university in the USA still earned on average USD 12,777 or 11% less than male doctors during the 1999-2000 fiscal year (Wright et al. 2003). Although there were no gender differences in pay among fellowship-trained surgeons, 74% of non-fellowship-trained men earned more than USD 200,000 in contrast to 36% non-fellowship-trained women in the USA (Yutzie et al. 2005).

Even if job descriptions and pay scales are neutral, men are able to advance faster due to their greater average seniority, faster promotion, wider access to training, longer work hours and availability of overtime as their careers are often informally subsidised by their wives (Standing 2000, Standing & Baume 2001). As one male Norwegian oncologist noted about his career path, "It is going well, but the development of my career has depended on my wife being a full-time home-maker at times" (Gjerberg 2003: 1332).

Even so sex differences still remain when controlling for number of hours worked, career breaks and other productivity variables. In the USA, between 1979 and 1981, only 5% of women faculty members in medicine achieved full professorships, in contrast to 23% of men, even when the number of hours worked and the number of articles published were accounted for (Tesch et al. 1995). Data collected between 1998-1999 showed that among surgeons in the USA, females, regardless of marriage or parenthood, published a median of 10 articles in contrast to 25 by their male colleagues (Schroen et al. 2004). Reichenbach & Brown (2004) argue that informal gender biases that involve mentoring, networks, patronage, sponsorship and gatekeepers, are pervasive within the institutional culture of medicine and work against women's interest.

In 1997, in one medical school in the USA, although there was no gender difference in access to mentoring, 24% of women and 6% of men felt that informal networking excluded faculty based on gender (Foster et al. 2000). In a larger study of 3,332 full-time faculty members at 24 medical schools in the USA, female faculty reported being 2.5 times more likely than male faculty to have experienced gender discrimination (Carr et al. 2000). In a follow up study with 18 women faculty who experienced gender discrimination from 13 institutions, 40% listed gender discrimination as first among 11 factors hindering their career, 35% listed it second after 'limited time for professional work' and 'lack of mentoring'. Respondents felt that they were poorly prepared to deal with gender discrimination and

reported effects on professional self-confidence, self-esteem, collegiality, isolation and career satisfaction (Carr et al. 2003).

One successful effort that helped to counteract such biases in the USA, leading to an increase in 4 to 20 female associate professors in 3 years, involved updating female faculty members about promotion criteria annually and providing a yearly assessment about each faculty member's appropriateness for promotion (Fried et al. 1996). Another postdoctoral training programme in older women's health in the USA offered individualised, competency-based career development plans, multiple years of financial support, career mentorship by other senior women and an explicit focus on equity issues. As a result, all 15 trainees were women and minority trainees increased from 10-80% (Carnes et al. 2006).

Although these focussed interventions are important in boosting women's advancement in medicine, in order to succeed on a longer term basis, efforts must also address gender biases that permeate the every day working cultures of medical practice (Reichenbach & Brown 2004). Hamel et al. (2006) note that a culture of working 60-70 hours per week, meetings held outside of traditional working hours and tenure clocks disfavour faculty members in medicine who have family responsibilities. For this reason, Standing & Baume (2001) argue that although focussed, affirmative action measures might achieve targets, this by itself it is not enough. There is also a need to address the more subtle forms of discrimination, as well as broader the structural barriers that inhibit women from participating in specialised labour forces (career paths, reward systems, child care). Moreover, a focus on targets alone might lead to backlash, as it focuses on the individual that is promoted rather than changing the organisation or on the management's responsibility for integrating diversity (McCourt 2000 cited by Standing & Baume 2001).

Female faculty have already identified strategic measures that are required to improve female representation in academic medicine. In 2001-2 in a university in the USA, female faculty identified the following intervention areas in order of priority: a flexible working environment without negative consequences for women with young children, a three-month sabbatical from administrative and clinical duties, departmental mentoring for academic career development and school/ departmental administrative secretarial support for grant and manuscript preparation (McGuire et al. 2004). More action oriented research needs to be carried out with health professionals to identify within their own contexts the strategic measures required to promote gender equality in their work environments.

Bickel (2000) concludes that the reasons for women not advancing in medicine are multiple, leading to cumulative disadvantages. They include women's strategic choices, sexism, cultural stereotypes, constraints in combining family responsibilities with professional opportunities and lack of effective mentoring. Multiple interventions are required to address these various forms of gender bias, which include but also go beyond improved family leave policies.

Stereotypical Gender Work Models

Many studies in the USA conclude with recommending mentoring for women. However, mentoring alone cannot address all the forms of gender discrimination at play, nor does it address the pervasiveness of male norms and male working models. Mentoring women into male working models without challenging their basis is problematic. Although the assumption that all staff are interchangeable is perceived as being gender neutral, it can mask the prevalence of male norms and working models. Women physicians in Quebec, Canada reflected, "You have to act like they do. They can have a sex, but not us". Another female physician in the same study said, "I felt as if I were asexual because being a woman made no

difference, as long as I did not get pregnant" (De Koninck et al. 1997: 1828). Equality becomes understood as conforming to male norms.

Does the increase of women in general practice, challenge gender stereotypes in medicine? A UK study found that many women entered general practice expecting to be generalists, but find themselves facing expectations to focus on women's health (reproductive health, paediatrics and psycho-social work) (Brooks 1998). Female doctors responded in two divergent modes. Some took on a more 'caring' approach to their work. In responding to female patients, they drew on their own personal, family experiences, as well as on their biomedical training. Nonetheless despite being doctors, because of their more 'caring' work, they also felt more threatened by nurse practitioners.

In contrast, women physicians who wanted to stay as generalists sought to work in practices with other nurses or nurse practitioners in order to retain their doctor role. They were hostile to female patients who did not respect their professional boundaries, which they interpreted as a lack of respect for their professional achievement. They relied more heavily on norms of clinical objectivity and professional distance. Furthermore, they were unhappier if working part-time or with other men as then could not avoid the gendering of their work.

Brooks (1998) concludes that both strategies followed by women general practitioners in the UK are problematic, as they both reinforce conservative gender stereotypes. They also do not contest a gendered form of accountability (West 1993), where women are expected to have both technical and emotional skills (help manage the practice and office personnel, as well as their patients), while men are only expected to be technical. Due to these gendered expectations of women being more emotionally sensitive to patients and to office personnel, female doctors are more likely to disappoint their colleagues and patients, even if they are behaving the same as their male colleagues (Brooks 1998).

Women's differences in these cases are stereotyped in ways that can be misleading. The assumption that women health providers are inherently more caring towards patients and more collegial to their co-workers, projects a static, homogenous view of women's capacities, that also serves to discounts men's capacities to incorporate such learned, rather than innate behaviour. The emotion work that women health providers undertake, may also be a way to increase the medical gaze and control over patients (Carpenter 1993), and thus not be in patient's best interests.

Ultimately a gender analysis reveals that interpretations of women's roles as either being inherently problematic or essentially caring, serve to deflect attention from "the social processes that naturalise and depoliticise the different positions of women and men in the organisation of health care" (Wegar 1993: 173). These social processes reflect power relations enacted through professional socialisation, organisation and practice. A study in the USA found that while female nurses viewed their gender as an important link to female residents, female residents placed more primacy on their occupational status than their gender in relating to female nurses (Wear & Keck-McNully 2004). Wegar concludes "that the probability that women physicians would promote patient interests is lessened by the gendered division of labour that puts women in jobs where they have little control over the organisation of their work. By reinforcing exisiting social divisions within the medical division of labour, neo-liberal policies aimed at rationalising and rationing health care are likely further to diminish the prospect of women health-care professionals' contributing to the collective empowerment of patients" (1993: 186).

Nursing

In contrast to medicine, nursing has always been female dominated. The following section reviews the historical evolution of nursing in the UK, South Africa, USA and Thailand, as a

means to reflect on processes of social stratification within the health professions. This serves as a useful background for contemporary discussions about delegation in health systems, as it places in context the professional struggles that shape the division of labour in health care.

Histories of Nursing

Nursing emerged in the UK during the mid-nineteenth century when the rise of hospitals and the prevalence of miasmatic[5] theories of disease required a labour force subordinated to doctors that would maintain patients and wards clean. To distinguish nursing from its menial and lower class origins and to make it respectable to middle class women, the nursing profession conformed to contemporary Victorian values that proscribed women's chasteness and submissiveness. Nurses were stereotyped as innately qualified to undertake the caring, nurturing and menial tasks required to complement male doctor's curative roles (Maggs 1983,Carpenter 1993). It is in this context that nursing emerged as an occupation secondary to and supportive of medicine. Hence, despite being a female dominated profession, from its origins gender bias constrained the location of nursing within the division of labour in health care.

With the emergence of germ theory, nursing became more scientific than intuitive and nursing skills were seen to require training. As medicine continued to specialise, the changing division of labour in health care meant that certain groups of nurses began to acquire elements of medical knowledge, although nursing was largely still rooted in hygiene and housekeeping. By the 1960s in the UK, the grade system reinforced these internal differences between untrained nursing auxiliaries and assistants, enrolled nurses with a two-year practically based training and registered nurses with a three-year, more academically focused training. As a result, "caring and curing responsibilities were redistributed within nursing, with a greater concentration of registered grades in the high-status, acute sector and unqualified and enrolled grades in the lower-status, more caring sectors" (Carpenter 1993: 121). Nursing in the UK also had separate registers for general nurses, mental health nurses and children's nurses. In the case of mental health nursing, this was due to its staffing by working class men who resisted being subsumed within the predominantly female, middle class profession of general nursing.

These social divisions within nursing in the UK continue today as clinical nursing in particular seeks to professionalise in ways that exclude its lower ranks. "Basic care, carried out previously by untrained or enrolled nurses (often black) after a two-year practical training and students as 'pairs of hands', is now being gradually assigned to an army of 'support workers' or 'health-care assistants' who are likely only to receive a limited training" (Carpenter 1993:122).

Concurrently, UK gender differentials in nursing pay have been increasing in men's favour (Gupta et al. 2003). Reforms that placed qualifying time periods for promotion inadvertently favoured men, as women who went on family leave were demoted to lower grades. As a result, while men took on average 8 years to reach Nursing Officer grade, women who took career breaks took 23 years. Even when not penalised for taking career breaks, women still took on average 15 years (Halford et al. 1997). This demonstrates that even within a female dominated profession, gender biases that influence how work is organised and valued can favour men over women.

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[5] Illness was caused by foul smelling air particles, suggesting that sanitation and fresh air were important for good health. Miasma is Greek for pollution. http://en.wikipedia.org/wiki/Miasma_theory_of_disease accessed January 26, 2007.

Considering these managerial reforms and the cost rationalisation pressures on the NHS, Carpenter is cautious about assumptions that female nurses are natural allies to or advocates for patients. Instead he suggests that the more divisions occur that mimic curative hierarchies in medicine, the more likely lower level ranks of nursing fall behind and be less sympathetic to patients (1993: 112). Hagbaghery et al. (2004) similarly argue that in Iran today, nurses avoid independent caring roles even though they may have the knowledge and skills to attend to patients, as their authority, self-confidence and authority is undermined by the physician-centred and routine-oriented hospital culture they are located in.

As seen in the UK, embedded within the histories of nursing are the markers of social divisions that continue today. In South Africa, nursing not only evolved as a profession along Apartheid segregationist lines, but also along class lines as historically upper class women became lady pupils (professionals), while probationers (apprentices) came from working class backgrounds. Currently, enrolled nurses feel alienated as they are lost in routine activities, misused, maternalised and domesticated in contrast to registered nurses (van der Merwe 1999). Rispel & Schneider (1991) argue that the ideology of nursing in South Africa further subordinated the lower ranks of nursing, as their professional ethics are defined in terms of loyalty and respect for those in authority, with nursing was viewed as a vocation or special calling. Consequently, protests about working conditions were seen as unprofessional, unethical and even criminal as strike action became a statutory offence. This reinforced the race and class inequalities among women in nursing in South Africa. At the same time race, class and gender dynamics also disenfranchised native medical aides trained in battlefields and in the mines of South Africa. They failed to get recognition as nurses and were relegated into preventive work for sexually transmitted and tropical diseases, plague and rodent control (Burns 1998).

Manley (1995) similarly reflects on the social divisions that mark nursing in the USA historically and currently. In addition, Manley (1995) notes how similar tactics deployed by occupational groups led to different outcomes due to their social position, rather than by what their occupations contributed to society. While the 1910 Flexner report reformed medicine in the USA, by eliminating the 3 year medical degree, raising medical school standards and restricting entry into medicine, the 1923 Goldmark report failed to do the same for nursing, constraining the professional aspirations of nurses. Doctors, as a socially more powerful group, framed nursing as instrumental in nature and thus influenced the compromises made in the Goldmark report. As a result, nursing emerged as a stratified profession with a two tier educational and licensing regime for nursing that differentiated between highly educated registered professional nurses and vocationally trained practical nurses.

Currently in the USA, there are three levels of nursing: registered nurses, licensed practical/ vocational nurses and nurse aides/ assistants. Although there is only one licensing exam to become a registered nurse, there are three educational tracks, leading to further differentiation within registered nurses. The educational tracks include: 2 year associate degrees through community colleges, 3 year hospital based diplomas or 4-5 year baccalaureates. Minority and poor women disproportionately make up the ranks of associate degree nurses due to the availability of government funding. However, only baccalaureate nurses are entitled to positions of teaching and leadership. Consequently, stratification within nursing has increased over time (Table 4), weakening its collective professional power (Manley 1995).

Table 4: Occupational Position of African American within Nursing from 1970s to 1990s

Nursing Categories	African American Nurses		
	1970	1980	1990
Registered Nurses	6.2%	6.9%	7.4%
Licensed Practical Nurses	21.6%	17.3%	17.6%
Nursing Aides	21.0%	23.3%	30.7%

Source: Manley 1995: 307, Unpublished data from Patrica Roos, US Bureau of Labour Statistics (1991)

In Thailand, nursing is characterised by various social groups that serve different instrumental roles. One division contrasts nurses that have "been socialised internationally and that comprise a growing urban professional minority and a provincially rooted and growing petty bourgeoisie majority. The former selects and rewards nurses on the basis of evidence of scholarship, access to which to date has been elitist; the latter, on the basis of conformity to bureaucratic regulations" (Muecke & Srisuphan 1989: 649). Furthermore, a 2 year technical course was created to train nurses to fill the provincial and community hospitals built by local politicians and an auxiliary 1 year course exists for basic patient care (bathing, toileting, feeding, taking temperature).

Male nurses have differentiated themselves from female nurses by self-selecting into areas that confirm ideals of masculinity, like for instance orthopedic nursing (large motor skills), in anaesthesia, operating rooms, emergency units and intensive care units (high technology and high risk mortality), for Buddhist monks (taboo for women) or in community nursing (great independence). In addition to these social divisions, nursing education is highly fragmented and dispersed between the Ministry of Public Health, Ministry of University Affairs, the private sector, Police, Navy, Airforce, Army and the Bangkok municipality, while medical and dental education is under single government university control (Muecke & Srisuphan 1989).

Other countries reflect similar findings. In Ghana, Malawi, Zambia and Kenya professional nurses' succeeded in banning the training of less qualified enrolled nurses (Dovlo 2004). In Nicaragua, 50% of nurses are called professionals, although the majority have no university degree (Nigenda & Machado 2000). In India, private sector nurses, who are informally trained are the worst off, as they earn the lowest wages and have few labour rights (Iyer and Jesani 1995, Baru 2005). These axes of differentiation in terms of education, roles and career paths make it hard for nurses to galvanise collective professional power in an inclusive manner.

Although medicine is also increasingly stratified, its professional power hinges on its ability to retain discretion and judgment; characteristics required to decipher the broad and uncertain range of ailments that affect patients and the clinical ambiguity that marks medical treatment. The essence of medicine therefore cannot be reduced to either a technical science, an administrative action or a market good. It is, in addition to these features, also an indeterminate art of healing that cannot be standardised or generalised (Jamous & Peloille 1970). Unlike nursing, it has guarded itself against being termed as an instrumental or routinised service.

Although a women's history as healers of the sick and reducers of risk during delivery exists, it has been discounted due to gender bias. As a result, women are stereotypically seen to "care for the sick. But the care they give is palliative care. They are a presence during uncertain episodes of sickness, but they do not alter its course or reduce its impact through intervention" (DeVries 1993: 144). Gender bias therefore plays a critical role in stereotyping medicine as curative from nursing, which is perceived to be caring and instrumental. Nonetheless, as discussed in the next section, current pressures affecting health systems has

led to efforts that increase differentiation within medicine and nursing, at times blurring and at other times reinforcing the historical struggles between them.

Delegation

The historical basis and current maintenance of these professional boundaries is of current policy relevance in light of discussions about delegation and substitution of health cadres. Substitution through the development of hybrid cadres is firmly established in some countries, with physician assistants, medical assistants, nurse anaesthetists and nurse practitioners firmly engrained in the USA. The histories and policy pressures that foreground these changes are specific to the health sectors they belong to. They encompass war and conflict situations, cost containment pressures and efforts to expand health service delivery.

The gender dynamics of delegation also needs to be considered on a contextual basis. In some parts of Africa, where nurses with internationally recognised degrees are able to depart for better financed health systems, reforms created new cadres with opportunities for men, rather than women. In Malawi, the "training of medical assistants (a Malawi-specific, male-dominated cadre, which shares common skills with nurses and primarily serves in rural postings) was reintroduced in 2001, following a hiatus of five years. Without an internationally recognised qualification, almost no medical assistants have migrated out of Malawi, in sharp contrast to their nurse colleagues" (Palmer 2006: 32).

In other contexts, efforts to delegate tasks to female dominated professions have met with resistance from male dominated professions. In Bangladesh, in efforts to scale up emergency obstetric training, "nurses often faced resistance from doctors to their taking part in manual vacuum aspiration and manual removal of placenta, and in some cases even in normal deliveries. They were also not easily allowed to act as first assistant during obstetric surgery. This appears to be due to negative attitudes of doctors towards nurses and a large number of trainee doctors in the department" (Tajul Islam et al. 2006: 64). In Brazil, obstetric nurses face resistance from managers and doctors who fear reputational and financial losses if they let nurses attend normal births. These current organisational tensions have revived historical differences between nurses and doctors, left professional differences about the knowledge and management of birth processes unresolved and impeded service delivery reforms in Brazil (Corrêa & Piola 2003).

These professional tensions are not insurmountable. In Mozambique, initial hostility to delegation efforts changed to collaboration and mutual recognition as professional boundaries changed (Bergstrom 1998 cited by Dovlo 2004). In Ghana, leadership from influential obstetric-gynecologists supported the enhanced role of midwives in post abortion care (Karolinska Institute 2001 cited by Dovlo 2004). Reduced workloads and increased time for higher professional skills are key incentives for professionals to aide delegation efforts (Dovlo 2004). However, transitions need political skills to manage, even when benefits to higher-level professionals and to health service delivery more broadly are objectively detailed. In Brazil, nurses were enlisted as supervisors to community health agents, helping to neutralise their resistance to this new cadre (Tendler & Freedheim 1994).

Table 5: Summary of types of substitution in Africa

Substitution Type	Brief Description	Examples
Indirect Substitution (Delegation of some professional tasks)	Substituting a professional with an existing but different professional (changes scope of practice of another cadres to cope with delegated tasks)	1. Enhanced midwives roles in Ghana 2. Nurse anesthetists 3. Enhanced abortion management roles for nurses in Zambia and South Africa
Direct Substitution (Delegation of most professional skills)	Substituting an existing profession with a newly created cadre (both cadres may coexist, with overlapping professional functions)	1. Clinical officers / medical assistants in Malawi and Ghana 2. Assistant medical officers and surgical technicians in Tanzania and Mozambique
Intra-cadre Skills Assignment (Delegation)	Delegating some specific 'specialist' tasks to professionals with less training, in the same profession	1. Diploma opthamologists, psychiatrists, ENT specialists 2. Theatre and intensive care nurses without formal training in Ghana
Delegation of Non-Professional Tasks	Delegating certain aspects of tasks in order to relieve professionals of unwarranted workload	1. Health aides in Ghana 2. Pharmacy assistants in Ghana
Informal Substitution	Existing 'lower-trained' cadres, especially in remote and rural areas, will carry out tasks in the absence of the appropriately recognised professional	Happens in many rural areas in Africa

Source: Dovlo 2004: 5

Although substitution and delegation is seen as a cost-saving measure, a broader perspective potentially qualifies this assumption. Quality of care is a concern for all cadres in all health systems and particularly so for underfunded ones. Sustaining supervision to maintain quality of care is not an automatic, costless process. It entails social processes of integration that must address the social characteristics and needs of an increasingly diverse workforce. Although delegation is seen as an intrinsic motivator, as it enhances the skill base of lower-level health workers, increasing their potential for social recognition, remuneration and career advancement, when the latter elements are constrained, frustration and discontent is likely to brew (Tendler & Freedheim 1994, Dovlo 2004). As such, substitution and delegation cannot be seen as temporary measures that can be technically determined and mechanically implemented. They need to be part of long term planning, that skillfully guides the professional reordering of health occupations in ways that restructures health systems to do more in different ways, rather than to stretch farther on a cheaper basis, resorting to under-paid and un-supported female labour.

In the absence of intentional delegation, unintentional skill mixing is the informal norm (Gerein et al. 2006). In the UK, nurses were equivocal about undertaking doctor's tasks,

by unofficially prescribing, diagnosing, taking blood and putting in cannulas, as it drew them away from their traditional roles as nurses and overburdened them with the low status, menial aspects of medical work. Yet the tacit acceptance of these blurred boundaries, "ensured that patients got symptomatic relief, tests were carried out on time, treatment continued without interruptions" (Allen 2004: 256). By unofficially taking on greater responsibilities and risks, nurses protected patients from the turbulent processes of coordinating care in large hospitals and smoothed organisational tensions (Allen 2004). Paid home care workers in the USA (Stacey 2006) and auxiliary staff in India (Iyer & Jesani 1995) similarly take on greater responsibilities and risks than their formal designations, with tacit understanding from management and policy makers that without doing so patient care would suffer and health services would stall. In order to succeed substitution and delegation efforts need to assess how gender hierarchies among the health occupations are formally and informally sustained and subverted, in order to alleviate rather than exacerbate current inequalities.

Community Health Workers

Community health workers are not a uniform category. They include volunteers, auxiliaries and even nurses depending on the health systems they belong to. This section discusses the gender biases these rural health workers face at multiple levels that question the appropriateness and effectiveness of their behaviour both at a personal and professional level. While auxiliary health workers at the community level have been extensively analysed from a gender perspective in the South Asian context (Simmons et al. 1992, Iyer & Jesani 1995, 1999, Barge & Ramachandar 1999, Visaria 1999, Bhatia 1999, Mumtaz et al. 2003, Blum et al. 2006, George 2007), I also draw examples from the gendered analysis of community health agents in Brazil (Portella & Gouveia 1997), gendered analysis of community based volunteers in Indonesia (Dwisetyani Utomo et al. 2006) and South Africa (Daniels et al. 2005) and analysis of challenges faced by community based nurses in Zimbabwe (Mathole et al. 2005).

Gendered Field Challenges

Female auxiliary health staff are often deployed to deliver services which are closely intertwined with gendered beliefs and practices that form an intimate part of community identities. For example, their work in family planning draws them into contentious discussions about family size and raising the age of marriage. With regard to delivery, an auxiliary nurse midwife in India reported, "If we ask them to go to the hospital, they say 'If we have to go to the hospital, why do you come here' and fight with us. During delivery, as per our training, we do the delivery. But they say, 'Don't touch this way.' They tell us, 'Give an injection, so delivery will take place soon" and fight with us. We have only Methargin injection [dilates the cervix], they say, 'If you give Epidocin or Centocin injection [induces contractions] delivery will take place faster' and fight with us" (George 2007: 141). Families who usually have women deliver at home, sometimes in unclean places befitting of a polluting act, not only retain authority over the home environment, but also have strong beliefs as to what amounts to appropriate care, which do not match with the clinical training of female auxiliary health staff (Blum et al. 2006). Left unaddressed these gender biases challenge the efficacy of deploying female health staff to work at the community level.

In addition, by working in the public sphere, travelling on their own to villages, interacting with male colleagues, female community health workers contravene gender norms. Simmons notes that in Bangladesh, these "women who break gender norms are ridiculed not so much because they harm themselves, but because the loss of their prestige

undermines the very foundations of society" (Simmons et al. 1992: 100). The backlash against them involves calling into question their sexuality. As one villager commented, "They call themselves doctors; they are not doctors but prostitutes" (Simmons et al. 1992: 101). In extreme cases, this can justify violence against community based female staff.

For many female health workers questions about the legitimacy of their work start at home, though this is open to change. In Pakistan, one female respondent noted, "I get more respect now. Nobody tells me to do housework with authority. If I go out, nobody stops me on the grounds that there is work to be done" (Mumtaz et al. 2003: 267). In India, similar responses were found on behalf of female auxiliary health staff, however gender still coloured the ways in which household support was viewed and valued (George 2007). The importance of secure government salaries enabled some female auxiliary staff to provide the financial basis for their families and to alter household relations. However, this support was not always unconditionally on offer. Several auxiliary nurse midwives reported that the main reason for not going to Lady Health Visitor (LHV)[6] training, a requisite for promotion, was the lack of household support. One respondent reported, "My husband was a health worker. Although I got three chances for training to become an LHV, he said, 'Why do you want to go?' That is the only deficiency in him. I wanted to become a LHV, but my husband said, 'LHV training is for six months. If you go, who will cook in the house? The children's education will be spoiled. The job that you have now is sufficient, why do you want the LHV job?' That is why I did not go for the training" (George 2007: 138).

Male health assistants also based their household status on their earning power, but in contrast to their female colleagues, they saw household support as an entitlement, not as a contributing support mechanism that might not always be available. One male health assistant noted, "As I alone earn and provide the money to run the house, they listen to me. There is no problem as such." Another echoed this, "I have 100% support of my family members. We eat out of my earnings, so who will oppose me?" (George 2007: 138).

In addition to their work not being supported in their homes or not seen as legitimate by communities, female auxiliary health staff can also be undermined by the programmatic biases that characterise service delivery. As auxiliary health staff working at the community level, female health workers are responsible for health education, promotive and preventive health care tasks. Yet in increasingly commercialised health systems, communities want curative commodities like tablets and injections, rather than health education that encourages self-reliance measures like homemade oral rehydration solution. In unregulated curative markets, these community based health workers encharged with preventive roles may no longer be the entry point into formal health care systems. As one respondent in Thailand noted, "They know nothing, they're not necessary because the village is so close to town. When people are ill, they go to the private hospital outside of town for good service and technology" (Kauffman & Hick Meyers 1997:253).

Without curative symbols to aide them or functioning referral systems to back them up, female auxiliary staff in India are sometimes referred to by communities as a 'dai' (traditional birth attendant). In contrast, male auxiliary health staff are referred to as 'malaria doctors' because they deploy health care commodities in the form of blood smear slides and malaria tablets. Pre-existing social hierarchies are reinforced, as male village elites or male peddlers can take on the role of village doctors, but lower caste, female birth attendants or volunteers do not dare to entertain such aspirations, despite at times having training and linkages with government or NGO programmes (Pinto 2004).

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[6] LHV (Lady Health Visitor) is the female senior health assistant, while ANM (Auxiliary Nurse Midwife) is the female junior health assistant.

As one respondent from Pakistan noted, "Compared to men, women must work harder to be accepted as serious and responsible workers. They first have to overcome the image of being *seedi-saadi* (simple-minded) housewives and then prove themselves as professionals" (Mumtaz et al. 2003: 265). This also explains why nurses in Zimbabwe persisted in the use of weighing scales in antenatal care checkups, although guidelines reduced the number of visits and eliminated the weighing scale. The clinical symbolism of the weighing scale and multiple visits served a more powerful purpose in the patient-provider interaction than what was rationalised by the clinical evidence base behind the policy change (Mathole et al 2005). Female staff whose professionalism and social status is questioned due to gender biases, may rely on such clinical symbols more than male counterparts.

While these family, community and health system pressures undermine the credibility of female health staff, they also concurrently are marginalised by the management hierarchies within government administration. In India, male auxiliary health staff often unofficially assume senior supervisory positions at the PHC level, but such informal promotion is not allowed for female auxiliary health staff (George 2007). Instead, as they remain the lowest health service delivery level within the health department, auxiliary nurse midwives are more likely to be scapegoated for problems in service delivery than her male peers (George 2007). In India, with limited educational backgrounds and with teaching as the only other alternative rural salaried occupation open to women, female auxiliary health workers are not in a position to bargain for better working conditions (Iyer & Jesani 1995).

Field Solutions

The gendered challenges to female health staff working at the community level are not insurmountable. In Matlab, Bangladesh, the personal prestige of female health staff was delicately negotiated in ways that redefined the meaning of *purdah* (seclusion) for female staff and the communities they worked in (Simmons et al. 1992). *Purdah* was reinterpreted from an "emphasis from the external and physical criteria of seclusion to an internalised, moral code of conduct. Observance of inner *purdah* does not require physical seclusion; rather, it manifests itself through politeness in interpersonal behaviour, religious orthodoxy, modesty in dress and language, and, above all, through strictly professional behaviour and attitudes towards men. As long as this moral code of conduct is followed, worker's argue, *purdah* is not broken" (1992: 101). This strategy sought to reform traditional gender norms that restrained health workers and their efforts in service delivery through a process of accommodation, rather than confrontation. The danger is that if not strategically managed, such efforts could also retrench conservative gender norms in communities.

In Brazil, Portella & Gouveia (1997) argues that despite the use of female health agents for community based maternal health outreach services, this programme served to reinforce forms of gender bias, rather than create a base to contest it. The reliance on only female staff in ways that accommodated prevailing gender norms reinforced the assumption that only women can provide maternal health advice. It also failed to contest conservative gender relations that excused men from taking responsibility for childcare, failed to sanction forms of male sexuality that increased STI risk among their wives and failed to question norms around domestic violence that inhibited women from talking to male health workers in their homes (Portella & Gouveia 1997).

In Indonesia community based female volunteers were women who were village elite role models. As such their social status helped to further the success of the family planning programme, however it also reinforced stereotypical roles of female domesticity, voluntarism and care giving in reproductive roles (Dwisetyani Utomo et al. 2006). Reflecting on a South African lay health worker programme that relied on volunteer female labour, Daniels et al.

(2005) concludes that although it opened up spaces and aspirations for women, more effort was required to avoid the partial retrenching of gender stereotypes. Women were still seen as best suited to be volunteers, who could elastically stretch to undertake community health work, income generating work and domestic work at the same time, even if this was rarely the case.

The success of the Bangladesh NGO effort discussed earlier relied not only on its accommodative approach to personal prestige, but on its twinning of personal prestige with professional prestige. After gaining the initial approval of village elites, female auxiliary health staff also gained respect for facilitating access to curative services. They gave out medicines and injections and came to be seen as the 'little doctor' linked to 'big doctor' through referral systems that were adequately resourced. Their management supported them; when senior staff visited them in the field they symbolically showed signs of respect to their more junior, female colleagues rather than reprimanding them in public. By combining perseverance and with these multiple supports, female health workers over time assumed increasingly influential and respected roles in the villages they worked in, often giving advice to villagers in making important decisions or resolving local disputes (Simmons et al. 1992).

Community based female lay health workers in South Africa were similarly supported through multiple relationships that ensured their continued performance and motivation (Daniels et al. 2005). They were allowed to assume broader roles than the original simple health care tasks they were encharged with and thus became trusted confidants and respected advocates for their fellow community members. They were explicitly and frequently acknowledged by health care workers and supported by functioning referral systems. Their work was also acknowledged by the communities they came from and this was further bolstered by the formation of their own peer support group. Managers were sympathetic to their concerns and responded by listening and providing infrastructural support where possible. Lastly, these workers received continuous training and regular supervision. The strategic support received by these female community based workers through the various relationships that sustained their work and the flexibility with which they were allowed to reinterpret their work to suit community needs is also documented in the community health agent programme in Brazil (Tendler & Freedheim 1994).

Another way to empower health workers to recognise and address gender biases in their personal, organisational and professional lives is through reflective and action oriented training using participatory methods, modelled by the 'Health Workers for Change' and 'Gender and Health Systems' courses developed under the leadership of the Women's Health Project in South Africa (Fonn 2003). These courses address not just gender relations, but also race, class and other axis of discrimination, reflecting the complexity of real life. Health workers go through a process of values clarification and self-reflection about how their organisation and work mirrors society more broadly. They are encouraged to put themselves in other people's shoes and thus develop empathy for the role of other actors in health systems. Actions devised through the training arise from analysing health workers' own context and experience base. "Course participants have frequently noted that the potential interventions they identify are practical, small things –not what they imagine a gender programme to be...Participants state that while they have been on gender training before, this is the first time that links between analysis and action have been made overtly and appear possible" (Fonn 2003: 116).

Evaluations of these training exercises highlight effects that resound on various levels over different periods of time (Onyango-Ouma 2001). At the personal level, one female health worker found the support and courage to take her husband to court for assault. Six months later half the participants noted a range of changes in their personal life due to the

training course. At the level of the organisation, changes were made that were within the power of an individual to realise. Institutional change, however, was much harder to effect.

Fonn concludes that "working with people's own constructs can increase understanding, assist participants to develop interventions and build motivation to act to decrease gender inequalities. These are bounded by the environment in which individuals operate. The gendered nature of institutions and societies means that while gender training has a place and can impact at the interpersonal level and to some extent within health care provision, it is not a panacea" (Fonn 2003: 118). As mentioned in the section on medicine, multiple forms of gender bias exist simultaneously to constrain the capacity of women and men working in health systems. They require holistic approaches that address the personal and professional struggles of health workers at both local level and higher levels of health systems management.

Home Carers

Self-care and home care form the base of health care systems. Women primarily carry out home care, whether paid or unpaid, formally regulated or informally arranged. Women undertaking home care assist others with their self-care or those who cannot care for themselves. This section reviews literature that documents the extent of home care; its gender dimensions and its consequences for women themselves and for health systems more broadly.

It is estimated that 90% of illness care is provided within the home (WHO 2000a, Uys 2003 cited by Ogden et al. 2006). It is mainly women who undertake this care within the home. In a Ugandan study of family care for those living with HIV, women cared for 86 out of 100 illness episodes (Taylor et al. 1996 cited by Ogden et al. 2006). In Tanzania, a study of health-seeking behaviour for malaria in children, found that 84% of mothers who arrived at the government dispensary with their sick child were unaccompanied by family members, friends or neighbours (Kamat 3006: 2955). In Japan, out of 868 caregivers and recipients using long-term care insurance, 73% of the caregivers were female (Sugiura et al. 2004). When efforts are made to specifically explore the role of men in care at the level of households, research has examined their decision-making roles (Smith 2003, 2006, Carter 2004, Tolhurst & Nyonator 2006), rather than their contributions in undertaking informal or formal caregiving.

Not only are women numerically more involved in caring work within families and homes, but significant gender differences exist between male and female carers in terms of their social background, kind of patients looked after and support received in undertaking their caring work. In the USA, informal female caregivers are more likely than informal male caregivers to be age 65 or older, black, married, unemployed and primary caregivers. Female caregivers are also more likely to provide more intensive and complex care, face more difficulties with care provision and struggle more in balancing caregiving with other family and employment responsibilities (Navaie-Waliser et al. 2002). In a study on stroke patients and their caregivers in the USA, although no differences were found for the patient in terms of receiving care from either a female or male caregiver, male caregivers had more advantages in carrying out their work than female caregivers (Tiegs et al. 2006). In Japan, although there were no differences in nursing needs among patients, recipients of female caregivers tended to be older and have more cognitive disorders than the recipients of male caregivers. While female caregivers spent more time providing care and undertook more care activities, including giving medications, dressing, bathing, feeding, preparing meals, shopping, laundry and managing money, male caregivers were more likely to use the home helper service provided by the insurance scheme (Sugiura et al. 2004).

As indicated care giving at home goes beyond assisting with curative or palliative health care to include basic services of a broad variety. The challenges of doing so in poor households where access to basic needs is compromised can be substantial. In order to care for one HIV positive person, up to twenty-four buckets of water are required per day to wash the sick person, to clean soiled sheets, to wash dishes and to prepare food (Columbia University 2004 cited by Ogden et al. 2006: 336).

A study in Chile found that only 40 minutes out of 9 hours of daily care was spent on administering medicines, physiotherapy exercises, giving injections, dressing wounds and inserting catheters. A third of the time was spent on domestic labour. Most importantly, half of the time was spent keeping the sick person company, maintaining their comfort and observing their possible needs. Most informal family carers slept in the same room or very near the ill person (Reca et al. 2002). In this sense, the great majority of home care requires constant attendance, since it cannot be regularly scheduled. It also entails substantial emotional involvement.

In the USA, in study of nine women, three of whom who were HIV positive themselves, who were informally caring for an HIV positive person, 'sustaining the relationship' was the main expression that women used to describe their experiences of caring. Their work went beyond focussed health care tasks and signified nurturing ongoing relationships between themselves and the recipient of their care (Bunting 2001). Carpenter (1993) citing Graham (1983) notes "that to define work as 'caring' in either the public or private sphere may be to impose a label which subsumes a wide variety of disparate activities, the only common denominator being the low economic value associated with them. Yet caring involves both emotional and physical labour, with at one and the same time expressive and instrumental outcomes" (1993: 112).

Stacey (2006) found in her study of formal caregivers in the USA, that although they were paid poorly and looked down upon by others due to menial aspects of their work, formal home carers drew a strong sense of pride from their work. They felt that they directly contributed to their patient's comfort and dignity and knew more about the patient than other more skilled health workers who depended on them. As one respondent noted, "When you're a Community Nurse Aide, that's the bottom they say. But you spend more time with the clients. And that's why I'll stay a Community Nurse Aide for a little while, because with the other ones –Licensed Vocational Nurses and Registered Nurses – they do a lot of paperwork. They don't spend their life with people. They don't know. They come to the Community Nurse Aides to ask about the patient, because they don't know. I'm like the number one person" (Stacey 2006: 161).

Many of them had also turned to home care as a more humane and autonomous alternative to providing care in formal care institutions, where they felt that working conditions and quality of care were unsupportable. Reflecting on her previous work in a nursing home, one respondent said, "To me it's too busy. It's not enough time for the client. You know what I mean? You have no personal time with them. You are going to give them a bath real quick, check their temperature, blood pressure and you're out of there. What about 'How do you feel today?' or 'Did you sleep well?' 'Did you have any dreams?' 'Is there anything bothering you?' You know, rub their head and take time to do all that. The important stuff, that's what I do" (Stacey 2006: 158).

Challenging how health work is conceptualised through a gender lens, leads to exploring how health work is valued and supported, with differential consequences for health workers and the health systems they belong to. While the Fair Labour Standards Act in the USA was amended in 1974 to include domestic workers, so they can claim the right to a minimum wage and to over-time pay, paid domestic caregivers were exempted because they are largely seen as 'companions' to the elderly and disabled, rather than as 'workers' (Biklen

2003 cited by Stacey 2006). The emotional bonds that develop between these paid home care workers and their clients led them to work beyond the hours they were paid for and at times paying out of their own pockets for medication for their clients (Stacey 2006).

Yet these workers are those that can least afford such voluntarism. In the USA, long-term care providers, of which home care aides are a subset, are among the lowest wage earners in the health system, with the smallest wage gain in the past four years and the highest percentage of minority workers (almost 50%) (Schindel 2006: 70). Moreover, 40-45% of home care aides in the USA lack health insurance (Lipson & Carol 2004). High levels of turnover are reported in this sector, although little research has been undertaken to document it (Schindel 2006).

Studies across the world noted that most female carers coped by internalising stereotypical female roles defined by self-sacrifice, silent suffering, altruism, piety, holding up against the odds, keeping harmony rather than asking for help and turning to religion (Chao & Roth 2000, Songwathana 2001, Reca et al. 2002, Navaie-Waliser et al. 2002, Suguira et al. 2004, Kramer 2005). The consequences for women are not benign. Female carers in Japan had higher scores for work burden and depression than their male counterparts (Suguira et al. 2004) and in the USA they suffered from poorer emotional health than male carers (Navaie-Waliser et al. 2002). In Chile, carers reported insomnia, stress, stomach ailments, over sensitivity, anxiety, sadness, depression, loneliness, anguish and worry. Yet few consulted doctors about their needs and even fewer undertook treatment or therapy (Reca et al. 2002).

In Canada, a study on women in nursing, medicine, physiotherapy and social work, who also care for elderly relatives at home found that the boundaries between their professional and personal lives were frequently blurred and eroded beyond their coping strategies, resulting in feelings of isolation, tension, extreme physical and mental exhaustion (Ward-Griffen et al. 2005). In Thailand, women providing care for HIV positive patients felt split as they could not always provide care, but felt obligated to do so (Songwathana 2001). In Botswana, among family caregivers, older women felt overwhelmed with the magnitude and multiplicity of the tasks to be done, felt exhausted, malnourished, depressed and neglected their own health. Younger girls missed school, were more at risk of sexual and physical abuse and depression. The lack of support and skills in caregiving left these families in social isolation, stigmatised, pauperised and in psychological distress (Lindsey et al. 2003). In Spain, not only did women mainly provide informal care in the home, but it was primarily less educated and poorer women who did so. Moreover, their unpaid care work for young, elderly and disabled family members constrained their ability to undertake paid work, maintain social relations with friends and other family members and increased their own mental and physical health risks (Garcia-Calvente 1999).

Through unsupported home care, women absorb the costs and contradictions of under-financed and skewed formal health systems, at times to the detriment to their own health and livelihoods. Baines (2006) argues that women's elastic caring roles appear crucial to the survival of some care agencies and the gender order in these workplaces. Ogden et al. (2006) conclude that women's informal care sustains and subsidises the formal economy, sometimes at great costs to women themselves in terms of forgone paid work, schooling and other health producing activities. Although these costs many not be easily measured or monetised, women's unsupported care efforts cannot be seen as a cheaper option for health systems (Columbia University 2004). In fact one could argue, that research highlighting the medical poverty trap, the pauperising effects of paying for health care, has yet to consider how much women's informal care serves to buffer the extent of these iatrogenic health system effects.

The role of women in home care is inequitable due to its invisibility. UN frameworks for community home based care (WHO 2002) define who the provider is in other formal spheres, but within the home they detail the kinds of care that needs to be carried out without specifying who is to provide such care, the consequences of doing so or the support needs for doing so (Ogden et al. 2006). This is particularly striking considering extensive feminist research that has questioned assumptions about households and revealed them to be dynamic, heterogenous sites of unequal power relations. Efforts to support home-based care must therefore take into consideration who in the household shoulders the burden of home care in terms of gender and age. It furthermore needs to distinguish between the needs of home based carers, who have access to formal programmes and others who continue to provide home care unlinked to any social services. Lastly, support needs to integrate various kinds of social services beyond the formal health care sector to encompass social protection, employment, water, sanitation, agriculture, nutrition and housing, keeping in mind the perspectives of women as primary home carers (Ogden et al. 2006).

Gendered Issues in Human Resources for Health

Migration

The international migration of health workers is today one of the most contentious policy issues concerning human resources in health (JLI 2004, Global Health Watch 2005). This section reviews how female migration patterns have changed, impacting on the nature of health professional migration flows. Discussions about migration are placed into a broader context that reflects on the structural pressures further stratifying health systems. The consequences of such dynamics on women migrants are reviewed, along with gender biases faced throughout the migration process.

While the proportion of the world's population that are international migrants has only risen from 2.3% in 1965 to 2.9% in 2000, this still translated into the doubling of the number of people living outside of their country at any one time since 1965 (United Nations Population Division 2002 cited by Stilwell 2004: 595). Within these global flows, women are playing an increasing role. "By 2000, female migrants constituted nearly 51% of all migrants in the developed world and about 46% of all migrants in developing countries" (ILO 2003: 9 cited by Piper 2005: 3). In 2000, UK work permit data indicated that female occupations were the fastest growing segments of migrant employment (Piper 2005: 7). Although female migration has traditionally been based in unskilled occupations (domestic work, child care, sex work), today the migration of female skilled health workers contributes a large part to global migration patterns. Research in migration studies has not caught up with this shift, as it has focused on the experiences of skilled men and unskilled women, rather than on skilled female labour, the latter often located in education, health and social work; social sectors that are heavily regulated by states (Iredale 2005, Purkayastha 2005).

Within the health sector, more nurses and health professionals other than doctors are currently leading migration flows, in contrast to 30 years ago when the first studies of global migration of the health labour force were undertaken (Bach 2004). In a study of migrating health professionals from the South Pacific, nurses were more likely to out-migrate rather than doctors due to higher earning differentials and also more likely to return (Brown & Connell 2004).

As mentioned, the scale of migration has also magnified. Between 1998 and 2002 the percentage of nursing applicants from abroad in the UK has increased from 25% to 50% (Buchan et al. 2004). Between 1996 and 2001, the number of nurses leaving the Philippines

has increased from 4,500 nurses to over 12,000. In South Africa, from 1995 to 2000, requests for verification of nursing qualifications (an indicator of intent to move) increased fivefold from 511 to over 2,500 (Vujicic et al. 2004: 2). Although aging populations, rising incomes and the feminisation of the workforce are put forward as reasons for fuelling the demand for female health workers from low income countries, research indicates that the demand is directly related to specific recent policy changes in OECD countries that facilitates the migration of health personnel (Pond & McPake 2006).

Some of these migration flows also reflect cultures of medical out migration (Madan 1980, Hagopian et al. 2005). Some countries have educational institutions that aim at preparing their graduates for external rather than local employment. For instance, 86% of Africans practising medicine in the USA come from 3 countries (Nigeria, South Africa and Ghana), with 79% trained in just 10 medical schools (Hagopian et al. 2004). In 2006, a study of nurses in the UK found that out of 30 source countries, most foreign nurses were trained in the Philippines, Nigeria and South Africa (Buchan et al. 2006).

Nonetheless, current international migration flows of health care workers do not just reflect the career trajectories of elite individuals. It draws its force from a latent pool of discontented, underemployed or unemployed health workers in both source and recipient countries, in search of alternatives from local health systems by seeking employment in foreign health systems or withdrawing from health work altogether. In response, in order to improve the retention of nurses in Botswana, reforms have introduced overtime allowance, part-time employment, flexi-time and housing. In Zambia, financial support from donors has enabled the doubling of nurse salaries in 2001 (SEW 2002, South Africa Migration Project 2002 cited by Gerein & Green 2006). However, more must be done in high-income countries to address the high-levels of burnout and turnover among local nursing staff, rather than resort to cheaper migrant nursing labour.

The resort to migrant labour reflects global processes of economic restructuring. In other words, "behind this 'freedom of movement' lie compelling structural factors based on global inequalities...links must be made between the individual and the wider socio-political institutions that shape worker's motivations and goals" (Van Eyck 2004:10). "Global economic inequalities, privatisation, structural adjustment policies, the chronic under-funding of health services in both North and South, the under-valuing of women's work in the caring professions and the aggressive policies of private recruitment agencies have all contributed to the massive increase in migration over the last decade" (Van Eyck 2004: 4).

Buchan et al.'s examination of immigrant nurses in the UK reveals many of these globalising trends (2006). 60% of immigrant nurses in the UK came from sub-Saharan Africa, a region that can ill afford the absence of such skilled personnel. Many of these nurses from developing countries represent experienced personnel. More than 40% of immigrant nurses from South Africa, India, Pakistan and Mauritius were aged 40 or older, in contrast to the much younger, novice nurses from Australia, New Zealand and the USA. Two-thirds of immigrant nurses were hired through a recruitment agency and most of them worked for the NHS (69%), rather than in private hospitals (13%) or private nursing homes (10%). Most of these international nurses reported being the major or sole wage earners, with 57% sending back remittances to their country of origin. While 60% planned to stay for at least 5 years in the UK, 43% were planning to move on to even better financed health systems in the USA (Buchan et al. 2006).

The migration of health workers further stratifies health labour markets in both source and recipient countries. Those most qualified and experienced are those most able to migrate, yet they often immigrate into jobs below their formal qualifications. Despite examples of technical excellence among immigrant doctors, in general immigrant doctors take on what others don't want to do and provide support for the elite careers of others (Hagopian et al.

2005). In Canada, foreign trained physicians are more likely to be found in rural and under-served areas than domestically trained physicians (Packer et al. 2006).

Hence a consequence of the global migration of health personnel is not just 'brain drain' from health systems that are severely under-resourced, but also 'brain waste', as health personnel are not efficiently incorporated into recipient health systems. "The home country loses the services of a skilled birth attendant and /or a professional nurse, while the receiving country may gain a health worker who is treated as having lower skill levels" (Gerein and Green 2006: 247). This trend of deprofessionalisation was counteracted by the Filipino Nurses Support Group which organised review classes for nurses to pass licensing exams and lobbied to ensure that Filipino nurses would not be penalised for breaking their live-in caregiver agreements if they found nursing positions instead (Van Eyck 2004). Moving beyond the individual repercussions of deskilling for migrant health professionals, their insertion into the lower end of high-income health sectors also reflects on a collective level a perverse subsidy by lower income countries to higher income countries (Packer et al. 2006).

The personal consequences for women involved in global migration are mixed. Research studies on migrant nurses document ambivalent experiences (Winkelmann-Gleed & Seeley 2005), reflecting both distress and accomplishment (Yi & Jezewski 2000). Migration has the potential to reconfigure gender relations, although little research exists on the gender implications of remittances[7] and the role of female migrants in diasporas (Piper 2005).

Alongside new opportunities, new vulnerabilities also exist. Migrants face a contradictory class positioning through the "simultaneous experience of upward and downward mobility in migration, which is not necessarily the same for men and women. Discrimination, loss of status, and erosion of skills in destination areas may be combined with upward mobility at home, as remittances are invested in small businesses, housing and children's education" (Piper 2005: 2). Nurses report struggling with social isolation, abusive practices by recruiting agencies and the strain from working several low paying jobs to break even, with 30% incurring higher debts than previously expected (Van Eyck 2000: 6). Although negative effects are reported on families and communities, as skilled migrant women leave behind their children in source countries to be looked after by extended families, more research is required to move the evidence base beyond anecdotal accounts.

Some source countries have set up government departments to address the migration problems faced by nurses (Packer et al. 2006). The Indian government has a government department responsible for facilitating international migration of nurses and to safegaurd them from exploitation. Similarly, the Filipino government set up the Philippine Overseas Employment Administration, an agency that markets Filipino workers, negotiates agreements, regulates private recruiting agencies, inspects contracts prior to departure, maximises remittances and helps to safeguard worker's rights. More research needs to be done on the functioning and effectiveness of these government efforts to manage migration, especially since they encourage nurse migration in countries that also face domestic nurse shortages (Packer et al. 2006).

Despite the demand from high-income countries for nurses, immigration point systems used to screen skilled labour usually hinder rather than help female skilled labour. Their criteria do not take into consideration the occupational gender biases women face in source countries. In the UK, immigration criteria for skilled labour are based on four areas (educational qualifications, work experiences, past earnings, prior professional achievement). Only recently was the amount of work experience required capped at four years, enabling more women to be on par with their male colleagues than before (Iredale 2005).

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[7] Remittances for most of the 1990s exceeded official development aid for source health worker countries (Stillwell et al. 2004).

Another way in which immigration systems are gender biased is from their treatment of skilled women "as trailing wives and not workers" (Kofman 2004 cited by Piper 2005: 9). Under family reunification schemes, when considered as secondary migrants, dependent wives sometimes face restricted employment rights or less access to language training programmes in recipient countries. They are thus more likely to enter a process of re-domestication, as their husband's career takes precedence. Skilled migrant wives then find it harder to maintain their skills as they lag behind in work experience and tend to drop out of professional networks, making it harder to pass licensing exams. This experience of cumulative disadvantage makes it harder for migrant women to catch up (Purkayastha 2005).

Even after being allowed to work as health providers in recipient countries, female health providers may face more challenges than men. In a study of migrant doctors in Israel, older and female migrant doctors were found to be the worst off, as they had the hardest time restarting their careers in the middle of their lives. Although there were no gender differences in passing the licensure exam or in getting employed as a physician, after five years significant differences existed in residency programmes, as migrant male doctors tended to specialise while migrant female doctors remained as general practitioners (Shuval 2000).

When their husband's careers take precedence, skilled migrant women find themselves trapped in suburban lifestyles that depend on volunteer female labour at school activities, neighbourhood activities, children's play dates. Yet most "studies on skilled migration have concentrated on the workplace and on career trajectories, leaving aside the incorporation of familial relations and wider social networks" (Kofman 2005: 151). This bias is due to male working models that assume that migrant men have dependent wives, who support their career advancement and subsidise the formal economy by running their homes, bringing up the children and organising their social lives in their new place of residence.

Concerns about children integrating into new environments entail extra efforts for minority migrant parents, often more likely to fall on minority migrant mothers than minority migrant fathers. In the USA, while gender relations have changed enough to enable white men to organise children's sleepovers and play dates with other men's wives, racial discomfort exists when minority migrant husbands try to do the same (Purkayastha 2005). Migrant skilled women not only struggle to manage these expanded domestic responsibilities, but they are furthermore expected to maintain their extended family obligations across international boundaries.

Despite the current salience and concern about the migration of health workers from low-income countries to better-funded health systems, this review found very little research on the gendered effects of such migration among health workers. While a significant literature exists on the gendered lives of migrants and emerging research is beginning to explore the gender dimensions of skilled migrants, neither of these may adequately represent the experiences of migrating health workers. Research is required to explore the gendered effects of migrant health workers on their personal and professional lives within the context of specific health occupations and specific recipient and source health systems.

Violence

Violence in the health sector is significant, yet often unappreciated. Even in advanced economies, like Sweden, it may constitute almost a quarter of all violence at work (Nordin 1995 cited by Di Martino 2002). In some health systems, while research on job stress and conflict exists, such work is yet to be located within a framework of workplace violence (Di Martino 2002). With respect to sexual harassment, one form of gender based discrimination sometimes leading to violence, most studies from low-income countries mention it as part of broader findings, rather than focus on it specifically. Even among high-income countries, research studies on sexual harassment in the health sector were only from the USA. This

section reviews research on gendered forms of violence in the health sector and research about violence in general in the health sector, which also has gender implications.

Gender Based Violence in the Health Sector

In the USA, a study of female faculty members in 24 medical schools revealed that about half the female faculty had experienced some form of sexual harassment, in contrast to few of their male faculty colleagues (Carr et al. 2000). In another study among medical students, 92.8% females and 83.2% males experienced, observed or heard at least one incident of gender discrimination and sexual harassment during medical school in 1997 (Stratton et al. 2005). This suggests that despite the increasing female presence among medical students and in medicine in general, harassment is still a very common experience in the USA.

The kinds of gender discrimination and sexual harassment reported by medical students were grouped into six main categories ranging from educational inequalities, stereotypical comments, sexual overtures, offensive, embarrassing or sexually explicit comments, inappropriate touching and sexist remarks (Witte et al. 2006). Female medical students were more likely than male medical students to report that these experiences affected their specialty choices (45.3% vs. 16.4%) and residency rankings (25.3% vs. 10.9%) (Stratton et al. 2005).

Despite the prevalence of gender discrimination and sexual harassment, research seems to indicate that women currently just cope with such inequities (Carr et al. 2000). Hinze (2004) examined the everyday lives and coping strategies of women in medical schools with regard to sexual harassment in the USA. Incidents were deflected away from the problem of sex harassment by re-framing the problem as one of women's sensitivity. Or women reacted by refusing to name sexual harassment as problematic and instead relegated it as small stuff when considered against the context of their rigourous training programme. Hinze (2004) concludes that both tactics of resistance fail because they individualise the problem of sexual harassment. In doing so, they deflect attention from systemic gender inequalities that permit the continuation of such forms of behaviour with impunity, as well as re-victimise the women by blaming their sensitivity or finding some reason to justify such harassment.

Gendered ideologies that sanction violence against women was also documented in a South African study, initially undertaken to explore the potential role of nurses in addressing domestic violence at the primary health care level (Kim & Motsei 2002). Group discussions revealed that violence was seen to be justified when women were disrespectful or didn't listen, were lazy with regard to their household or childcare duties, were allegedly unfaithful, tried to stand up for their rights or questioned men's infidelity or lack of household support. These gender-biased perspectives saw violence by men against women as normal and even approved of men disciplining or punishing their wives. Most preoccupying was the perception that violence by men was a means through which they were able to forgive and love women.

Another striking finding was that nurses were at greater risk of abuse due to their professional status. Many of them relied on their husbands in order to attend nursing school. As a result, they felt obliged to hand over their salaries to their spouses at the end of the month, leading them to have little control over their own finances. Tension and violence in the house was reported due to their spouses feeling threatened by their professional, income-earning status and because of their interactions with male colleagues. As one female nurse reported, "In a working situation...doctors are males, drivers for the ambulances are males, people in the workshop are males...paramedics, they are all male. So if they find you with a

doctor, then you know, we are 'in love' with this one...You know, you come from home with bruises everyday" (Kim & Motsei 2002: 1248).

These findings question the assumption that female health workers will be naturally empathetic to victims of domestic violence, as "it is difficult to imagine how a nurse who is unable to exert meaningful control over her own salary and finds herself unable to leave an emotionally and physically abusive spouse, might counsel and advise a client in a remarkably similar position" (Kim & Motsei: 2002:1251). The authors suggest that participatory training that engages with health worker's own personal experiences, values and attitudes is essential, before the acquisition of technical skills to develop professional responses by health workers to domestic violence can start.

As mentioned earlier, gender ideologies in South Asia also frame community based female health workers as immoral due to their involvement in delicate subjects like family planning, their interactions with male colleagues and their unchaperoned travel across villages. Significant amounts of sexual harassment exist for female auxiliary health staff in Pakistan starting from the time of their job application onwards (Mumtaz et al. 2003). One female health worker reported, 'When I leave home to come to the Basic Health Unit, I need to travel by local transport and there are men who offer a lift or pass comments. I feel so bad and insulted that when I reach the Basic Health Unit I misbehave with my patients" (Mumtaz et al. 2003: 264).

With respect to personal security, female auxiliary health staff in India reported being afraid to walk on their own in between villages, coping with remotely located housing with inadequate lighting, facing harassment from villagers and not trusting villagers when called out to help at odd hours. In the same study, only one male auxiliary health worker answered the question about personal security. His response was, "Personally, there is no problem, because I have all-round support. There is no problem." (George 2007: 138).

These responses show that the lack of infrastructural support, in terms of transport, housing and lighting, has gendered consequences for female health workers, most intimately embodied in their personal security. Although supervisors informally acknowledge these problems, they do not see these problems as part of their official managerial remit (Mohan et al. 2003). Due to concerns about personal safety at night, antagonism of villagers against them and the risks involved in attending to delivery complications without emergency obstetric care, auxiliary nurse midwifes in India hesitate to attend deliveries. The government response thus far has been mainly to provide financial incentives for institutional deliveries, yet this does not address the security and supervision concerns that are at the heart of why female health workers avoid attending deliveries. In the absence of managerial support to counter these security problems, female health staff in India rely on spouses who accompany them or cultivate support and trust among local people they later rely on to accompany them to village households for night deliveries. These efforts reflect informal adjustments and individual private coping strategies to problems of gender bias that require collective, public acknowledgement and resolution.

General Violence in the Health Sector

Results from a study of violence in the health sector across several countries revealed that women are at greater risk as they are more likely be victims of violence and to suffer longer health and psycho-social consequences than men from the violence (Di Martino 2002). While ambulance staff are thought to be at greatest risk, nurses were found to be three times more likely on average to experience violence in the workplace than others. Among Bulgarian nurses, more female than male victims of verbal abuse suffered to an average to high degree from disturbing memories and thoughts (67% vs. 56%) and became super-alert and watchful

(70% vs. 60%) (Di Martino 2002). Younger women working in the health sector are also more at risk of violence due to combined age and gender biases (Di Martino 2003). When one considers the informal sector, which is over-represented by less qualified, female health workers, often working in illegal conditions, the rates of violence although undocumented could be higher.

Not only are the rates of violence higher than previously understood in the health sector, but the forms of violent acts is broader than previously realised. Both physical and psychological forms of violence are prevalent, with the latter being more frequently reported. They are closely inter-related and often overlap at the workplace. Moreover, "until recently the typical profile of violence at work largely featured isolated, major incidents. In more recent years however, attention is also being focused on violence which is perpetrated through repeated behaviour, of a type which by itself may be relatively minor, but which cumulatively can become a very serious form of violence" (Di Martino 2002: 17). Although the evidence does not establish a general profile of perpetrators or victims, it seems that physical violence is more likely between patients and health providers, while psychological violence is more likely to take place by supervisor against subordinates (Di Martino 2002)[8].

In terms of strategies to prevent violence in the health sector, nurses in Thailand observed that those who were more senior and experienced were more able to diffuse violent situations. In contrast, "nurses with low levels of self-confidence and poor defence skills were more likely to be victimised while "quick-witted persons tended to be invulnerable"".

Table 7: Incidence of Violence in Health Sectors

In the previous year	Portugal Health Centre	Portugal Hospital	Bulgaria	Lebanon	S. Africa Public	S. Africa Private	Thailand	Australia	Brazil
N	221	277	508	1016	1018		1090	400	1569
N % Women	77	79.9	80.3	69.8	78		72.7	68.5	70.46
Any violence	60	37	75.8		71.1	51.6	54	67.2	46.7
Physically attacked	3	3	7.5	5.8	17	9	10.5		6.4
Verbally abused	51	27.4	32.2	40.9	60.1		47.7	67	39.5
Being bullied/ mobbed	23	16.5	30.9	22.1	20.6		10.7	10.5	15.2

Source: Di Martino 2002

Although many health workers suggested the importance of reporting and investigation mechanisms, as well as security personnel, administrators in Thailand also saw the importance of focusing on prevention efforts and not solely relying on a strategy of "building a shed after the loss of cows"(Di Martino 2002: page nos.). In South Africa, prevention efforts among staff included supporting training in skills, stress management, communication and conflict management; promoting a culture of dignity and respect; regular meetings to get to know each other and new recruits better and ventilate feelings; and other team building excercises (Di Martino 2002: page nos.). Brazilian health workers similarly identified prevention strategies that went beyond immediate concerns addressed by better policing and reporting. They linked the incidence of violence in the health workplace to social problems of inequality in society, their lack of working conditions that have a direct affect on quality of care for patients and their lack of worker's rights in the health sector (Box 1).

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[8] There is an emerging literature about the gender biases and violence perpetrated by health providers against patients. This is not reviewed in this paper, but is discussed in a companion review undertaken by Penn-Kekana and Govinder on patient-provide relations.

Box 1: Brazilian health workers' analysis of the causes of violence in the health sector

General public policy related factors:
  - lack of education for the population that increases the cultural distance between those seeking medical attention and health care personnel
  - unemployment, due to which people are already stressed and in need. It also results in a great number of people falling sick;
  - lack of adequate policies on safety

Factors causing aggression by patients and relatives:
  - lack of attendance or poor quality attendance;
  - overload of patients
  - lack of communication between health care personnel and patients
  - lack of respect for a patient's dignity
  - lack of humanity in treating patients
  - non-resolution of health problems
  - lack of basic material needed for attending on patients
  - lack of training of health personnel
  - lack of clear limits to areas of public access
  - aggressiveness / stress of patients

Factors causing aggression by staff and managers:
  - impunity
  - lack of labour rights and collective agreements
  - lack of consensus in health teams
  - lack of discussion spaces to deal with conflicts in teams
  - lack of training in leadership
  - unhealthy conditions of work
  - low wages
  - threat of unemployment
  - insecurity concerning retirement
  - stress
  - vacancies
  - work overload and intensification
  - excessive number of trainees taking the place of graduate professionals
  - simultaneous existence of several types of contracts in the public sector with different wages for performing same or similar functions

Source: Di Martino 2002: 22

Summary Conclusions

Gender, as a social construct enforced by power relations, affects how health work is conceptualised, valued and supported with differential impacts on the professional and personal lives of health workers, the services they deliver and the health systems they belong to. It consequently determines the structural location of women and men across and within health occupations, as well as the subjective experiences of these locations. Although gender biases have distortionary effects on both women and men that are contextually dependent; in general, women tend to be disproportionately disadvantaged, while men tend to be disproportionately privileged.

These gender biases are inequitable, as they are in of themselves unfair. But their power resonates through various other distortions. They can be invisible due to description biases that affect how we view and understand the nature of health work and health systems. They can be ingrained as they affirm forms of privilege that resist change and marginalise those that seek change, with gender tensions often being resolved through private, individual adjustments rather than through public, collective transformations. They are also inefficient or unproductive as they restrain the true capacity of individuals working in health systems. Finally, they are iatrogenic, as those least supported, trained and rewarded absorb the contradictions of gender biased and resource constrained health systems at great cost to their own health and livelihoods.

The first form of gender bias that must be addressed pertains to describing who does health work and how it is done. The omission of sex-disaggregated data and the biases involved in conceptualising and measuring health work either hide the presence of women entirely or misrepresent their work. Health work is often categorised by stylised oppositional categories, whether curative or caring, formal or informal, full or part-time, skilled or unskilled, paid or unpaid work. Not only are women over-represented in caring, informal, part-time, unskilled and unpaid work, elements of work that are routinely not measured, but women's contributions also span a range of activities that blur some of these stylised distinctions. By failing to accurately describe the gendered nature of health work, women's contributions to health systems continue to be unsupported as they are under-valued or not recognised at all. Despite increased attention to human resources in health, the lack of research dedicated to documenting its gendered nature and in assessing interventions that redress gender inequalities must urgently be rectified.

As mentioned gender bias exists across as well as within health occupations. As a result, measures like substitution and delegation, which affect the professional ordering of health systems, cannot be seen as technical interventions alone. The gender dynamics of these measures need to be considered on a contextual basis, with an assessment of how gender hierarchies among health occupations are formally and informally sustained or subverted, in order to eliminate rather than exacerbate current inequalities across health occupations. It is essential that delegation be seen as part of long term planning and investment efforts that skillfully restructures health systems to do more in different ways, rather than as a means to stretch farther on a cheaper basis, often falling back on unsupported female labour.

Gender also influences the structural location of women and men within health occupations, resulting in significant gender differences in terms of employment security, promotion, remuneration, etc. It is important to not perceive these differences as either static or universal. They need to be analysed and monitored within changing national contexts, specific health system circumstances and by other social determinants. Nonetheless, research has shown that in several contexts even when organisational location, productivity and family leave are adjusted for, significant levels of gender difference remain, indicating unadulterated gender bias.

This explains why although focused mentoring and professional assessment and guidance programmes can quantitatively increase the number of women at key levels and in certain positions, such affirmative action efforts cannot single handedly improve gender equity among health professionals. By focusing solely on the advancement of individual women, without addressing the gender biases that constrain women's potential as a group, these efforts may paradoxically reinforce gender biases by raising false expectations.

Participatory gender training that focuses on values, is based on health workers own experiences and is also action oriented can succeed in raising individual health worker awareness of their own biases, empowering them to identify programmatic changes that can be made at their level of service delivery. Nonetheless gender training by itself cannot

address the multiple forms of gender bias that exist simultaneously to constrain the capacity of women and men working in health systems. Such biases require holistic approaches that address the personal and professional struggles of health workers at both local level and higher levels of health systems management.

In order to succeed, affirmative action and training measures must be coupled with efforts that qualitatively transform how health work is conceived of and organised, so that the multiple forms of gender bias that act to obscure, devalue and constrain women's contributions to health care are addressed. This means sustaining a range of efforts spanning concrete and diffuse actions, including improving access to family leave or child care provisions in a gender equitable manner; resolving gender differences in access to strategic resources like mentoring and supervision, administrative and infrastructural support, secure funding sources and employment contracts, formal and informal networking; addressing gendered vulnerabilities to sexual harrassment and other forms of violence experienced by health workers; addressing gender biases in measuring, rewarding and supporting work; and neutralising stereotypical work models.

Stereotypical work models either assume women are the same as men and thus expect them to conform to male work models that ignore their specific needs or swing to the other extreme and naturalise women's difference so they are seen as inherent to individual women rather than as differences structured by the social environment. For instance, women are more likely to be stereotyped as caring health personnel than men. This not only excludes, or even worse excuses men, but also presents a homogenised, static expectation of women's capacities that absolves managerial responsibility from addressing their less autonomous and under-resourced roles in health systems. At the same time, the specific needs of women health workers are often not addressed, whether it is childcare or protection from violence. These problems are seen as caused by women, rather than by how health services are organised. By stereotyping women as being more caring in health work or conversely as being problematic for health care organisations due to their sexuality and childcare needs, gendered ideologies obscure important structural elements of disadvantage and bias. Although the consequences of these biases are blunted by women's individual private adjustments, they are not 'women's problems' alone and require collective, public efforts to resolve.

With respect to female community health workers, they negotiate gender biases at various levels, starting from their own homes, the communities they work in and the health systems they belong to. Strategies that most successfully address the gender biases that question the legitimacy of female health workers deployed at community level address both elements of personal and professional prestige. Successful programmes provide them with avenues for growth by questioning and reinterpreting gender norms in a constructive manner; allowing them to assume broader roles than the original simple health care tasks they were encharged with; guide them with continuous training and supervision; back them up with functioning referral systems; and support them through positive relationships with peer groups, community members, other health professionals and managers. Although these system wide improvements will benefit all health workers at the community level, it is notable how these systemic improvements are often undertaken in a gender blind manner, if at all. Too often community based health workers are expected to improve health outcomes, despite the lack of functioning health systems, reflecting false expectations that are themselves gendered.

Similar broad measures that strengthen the health systems that health workers are located in are required to address the gender dimensions of care work that is currently undertaken primarily by women in ways that are unsupported, poorly paid or unpaid at great cost to their own health and livelihoods. Significant effort must urgently address the biases in

health services that work against recognising the value, difficulties and rewards of care work. Care work goes beyond assisting curative or palliative health care service provision to include basic services of a broad variety, it requires constant attendance since it cannot be regularly scheduled and entails substantial emotional involvement. In addressing these challenging realities, it is no longer acceptable for home-based care efforts to remain blind to who in the household shoulders the burden of home care in terms of gender and age. Support needs to integrate various kinds of social services beyond the formal health care sector to encompass social protection, employment, water, sanitation, agriculture, nutrition and housing, keeping in mind the perspectives of women as primary home carers, without stereotyping them as the only ones who can undertake care work.

The structural characteristics of increasingly globalised and under-resourced health systems also have gendered impacts through the migration of health workers. Not only are more female health workers migrating than before, but as skilled labour is drawn to more formal, better financed and functioning health systems, lower level health workers, who are more likely to be women, whether paid or not, are expected to shoulder the burden of sustaining crumbling health systems in source countries. Although pull factors play a critical role in sparking the current crisis of the global migration of health workers, this phenomena also draws its force from the significant numbers of unemployed or unproductive local health workers that form a pool of latent discontent within health systems. More must be done in both source and recipient countries to retain local nursing staff, who in the absence of support either quit or migrate to better work environments.

While migration opens up new opportunities, it is also associated with new vulnerabilities and challenges that have gender dimensions. Female health workers are more likely that their male counterparts to face immigration or licensing systems that use gender blind criteria; have more difficulties reestablishing their careers in mid-life or even being recognised as a worker if termed as secondary migrants or dependent wives; unequally shoulder the responsibility of integrating their families into new communities, while maintaining family ties across farther distances; and are more likely to face sexual harassment and other forms of gender discrimination that may be heightened by the isolation and other insecurities specific to the migration process. Although some organisations and policies have responded to addressing these multiple forms of cumulative disadvantage faced by migrant female health workers, more research is needed to understand the gendered needs of migrant health workers and to assess the effectiveness of efforts to address their needs.

A gender analysis of the health labour force also reveals significant levels of violence experienced by health workers in the health sector. Women health workers are disproportionately victimised by such violence due to gendered ideologies that subjectively sanction such violence or due to their structurally disadvantaged position within the health labour force. As female health workers contravene conservative gender norms in their homes, in public spaces and through their health work, they risk attacks on their intimate selves, endangering their sexuality and personal safety, despite being educated and economically viable. Interventions must address both the normative values that naturalise and sanction such violence, as well as the structural biases that place female health workers at greater risk through poor working conditions and gender blind management practices.

In conclusion, a gender analysis of human resources in health reveals that although health systems are themselves meant to provide a source of healing and a social safety net for society, it can replicate and exacerbate many of the social inequalities it is meant to address and itself be immune from. Health systems rely on a foundation of health workers that are often informal, poorly paid or not paid at all, poorly supported and disproportionately female. Even among formally recognised sections of the health labour force, significant forms of gender bias exists across and within health occupations. Despite the prevalence of such

structural and subjective biases, they are neither static nor universal, but actively contested, negotiated and adjusted to at the individual level. These individual efforts by women and men must be constructively and collectively amplified through policy and programme efforts at higher and broader levels in health systems. The results of such policy and programme efforts would result not only in more gender equality in the health labour force, but also improved health system functioning more broadly.

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