



Ministry of Health

Gender Inequality and Discrimination Analysis Report

August 2012



IntraHealth International
6340 Quadrangle Drive Suite 200
Chapel Hill, NC 27518
Tel: 919-313-9100
intrahealth@intrahealth.org



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ABBREVIATIONS

CAW	Commission for the Advancement of Women
DHO	district health officer
FGD	focus group discussion
GDIA	Gender Discrimination and Inequality Analysis
HC	health center
HR	human resources
HRH	human resources for health
HSSIP	Health Sector Strategic Investment Plan
ILO	International Labour Organization
HRIS	human resources information system (of the Ministry of Health)
MOH	Ministry of Health
MOPS	Ministry of Public Service
NDP	National Development Plan
NHP	National Health Policy
PRSP	Public Service Reform Program
UCP	Uganda Capacity Program
USAID	United States Agency for International Development

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The UCP/IntraHealth Assessment Team (Constance Newman, Maude Mugisha, Charles Matsiko)
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EXECUTIVE SUMMARY

Study Rationale, Objectives, and Major Questions

The purpose of the Gender Discrimination and Inequality Analysis (GDIA) was to assess the status of gender equality and equal opportunity for women and men within the public health sector to promote gender equality in the human resources for health. Gender equality in human resources for health (HRH) means that women and men have an equal chance of choosing a health occupation, acquiring the requisite skills and knowledge, being hired and fairly paid, enjoying equal treatment, and advancing in a career. When gender inequalities and discrimination operate in the workforce outside of the awareness of HRH policy-makers and managers, they impede entry into health occupations or contribute to attrition, absences from work, lower productivity, poor health, and low morale of health workers. The result is a limited pool of formal and informal health workers to deal with Uganda's health and development challenges¹.

Gender equality in HRH is important in three critical ways: First, gender equality enables women to enter the health labor market, which increases the likelihood that women will enjoy an equal share of the benefits of social and economic development. Second, gender equality in HRH is a matter of human rights, social justice, and poverty alleviation, as it addresses women's often more marginal position in the labor market by assuring equal access to well-paying occupations; training; equitable conditions of work; and the social protection mechanisms that are usually available to full-time, paid workers (such as insurance, maternity protection, retirement pension, etc.). Finally, gender discrimination and inequality can be viewed as systems inefficiencies that contribute to recruitment bottlenecks, absences from work, lower productivity, poor health, low morale, attrition or mal-distribution of workers in health workforces. Therefore, gender-aware HRH policies and human resources management, rigorously pursued, are instrumental in assuring equal access to well-paying jobs and enabling health workers to effectively manage life-cycle events such as child-bearing, child-rearing, and caring for the sick and elderly at home.

The Uganda Capacity Program (UCP) supported the Ministry of Health to identify and address gender-related barriers to workforce entry, retention, and career advancement. The GDIA focused on gender equality in terms of equal opportunity and equal enjoyment of benefits and privileges of employment by women and men working with the health public sector. The analysis also explored the existence of staff technical capacity and financial resources for gender mainstreaming in the health sector, and in particular, in the workforce and in its leadership and governance. The GDIA set out to answer the following overarching questions, which are at the heart of workplace equity and good human resources management:

- In what ways is the Uganda legal and policy environment promoting equal opportunity and gender equality?
- What, if any, types of gender inequalities, gender bias, or gender discrimination exist in the public health sector?
- In what areas could the Ministry of Health and other ministries increase efforts toward equal opportunity and gender equality at work and in programming?

¹ Newman, Constance. 2010. Gender equality in human resources for health: What does this mean and what can we do? Chapel Hill, NC: IntraHealth International.

The specific objectives of the GDIA were to:

1. Assess employee beliefs, perceptions, and experience regarding equal opportunity and gender equality in the public health sector of Uganda
2. Determine the extent to which national and human resources policies promote equal opportunity and gender equality with respect to employment in the public health sector
3. Assess the extent to which equal opportunity and gender equality are promoted in the health sector's programming
4. Assess the extent of technical capacity and availability of financial resources to advance equal opportunity and gender equality in the public health sector.

Methodology

Data collection

The assessment methodology was partly based on an already-tested gender audit survey tool developed by InterAction². It also included tools to collect data related to gender discrimination and equal opportunity³. The study employed five data collection techniques, including 1) staff and program managers' surveys; 2) focus group discussions (FGDs); 3) document review; 4) key informant interviews; and 5) the generation of gender reports from the human resources information system (HRIS) of the Ministry of Health. Data collection took place through November and December 2011. The assessment tools examined four dimensions of gender integration in organizations (including political will, accountability, technical capacity, and organizational culture) and five dimensions of gender integration in programming (including program planning and design; program implementation, monitoring, and evaluation; partner organizations; human resources; as well as staff perceptions regarding non-discrimination, equal opportunity, and gender equality at the Ministry of Health. Within the last category, the existence of gender bias and discrimination was explored. HRIS gender reports were generated in May and June 2012.

Sample

The sample was based on the 80 districts of Uganda as of June 2010. The districts formed after that period were not yet fully operational at the time of sampling. (Uganda now has 112 operational districts, and 36 more have been recently created in July 2012). The study used *purposive* sampling of 10 districts—6 core districts where UCP operates and 4 districts from other areas (to take into account regional diversity)—and regional referral hospitals, general hospitals, and health centers (HC IV and HC III) from the selected districts (i.e., Rukungiri, Mubende, Kabarole, Arua, Oyam, Dokolo, Busia, Kamuli, Moroto, and Kampala.) National-level facilities were purposively selected, including Mulago National Referral Hospital, Butabika National Mental Referral Hospital, Uganda Virus Research Institute, and National Blood Transfusion Services. Health facilities within the selected districts were chosen by random sampling. A total of 28 facilities were included in the study. Interviews were held with key informants at the district level and included district administrative officers, district personnel officers, and district community development officers. In addition, District Service Commission members and senior staff of the Health Service Commission were interviewed as key informants.

²Morris, Patricia T. 2003. *The Gender Audit: Questionnaire Handbook*. Washington, D.C.: InterAction. .

³ From IntraHealth's *Gender Discrimination and Inequality Analysis* (GDIA) methodology

Individual interviews were held with two Health Service Commission senior staff and some members of District Service Commissions who recruit health workers at national and district level, respectively. A total of 37 (29 male, 8 female) key informants were interviewed. A total of 499 health staff members completed the staff survey, and 68 managers completed the managers' survey. There were 34 FGDs conducted with a total of 279 participants (157 female and 122 male, or 56.3% and 43.7%, respectively). There were male and female focus groups. A key methodological element of the study was the validation of GDIA results through a meeting with the Human Resources Technical Working Group that took place on July 19-20, 2012.

Study limitations

There were fewer male staff survey respondents than expected (one-third of survey respondents were male) due to the unwillingness of (mostly) doctors to take the time to complete the questionnaire. On the other hand, most of the key informants were male (only 22% of district and sub-county officials were female). Key informants were selected on the basis of the positions they held, and the majority in these positions were male. This led to a preponderance of female staff survey respondents, and a preponderance of male key informants. This meant that we learned more about the perceptions of female health workers and the perceptions of male key informants. As may happen with opinion surveys, there was the potential for non-response bias (possible unwillingness to respond to particular questions), or a positive response bias (possible tendency of respondents to give the "morally correct" answer, or what they think the data collectors want to hear). To mitigate these potential sources of bias: 1) data collectors were trained; 2) indicators of discriminatory behaviors were listed, as well as definitions for types of discrimination, on the instruments; 3) instruments were pre-tested and revised to improve the validity and reliability of measures; 4) respondents were assured of confidentiality; and 5) data from other sources were triangulated to confirm themes (FGDs, surveys, key informant interviews, HRIS, documents).

Major GDIA Findings and Conclusions

Document review revealed that there are provisions for paid maternity/paternity leave (for women, 60 working days; for men, 4 working days) and employment security for women on maternity leave (not losing the job when on maternity leave). However, there is no specific support for (male or female) workers with family responsibilities—perhaps due to the non-ratification of the International Labour Organization's Convention 156, relating to "Workers with Family Responsibilities," which might address needs such as flex-time, child care, and personal leave.

The study findings suggest that the political will for gender equality exists at the highest level of government with respect to the policy and legal environment (e.g., the Uganda Constitution, National Gender Policy, Employment Act, Equal Opportunities Act, Ministry of Public Service Circular Standing Instructions No.2 of 2011, Guidelines for Gender Mainstreaming in Human Resources Management in the Public Service). The Employment Act defines sexual harassment in terms of employee/employer relationships and specifies the forms of sexual harassment and what constitutes sexual harassment. The Ministry of Public Service Circular Standing Instructions mention sexual harassment as one of the forms of misconduct by public servants which, when it happens, calls for disciplinary measures to be taken. The Employment Act now has Sexual Harassment Regulations (2012). This rich national policy environment has not been translated into relevant sector policies, strategies, and operational guidelines at the national, district, and facility level, suggesting a need for greater political will and accountability to operationalize

these policies and laws in the public health sector. While the Uganda Constitution guarantees gender equality, there is no national-level affirmative action policy to compensate for historical disadvantages faced by female health workers in the public service or in the health sector workforce. The Local Government Act (1997) has affirmative action for local councilors.

The study findings indicate that women and men are concentrated in “male” and “female” jobs in the health sector. This includes the concentration of men at the top of occupational hierarchies and of women at the bottom. HRIS data show that in eight district health facilities and four national facilities, men occupied 77% of senior management jobs, while women occupied 23% of them. Sixty-three percent (63%) of middle management jobs were occupied by men and 37% by women. There was also a concentration of men and women in different jobs. Women dominate nursing and midwifery and are concentrated in U5 to U7 employment grades; men dominate clinical services such as medicine and are concentrated in U1-U4 positions.

Unequal opportunities related to pregnancy and family responsibilities

The GDIA FGDs suggested that female health workers go through a period in their lives and careers when they need to raise and take care of a family (children and husband) and are not able to take opportunities for career advancement. Thus, while there is no discrimination or gender inequality in the written policy or law at the national level, there appears to be de facto inequality in opportunities, and male bias in recruitment and promotion practices, especially in appointment and promotion to the most senior positions. Unequal opportunity for career advancement for female health workers appears to be linked to preconceptions of women’s roles or negative beliefs about female managers, which also seem to be linked to pregnancy and family responsibilities.

Caring for children and other dependents and doing domestic tasks can be a major handicap in the labor market, restricting options and limiting earning capacity. Work/family conflict prevents the attainment of equal opportunity and treatment, since the constraints and disadvantages that family responsibilities bring in the labor market fall mainly on women. FGD participant responses indicated work/family conflict was indeed a contributor to women’s disadvantage in the public health workforce. There was/were:

- No policy on flex-time (especially for pregnant women and breast-feeding mothers or fathers who need to provide child care and or take care of other parental responsibilities)
- No official breaks for breastfeeding mothers
- No official child care leave
- Very few days (only four) provided for male employees for paternity leave.

Work/family conflict and lack of family-friendly leave policies raised questions about the efficacy of gender-neutral human resources policies and practices because they do not address inequality of opportunity for health workers who have the main responsibility for family care-giving. Further, recruitment criteria for hiring candidates into top management positions exclude women if they are not sensitive to lifecycle constraints, or if they ask that candidates “Must have a degree in medicine, pharmacy” which are the typically “male jobs.” (Nurses/midwives, who are mostly women, cannot comply with these criteria or qualifications).

Key informants, most of whom were managers and recruitment officers at the district level, had largely positive perceptions of affirmative action to increase access for women to management jobs in the health sector.

Sexual harassment

The findings suggest that sexual harassment: 1) exists in the public health sector; 2) is probably experienced more by female employees; and 3) is largely silent. FGDs revealed that situations where sexual favors are demanded or provided in return for favorable treatment (quid pro quo sexual harassment) were a reality that female health workers lived with at the workplace, although they did not readily talk about it. The staff survey data confirmed this finding, showing that 32.1% of health workers reported that quid pro quo sexual harassment was either very common or somewhat common. This suggests that nearly one-third of health workers may experience this at work. The commonest forms of sexual harassment reported were sexually suggestive gestures (12.9% men and 17.2% women), unwanted attempts to establish sexual relationships (7.1% male; 15.3% female), and being the object of sexual jokes, comments, or leering (5.3% male 14.1% female). An opportunity exists to address this issue in the form of new regulations on sexual harassment developed by the Ministry of Gender, Labour and Social Development (Labour Directorate 2012).

Promoting gender equality in programming, monitoring, and evaluation

The program managers' survey asked about their perceptions of the extent to which gender equality and equal opportunity was advanced in public health sector programming. Managers perceived that health programs benefited both women/girls and men/boys. However, respondents indicated that they did not know whether gender-disaggregated data were collected, whether gender equality was monitored, or whether gender indicators were measured. Over half (61.2%) of the respondents perceived that the public health sector does not provide sufficient information on, and practice in, the use of tools to conduct gender analyses and, therefore, such analyses were not incorporated into the design process of programs and projects. This suggests a technical capacity gap in gender mainstreaming. Managers also reported that they were unaware of the existence of financial resources for gender equality work, in particular for gender training and implementation of gender-sensitive programs, or whether gender-sensitive budgeting was done in the health sector. The extent to which the health sector is actually promoting gender equality at operational levels (as measured by perceptions of political will, accountability, and organizational culture) was perceived by health managers to be only *moderate*. Finally, the extent to which the health sector is able to promote gender equality, as measured by perceptions of technical capacity, was perceived to be *limited* by health managers.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

- Men and women are concentrated in different jobs and at different levels in the health sector, with women in fewer jobs and at lower levels. This points to unequal opportunities for men and women and an associated wage differential.
- There is evidence of unequal opportunity for career advancement for female health workers, positive beliefs about men as managers, negative beliefs about women as

managers, and perceptions of pregnancy and family responsibilities as factors hindering career advancement.

- Some health workers appear to experience work-family conflict without a range of family-friendly policies to mitigate it. There is/are:
 - No policy on flex-time (especially for pregnant women and breastfeeding mothers, or for fathers who need to provide child care and have other parental responsibilities)
 - No official breaks for breastfeeding mothers
 - No official child care leave
 - Very few days (only four) provided for male employees for paternity leave.
- Sexual harassment exists in the public health sector, appears to be experienced mainly by female employees, and remains largely silent as those affected do not talk about it or report it. Government regulations on sexual harassment have not reached health facilities, and there are no reporting mechanisms.
- Managers and recruitment personnel at the district level have a largely positive understanding that affirmative action provides the means to equalize opportunities and increase access for women to better jobs in the health sector.
- Uganda's policy and legal framework has not been operationalized in districts and health facilities. Operationalizing the existing framework this could equalize opportunity and promote greater gender equality in health workplaces.
- Health leaders and managers would benefit from awareness-raising and training in areas such as equal opportunity and gender equality in human resources for health, affirmative action, and sexual harassment.

Recommendations

For the Ministry of Health:

- Develop a gender policy, strategy, implementation guidelines, activities, and indicators for the public health sector—and budget for their implementation.
- Disseminate GDIA results to (at least) district and facility managers and staff.
- Sensitize and build capacity of key health sector stakeholders to advance equal opportunity and gender equality in the workforce—for example, Ministry of Health policy-makers, recruiters, district health officers, human resources managers, and facility managers.
- Provide staff development and mentoring for female staff members in order that they might better compete for higher management jobs.
- Challenge negative beliefs about women as managers.
- Develop a sector-specific code of conduct against sexual harassment and disseminate the code to districts through district health officers. This should be accompanied by training trainers who understand the issues, training managers and health workers to recognize sexual harassment, creating and disseminating a wall poster on zero tolerance for sexual harassment, and putting in place a confidential system of reporting, starting with the ten sites in which the GDIA was conducted.

- Develop and disseminate standards for women and family-friendly health workplaces.
- Monitor the concentration of men and women in health sector jobs using the HRIS.
- Adapt the *MOPS Guidelines for Gender Mainstreaming in HRM* to human resources for health and disseminate to health managers and recruitment personnel. This should be accompanied by gender and HRH analysis training.
- Integrate activities to promote equal opportunity and gender equality in district action plans.
- Upon approval of the GDIA Report, the Human Resources Technical Working Group should appoint a task force on the status of gender equality in the public health sector to move the GDIA recommendations forward.

For the Health Service Commission/District Service Commissions:

- Work with the Equal Opportunities Commission and the Ministry of Public Service to develop guidelines for equal opportunity and affirmative action in the government civil service to be in line with the Constitution of Uganda, which provides for the right to affirmative action for marginalized groups.
- State in recruitment notices that the Ministry of Health is “an equal opportunity employer” and that “women are encouraged to apply” to broaden the range and level of jobs to which female health workers have access.
- Expand hiring criteria for senior management positions to include wording such as “or another relevant degree” or “or equivalent years of experience” to open opportunities for female health workers to advance their careers in the health sector.
- The Health Service Commission should develop an affirmative action strategy to recruit more women into senior management positions in the government health sector, as provided for in the Ministry of Public Service’s *Guidelines for Gender Mainstreaming in HRM* [Human Resources Management].

For the Ministry of Gender Labor and Social Development:

- Work with the Equal Opportunities Commission and the Ministry of Public Service to develop guidelines for equal opportunity and affirmative action in the government civil service to be in line with the Constitution of Uganda, which provides for the right to affirmative action for marginalized groups.
- Develop a reader-friendly “Know Your Rights” booklet for public sector workers.

For the Ministry of Public Service:

- Disseminate the *Gender Mainstreaming Guidelines in HRM* as well as the *Employment (Sexual Harassment) Regulations (2012)* through targeted forums of government sectors (including the health sector, also adapted to human resources for health).

General:

- The Government of Uganda (GOU) should ratify ILO Convention 156, Workers with Family Responsibilities, to support work/family balance.

- If the GOU ratifies ILO Convention 156, the Ministry of Gender, Labour and Social Development should update the 2006 Employment Act to include family-friendly provisions.

BACKGROUND

The Ministry of Health, with support from the United States Agency for International Development-funded (USAID-funded) IntraHealth/Uganda Capacity Program, has been working toward the strengthening of human resources for health (HRH) to contribute to the realization of the Health Sector Strategic Investment Plan (HSSIP). The Uganda Capacity Program was established to respond to the HRH crisis in Uganda “characterized by inadequate number and skill mix of the health workforce to effectively respond to the health needs of the country, low retention and motivation, poor performance and high rate of absenteeism”⁴.

Gender and Human Resources for Health

Management policies, practices, and organizational cultures that promote non-violence, non-discrimination, equal opportunity, and gender equality at work foster safer and more gender-equitable work environments. However, these are often poorly understood conditions for workforce attraction, productivity, and retention⁵. Because of this, the Uganda Capacity Program technically supported a Ministry of Health (MOH) Gender Discrimination and Inequality Analysis (GDIA) to inform gender mainstreaming in the public health sector of Uganda, and in particular, to promote gender equality in HRH planning. Such research is consistent with Uganda’s Gender Policy mandate of “promoting and carrying out gender-oriented research in order to identify gender inequalities”⁶.

There is information on the situation of health services in Uganda, including the challenges and constraints to the provision of quality health, but there is limited information on gender constraints and opportunities in HRH. Previous studies shed some light on gender as it affects conditions of work in Uganda. One recent study substantiated the presence of gender wage differentials in Uganda’s workforce (though not yet in the health workforce)⁷. In 2011, the Ministry of Public Service (MOPS) documented that men predominate in the public sector (representing 77% of public sector jobs) and that there is a concentration of men in senior and middle management, with an associated gender wage differential (i.e., that 78% men hold senior management jobs at the U1 level, as opposed to 22% of women; and that men are also highly concentrated in middle management jobs—U2 and U3—at 84% to women’s 16%⁸).

⁴ Newman Constance: Trip Report to Uganda 2010 (unpublished)

⁵ Newman, C. 2010. Gender equality in human resources for health: What does this mean and what can we do? Chapel Hill, NC: IntraHealth. *“Gender discrimination and inequality affect health workers’ chances of being recruited and hired for jobs for which they are qualified, to work productively and advance in a career while at the same time, affect their ability to effectively manage life-cycle events that particularly impact, and create particular challenges for female workers, such as marriage, child-bearing, child-rearing and caring for the sick and elderly at home. Further, sexual harassment, discrimination based on pregnancy and family responsibilities, wage discrimination and lack of promotion possibilities weaken women’s ties to the health workforce.”*

⁶ Ministry of Gender, Labour, and Social Development. 2007. National gender policy. Kampala, Uganda: Ministry of Gender, Labour, and Social Development.

⁷ Kigundu, Paul and Olga Pavlova. 2007. Gender Wage Differentials in Uganda: Evidence from the Uganda National Health Survey. Andrew Young School of Policy Studies Research Paper Series Working Paper 07-25., Atlanta, GA: Georgia State University

⁸ Ministry of Public Service, Guidelines for Gender Mainstreaming in Public Services. Data source was Ministry of Public Service, Payroll Monitoring Unit

A survey on maternity protection in Uganda by Public Services International suggested that the “glass ceiling,” pay inequities, and lack of support for health workers who had recently given birth were present in the health workforce. The survey also found that health workers did not understand or exercise their employment rights, including their maternity rights provided for in Uganda’s Employment Act; pregnancy-related illness affected time management and cooperation from work-mates; and breastfeeding created challenges for female employees during work⁹. These studies suggested that there was a need for more in-depth study of gender equality in Uganda’s health workforce. In the meantime, the MOH began working to transform its policies, processes, and programs to promote gender equality, having sponsored a cross-sectoral gender and HRH orientation in 2011, and having integrated gender equality content into its leadership and management training.

Purpose and Objectives of the GDIA

The purpose of the GDIA was to assess gender equality in terms of equal opportunity and equal enjoyment of benefits and privileges of employment by women and men working with the health public sector. The analysis also explored the existence of staff technical capacity and financial resources for gender mainstreaming in the health sector, and in particular, in the workforce and its leadership and governance. The GDIA set out to answer the following overarching questions, which are at the heart of workplace equity and good human resources management:

- How is equal opportunity and gender equality promoted in the public health sector?
- What, if any, are the types of gender inequalities, gender biases, or gender discrimination that exist in the public health sector?
- In what areas could the health sector (and other sectors) increase efforts to promote equal opportunity and gender equality in workplaces and in programming?

The specific objectives of the GDIA were to:

- Assess employee beliefs, perceptions, and experience regarding equal opportunity and gender equality in the public health sector of Uganda
- Determine the extent to which national and human resources policies promote equal opportunity and gender equality with respect to employment in the public health sector
- Assess the extent to which equal opportunity and gender equality are promoted in the health sector’s programming
- Assess the extent of technical capacity and availability of financial resources to advance equal opportunity and gender equality in the public health sector.

This report highlights the findings, conclusions, and recommendations that have particular importance for HRH policy, planning, and programming. However, other GDIA data and results

⁹Case Study: Maternity Protection in Uganda, Public Services International, n.d.

are included in appendices for the interested reader. Appendix A defines terms and concepts related to gender equality in the health workforce.

Methodology

The study employed five data collection techniques: the survey method; focus group discussions; document review; analysis of human resources information system (HRIS) data; and key informant interviews.

The Survey Method

Two self-administered questionnaires were used: a general staff survey questionnaire administered to selected staff across all levels, and a programmatic survey questionnaire administered to health managers¹⁰.

A general staff survey questionnaire for all categories of staff in the public health sector (Tool#1, See Appendix B i)

This was a self-administered questionnaire with four sections:

- Section I contained questions related to demographic information of the respondents.
- Section II focused on organizational policies, decision-making, human resources policies, and organizational culture.
- Section III focused on staff perceptions of gender equality.
- Section IV focused on the conditions of work.

The tool contained both closed and open-ended questions. This tool was administered to a sample of MOH staff of different categories and levels. The sample included 10% of all staff at national level facilities; 30% of all staff at regional and general hospitals; 50% of staff at health centers at county and sub-county levels (health center V and III). The response rate for the staff survey was 58%. This was largely because some of the staff members, especially male staff members, did not give time to answer the questionnaire.

Table 1. Sample and Response Rate for the Staff Survey of Selected Facilities in Each District

District/facility	Expected (completed questionnaires)	Secured (completed questionnaires)
Arua	124	59
Oyam	33	11
Dokolo	29	16
Moroto	53	32
Busia HC IV and HC III	34	12
Kampala	38	22
Kamuli	57	57
Rukungiri	33	15
Kabarole	105	64
Mubende	56	34
Mulago National Referral Hospital	196	124
Butabika Mental Referral Hospital	40	34

¹⁰Adapted from: Morris, Patricia T. 2003. *The Gender Audit: Questionnaire Handbook*. Washington, D.C.: InterAction .

District/facility	Expected (completed questionnaires)	Secured (completed questionnaires)
Uganda Blood Transfusion Services	23	10
Uganda Virus Research Institute	10	09
Total	865	499

Source: Staff survey questionnaires

Health managers' survey questionnaire (Tool # 2, See Appendix B ii)

This was a self-administered questionnaire. It was originally designed to be an interview schedule, but the pre-test of the tool indicated that respondents preferred to fill it out as a self-administered questionnaire. The tool was a structured questionnaire with multiple choice and open-ended questions. The tool was divided into six sections covering program planning and design, program implementation, monitoring and evaluation, financial resources, staff technical capacity, and partnerships and general organizational issues.

Table 2. Sample and Response Rate of the Health Managers' Survey of Selected Facilities in Each District

District	Expected	Secured	% of secured completed questionnaires
Arua	12	7	58
Oyam	2	2	100
Dokolo	2	2	100
Moroto	11	5	45
Busia	2	1	50
Kampala	2	2	100
Kamuli	8	4	50
Rukungiri	2	2	100
Kabarole	12	12	100
Mubende	7	5	71
Mulago National Referral Hospital	31	17	54
Butabika Mental Referral Hospital	15	7	46
Uganda Blood Transfusion Services	4	2	50
Uganda Virus Research Institute	5	0	0
Totals	133	68	51

Focus group discussion guide (Tool #3, See Appendix B iii)

The focus group discussion (FGD) guide contained questions cutting across all the themes of the study (i.e., perceptions of equal opportunity and gender equality, human resources policies, organizational culture, programs, staff technical capacity, and financial resources). The focus group guide included guiding questions for discussion and agree/disagree statements. Focus groups were organized at national-level health facilities, regional referral hospitals, general hospitals, and at county-level health centers (HC IVs). No FGDs were held at district health officers' (DHOs') office level or HC III because of the fewer numbers of staff at those facilities. Each FGD consisted of 7-12 participants. A total of 34 focus groups were held with a total of 251 staff members (133 females and 108 males). Details of how FGDs were organized are provided in Table 3.

Table 3. Number of Focus Groups and Participants at the Facility Level

Level of facility	No. of facilities	No. of FGDs per facility (planned)		Number of FGDs held and participants		Total FGDs held/participants
		Female	Male	Female	Male	

Level of facility	No. of facilities	No. of FGDs per facility (planned)		Number of FGDs held and participants		Total FGDs held/participants
		Female	Male	Female	Male	
National referral hospitals	2	2	2	4 (32)	2 (18)	6 (50)
Regional referral hospitals	3	2	2	3(28)	3(19)	6 (47)
General hospitals	2	1	1	2 (11)	2 (13)	4 (24)
HC IV	9	1	1	9 (62)	9 (68)	18 (130)
Total	16	21	21	18 (133)	16 (108)	34 (251)

Key informant interview guide (Tool # 4, See Appendix B iv a and b)

Two interview guides for non-health staff were developed to assess perceptions and opinions of officials in positions that have implications for health staff, especially recruitment, hiring, and supervision. One interview guide (Tool #4 a) was for officials at the district and sub-county level. The other key informant interview guide (Tool# 4 b) targeted members of the District Service Commissions and the Health Service Commission at the national level. A total of 37 (8 female and 29 male) key informants were interviewed.

Interviews with key informants at the district level—including district administrative officers, district personnel officers, and district community development officers—were held. In addition, District Service Commission members were interviewed. At the Health Service Commission, only two senior staff members were available¹¹. A different interview guide for this category was used. Individual interviews were held with the representatives of two service commissions. Both the Health Service Commission and the District Service Commissions are responsible for recruiting and hiring health workers at national and district levels, respectively. Key informants included in the sample were selected on the basis of the positions held. A total of 37 (29 male, 8 female) key informants were interviewed.

Table 4. Number of Key Informants by Category and Sex
(N=37)

Position	Female	Male	Total
Commissioner/assistant commissioner, Health Service Commission	1	1	2
Assistant	2	2	4
Acting community development officer	0	1	1
Chairperson, District Service Commission	0	3	3
Chairperson	0	2	2
Assistant/community development officer	2	6	8
Assistant district health officer/district health officer	0	3	3
Member, District Service Commission	1	0	1

¹¹ The term for the then Health Service Commission members had expired, and new commissioners were not yet appointed at the time of the assessment.

Position	Female	Male	Total
Personnel officer	1	5	6
Secretary, District Service Commission	1	3	4
Senior assistant secretary	0	1	1
Sub-county chief	0	2	2
Total	8 (22%)	29 (78%)	37 (100%)

Source: Key informant interview questionnaires

Document review (Tool #5, Document Review Guide, See Appendix B iv)

Document review was undertaken to supplement employee perceptions of gender equality and equal opportunity. A document review guide was used with specific indicators of interest to the study. The document review collected data on equal opportunity and gender equality as reflected in MOH policies, procedures, and programs to supplement the perceptions and opinions assessed through the survey and FGDs. The research consultant compiled data regarding employment, career advancement, access to pregnancy and family-related time off and benefits. The document review also included questions regarding the existence of policies, such as sexual harassment and maternity leave, and the inclusion of gender equality in programs. A list of documents reviewed is found in Appendix C.

Analysis of the human resources information system

Data relating to human resources in the ten facilities included in the study were obtained through the MOH HRIS and analyzed to supplement staff perceptions related to the concentration of men and women in jobs and occupations.

Informed consent

Each tool had an 'informed consent' clause which was read and signed by each respondent (in the case of self-administered questionnaires and key informant interview schedules) or read to focus group participants, with verbal consent secured.

GDIA results validation meeting with the Human Resources Technical Working Group

A key element of the methodology was the validation of results of the GDIA through a meeting that took place on July 19-20, 2012. The meeting was attended by members of the Human Resources Technical Working Group and invited resource persons, including representatives of the Ministry of Gender, Labour and Social Development, the MOPS, the Health Service Commission, the Equal Opportunities Commission, and the Uganda Women's Network. Participants received the GDIA results, made comments, and provided input to strengthen the report, especially the conclusions and recommendations of the study.

Sampling

Staff survey sample

A purposive sampling technique¹² was chosen for selection of districts and health facilities in order to include core districts covered by the Uganda Capacity Program (UCP) and a variety of

¹² Purposive sampling refers to a type of nonprobability sampling in which the researcher consciously selects specific elements or subjects for inclusion in a study in order to ensure that the elements will have certain characteristics relevant to the study. <http://medical-dictionary.thefreedictionary.com/purposive+sampling>. Accessed August 27, 2012.

health facilities offering different types of health services (for example, referral and general hospitals, health centers, and specialized health services such as research and blood transfusion services). Additional districts outside the UCP coverage were selected purposively to increase representativeness of certain characteristics of the health sector (nearness/distance from Kampala, rural and urban; extremes of social/economic differences in regions of the country). Facilities at county and sub-county levels were randomly selected to increase the chances that all facilities might be included in the GDIA. Survey respondents were selected using a 'convenience'¹³ sampling technique within stratified categories of salary scales (U1-U4 and U5-U8) of the Uganda Government Public Service Salary Scales. Table 5 gives the complete sample.

Table 5. Districts, Number, and Type of Health Facilities Selected of the Study Sample

District	Hospital	HC IV	HC III	No. of facilities
Arua	Arua Regional Referral Hospital	Adumi	Aroi	3
Busia	-		Buteba	2
Dokolo	- ¹⁴	Dokolo	Bata	2
Kabarole	Fort Portal Regional Referral Hospital	Bukuku	Kaswa	3
Kampala	-	Kawempe	Kiswa	2
Kamuli	Kamuli General Hospital	Namwendwa	Namasagali	3
Moroto	Moroto Regional Referral Hospital	- ¹⁵	Lotome	2
Mubende	Mubende Regional Referral Hospital	Kiganda	Bukuya	3
Oyam	-	Anyale	Ngai	2
Rukungiri	-	Kebisoni	Bwambara	2
National-level facilities	Mulago National Referral Hospital	-	-	1
	Butabika National Mental Referral Hospital	-	-	1
	National Blood Transfusion Services	-	-	1
	Uganda Virus Research Institute	-	-	1
Total number of health facilities selected				28

Selection of staff survey respondents at the facility level was based on percentages for each level. The percentages for each facility were based on the number of staff in the facility (MOH Facility Audit 2010) and anticipated availability. Selection of study respondents for the staff survey was as follows:

- National-level facilities: 10%
- Regional referral hospitals: 30%
- General hospitals: 30%

¹³ A convenience sample refers to a type of non-probability sampling in which the population selected is easily accessible to the researcher; available subjects are simply entered into the study without any attempt at randomization. <http://medical-dictionary.thefreedictionary.com/purposive+sampling>. Accessed August 27, 2012.

¹⁴ No health facility at the level of hospital in Dokolo (Ref MOH – Audit of Health Facilities in Uganda 2010)

¹⁵ There is no HC IV in Moroto (Ref. MoH -Health Facilities in Uganda 2010).

- Health centre four (HC IV): 50% (A higher percentage was taken because the number of staff at this level was expected to be smaller.)
- Health centre three (HC III): 50%
- District health officer's (DHO's) office: 50%

Table (i) in Appendix E summarizes respondents sampled from each facility by district.

Health managers' sample

The programmatic survey respondents included heads of health facilities at the different levels (national level, district level, and HC IV and HCIII levels). MOH directors, commissioners, and assistant commissioners were included in the sample. A total of 133 respondents were expected, and only 68 (51%) health managers responded to the managers' survey.

Organization of Data Collection

Selection and training of research assistants

Research assistants, including data recorders, were selected and trained. The research assistants were trained in the GDIA methodology, including: data collection techniques, facilitation of FGDs, note-taking, and observation. The research assistants were also taken through IntraHealth International's *Human Subjects Protection Procedures*.

Pre-testing of tools

All the tools were pre-tested in two locations within the districts near Kampala. These were: Wakiso and Mukono districts. One location was a general hospital and the other was an HC IV (Entebbe Grade B Hospital and Mukono HC IV). The outcomes of the pre-test informed the revision of the sampling plan and the data collection tools.

Data collection

The field data collection lasted four weeks between November and December 2011. The research team was divided into five teams, each comprising four team members. The team consisted of a key facilitator of FGDs, a note-taker, and an observer who also supported the team by taking care of the audio recording and making observations as necessary. There were female FGD facilitators and note-takers for female groups, and male facilitators and note-takers for male FGDs.

Quality control in the field

In the field, each team leader took the responsibility to review the questionnaires submitted by the data collectors for accuracy and completeness. This was done at the end of each day. Team leaders worked with each data collector to check completeness and accuracy. Questionnaires with incomplete sections were sorted out and set aside for the research consultant to review and make a decision on how they should be handled. Those found to have whole sections not filled in were left out. This was done on a team-by-team basis with the team leaders. There were 15 questionnaires that were partially filled in which were left out of the count of complete questionnaires.

Data cleaning, coding, entry, and transcription

On return from the field, research assistants reviewed and transcribed FGD notes. This could not be done in the field since most of the field stations did not have an adequate supply of

electricity. Cleaned data from program and staff survey questionnaires were entered into the computer by two data entry clerks.

Data Analysis

Survey data (closed-ended questions)

The data were analyzed using SPSS 19.0 for Windows and Excel Pivot Tables. Data analysis was done following an analysis plan, at univariate and bivariate levels.

Univariate analysis

This focused on responses to a single question at a time. This analysis described the range and average answers that respondents provided to each question. The number of respondents who provided the same response for each question was counted and the totals for each response category were calculated as percentages.

Data from the survey questions and FGDs

Bivariate analysis of responses to closed-ended questions focused on two variables at a time. Cross-tabulations were generated to illustrate patterns between demographic characteristics and particular responses.

Qualitative data within the survey questionnaires

Responses to open-ended survey questions were reviewed to identify themes and a range of responses. The top responses were tallied and presented. Responses to these questions were also grouped into the four dimensions of gender integration (political will, accountability, technical capacity, and organizational culture).

Analysis of FGDs

FGD analysis involved content analysis, with the creation of preliminary codes along the key themes and sub-themes. Main codes were derived from the key themes of the study as per the objectives, and the sub-codes were derived from the nature of responses. The research team then discussed and agreed on the codes, and two people from each team did the coding of the responses. The information under each code was described by initially reading through all the information from the different groups under each code, looking out for similarities across groups, noting the differences, and picking out good quotes that illustrated important points. Summaries of key themes and sub-themes were made, and these were later used in drafting the report.

Composite scores

Composite scores were developed from the staff survey for four dimensions of gender integration/mainstreaming, as measured in: political will; accountability; organizational culture; technical capacity, as per the Commission for the Advancement of Women (CAW) Gender Integration Framework¹⁶. The CAW framework is depicted in **Figure 1**, "The Tree of Gender Integration." **Table 6** defines the components of the gender integration framework.

¹⁶ Committee for the Advancement of Women (CAW), 2003.

Figure 1. The Tree of Gender Integration

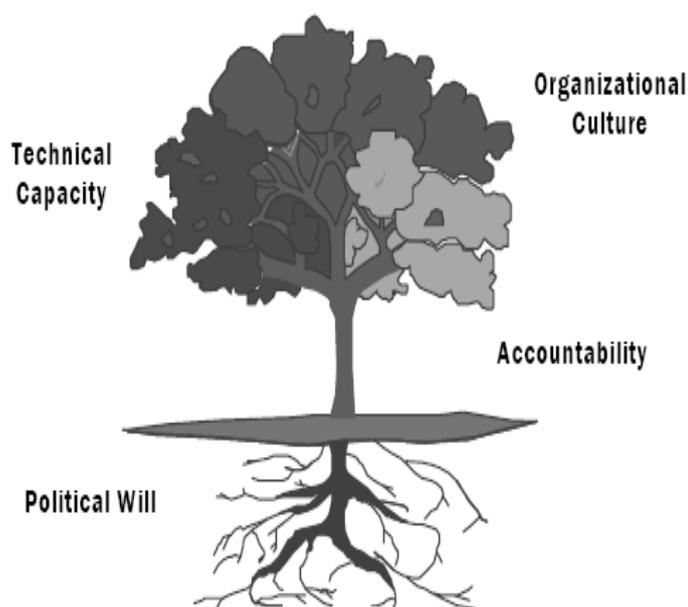


Table 6. Components of the Gender Integration Framework

<p>Political will: The ways in which leaders use their position of power to communicate and demonstrate their support, leadership, enthusiasm for and commitment to working toward gender equality in the organization.¹⁷</p>	<p>Political will constitutes the organizational “roots” of gender integration.</p> <p>Organizational mandate, goals, indicators, strategies, own, manage, senior level, field staff distribution, board of directors/executive team composition , budgets for gender recruiting or activities</p>
<p>Accountability: Mechanisms an organization establishes to ensure it “walks the talk” on gender equality.</p>	<p>Accountability is the trunk of the tree of gender integration.</p> <p>Data, policies, performance appraisal</p>
<p>Technical capacity: The level of individual and organizational competencies needed to promote and advance gender equality in an organization. The “how to” related to gender mainstreaming.</p>	<p>Technical capacity constitutes the branches of gender integration.</p> <p>Gender experts, gender training, gender analysis and integration/mainstreaming guidelines</p>
<p>Organizational culture: The informal beliefs, norms, and codes of behavior in an organization that support or undermine gender equality.</p>	<p>Organizational culture constitutes the foliage (leaves) of the gender integration tree, the manifestations of gender equality/inequality.</p> <p>Organizational practices, procedures, behavioral systems, procedures</p>

Source: InterAction’s Gender Integration Framework

The composite scores were computed following a three-part process:

¹⁷ Political will and accountability are aspects of organizational leadership and governance.

- Identify questions which express each of the four dimensions , i.e., the indicators of political will, accountability, organizational culture, and technical capacity. (See Appendix Bvi for indicators.)
- Sum the scores for each respondent's answer to the question(s) for the selected dimension you are measuring (e.g., political will). Then divide the sum by the number of questions for the selected concept you are measuring. The result is an index score for each respondent.
- To get the index score for the entire staff who completed the survey questionnaire, divide the sum of the individual scores by the total number of questionnaire respondents.

Composite scores were similarly calculated for the extent to which gender is integrated in field programs, based on mean responses to questions on the managers' survey in the following areas:

- Program planning and design
- Program implementation
- Research monitoring and evaluation
- Partner organizations.

Issues in Gender Discrimination Research

Gender discrimination research faces particular measurement challenges: First, gender discrimination may be normalized, so that respondents will not necessarily categorize their experience as discrimination. In this study, we provided behavioral indicators of discriminatory behaviors, as well as definitions for types of discrimination, on the instruments. Second, people may not know they are being discriminated against because they do not have information about it. For example, if wage data are confidential, respondents do not have access to the information that would demonstrate that they are being treated more unfavorably than others in pay; or, recruiters may be biased against certain types of workers, but this may remain covert where official policy requires unbiased, equal opportunity in recruitment. Because of these factors, discrimination research requires a multi-method approach.

Limitations of the Study

- There is a possibility of: a positive response bias, or the tendency of respondents to want to please the surveyor, or to give the "morally correct" answer; a misunderstanding of the concepts; and an unwillingness to respond to a particular question. To mitigate these sources of bias, instruments were pre-tested to improve the validity and reliability of measures. Respondents were also assured of their confidentiality.
- Non-response from a number of respondents selected for the staff survey, and cancellation of questionnaires which were not complete, resulted in a smaller sample than desired.
- Having more female survey respondents resulted in our learning more about female health workers' perceptions (of the experience of gender equality in the public health sector) and less about male health workers' perceptions. Having more male key

informants resulted in our learning more about male recruitment/management personnel's perceptions of equal opportunity, sexual harassment, and affirmative action.

- There were occasional instances of divergence between responses on the multiple choice questions on the staff survey regarding equal opportunity for advancement, and responses in FGDs on the same topic. To deal with such divergences, we triangulated data (for example, drew on the HRIS reports) to arrive at conclusions.

FINDINGS

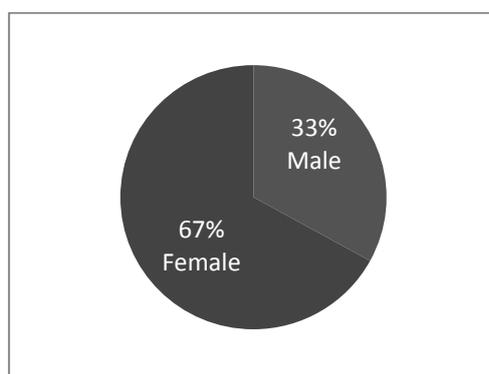
The GDIA's purpose was to assess gender equality in terms of equal opportunity and equal enjoyment of benefits and privileges of employment by women and men working with health public sector. The analysis also explored the existence of staff technical capacity and financial resources for gender mainstreaming in the health sector—particularly in the workforce—and its leadership and governance. The results of the GDIA are presented in this chapter.

Demographic Characteristics of Respondents

Staff survey

The demographic characteristics disaggregated by sex of the general staff survey participants (499¹⁸) are provided in Table (ii) in Appendix E. Sixty-seven percent (67%) of staff survey respondents were female, and 33% were male, as illustrated in Figure 2. A large proportion of the respondents were married females (39.9%), in the age category 31-40 years, who completed diploma level of education (27.8%). Almost a third of staff survey respondents worked in the national referral hospital (31.2%) and about one-quarter at regional referral hospitals (25.3%). The majority of the participants were in the “permanent” category (83.3%) of employment. The largest single category of respondents was nurses (46.2%), followed by midwives (28.8%), then medical doctors (11.5%). The characteristics of the sample indicate that the health sector is dominated by female workers.

Figure 2. Staff Survey Respondents by Sex



Health managers

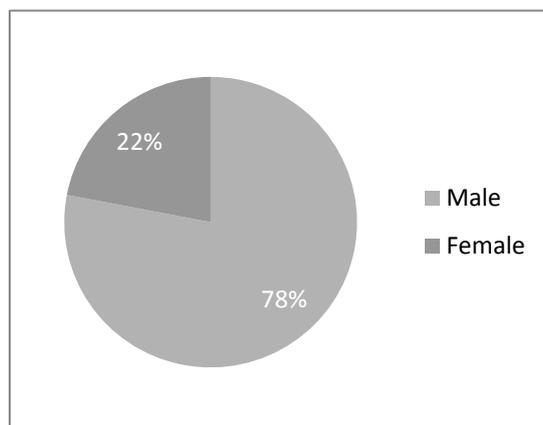
The majority of health managers who responded to the health managers' survey questionnaire were male (56.5%), and 43.5% were female.

Key informants

Key informants included personnel in positions related to the recruitment, hiring, and supervision of health staff at national, district, and sub-county levels. At the national level, the key informants were drawn from the Health Service Commission (the commissioner and assistant commissioner). The political appointees of the Health Service Commission were not yet appointed at the time of the study. Figures 3 and 4 indicate the distribution of key informants by sex.

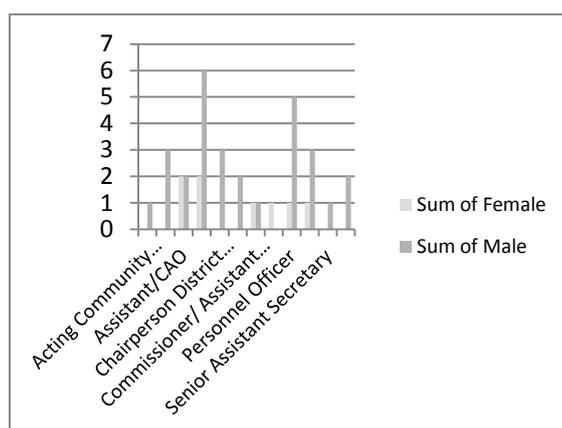
¹⁸ The number of respondents varied depending on the completeness of the questionnaires obtained from the field.

Figure 3. Characteristics of Key Informants by Sex
(N=37)



Source: Key informant secured questionnaires

Figure 4. Characteristics of Key Informants by Position Title
(N=37)



Source: Key informant secured questionnaires

Out of a total of 37, only 8 key informants were female, who held mainly positions of assistants in the district or sub-county while 29 were male and in top management positions, indicating that the majority of officers working in these recruitment/hiring/management positions are male.

Gender Equality in the Policy and Legal Environment

(See Appendix C for List of documents reviewed)

The Constitution of Uganda (1995) is the overarching national framework for ensuring the attainment of gender equality and women's empowerment. It recognizes gender equality as a fundamental human rights principle; provides for affirmative action to redress imbalances including those based on gender and specifically recognizes the rights of women¹⁹ to reach

¹⁹ Constitution of the Republic of Uganda art. XXXIII (1995)

their full potential in social, economic, and political activities; and calls for the outlawing of customs, traditions, and practices that undermine the welfare, dignity, and interests of women. Article 21 (1) states that “all persons are equal before and under the law in all spheres of political, economic, social and cultural life, and in every other respect and shall enjoy equal protection of the law.” Article 32 provides for affirmative action in favor of marginalized groups and states that “the State shall take affirmative action in favor of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them.” Article 33 (5) states that “women shall have the right to affirmative action” while Article 33 (1) states that “women shall be accorded full and equal dignity of person with men.” Article 33 (2) enjoins the State to provide facilities and opportunities for enhancing the welfare of women and to enable them to realize their full potential.

Uganda also has a national gender policy developed in 1997 and revised in 2007 that provides a framework and strategies for gender mainstreaming and women’s empowerment, in line with national, regional, and international commitments on women’s rights to which Uganda is signatory. These include: The Convention on the Elimination of All Forms of Discrimination Against Women (1979), the United Nations Declaration on Violence Against Women (1993), the International Conference on Population and Development Plan of Action (1994), the Beijing Declaration and Platform for Action (1995), the Millennium Declaration (2000), and the Commonwealth Plan of Action on Gender and Development (2005-2010). Uganda is also signatory to three International Labour Organization (ILO) gender equality standards and has incorporated them in the National Employment Act (2006). These standards relate to equal remuneration, equal opportunity, non-discrimination, and maternity protection. However, Uganda has not ratified the ILO C. 156 relating to “Workers with Family Responsibilities.”

The 2007 Uganda gender policy includes an affirmative action clause and characterizes affirmative action as “bridging the gender gaps in the various development sectors that requires preferential attention for the disadvantaged,” adding that “[a]ffirmative action as enshrined in the Constitution will be pursued to redress historical and present forms of discrimination against women and girls in the political, economic and social spheres”²⁰. Some progress has been registered in the attainment of gender equality and women’s empowerment in Uganda. For example, Uganda was ranked 40th out of 134 countries in the 2009 Gender Gap index²¹. The percentage of women in parliament currently stands at 33.4%, which is however considerably lower than the 50% parity target set by the African Charter on Democracy, Elections and Governance. Women’s representation in parliament has been buoyed by affirmative action since 1995 and a one-third quota in local governments since 1997.

The Equal Opportunities Commission established by an Act of Parliament (The Equal Opportunities Commission Act 2007) was put in place to address discrimination and inequalities across the board in the Ugandan society. The mandate of the Commission is specified as, “An Act to make provision in relation to the Equal Opportunities Commission pursuant to articles 32

²⁰ Ministry of Gender, Labour, and Social Development. 2007. National gender policy. Kampala, Uganda: Ministry of Gender, Labour, and Social Development

²¹ The Gender Gap Index is designed to measure gender-based gaps in access to opportunities and resources on political empowerment, economic participation and opportunity, educational attainment, and on health and survival.

(3) and 32 (4) and other relevant provisions of the Constitution; to provide for the composition and functions of the Commission; to give effect to the State's constitutional mandate to eliminate discrimination and inequalities against any individual or group of persons on the ground of sex, age, race, colour, ethnic origin, tribe, birth, creed or religion, health status, social or economic standing, political opinion or disability, and take affirmative action in favor of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom for the purpose of redressing imbalances which exist against them; and to provide for other related matters."

In the public service, which is not regulated by affirmative action, it is reasonable to wonder whether women are underrepresented, particularly in senior positions. Despite the existence of the Equal Opportunities Commission, inequalities in the public service in the form of low numbers of female employees, especially in leadership and senior staff positions, remain glaring²². An indication of this is found below, in **Table 7**.

As a step toward addressing inequalities, the Uganda Public Service has, under the Public Service Reform Program (PRSP), developed guidelines for mainstreaming gender in human resources management focusing on gender-responsiveness (including affirmative action) recruitment; remuneration; training and staff development; deployment; working environment; and managerial decision-making. These guidelines, issued in April 2011, are yet to be implemented by government ministries. The Gender Policy 2007 and the Employment Act 2006 provided the framework for the guidelines. More recently (2012) regulations on sexual harassment have been developed to give effect to the provisions on sexual harassment in the Employment Act.

The MOH²³ is guided by the National Health Policy which is operationalized through the HSSIP and annual ministerial statements presented to parliament. The second National Health Policy (NHP II) is informed by the National Development Plan (NDP) and the Constitution of Uganda (1995). The NHP II (2010/11 – 2019/20) and the current HSSIP (2010/11 – 2014/15) define the long- and medium-term agenda for the health sector in Uganda. A key component of the HSSIP is the focus on strengthening HRH to support the health sector to deliver on its mandate. However, neither the NHP II nor the HSSIP provide for equal opportunity, affirmative action, or gender equality in the health workforce, and there are no indicators to that effect. The public health sector also has no gender policy and strategy, as called for by the National Gender Policy.

The review of documents demonstrated political will to promote gender equality at the highest level of government, but the policies and laws have not yet been operationalized at the public health sector level.

The concentration of men and women in health sector jobs

Where men and women are concentrated in the workforce can provide insight into the extent of equal opportunity for occupations and jobs. The GDIA sought to understand the patterns of

²² Ministry of Public Service: Circular Standing Instructions No. 2 of 2011 – Guidelines for Gender Mainstreaming in Human Resource Management, April 2011.

²³In this report, the Ministry of Health (MOH) refers to the public health sector including national-level and district-level health facilities. The private health sector is not included, nor faith-based organizations.

occupational/job concentration, and the extent to which the concentration of men and women in types of jobs and at different hierarchical levels in the public sector was reflected in the health sector.²⁴

Table 7. Concentration of Ugandan Public Service Employees by Sex as of April 2011

Uganda Public Civil Service by Sex and Category ²⁵			
Category	Total employees	Percentage of men	Percentage of women
Senior management (U1) ²⁶	808	78	22
Middle management (U2-U3)	4,180	84	16
Graduate and diploma Entry (U4-U5)	59,973	72	28
Lower level (U6-U8)	206,893	65	35
Total	271,854	67	33

Source: Ministry of Public Service, Guidelines for Gender Mainstreaming in Human Resources

Table 7 shows that there is a preponderance of men concentrated at all levels of jobs, which suggests a predominantly male civil service. Men also predominate in senior and middle management (U1 and U2-U3), graduate, and diploma levels, at 78%, 84%, and 72%, respectively. These are presumably the higher paying jobs. There are fewer women than men at every level and category of the civil service, with the largest concentration of women (35%) at the U6-8 level. It should be noted that the lowest level of women's representation is at middle management level (16% in U2-U3), a critical level to draw from in promotion to senior management level.

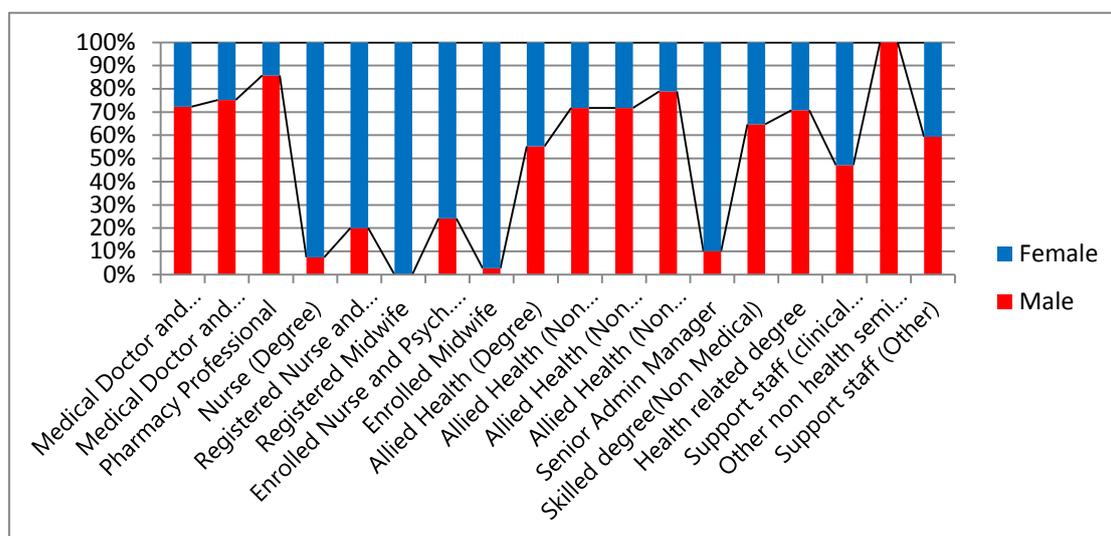
Analysis of data from the 2005-2020 Uganda Human Resources for Health Strategic Plan and the MOH HRIS was undertaken to identify the patterns of concentration of women and men in public health sector jobs.

²⁴ This was an exploration of the worldwide phenomenon called *occupational segregation*. Horizontal occupational segregation refers to the concentration of women in a narrower range or type of work while men are concentrated in technical, management, or strength-based jobs. Vertical segregation refers to a concentration of women in lower grade and less well-paid jobs while men are concentrated in managerial and leadership jobs.

²⁵ Ministry of Public Service. 2011. Circular standing instructions No. 2 of 2011: Guidelines for gender mainstreaming in human resource management. Kampala, Uganda: Ministry of Public Service.

²⁶ The Uganda civil service scale U8 – U1 represents both salary scale and category of employment.

Figure 5. Concentration of Men and Women in Uganda’s Public Health Workforce Based on 18 Job Categories
(N=6,450)



Uganda Human Resources for Health, Strategic Plan 2005 – 2020, June 2007

Figure 5 shows that women are most concentrated in nursing and midwifery positions of all types (registered, enrolled, etc.) and in administration—a narrow range of jobs. Men are found in a broader range of jobs, from medical doctors and dentists (on the left of the graphic) to allied health (middle of the graphic) to support staff jobs (at the right of the graphic).

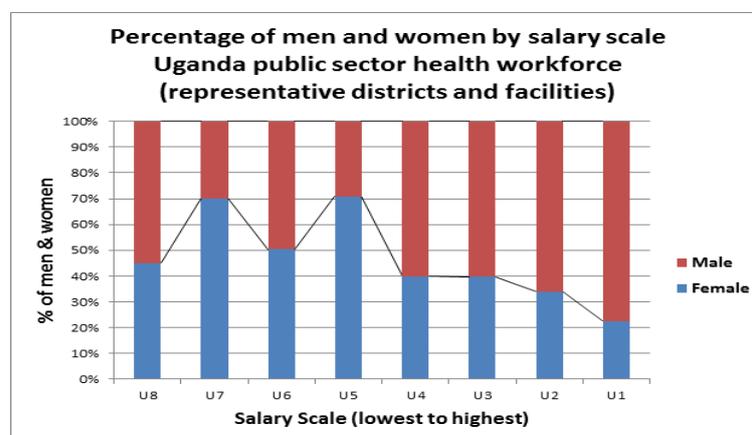
Table 8. Percentage of Women and Men Concentrated in Public Health Sector Workforce Jobs in Eight Districts and Four National-Level Facilities
(N=6,450)

Salary Scale	Number of Employees	Male	Female
Senior management level (U1)	133	77%	23%
Middle management level (U2-U3)	326	63%	37%
Graduate and diploma entry level (U4-U5)	2,406	39%	61%
Lower level (U6-U8)	3,585	43%	57%
Total	6,450	43%	57%

Source: MOH HRIS, May 2012

Table 8 depicts a pattern of vertical concentration of male workers at U1-3 levels similar to the pattern found in the civil service, especially in the concentration at the U1 level of top management (77% male and 22% female). The percentages men and women at the U3-U2 middle management/salary level (63% and 37%) still follow the pattern of the civil service, though less dramatically so. This table also shows that there are more women at the lowest level (U8) as well as in the lower/middle categories (U7 – U4)—the technical categories where most of the nurses and midwives fall. The pattern of vertical concentration of male workers found in civil service jobs therefore appears to be reflected in the public health sector. **Figure 6** is a graphic representation of this.

Figure 6. Percentage of Men and Women Concentrated by Salary Scale and Category in the Ugandan Public Health Sector Workforce in Eight Districts and Four National-Level Facilities
(N=6,450)



Source: MOH: HRIS May 2012

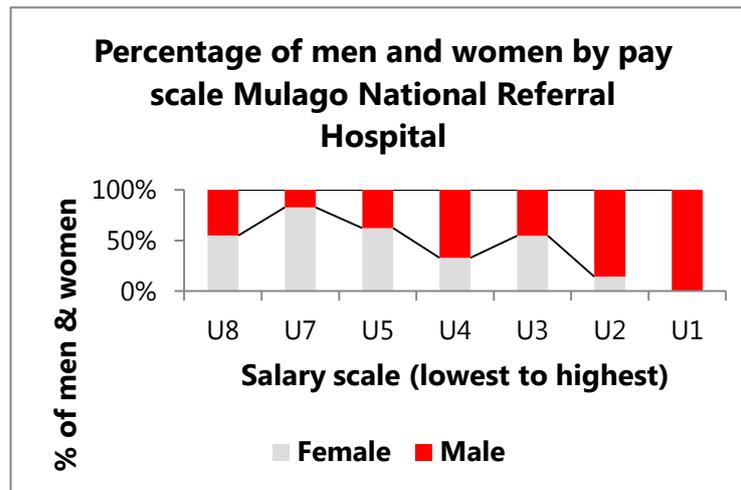
Table 9. Number of Health Workers by Sex at National Health Institutions

Institution	Female	Male	Grand Total
Ministry of Health Headquarters	187	310	497
Mulago National Referral Hospital	1455	731	2186
Butabika National Referral Hospital	233	168	401
National Blood Transfusion Services	105	135	240
Uganda Virus Research Institute	37	58	95
Grand total	2017	1402	3419

Table 9 shows that there are more female health workers than male in the health workforce in national health institutions. At Mulago National Referral Hospital, the largest health facility in the country, the number of female health workers is almost twice that of male 1,455 women and 731 men.

However, **Figure 7** shows that the greatest concentration of male health workers at Mulago National Referral Hospital is at the U1 level—that is, almost three-quarters of the top management consists of men, with large concentrations of women at the mid (U7) and U5 (lower) levels.

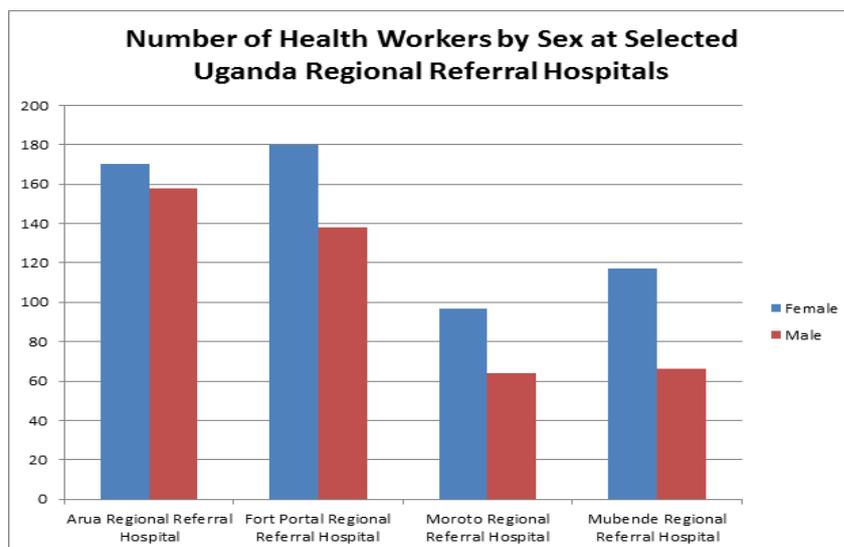
Figure 7. Percentage of Women and Men by Pay Scale at Mulago National Referral Hospital (N=2186)



Source: HRIS May 2012

Figure 8 shows that there are more female than male health workers at the four regional referrals sampled for the study.

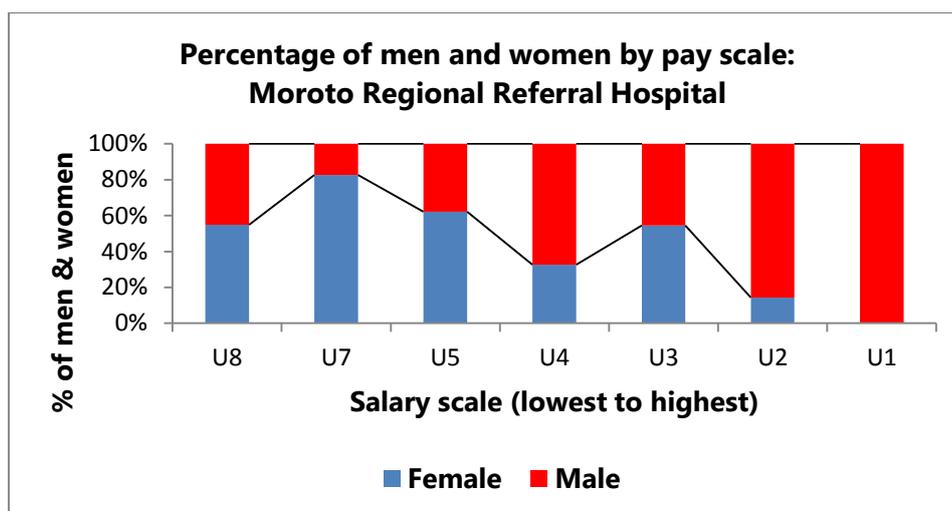
Figure 8. Number of Health Workers by Sex at Uganda Regional Referral Hospitals (n=1362)



Source: MOH: HRIS May 2012

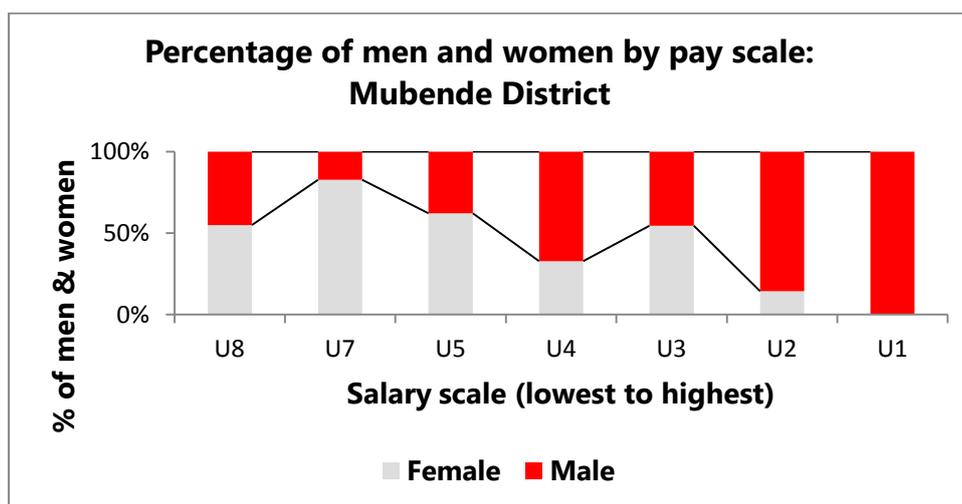
Figures 9 and 10 also graphically show a similar pattern of vertical concentration of men and women in two of the regional hospitals (Moroto in the northeast and Mubende in the central region), in which male health workers are concentrated in the top two salary grades (U1 and 2), and female health workers are concentrated at the lower end of the salary scale (U5-U8). Thus, although there is a preponderance of women in the health workforces of Moroto and Mubende regional referral hospitals, men predominate in middle and senior management and the better-paid positions.

Figure 9. Percentage of Men and Women at Moroto Regional Referral Hospital (n=161)



Source: MOH HRIS May 2012

Figure 10. Percentage of Men and Women at Mubende Regional Referral Hospital (n=183)



Source: HRIS May 2012

The GDIA findings on horizontal and vertical concentration of male and female workers in both the civil service and public health sector demonstrate a link between type and level of job and wages, and suggest a gender wage gap in both these sectors. These findings raise questions about real equality of opportunity in the health workforce and the possible contributors to unequal opportunity. Relevant findings about the possible contributors to inequality of opportunity are treated in the next section.

Staff and Key Informant Perceptions of Equal Opportunity and Affirmative Action

Equal opportunity

Uganda's 2007 Equal Opportunities Employment Act describes equal opportunities as "having the same treatment or consideration in the enjoyment of rights and freedoms, attainment of access to social services, education, employment and physical environment...or the participation

in social, cultural and political activities...regardless of sex, age, race, colour, ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability." Affirmative action, an equal opportunity strategy, consists of measures to ensure that groups that have been excluded in the past receive equal educational and employment opportunities to enter all fields and has been defined in the 2011 MOPS Gender Mainstreaming Guidelines as "[d]eliberate actions taken to promote gender equality." As noted earlier, the 1995 Constitution of Uganda mandates that "the State shall take affirmative action in favor of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them."

If a policy and legal environment so favorable to equal opportunity and affirmative action exists—as it does in Uganda--what might account for the unequal opportunity apparent in the civil service and health sector (HRIS) data? And to what extent are opportunities actually perceived as equal or unequal in the public health sector?

Equal opportunity perceptions from focus group discussions

Responses to questions about equality in recruitment, hiring, and promotion varied, with some participants observing that there are "male" and "female" jobs in health services. FGD participants pointed out that women dominate the nursing and midwifery jobs while men dominate clinical service jobs such as medicine. For example:

"Courses like nursing [and] midwifery men are not in. Men only qualify in gynecology. We also need men to be involved in midwifery. That will bring about equality. It's not clear whether they should be involved or not. How would a male midwife be referred to? The job title needs to change." —Male respondent, non-management

Participant responses from both male and female management and non-management FGDs indicated that senior and management positions in all job categories are seen to be skewed toward men. Female FGD participants perceived that they had limited chances for promotion and were of the view that recruitment and promotion to senior positions was actually biased toward men and that female health workers had not experienced efforts by the MOH to bridge the gender gap at higher levels of employment. The FGDs also brought out beliefs or opinions about men and women that probably contribute to unequal opportunity in the workforce (in **bold**). The examples that follow show the range and acuity of these perceptions.

"It depends on what is being interviewed for. Take an example of the nursing profession where female are preferred: male[s] are ignored. But if the position is for a clinical officer, male[s] are preferred because they are **strong and better administrators**, i.e., in the field the in-charges are men; but again for the senior posts in nursing, females are considered [more often] than male[s]." —Male respondent, non-management

"There are fewer women in top management positions: for example, in-charges at HC IV and HC III, even hospital directors tend to be men. [W]omen are not always considered in these higher posts." —Male respondent, non-management

"Men tend to be more confident than women, so it is most likely that [the] MOH would hire a man for position of director." —Female respondent, non-management

When women are put in higher positions, they tend to rule using **emotions** and not what is on the ground so they are bound to **making more mistakes**. —Female respondent, non-management FGD

Management and non-management staff, women and men, were asked about the likelihood of women or men being recruited for certain positions. The possibility of differential treatment and preferences for men or women emerged. FGD participants were asked, "If there were two persons, a man and a woman, equally qualified for the position of 'director,' who would be more likely to be given the job by the recruiting authority?" FGD participants were emphatic that in such circumstances, a man was more likely to get the job of director than a woman:

"Uganda being a country that is still in the process of uplifting women, it is most likely that a man would take the job since the process of uplifting women is still ongoing, and there are still some **doubts about women's performance** at [the] leadership level." —Female respondent, non-management

"A man would be chosen because [men] are believed to be **more productive and better decision-makers** than the women." —Female respondent, non-management

"A man is more likely to be hired because for us women we think that doing a first course is enough whereas the men will always upgrade, and this gives them a better chance to be hired for higher posts." —Female respondent, non-management

"A man is more likely to be hired because people tend to **despise women**." —Female respondent, non-management

"Men have more chances for promotion when they have been in the post long enough and when they have the papers." —Female respondent, non-management

"A woman should be given [sic] but in most cases men are given [sic]." —Female respondent, management

FGD participant responses indicated that society still considered men to be more suited for higher positions of responsibility and to be better decision-makers and managers: .

"It's also very **hard for men to work under women**, so it is most likely that a man is hired." —Female respondent, non-management

"Still a man would be given such a job because **they think women cannot manage**." —Female respondent, management

Men's FGDs elicited mixed responses. Some individuals maintained that a woman would not be suitable for such a job while others said that a woman, if given such a job, would still perform as well as a man, or even better. The operation of male preference in recruiting, hiring, and promoting for senior positions appears to be based on deeply ingrained gender beliefs and norms, which limit women's real opportunities:

"The rate at which a man works at his desk is not the same as the woman. Men are **faster in thinking** than the women. They also tend to make decisions faster than women." —FGD male respondent, non-management

“Women have a lot of **mood swings**, periods, maternity, which affect their work negatively. In a hospital, you expect a **versatile** person—[this] description fits a man more in such positions as director.” —Male respondent, non-management

“The current deputy is the first woman in the history of this hospital, but all along, it has been men.” —Female respondent, management

“I believe that that the MOH has gone past all that: they don’t consider that, for example, the executive director of this institution is a lady and all the four departments are headed by women.” —Male respondent, management

“I think any sex can take the job (of director) because they (women and men) are equal and have similar qualifications.” —Male respondent, management

“Those were things of the past because here most of the health workers do not have such kind[s] of belief[s]. Women are also capable of doing things that men can do.” —Male respondent, management FGD

The FGD responses suggest that contributors to unequal opportunities include: the stereotype of women as nurses; negative beliefs about women as managers; positive beliefs about men as decision-makers; and pregnancy as a factor that disqualifies women for higher levels of management (see section, “Pregnancy and maternity”). However there are countervailing “voices” that emerge from the FGDs that support change in this area in favor of more equal opportunity.

Staff Perceptions of Equal Opportunity in Human Resources Policies

The staff survey asked whether MOH human resources policies promote fair evaluation, equal pay for equal work, and equal access to in-service training. The majority (77.4%: Table 10) of staff survey respondents indicated that policies fully promote equal pay and that half (50.1%) perceived that policies fully promoted equal access to in-service training opportunities. Finally, slightly more than a third (36.2%) of staff respondents indicated that evaluation policies fully promoted fairness. These responses suggest that there are positive staff perceptions of these particular MOH human resources policies.

Table 10. Staff Perceptions of the Extent to Which Public Health Sector Human Resources Policies Provide for Equal Opportunity in Relation to Fair Evaluation, Equal Pay, and Access to In-Service Training
(N=499)

Extent	Strategies to recruit women	Strategies to promote women	Fair evaluation	Equal pay	Access to in-service training	Equal chance for being hired
Not at all	95 (22.7)	60 (14.5)	49 (11.0)	27 (5.8)	42 (9.1)	50 (11.0)
Limited extent	50 (12.0)	68 (16.5)	63 (14.1)	18 (3.9)	47 (10.2)	48 (10.5)
Moderate extent	69 (16.5)	82 (19.9)	76 (17.0)	18 (3.9)	65 (14.1)	77 (16.9)
Significant extent	84 (20.1)	71 (17.2)	97 (21.7)	42 (9.0)	76 (16.5)	109 (24.0)
Fully	120 (28.7)	132 (32.0)	162 (36.2)	360 (77.4)	231 (50.1)	171 (37.6)
Total	418 (100)	413 (100)	447 (100)	465 (100)	461 (100)	455 (100)

Source: Staff survey responses

Table 10 indicates positive responses (i.e., fully or to a significant extent) on strategies to recruit and promote women, fair evaluation in respect to gender, equal pay for work of same value, access to in-service training, and an equal chance of being hired. However, FGD responses contradicted the positive perceptions of the staff survey on equal chances of being hired, at least for top management jobs. The FGD findings suggested that the health workers in the GDIA sample in fact perceived the unequal and limited opportunity, especially related to moving into nontraditional “male” and “female” jobs, for women to move up the ladder of seniority--the latter finding being supported by the HRIS occupational data analysis.

Workers with family responsibilities and the integration of work and family

Competing demands of work and family may lead to health worker lateness, absenteeism, lower concentration or productivity, or dismissal. Incompatibility of working hours with family responsibilities may cause recruitment or attrition problems. If family responsibilities impede a health worker’s career progression, limit workforce participation, and prevent use of skills and education, the health system is in danger of waste and inefficiency in the management of its human resources. There is abundant evidence from all over the world that caring for children and other dependents and doing domestic tasks can be a major handicap in the labor market, restricting options and limiting earning capacity. What is referred to as “work/family conflict” is a major contributor to *women’s disadvantage* in the labor market—preventing equal opportunity and treatment—since the constraints and disadvantages that family responsibilities bring in the labor market fall mainly on women.²⁷

The GDIA did find evidence of work/family conflict in the FGDs, and a source of it in the human resources (HR) policy environment.

Pregnancy and maternity

Focus group discussions elicited evidence of disadvantages linked to women’s roles as mothers or bias against pregnant workers which would prevent women from progressing in their careers or accessing management positions:

“Women always have interruptions like pregnancy, breastfeeding while men keep advancing because they don’t have obstacles.” —Female respondent, non-management FGD

“If I were to be part of the interviewers in recruiting for a hospital director, I would appoint a man. Women have other issues like pregnancy and would need to go for maternity leave, etc. Therefore a woman would not be suitable for such a high position that requires a lot of responsibility.” —Male respondent, non-management FGD

Work/family conflict

“Women have a lot of work at home. A woman cannot report on duty when her child is sick.” — Male respondent, non-management FGD

“There is no gender equality when it comes to maternity and paternity leave. Women are given many days, and men are only given four days. Does the Ministry know that even men want to take care of the family when a spouse gives birth?” —Male respondent, non-management FGD

²⁷ Any worker with family responsibilities may experience this disadvantage in comparison to workers without family responsibilities.

These FGD responses may also shed light on the vertical concentration of men and women in health sector jobs demonstrated earlier through the HRIS reports. It is therefore reasonable to ask if or how lifecycle events like pregnancy, maternity, paternity, and the assumption of family responsibilities are reflected in HR policies: To what extent are health workplace policies sensitive to the human lifecycle, and are “family-friendly?” (Appendix D “Characteristics of a Family-Friendly Workplace”)

HR policies and practices that govern family and work integration

Some characteristics of family-friendliness include flexible time schedules, paid maternity and paternity leave, protection of female staff members from dismissal when they have had a baby, being able to return to the same job or another job of equal status and pay after childbirth, breastfeeding breaks treated as work time, child care, or personal leave. **Table 11** shows how public health sector staff members perceive the HR policy environment with respect to family-friendliness.

Table 11. Staff Perceptions of the Extent to Which HR Policies and Practices Support Pregnancy and Family Responsibilities
(N=499)

Extent/scale	Flexible schedule	Maternity leave policy	Encourage maternity leave	Paternity leave policy	Encourage paternity leave	Child care leave	Paid pregnancy leave	Health protection during pregnancy	Protection from dismissal after maternity leave
Not at all	96 (20.9)	14 (3.0)	35 (7.5)	162 (35.2)	205 (45.7)	336 (76.4)	178 (39.6)	217 (48.8)	66 (14.6)
To a limited extent	121 (26.3)	17 (3.7)	39 (8.4)	96 (20.9)	78 (17.4)	34 (7.7)	14 (3.1)	70 (15.7)	44 (9.8)
To a moderate extent	95 (20.7)	28 (6.0)	45 (9.7)	46 (10.0)	50 (11.1)	26 (5.9)	13 (2.9)	61 (13.7)	54 (12.0)
To a significant extent	88 (19.1)	55 (11.9)	84 (18.1)	50 (10.9)	50 (11.1)	21 (4.8)	34 (7.6)	37 (8.3)	90 (20.0)
Fully	60 (13.0)	349 (75.4)	261 (56.3)	106 (23.0)	66 (14.7)	23 (5.2)	211 (46.9)	(13.5)	197 (43.7)
Total	460 (100)	463 (100)	464 (100)	460 (100)	449 (100)	440 (100)	450 (100)	445 (100)	451 (100)

Source: Staff survey

Table 11 shows that an overwhelming majority of staff survey respondents (75.4%) perceived that the maternity leave policy “fully” exists, that taking maternity leave is encouraged “fully” (though this was a smaller majority at 56.3%), and that female health workers who took maternity leave were “fully” protected from dismissal after maternity leave. However, there seems to be a perception that paid pregnancy leave exists “[n]ot at all” for an important minority of respondents (39.6%). This perception should be further explored, and corrected, if there is in actuality paid maternity leave for all workers.

That 76.4% of respondents perceived child care leave to exist “not at all” seems to point to an actual gap in family-friendliness in health workplaces. Also, taken together, almost half of the staff survey sample (47.2%, or 20.9% + 26.3%) perceived flexible scheduling to exist either “not at all” or “to a limited extent,” respectively.

Only 23% of respondents perceived that paternity leave existed “fully” for fathers²⁸. Slightly more than one-third of respondents (35.2%) indicated that paternity leave existed “not at all,” and 45.7% perceived that paternity leave was encouraged “not at all.”

Table 12. Staff Perceptions of the Extent to Which HR Policies and Practices Support Pregnancy and Family Responsibilities
(N=499)

Extent/scale	Same job after maternity	Breastfeed breaks	Sexual harassment policy	Enforce sexual harassment policy	Women recruitment strategy	Women promotion strategy
Not at all	13 (2.8)	259 (56.7)	281 (66.6)	276 (66.0)	95 (22.7)	60 (14.5)
Limited extent	19 (4.1)	59 (12.9)	41 (9.7)	46 (11.0)	50 (12.0)	68 (16.5)
Moderate extent	19 (4.1)	45 (9.8)	29 (6.9)	33 (7.9)	69 (16.5)	82 (19.9)
Significant extent	57 (12.4)	46 (10.1)	33 (7.8)	29 (6.9)	84 (20.1)	71 (17.2)
Fully	353 (76.6)	48 (10.5)	38 (9.0)	34 (8.1)	120 (28.7)	132 (32.0)
Total	461 (100)	457 (100)	422 (100)	418 (100)	418 (100)	413 (100)

Source: Staff survey

Table 12 offers further insight into staff perceptions regarding the extent to which HR policies and practices support pregnancy and family responsibilities. Key findings here include: the vast majority (76.6%) of respondents perceive that women can have the same job after maternity leave to a full extent, but a majority (56.7%) of respondents perceive the existence of breastfeeding provisions to be “not at all.”

Some staff survey questions focused on “woman-friendliness” of health workplaces. For example, the findings on the sexual harassment policy and its enforcement at workplaces—66.6% and 66% of respondents, respectively, perceived these to be “not at all”—indicates a staff perception that no policy or code exists or is enforced to govern conduct in this area (Also, see section on “Sexual harassment as an indicator of gender inequality and poor workplace climate”, the GDIA findings on sexual harassment). Interestingly, almost a third (32%) of survey respondents perceived that a women’s promotion strategy exists “fully.”

The foregoing FGD and survey findings, taken together, suggest that GDIA participants do not perceive workplace policies and practice to be fully supportive of work/family integration (“family-friendly”) nor are policies fully “woman friendly.” It seems reasonable to conclude that:

- Female health workers especially experience work-family conflict unrelieved by a full range of family-friendly policies and provisions in workplaces. Some men want increased paternity leave. Workplaces are therefore not really family-friendly when they have:
 - No policy on flex-time (especially for pregnant women and breastfeeding mothers or fathers who need to provide child care and other parental responsibilities)

²⁸ The MOPS Standing Orders provide 60 working days of maternity leave for mothers and 4 days paternity leave for men whose spouses have had a baby.

- No official breaks for breastfeeding mothers
- No paid child care leave
- Very few days (only four) provided for male employees for paternity leave.
- The absence of sexual harassment policy and reporting systems renders some health workplaces woman-“unfriendly.”
- Public sector health workplaces need family- and woman-friendly HR policies and an affirmative action strategy to lessen (especially) female workers’ disadvantage in the workforce and to equalize opportunity.

Affirmative Action

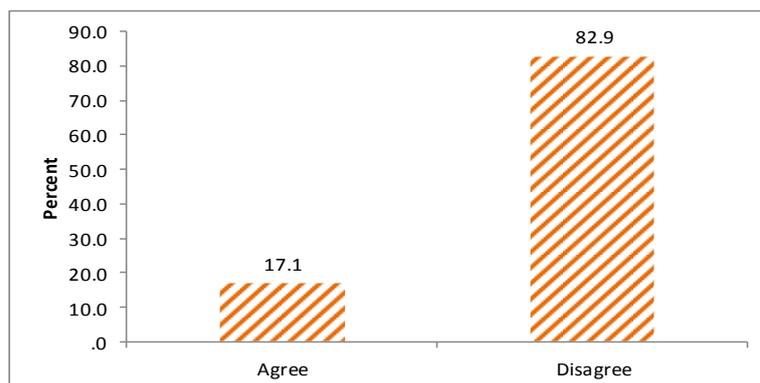
What do hiring managers and recruitment personnel believe about equal opportunity, gender equality, and affirmative action? Key informants were presented with “agree” or “disagree” statements related to equal opportunity, affirmative action, gender discrimination, and inequality, on which the key informants were asked to take a position. The positions taken by the key informants are presented below, along with reasons and explanations.

Accommodating women’s needs in the workplace

A statement about accommodating women’s needs in the workplace was made to the key informants: Do you agree or disagree with the following statement: *“The burden of accommodating women’s needs in the workplace is too costly and inefficient” (e.g., maternity leave, flex time, job sharing, time off for taking children for immunizations, etc.).*

Most of the key informants (82.9%) disagreed with the statement as indicated in **Figure 11**. This may suggest that key informants, some of whom are in positions of hiring the health workforce, would have positive perceptions of family-friendly policies.

Figure 11. Key Informants’ Perceptions on Accommodating Women’s Needs in the Workplace
(N=37)



Source: Key informant interview guide

The reasons advanced by key informants to support their perceptions included:

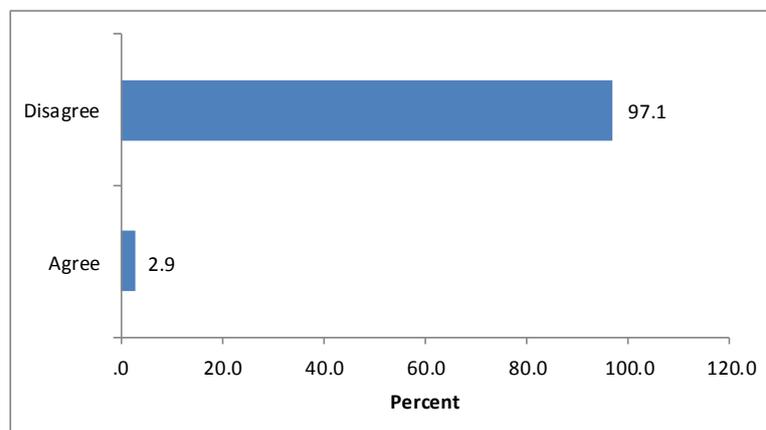
- “It is not a burden but being gender-sensitive.”
- “Some women’s needs are natural, like maternity leave; there is no control over such circumstances.”

- “These needs show how a woman gets double burden, but the burden can be shared with their spouses.”
- “These are not burdens but necessities in life. Who does not need children, and who is to look after them?”
- “If women are put to work, it will be hard to balance work and those related incidences.”
- “With proper staffing and planning, this can be balanced.”
- “It does not affect much of the women’s work because it is not done all the time.”
- “Irrespective of such needs, women do deliver targeted outputs at work.”
- “Since they contribute to society, it’s not a burden.”
- “Constitutional rights and standing orders allow for women to be employed equally as men.”
- “Men could shift to fill in these gaps.”
- “The duty roster should be organized to close such gaps.”

Investing in training and promoting women at work

The following statement was presented to key informants: “It is risky to invest in training and promoting women at work because they are not as committed to their jobs as men” (agree or disagree). **Figure 12** shows that the majority of the participants (97.1%) disagreed with the statement.

Figure 12. Perceptions of Key Informants on Investing in Training and Promoting Women at Work (N=37)



Source: Key informant interview guide

Some of the reasons for the strong disagreement with the statement included:

- “Over the years we have seen women excel in various capabilities when trained well and given time to perform. Therefore, there is no risk in investing in women.”
- “Women too can work well if empowered with the necessary tools.”
- “Women are hardworking and committed to their work more than men.”

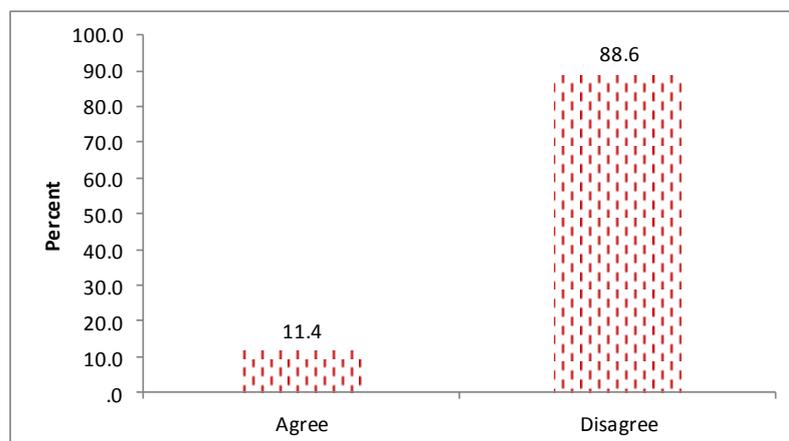
- “Women just like men can be resourceful, committed, and hardworking. Therefore, they should not be discriminated against.”
- “Women are not as adventurous as men and are more likely to stick to a job if conditions are stable.”
- “If women are trained they can do better work than men.”
- “Women need to be employed to avoid the discrimination.”
- “It is good to employ women because they can supplement the family income; one woman trained changes a lot in society.”

These findings indicate that there is support among some of the people entrusted with recruiting and hiring health personnel for investing in training women and promoting them.

Advancement of men in their jobs

The majority of the participants (88.6%) disagreed with the statement: “If men spend/devote most of their lives to their careers, then it is only fair that they should advance more quickly in their jobs than women.”

Figure 13. Key Informants’ Perceptions on Whether Men Should Advance in Their Careers More Quickly Than Women
(N=37)



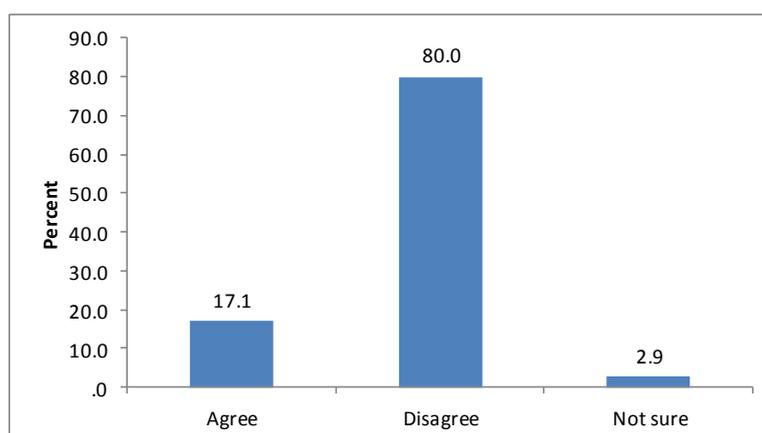
Some of the explanations given for the level of disagreement (Figure 13) included:

- “Devotion to work is not only for men; any devoted person must advance regardless of the[ir] sex. A platform for both should be created.”
- “Devotion to work depends on character, not gender.”
- “Women should be given chance[s], and advancement should be given basing on merit for both sexes.”
- “Women who are employed work as well as men do.”
- “Fairness is necessary for women too to advance.”
- “It has been proved that it is necessary for both sexes to advance accordingly for a more productive organization and nation at large”

Role of affirmative action

When asked if they agreed or disagreed with the statement: "Affirmative action policy often puts managers in the position of hiring non-deserving or unqualified people," an overwhelming majority (at 80%) of key informants disagreed with the statement, 17.1% agreed, and 2.9% were not sure (Figure 14).

Figure 14. Key Informants' Perceptions on Affirmative Action Policy as Often Putting Managers in Position of Hiring Non-Deserving or Unqualified People
(N=37)



Key informants' reasons for support of affirmative action (Figure 14) included:

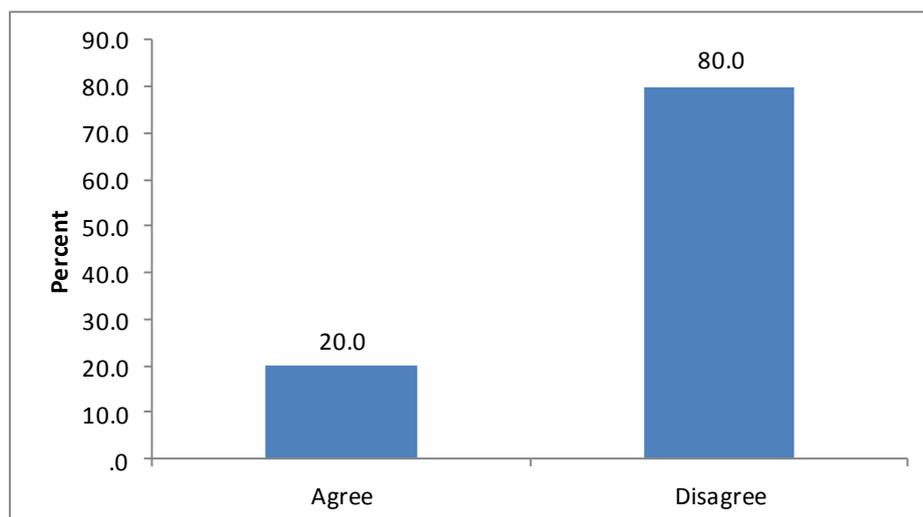
- "Affirmative action addresses issues of tradition, culture, marginalization, and discriminated persons who may at times be better qualified."
- "It depends on how affirmative action is applied; if two people tie in their score, always a woman is given the post."
- "Affirmative action policy is still required for women who still have so many responsibilities."
- "It enables the marginalized groups to have opportunities that promote their empowerment socially and politically."
- "It helps to balance gender between men and women."
- "Affirmative action just bridges the gap."
- "All recruited should go into the same procedure so that the issue of non-deserving is solved."
- "It is helping in changing ideas such as marrying off girls at an early age; girl child has an opportunity in life through education."
- "It is just giving the marginalized an opportunity to advance too."
- "Affirmative action is positive discrimination with clean intentions."

A minority view is represented by the following statement: "Affirmative action makes you go in for the second best."

Affirmative action as a form of reverse discrimination

Asked whether affirmative action was a form of “reverse discrimination,” an overwhelming majority (80%) of the key informants disagreed, indicating that they do not perceive affirmative action to be a form of “reverse discrimination.”

Figure 15. Key Informants’ Perceptions on Whether Affirmative Actions Is a Form of Reverse Discrimination
(N=37)



Source: Key informant interview guide

Reasons put forward in support of affirmative action (Figure 15) included:

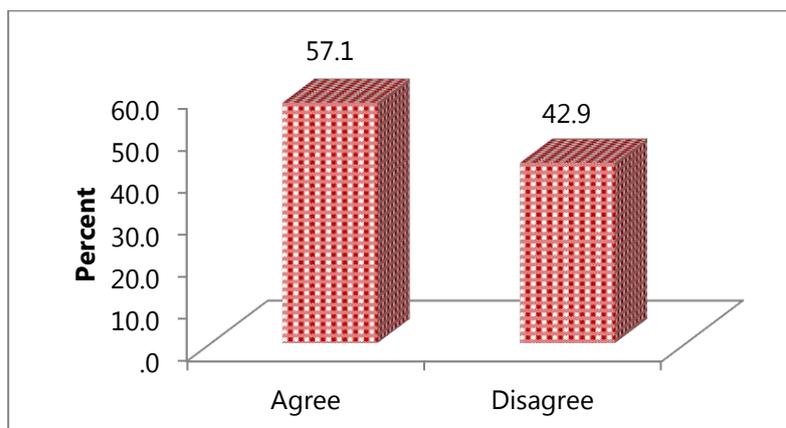
- “Affirmative action enables us to utilize all human resources at our disposal.”
- “It is just a positive discrimination meant to correct an historical imbalance.”
- “Affirmative action comes into play to decide on the best way to address past discrimination.”
- “It helps to balance gender—[It is] not discrimination.”
- “As long as affirmative action is exercised positively it won’t amount to discrimination.”
- “It is not automatic appointment so why should it be a form of discrimination? Affirmative action brings about equality.”
- “If the situation comes to 50/50% for women and men, then there will be no further need for affirmative action.”

Differential treatment in hiring as a necessity to combat past and present institutional discrimination

Figure 16 indicates that the majority (57.1%) of the key informants agreed with the statement that differential treatment in hiring is necessary to combat past and present discrimination and that 42.9% disagreed.

Figure 16. Key Informants' Perceptions on Differential Treatment in Hiring

(N=37)



Source: Key Informant Interview data

Various explanations were provided to support their level of agreement/disagreement with the statement. The following provides the range of perceptions.

Statements supporting differential treatment in hiring:

- "Not only have we had institutional discrimination but right from our homes, culture, institutions at some level special consideration is necessary."
- "Discrimination against women is historical which has taken decades to correct; therefore hiring is sometimes necessary to correct the gap which exists."
- "Even in schools, boys are more [present] than girls', [and] affirmative action is still required."
- "It is helping to bring women on board who were left behind."
- "The organization at [the] end of it will harvest a competent team of both men and women."

Statements not supporting differential treatment in hiring:

- "Hiring should be done based on someone's abilities and competence at all levels in all institutions."
- "It will just promote institutional discrimination since it does not take into account someone's competence."
- "People should compete favorably regardless of sex."
- "Equal opportunities should be given to both as long as both sexes fulfill the requirements of the job. "
- "In a way it creates unequal treatment during recruitment, unless one ensures equal selection and maintains a status quo in the organization."
- "Health workers handle life issues; therefore when being recruited no special considerations should be given."

The weight of the evidence from key informant interviews indicates that persons entrusted by the civil service to recruit and hire personnel for the health sector view affirmative action and accommodation to women's domestic and reproductive roles at work in largely positive terms.

However, there was less consensus on "differential treatment in hiring," perhaps because some key informants believe that "differential hiring" means hiring women who are not qualified or competent. There is also evidence that some key informants believe that the burden of family responsibilities should not be taken into account in the workforce ("People should compete favorably regardless of sex" and "Health workers handle life issues therefore when being recruited no special considerations should be given."). At first glance, this might be viewed as fair, as "gender neutral." However, we recall the FGD perceptions related to pregnancy and family responsibilities (in section, "Pregnancy and maternity") where such lifecycle events as pregnancy and family responsibilities were cited as bases to disqualify women from jobs ("Women always have interruptions like pregnancy, breastfeeding while men keep advancing because they don't have obstacles" and "If I were to be part of the interviewers in recruiting for a hospital director, I would appoint a man. Women have other issues like pregnancy, and would need to go for maternity leave, etc. Therefore a woman would not be suitable for such a high position that requires a lot of responsibility."). One is moved to ask: Is recruitment/hiring policy and practice really gender "neutral" when pregnancy and family responsibilities—mainly female responsibilities-- are used to disqualify women from jobs?

It is possible that some managers promote gender "neutral" equal opportunity policy in good faith, thinking that such policies would result in gender-equal opportunities. However, gender-neutral HR policies and practices that do not address the real inequality of opportunity for female health workers who become pregnant and have the main responsibility for family caregiving are really "gender-blind." For example, if promotion to senior management depends solely on years of service, then women will be excluded since they typically take time out of their careers for childrearing. Similarly, criteria for recruitment, hiring, or promotion into top management positions that ignore the real day-to-day gender constraints and inequalities of opportunity effectively exclude women. For example, if hiring criteria state that candidates "[m]ust have a degree in medicine, pharmacy" (the typically "male jobs"), then nurses and midwives (who are mostly women) cannot comply with these criteria or qualifications.

In any case, these largely positive findings point to a great opportunity to enlarge recruitment/hiring and management personnel's understanding of equal opportunity, and to develop and implement family-friendly policies and provisions, as well as an affirmative action strategy. These will equalize opportunities for workers with family responsibilities to be hired and promoted into senior management positions.

Staff Survey Perceptions of Gender Equality along Four Dimensions of Gender Integration

Composite scores for four organizational dimensions of gender integration were derived from the staff survey. The technical capacity component includes a composite score from the managers' survey where most of this type of indicator was contained (See Appendix B vi for indicators). The composite scores for the staff survey were based on 499 respondents. The scores for technical capacity in the managers' survey were based on 68 respondents. The GDIA team agreed that the "3" point on the scale was the midpoint. If composite scores were 2.5 and above, they would be rounded up to count as "3" or "moderate." Composite scores under 2.5

would be counted as “limited.” Based on the rating scale above, the composite scores denote that staff perceived political will for gender equality to be *moderate* (2.82), accountability to be likewise *moderate* (2.96), technical capacity to be *limited* (2.49, 2.03), and organizational culture to be *moderate* (2.79). The scores in Table 13 below indicate the composite scores for the four dimensions of the Gender Integration Framework.

Table 13. Composite Scores for Four Dimensions: Political Will, Accountability, Technical Capacity, and Organizational Culture for Staff and Programmatic Survey Questionnaires

(N=499 staff survey; N=68 managers' survey)

Survey rating scale: (1) Not at all, (2) To a limited extent (3) To a moderate extent (4) To a significant extent (5) Fully	
Dimension	Composite scores
Political will: The ways in which leaders use their position of power to communicate and demonstrate their support, leadership, enthusiasm for and commitment to working toward gender equality in the organization.	2.82
Accountability: Mechanisms an organization establishes to ensure it "walks the talk" on gender equality.	2.96
Technical capacity ²⁹ : The level of individual and organizational competencies needed to promote and advance gender equality in an organization. The "How to" related to gender mainstreaming.	2.49 (mean score for the staff survey) 2.03 (managers' survey)
Organizational culture: The informal beliefs and codes of behavior in an organization that support or undermine gender equality.	2.79

Source: Staff and managers' surveys

The details in the analyses that follow explicate the composite scores.

Staff perceptions on political will for promoting equal opportunity and gender equality in the public health sector

The staff survey assessed whether employees of the health sector were aware of the existence of written policies and legal provisions that promote equal opportunity and treatment for all employees, and protection for women against intimate partner violence; whether such policies, if in existence, were implemented; and whether management takes responsibility for development and implementation of equal opportunity policies.

Staff survey responses in Table 14 indicate that more than a half (56.7% or 34.3% + 22.4%) of the respondents reported that either equal opportunity policies did not exist at all, or existed to a *limited* extent respectively; and that 17.9% perceived these policies to exist only to a *moderate* extent. The preponderance of responses seem to suggest that survey respondents perceive a largely limited- to- nonexistent equal opportunity policy environment. Response patterns on implementation of such policies closely reflect those related to the existence of policies.

Table 14. Staff Perceptions of the Extent to Which Equal Opportunity Policies Exist and Are Implemented and the Existence of Policies on Protection against Intimate Partner Violence

(N=499)

Extent	Existence of policies on equal opportunities and treatment No (%)	Development and implementation of equal opportunities policies No (%)	Policies on protection against intimate partner violence No (%)
Not at all	159 (34.3)	100 (22.0)	262 (59.1)
To a limited extent	104 (22.4)	106 (23.3)	73 (16.5)

²⁹ There was only one question relating to technical capacity in the staff survey giving a mean score of 2.49. Technical capacity questions were mainly in the managers' survey with a composite score of 2.03, thus the two scores.

Extent	Existence of policies on equal opportunities and treatment	Development and implementation of equal opportunities policies	Policies on protection against intimate partner violence
	No (%)	No (%)	No (%)
To a moderate extent	83 (17.9)	113 (24.8)	42 (9.5)
To a significant extent	61 (13.1)	68 (14.9)	39 (8.8)
Fully	57 (12.3)	68 (14.9)	27 (6.1)
Total ³⁰	464 (100)	455 (100)	459 (100)

Source: Staff survey

It is important to note that the document review earlier established that these policies do in fact exist in the provisions of the Equal Opportunities Act (2007), the Employment Act (2006), and the Government Standing Orders (2010), all of which mandate equal opportunities for employees of government.

FGDs indicated staff members were aware of the existence of some policies and laws related to equal opportunity. A few FGD participants indicated they knew about the existence of the gender policy and were aware of some of the provisions in the Government Standing Orders related to employment with government:

“I believe that policies exist that cater [to] both men and women, but the only downside is that [the policies] are not enforced.” —Male respondent, non-management

“Policies are not known by the employees. These policies should be made known to employees on appointment or promotion” —Male respondent, non-management

This discrepancy between the existence of an equal opportunity policy and staff perception may be due to a lack of dissemination to health facility levels. The FGD results certainly suggest that some staff perceive that there are adequate policies but these policies are not adequately disseminated or enforced.

The 2010 Domestic Violence Act contains strong provisions for protection against intimate partner violence. However, implementation guidelines for the Domestic Violence Act had not yet been developed, and it had not been adequately disseminated by the government at the time of the study. Again, the discrepancy between existence of policy and staff perception in Table 14 may be due to a lack of dissemination to the level of the health facility.

A larger conclusion to be drawn from these finding is that the political will to develop equal opportunity and gender equality policies may be greater than the political will to disseminate, communicate about, and operationalize commitment at the health facility level.

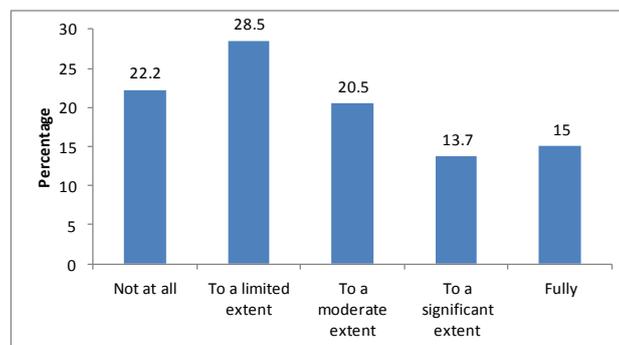
Staff perceptions of accountability in promoting gender equality

The GDIA assessed the level of perceived accountability in the health sector in relation to a set of indicators which included management and leadership responsibility in acting on gender equality policies in planning, meeting agendas, manager decision-making, communiqués to staff, and other indicators (see Appendix Bvi).

³⁰ Some respondents did not give responses to certain questions, thus the total number of respondents varies.

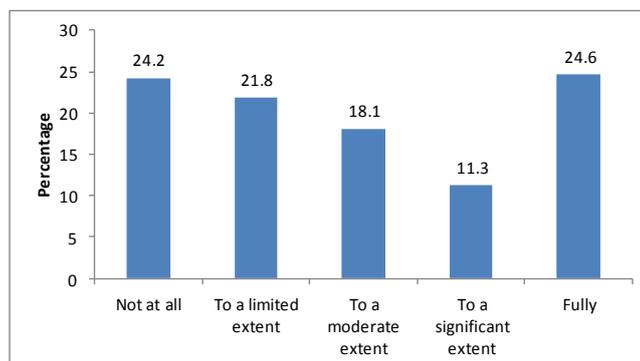
The findings on accountability as shown in Figures 17-20 seem to say that staff perceive very limited to moderate management/leadership accountability to act on equal opportunity and gender equality, as most of the survey responses fall between “not at all” and “to a moderate extent” (that is, 71.2% of responses in Figure 17 fall between not at all and to a moderate extent; 64.1% of responses in Figure 18; 62.7% in Figure 19; and 70.7% of responses in Figure 20).

Figure 15. Extent to Which Gender Equality Is Taken Into Account in Planning of Activities
(N=499)



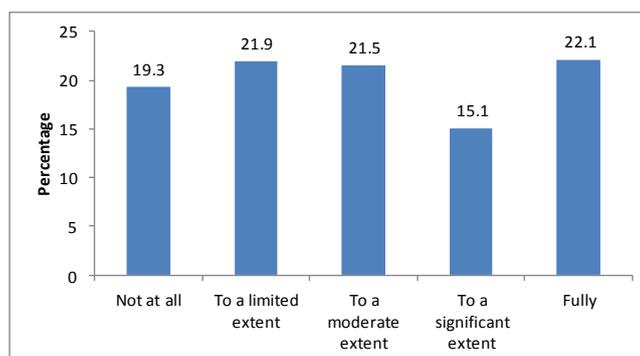
Source: Staff survey

Figure 18. Perceptions of Staff on the Extent of Inclusion of Gender Equality Issues in Meeting Agendas
(N=499)



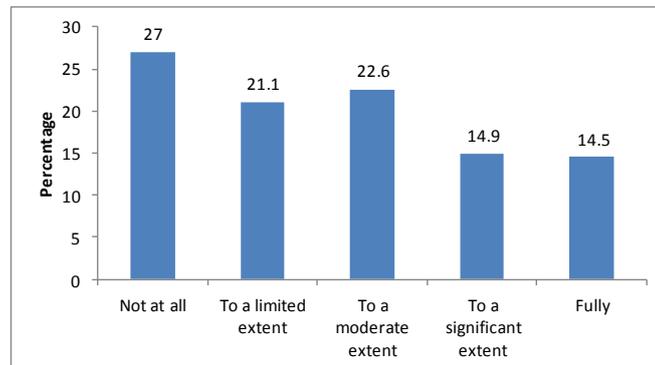
Source: Staff survey

Figure 19. Perceptions of Staff on the Extent to Which Decisions Are Made by Health Managers to Promote Equal Opportunities Irrespective of Gender



Source: Staff survey

Figure 20. Staff Perceptions on the Extent to Which Gender-Related Decisions are Disseminated to All Staff



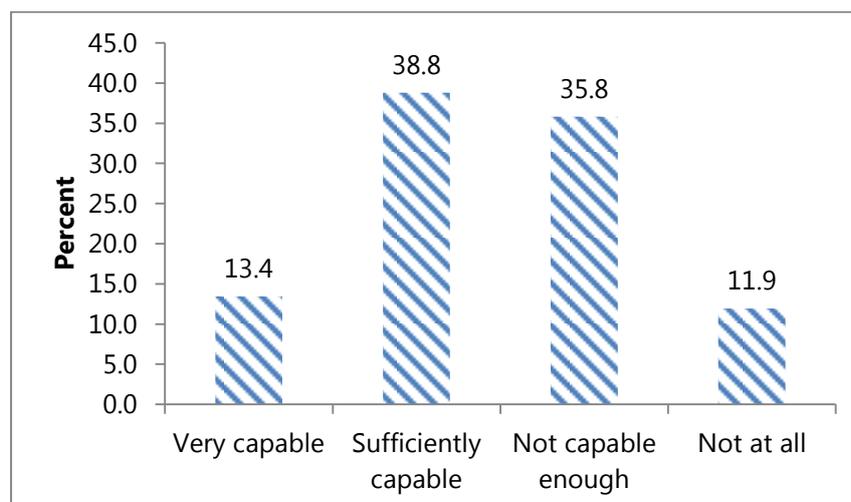
Source: Staff survey

Staff and managers' perception of technical capacity to promote gender equality

Table 13 shows the composite score for perceived technical capacity to promote gender equality in the health sector to be 2.49 for the staff survey and 2.03 for managers' survey.

Respondents were asked a closed-ended question requiring a "yes" or "no" answer: "Do you consider that as a manager you are expected to introduce gender issues in different stages of program or project design and implementation at any level?" The overwhelming majority of the managers (88.2%) answered in the affirmative. However, with respect to their capability to meet this expectation, a much smaller proportion of managers answered affirmatively. For example, Figure 21 shows that only 13.4% felt themselves very capable. While a higher proportion of managers indicated they felt sufficiently capable (38.8%), 47.7% (35.8 + 11.9%) felt themselves not capable enough (35.8%) and not capable at all (11.9%).

Figure 21. Capability of the Managers to Fulfill the Expectation to Integrate Gender Issues in Programs



Source: Managers' survey

Overall, Figure 21 results are evidence that managers perceive themselves to be sufficiently or very capable to integrate gender in programs and projects (52.2%), though capacity gaps exist as indicated by the "not capable enough" and "not at all" responses (47.7%).

Perceptions of gender equality in organizational culture and workplace climate

The assessment of organizational culture elicited interesting findings on teamwork and respectful interactions between men and women at the workplace. Additionally, the GDIA examined whether sexual harassment was an issue of concern to staff because sexual harassment is an indicator of gender inequality and poor workplace climate.

As **Table 13** shows, the composite score for staff perceptions of gender equality in organizational culture was 2.78 on a scale of 1-5. This indicates that the staff perceived gender equality in organizational culture to be *moderate*.

Staff perceptions of promotion of team work among staff

Teamwork is a key factor in promoting staff morale, positive work relations, and productivity. Teamwork is particularly critical in the provision of health services and is enhanced when workers—both women and men—have equal say in making decisions affecting their work. In the staff survey, perceptions about the existence of teamwork and whether male and female leaders had equal say were examined. **Table 15** addresses these related dimensions.

Table 15. Promotion of Teamwork among Female and Male Staff
(N=499)

Perception rating	Promotion of team work among women and men as equal partners	Equal say by female leaders as male leaders	Equal say by male leaders as female leaders
Strongly disagree	34 (7.3)	34 (7.3)	33 (7.2)
Disagree	51 (11.0)	63 (13.6)	55 (11.9)
No opinion	66 (14.3)	59 (12.7)	65 (14.1)
Agree	172 (37.1)	167 (36.1)	167 (36.2)
Strongly agree	140 (30.2)	140 (30.2)	141 (30.6)

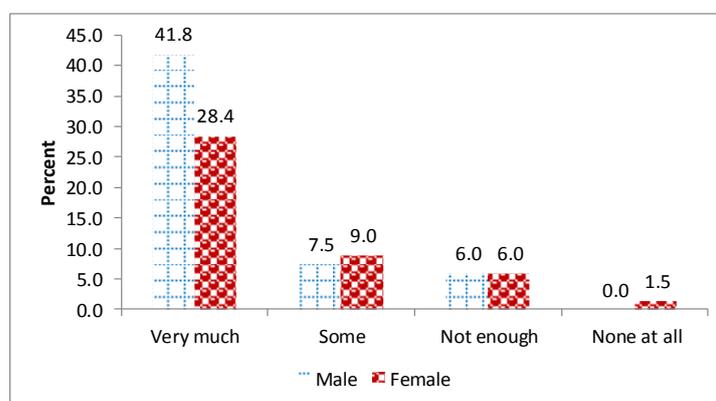
Perception rating	Promotion of team work among women and men as equal partners	Equal say by female leaders as male leaders	Equal say by male leaders as female leaders
Total	463 (100)	463 (100)	461 (100)

The combined “agree” and “strongly agree” responses in Table 16 show that positive staff perceptions of teamwork predominate (i.e., 37.1%+30.2%=67.3% with respect to promotion of teamwork; 36.1%+30.2%=66.3% with respect to female leaders having an equal say; and 36.2%+30.6%=66.8% with respect to male leaders having an equal say).

Management commitment to promoting gender equality at work

Figure 22 shows that managers perceive that they pay attention to respectful relations between male and female staff at work.

Figure 22. Managers’ Attention to Respectful Relations between Male and Female Staff at the Workplace



Source: Managers’ survey

Sexual harassment as an indicator of gender inequality and poor workplace climate

The Uganda 2006 Employment Act defines sexual harassment in terms of employee/employer relationships and specifies the forms of and what constitutes sexual harassment (see Box 1). The Government Standing Instructions (2010) mention sexual harassment as one of the forms of misconduct by public servants which, when it happens, calls for disciplinary measures to be taken. However the staff survey established that majority of staff (66.6%, Table 12, above) perceived that government policy on sexual harassment existed “not at all.” Similar perceptions were expressed during FGDs with staff members, who professed a lack of knowledge of the policy, or mentioned that if there is a policy, they had not heard of it.

In the staff survey, respondents were asked, “How common is the expectation to provide sexual favors to a manager or supervisor in order to get a job, a good evaluation, a promotion, or a salary raise?”

Responses to this question are presented in **Figure 23**. A total of 19.5% reported that the practice was “neither common” nor “uncommon,” and 48.4% (33.5%+14.9%) of survey respondents reported that this type of sexual harassment was either “very” or “somewhat” uncommon.

However, the findings also show that 32.1% of respondents (18.3%+13.8%=32.1%), or almost one-third of the staff survey sample, reported that sexual harassment involving manager/supervisor expectations of sexual favors in order (for staff) to get a job, a good evaluation, a promotion, or a salary raise (i.e., *quid pro quo* sexual harassment) were “somewhat common” and “very common,” respectively.

Box 1: Sexual harassment

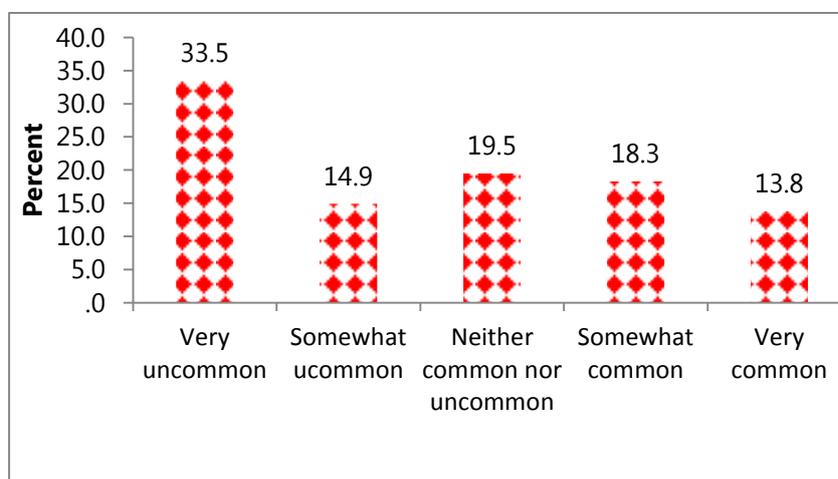
The Employment Act of Uganda (2006), article 7:1 states that:

“An employee shall be sexually harassed in that employee’s employment if that employee’s employer, or a representative of that employer:

- (a) directly or indirectly makes a request of that employee for sexual intercourse, sexual contact or any other form of sexual activity that contains:
 - (i) An implied or express promise of preferential treatment in the employment
 - (ii) An implied or express threat of detrimental treatment in employment
 - (iii) An implied or express threat about the present or future employment status of the employee
- (b) Uses language whether written or spoken of a sexual nature
- (c) Uses visual material of a sexual nature
- (d) Shows physical behavior of a sexual nature

Which directly or indirectly subjects the employee to behavior that is unwelcome or offensive to that employee and that, either by its nature or through repetition has a detrimental effect on that employee’s employment, job performance or job satisfaction?”

Figure 23. Staff Perceptions on Expected Sexual Favors to a Manager/Supervisor to Get a Job/Good Evaluation/Promotion/Salary Raise



Source: Staff survey

The staff survey respondents were also provided with a checklist of 12 forms of sexual harassment to check if the respondents had experienced any of the different forms of sexual harassment while working or training for the employment in the public health sector in the last 12 months. This question covered whether the respondent had personally experienced the form of sexual harassment or had heard of a colleague who had experienced that form of sexual harassment.

Figures 24, 25, 26, and 27 represent staff perceptions of the most common forms of sexual harassment experienced in the public health sector (N=499).

Figure 24. Staff Perceptions of Unwanted Attempts

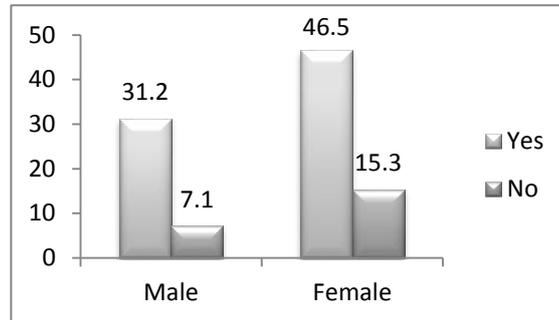


Figure 25. Staff Perceptions of Sexual Jokes

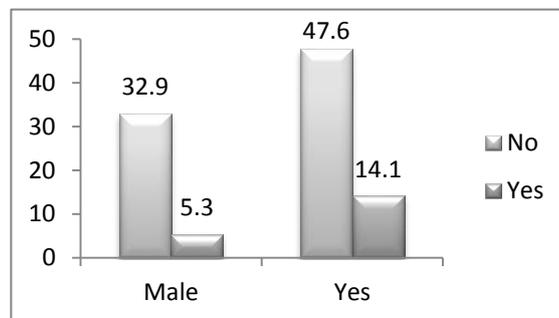


Figure 26. Staff Perceptions of Sexually Explicit Discussions

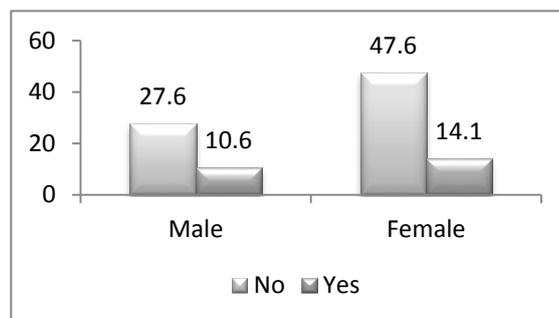
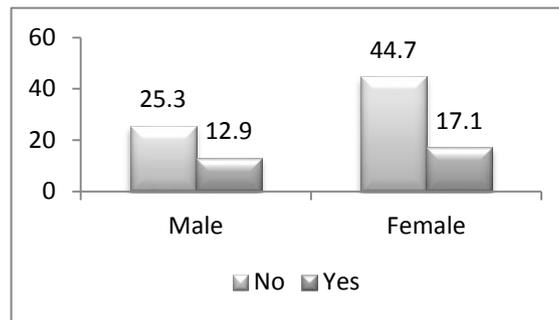


Figure 27. Staff Perceptions of Sexual Gestures



Source for Figures 24-27: Staff survey

The first thing that strikes the reader is the higher frequency of “yes” responses from female staff respondents. Survey responses also revealed the most common forms of sexual harassment reported to be:

- Sexually suggestive gestures (Figure 27: 12.9% +17.2%=30% of respondents)
- Being exposed to sexually explicit discussions or conversations (Figure 26: 10.6%+14.1%=24.7%)
- Unwanted attempts to establish sexual relationships (Figure 24: 7.1%+15.3%=22.4%)
- Being the object of sexual jokes, comments, or leering (Figure 25: 5.3%+14.1%=19.4%).

Were these results confirmed by other sources of data? Results from focus groups confirmed the existence of both *quid pro quo* and hostile environment forms of sexual harassment. Quotations from FGDs reveal the experience of sexual harassment at work:

“When men are bosses, they think they can take anything they want from female subordinates, so they start asking for sexual favors from females.” —Female, non-management FGD

“In some of our offices, I believe some managers ask for sex in order for one to be promoted.” —Male, management FGD

“I do not agree that sexual harassment is not common. I was a victim. But I failed to [find out] where to report [it]. Is there a way we could find where to report? I don’t see it in any policies.” —Female, management FGD

“Sexual harassment is silent; no one discloses.” —Male, non-management FGD

The 2011 Sexual Harassment Regulations include information on the reporting and disciplining of perpetrators. With regard to measures taken to address sexual harassment at the workplace, it was mentioned that when reported, the perpetrators can be disciplined. However, some female FGD participants stated that when it happens, those targeted find different ways of coping rather than reporting. Further, these respondents said that even when reported, men tend to deny such incidents, and the cases may not be taken further.

In one FGD, a participant said of targets, “Some decide to ignore it while others suffer quietly.”

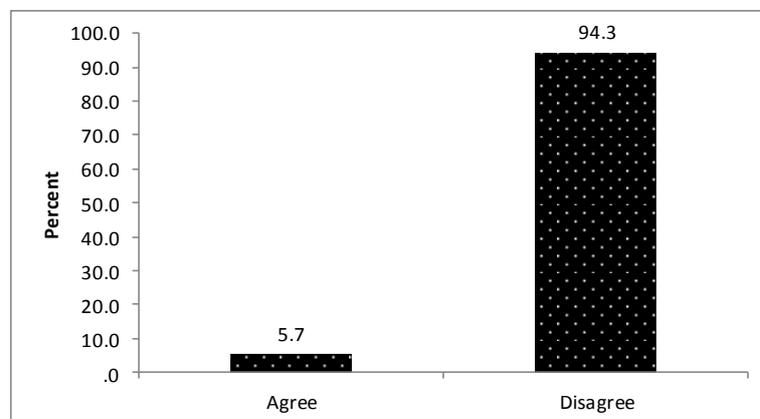
In another FGD, a participant said, "Other people quit their jobs. For example, there was a nurse called Penny, and men always called her penis. She did not like it, and she quit her job."

Sexual harassment was recognized by most participants to be happening in all sites of the study. Although there was a level of denial in some FGDs, most participants talked openly about it once it was acknowledged in the FGD. Both *quid pro quo*³¹ and hostile environment sexual harassment³² were recognized and happened mostly to female employees.

Sexual harassment as a Western concept and not relevant in the Ugandan context

The vast majority (91.4%) of the key informants did not agree with a statement that "sexual harassment is just a Western cultural concept that does not really apply to Uganda" (see Figure 28). The main reasons given for this perception are listed after the graphic.

Figure 28. Perceptions of Key Informants on Sexual Harassment as a Western Concept That Does Not Apply to Uganda



- "Sexual harassment is rampant. [I]n Uganda it may even be taking diverse trends. [I]t is a serious form of corruption. A woman should be in control of her body."
- "Respect ought to be given to ladies at [the] workplace. This normally is done by men who see women as sex objects."
- "[This is a] [d]elicate issue that is even spoken about in churches here in Uganda."
- "It happens in Uganda too; however, it differs from organization to organization."
- "It is a global phenomenon."

Bullying³³ as an indicator of poor workplace climate

³¹ "Quid pro quo" refers to a form of sexual harassment where a person's rejection of, or submission to, such conduct is used explicitly or implicitly as a basis for a decision which affects that person's job.

³² "Hostile environment sexual harassment," refers to a situation in which conduct/behavior of a person creates an intimidating, hostile or humiliating work environment for the recipient.

³³ Bullying refers to offensive (vindictive, cruel, malicious) repeated behavior intended to humiliate, intimidate, undermine, or isolate an individual or group of employees. It is distinguished from verbal abuse and physical violence in that it is persistent and occurs over time and not as an isolated event. Bullying can be committed by either an individual or a group (in the latter case, it is sometimes referred to as "mobbing").

“Being bullied by a supervisor or colleague” was reported by respondents of the staff survey. Responses to this question indicated that about 31% of male employees and 28.1% of female employees had been bullied at the workplace (Table 16).

Table 16. Percentages of Staff Members Who Said They Had Experience of Being Bullied by a Supervisor or Colleague, by Sex
(N=499)

Sex	Being bullied by a supervisor or colleague			Total
		No	Yes	
Male	Count	100	45	145
	% within sex	69.0%	31.0%	100.0%
	% of total	22.5%	10.1%	32.7%
Female	Count	215	84	299
	% within sex	71.9%	28.1%	100.0%
	% of total	48.4%	18.9%	67.3%
Total	Count	315	129	444
	% of total	70.9%	29.1%	100.0%

Source: Staff survey

Overall, staff and managers’ surveys elicited mixed findings related to perceptions of political will, accountability for promoting gender equality, technical capacity, and an organizational culture of gender equality. With respect to the latter, the most positive findings are perceptions of teamwork and male and female staff having an equal say in decision-making at health workplaces.

However, the survey and focus group findings—especially on family-friendliness of workplaces, sexual harassment and related abuse of supervisors’ power, and bullying—suggest that there are social factors at work that contribute to poor workplace climate, a lack of health worker satisfaction with working conditions, and even worker attrition³⁴. Implementing Uganda’s policy and legal framework for equal opportunity, gender equality, and protection from sexual harassment would go a long way in improving the conditions and climates in which public health workers currently work.

Managers’ Perceptions of Gender Mainstreaming in Public Health Sector Programs

Composite scores were calculated for the extent to which gender is mainstreamed in field programs, based on mean responses to all questions on the program managers’ survey in the following areas: program planning and design; program implementation; research monitoring and evaluation; partner organizations.

³⁴ Attrition was not formally measured in this study, but sexual harassment and bullying especially have been linked to attrition or intention to quit in other studies. For example, see Newman et al., *Workplace Violence and Gender Discrimination in Rwanda’s Health Workforce: Increasing Safety and Gender Equality*. July 2011. *Human Resources for Health*. Vol. 9. <http://www.human-resources-health.com>

The program integration scores (Table 17) are based on (68) program managers' perceptions, with mean responses on a scale from 1-5, with one (1) being low and five (5) being high (excluding "Don't Know" responses).

Table 17. Program Composite Scores for Gender Mainstreaming in Public Health Programming

Survey rating scale: (1) Not at all (2) To a limited extent (3) To a moderate extent (4) To a significant extent (5) Fully	
Component	Score
Program planning and design	2.55
Program implementation	2.52
Monitoring and evaluation	1.28
Partner organization	1.80

Source: Managers' survey

The GDIA team agreed that the "3" point on the scale was the midpoint. If composite scores were 2.5 and above, they would be rounded up to count as "3" or "moderate." Composite scores under 2.5 would be counted as "limited" or "not at all." Based on the rating scale above, the composite scores denote that managers perceived gender mainstreaming:

- In programming and design, to be *moderate* (2.55)
- In program implementation, to be moderate (2.52)
- In monitoring and evaluation, to be *limited to not at all*
- In selection of partners on the basis of their commitment/capacity in gender equality, to be *limited*.

The reader will find highlights of the data below.

Program planning and design

The GDIA assessed: the extent to which gender mainstreaming was mandated in the public health sector; whether gender equality goals and objectives were included in the design of the programs and projects; whether gender analysis was part of needs assessments/situation analyses; inclusion of gender indicators; whether gender analysis results informed the design processes of programs and projects; and whether gender was a criterion in proposal development. **Table 18** shows the results, which are composite scores based on managers' responses to questions relating to gender mainstreaming in programs.

Table 18. Managers' Perceptions of the Extent of Gender Mainstreaming in Selected Aspects of Program Planning and Design

(N=68)

Perception/ extent	Is gender equality mandated	Are gender goals and objectives included in program/ project designs?	Is gender analysis part of needs assessment	Do program strategy documents include gender indicators	Strategies for addressing gender gaps	Incorporation of best practices	Gender as criterion in proposals
Fullest extent	8 (11.9)	7 (10.3)	6 (9.1)	4 (6.0)	3 (4.5)	4 (6.0)	5 (7.4)
Great extent	21 (31.3)	22 (32.4)	10 (15.2)	11 (16.4)	9 (13.6)	6 (9.0)	10 (14.7)
Moderate extent	15 (22.4)	18 (26.5)	18 (27.3)	24 (35.8)	18 (27.3)	23 (34.3)	15 (22.1)
Limited extent	12 (17.9)	12 (17.6)	14 (21.2)	11 (16.4)	17 (25.8)	18 (26.9)	10 (14.7)
Not at all	8 (11.9)	5 (7.4)	11 (16.7)	10 (14.9)	11 (16.7)	7 (10.4)	17 (25.0)
Do not know	3 (4.5)	4 (5.9)	7 (10.6)	7 (10.4)	8 (12.1)	9 (13.4)	11 (16.2)

Source: Managers' survey

The key findings in this area were that: the highest percentage of managers indicated that gender equality was mandated (31.3%) and that gender goals and objectives were included in program/project designs (32.4%). However, the findings also show that gender analysis, inclusion of gender indicators, putting in place strategies for addressing gender gaps, incorporation of best gender practices, and using gender awareness as criterion for evaluation of proposals was perceived to occur to a *moderate* extent.

This suggests that while gender equality is mandated and gender goals and objectives are set, program/project designs do not sufficiently integrate gender. This may be related to the earlier finding (**Figure 21**) that 47.7% of managers feel that they are not capable enough, or not at all capable, to promote gender equality in their programs.

Program implementation

Under "program implementation" the GDIA focused on program activities that strengthened the skills of women and girls, men and boys and that provided them with equal access to services and training. The GDIA also looked at the extent to which program activities took into account gender roles and the interests of both male and female participants and whether both male and female beneficiaries valued programs and services offered by the MOH.

The results in **Table 19** show that the highest proportions of managers agree that MOH programs benefit both women/girls and men/boys.

Table 19. Managers' Perceptions of the Benefits of the Program/Project Activities to Male and Female Clients

(N=68)

Perception/extent	Benefits of programs to females		Benefits of programs to males	
	Male	Female	Male	Female
Strongly agree	9 (13.2)	8 (11.8)	8 (11.8)	4 (5.9)
Agree	23 (33.8)	18 (26.5)	24 (35.3)	22 (32.4)
Disagree	0 (0.0)	1 (1.5)	1 (1.5)	0 (0.0)
Strongly disagree	1 (1.5)	1 (1.5)	0 (0.0)	1 (1.5)
No opinion	5 (7.4)	2 (2.9)	5 (7.4)	3 (4.4)

Source: Managers' survey

Table 20 shows that more female managers than male managers agreed that the MOH had the capacity to recognize and address resistance to gender equality (29.4% female and 17.6% male, respectively), though these percentages are not very high.

Table 20. Managers' Perceptions of the Capacity of the MOH to Recognize and Address Resistance to Gender Equality
(N=68)

Perception/extent	Capacity of the MOH to recognize and address resistance to gender equality	
	Male	Female
Strongly agree	5 (7.4)	0(0.0)
Agree	12 (17.6)	20 (29.4)
Disagree	8(11.8)	4(5.9)
Strongly disagree	1(1.5)	2(2.9)
No opinion	12 (17.6)	4(5.9)

Source: Managers' survey

Monitoring and evaluation

The GDIA assessed the extent to which gender-disaggregated data and information were incorporated in the monitoring and evaluation of MOH's program/project outcomes.

Table 21. Managers' Perceptions of the Level of Gender Mainstreaming in Monitoring and Evaluation

(Collection of gender disaggregated data, including gender indicators and monitoring gender impacts)
(N=68)

Perception/extent	Gender-disaggregated data, collected	Gender indicators included	Gender impacts monitored
To the fullest extent	7(10.3)	2(3.0)	4(5.9)
To a great extent	10(14.7)	4(6.0)	5(7.4)
To a moderate extent	14(20.6)	16(23.9)	11(16.2)
To a limited extent	8(11.8)	9(13.4)	12(17.6)
Not at all	16(23.5)	26(38.8)	17(25.0)
Do not know	13(19.1)	10(14.9)	19(27.9)

Source: Managers' survey

Table 21 shows that the collection of gender-disaggregated data, the inclusion of gender indicators, and the monitoring of gender impacts are perceived to be done not at all, or to a *moderate extent*. The highest percent of respondents did not know if gender impacts were monitored. The findings suggest that the extent of gender mainstreaming in monitoring and evaluation is quite *limited*.

Financial resources

There was a section of the managers' survey that assessed the availability of financial resources to support gender mainstreaming activities in the public health sector, including for training and development of gender tools or policies, and for activities to promote gender equality and women's rights. The survey also assessed the extent to which the public health sector had a

budgeting system that tracks expenditures for gender equality programming and whether there were gender-sensitive budgeting mechanisms.

Table 22. Managers’ Perceptions of the Availability of Financial Resources for Gender Training, Activities on Gender Equality and Women’s Rights, and Gender Budgeting Mechanisms

Perception/extent	Availability of financial resources for gender training, tools/policies	Availability of financial resources for gender equality and women’s rights activities	Budgeting system that tracks gender expenditures	Gender-sensitive budgeting mechanisms
Do not know	23 (33.3)	29 (42.0)	34 (49.3)	30 (43.5)
Not at all	14 (20.3)	12 (17.4)	8 (11.6)	8 (11.6)
To a limited extent	12 (17.4)	9 (13.0)	12 (17.4)	8 (11.6)
To a moderate extent	8 (11.6)	12 (17.4)	8 (11.6)	7 (10.1)
To a great extent	6 (8.7)	2 (2.9)	5 (7.2)	10 (14.5)
To the fullest extent	6 (8.7)	5 (7.2)	2 (2.9)	6 (8.7)

Source: Managers’ survey

Table 22 shows that the highest proportion of managers (33.3%, 42.0%, 49.3%, and 43.5%) did not know if there were financial resources available for gender equality training, tools, policies, the availability of financial resources, the existence of tracking mechanisms for gender expenditures, or a gender-sensitive budgeting system, respectively. The latter results were corroborated by document review of a study of gender and equity mainstreaming in the health sector, which indicated in a report that “in most of areas, it does not seem that the sector [health sector] purposively includes gender in its plans and budgets”³⁵. These findings on the availability of financial resources for gender-related activities and mechanisms for gender-sensitive budgeting suggest that gender-related activities are not specifically budgeted for and that there are no mechanisms for tracking gender expenditures.

Partnerships

Health program managers were asked to give their perceptions about the extent to which gender equality was promoted in MOH partner relations, as measured by its commitment to the extent to which:

- Commitment to gender equality was a criterion in selection of partners or local nongovernmental organization affiliates
- The MOH included a gender policy in the written agreements with partners
- The MOH provided training and tools on gender planning, analysis, and evaluation to partner or local nongovernmental organization affiliate staff.

Results presented in **Table 23** indicate that more than a third (35.8%) of the health managers reported they did not know whether gender was used as criterion for selecting partners or nongovernmental organization affiliates, and 25.4% responded “not at all” to the same indicator. Similarly, 51.5% of health managers reported that they did not know whether gender training or

³⁵ Ministry of Finance, Planning and Economic Development. 2012. A report on the assessment of gender and equity mainstreaming in the health sector. Kampala, Uganda: Ministry of Finance, Planning and Economic Development.

gender tools were provided to partners while 17.6% said that this was not done at all. From the findings in **Table 23**, it is reasonable to conclude that gender equality is not mainstreamed in MOH partner relations.

Table 23. Managers’ Perceptions of the Extent to Which Commitment to Gender Equality Is a Criterion for Partner Selection and MOH Provision of Gender Training and Tools to Partners

Perception/ extent	Commitment of partners to gender equality as criterion for selection by MOH	MOH provides gender training and tools to partners
Do not know	24 (35.8)	35 (51.5)
Not at all	17 (25.4)	12 (17.6)
To a limited extent	7 (10.4)	5 (7.4)
To a moderate extent	13 (19.4)	8 (11.8)
To a great extent	4 (6.0)	5 (7.4)
To the fullest extent	2 (3.0)	3 (4.4)

Source: Managers’ survey

Results from the managers’ survey suggest that gender mainstreaming in public health sector programming is limited. Policies and laws have not been operationalized at lower levels and, hence, there is a lack of awareness about some of the legal and policy protections that could improve health workplace climates. The reasons for this may lie in the newness of legislation, non-dissemination of existing policy/legal protections, a gap in technical capacity, the availability of financial resources, the lack of a gender budgeting mechanism, or the criteria for selecting MOH partners.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

- Men and women are concentrated in different jobs and at different levels in the health sector, with women in fewer jobs and at lower levels. This points to unequal opportunities for men and women and an associated wage differential.
- There is evidence of unequal opportunity for career advancement for female health workers, positive beliefs about men as managers, negative beliefs about women as managers, and perceptions of pregnancy and family responsibilities as the bases for the lack of career advancement for female health workers.
- Some health workers appear to experience work-family conflict, without a range of family-friendly policies to mitigate it. There is/are:
 - No policy on flex-time (especially for pregnant women and breastfeeding mothers, or fathers who need to provide child care and take care of other parental responsibilities)
 - No official breaks for breastfeeding mothers
 - No official child care leave
 - Very few days (only four) provided for male employees for paternity leave.
- Sexual harassment exists in the public health sector, appears to be experienced mainly by female employees, and remains largely silent as those affected do not talk about it or report it. Government regulations on sexual harassment have not reached health facilities, and there are no reporting mechanisms.
- Managers and recruitment personnel at the district level have a largely positive understanding that affirmative action provides the means to equalize opportunities and to increase access for women to better jobs in the health sector.
- Uganda's policy and legal framework has not been operationalized in districts and health facilities but could equalize opportunity and promote greater gender equality in health sector workplaces.
- Health leaders and managers would benefit from awareness-raising and training in areas such as equal opportunity and gender equality in HRH, affirmative action, and sexual harassment.

Recommendations

For the Ministry of Health:

- Develop a gender policy, strategy, implementation guidelines, activities, and indicators for the public health sector—and budget for their implementation.
- Disseminate GDIA results to (at least) district and facility managers and staff.
- Sensitize and build capacity of key health sector stakeholders to advance equal opportunity and gender equality in the workforce—for example, of MOH policy-makers, recruiters, DHOs, HR managers, and facility managers.

- Provide staff development and mentoring for female staff in order that they might better compete for higher management jobs.
- Challenge negative beliefs about women as managers.
- Build capacity of program staff in gender analysis and gender programming through targeted training.
- Adapt the *MOPS Guidelines for Gender Mainstreaming in HRM* to HRH and disseminate these to health managers and recruitment personnel.
- Develop a sector-specific code of conduct against sexual harassment and disseminate this code to districts through DHOs. This should be accompanied by training trainers who understand the issues, training managers and health workers to recognize it, creating and disseminating a wall poster on zero tolerance for sexual harassment, and putting in place a confidential system of reporting, starting with the ten sites in which the GDIA was conducted.
- Develop and disseminate standards for women-friendly and family-friendly health workplaces.
- Monitor the concentration of men and women in health sector jobs using the HRIS.
- Integrate activities to promote equal opportunity and gender equality in district action plans.
- Upon approval of the GDIA Report, the Human Resources Technical Working Group should appoint a task force on the status of gender equality in the public health sector to move the GDIA recommendations forward.

For the Health Service Commission/District Service Commissions:

- Work with the Equal Opportunities Commission and the MOPS to develop guidelines for equal opportunity and affirmative action in the government civil service that are in line with the Constitution of Uganda, which provides for the right to affirmative action for marginalized groups.
- State in recruitment notices that the MOH is “an equal opportunity employer” and that “women are encouraged to apply” to broaden the range and level of jobs to which female health workers have access.
- Expand hiring criteria for senior management positions to include wording such as “or another relevant degree” or “or equivalent years of experience” to open opportunities for female health workers to advance their careers in the health sector.
- The Health Service Commission should develop an affirmative action strategy to recruit more women into senior management positions in the government health sector, as provided for in the *MOPS Guidelines for Gender Mainstreaming in HRM*.

For the Ministry of Gender, Labour and Social Development:

- Work with the Equal Opportunities Commission and the MOPS to develop guidelines for equal opportunity and affirmative action in the government civil service that are in line with the Constitution of Uganda, which provides for the right to affirmative action for marginalized groups.

- Develop a reader-friendly “Know Your Rights” booklet for public sector workers.

For the Ministry of Public Service:

- Disseminate the *Gender Mainstreaming Guidelines in HRM* and the *Employment (Sexual Harassment) Regulations (2012)* through targeted forums of government sectors (including the health sector, also adapted to HRH).

General:

- The Government of Uganda should ratify ILO C. 156, Workers with Family Responsibilities to support work/family balance.
- If the Government of Uganda ratifies ILO C. 156, the Ministry of Gender, Labour and Social Development should update the 2006 Employment Act to include family-friendly provisions.

LIST OF APPENDICES

Appendix A: Definition of Terms and Concepts

Appendix B: Data Collection Instruments and Indicators

- Staff Survey Questionnaire (Tool #1)
- Programmatic Survey Questionnaire (Tool #2)
- Focus Group Discussion Guide (Tool #3)
- Key Informant Interview Guide (Tool #4a and 4b)
- Document Review Guide (Tool #5)
- Illustrative Indicators for Gender Integration (Bvi)

Appendix C: List of Documents Reviewed

Appendix D: Characteristics of a Family-Friendly Organization/Workplace

Appendix E: Supplemental Tables and Charts