Special Article

Gender - a Missing Dimension in Human Resource Policy and Planning for Health Reforms

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Abstract

This article takes up the relatively neglected issue of gender in human resources policy and planning (HRPP), with particular reference to the health sector in developing countries. Current approaches to human resources lack any reference to gender issues. Meeting the health needs of women as major users and potential beneficiaries of health services is a key international concern. This article argues that in order to do this, attention must also be paid to both equal opportunities and efficiency issues in the health sector workforce, given the highly gender segregated nature of occupations in the health sector and the potential for both gender inequity and inefficiency in the use of human resources which this poses. Taking gender seriously in HRPP entails developing appropriate methodologies for data collection, monitoring and evaluation. The paper suggests some basic ways of doing this and provides a framework for incorporating gender concerns in health reform processes.

Key words: Gender, health providers, human resources planning, health sector reform

1. Context - why consider gender in human resource policy and planning?

In view of the importance of human resources planning to delivering the health sector reform agenda, the lack of attention to its gender dimensions requires rectifying. This is a preliminary attempt to address the issue and provide some guidance in how to make human resources policy and planning more gender aware. It is based mainly on secondary sources and focuses particularly on nursing.

In general, most work on gender and health care has focused on demand side issues. These include in particular the wide range of barriers to institutional access experienced by women users[1,2], gender discrimination in health care expenditure affecting women and girls, the exclusive concentration on women's reproductive health to the neglect of other dimensions of their health[3], and the impact of cost recovery programmes on women and children[4].

There has been much less emphasis on gender in relation to the production of health care[5,6]. Yet there is often a clear gender dimension to both formal and informal care systems. Much of the noninstitutional care of the sick is carried out by female household and community members[7]. Similarly, formal health systems tend to be gender differentiated in terms of their divisions of labour and associated hierarchies, with women frequently concentrated in specific segments of the health care labour force. They are less likely than men to be in senior professional, managerial and policy making roles[5,8,9]. A study of human resources in Zimbabwe notes that women's formal sector employment is mainly in the service sector. In health, women outnumber men as employees, holding 57.4% of the total employment[10]. It also notes that women are concentrated at the lower end of the hierarchy and salary grades.

2. Human resources and health sector reform

During the 1970s and 1980s, considerable investment was made by both donors and national governments in poor countries to increase the number of health workers to meet primary health care objectives[11]. Very substantial numbers were trained to varying levels of skill at considerable cost. Yet with the exception of a few areas, such as immunization drives, major improvements in access to services have not taken place and better health outcomes, particularly for poorer, rural populations, have not always materialized. Access to and utilization of services, particularly by poorer populations and by women, remains a major problem. Thus, the paradox is that health is a labour intensive sector - salaries generally make up the bulk of health sector expenditure - yet the investment in expanding the workforce has not yielded an equivalent return.

Partly in recognition of this, health sector reform policies in a number of countries have begun to address the issue of human resources, particularly through public sector reforms and strategies for improved human resource management. Human resources restructuring is central to the implementation of health sector reform initiatives in developing countries. One of the major objectives of health sector reform must be to make better use of existing trained personnel and of those currently undergoing training. Key reforms, such as decentralization, district management strengthening and civil service reform depend on appropriate and imaginative use of human resources. Decisions on pay and reward structures, accountability and regulation will all influence the outcomes of these reforms and the quality of services they are intended to improve.

However, human resources planning and policy has failed in several respects to deliver an appropriately trained workforce to the places where it is actually needed[12].

Areas of failure include:

- poor selection of candidates for training (e.g. through urban bias in recruitment);
- inappropriate training curricula (e.g. lack of sensitivity to users and their needs);
- failure to recruit for and retain personnel in rural areas;
- failure to create contractual conditions which would ensure staff carry out the work for which they are paid;
- failure to manage or reverse the decline in health workers' pay and conditions of service;
- inappropriate career structures (e.g. ones which remove health workers from practice);
- failure to stem the exodus from the public to the private sector or to other countries.

HRPP has generally been top down and concerned with bureaucratic targets. This article puts forward two key arguments. First, the failures of HRPP can be related to the failure to take account of qualitative factors which in practice determine who enters the workforce, for how long, where they work and under what terms and conditions. Gender is one such major qualitative factor. The health sector workforce is one of the most "female" in composition[1], particularly at basic service level. For example, in southern Africa, front line nursing care is provided overwhelmingly by nurses. Historically, in this region, nursing is a female profession[13].

Second, HRPP has not involved the stakeholders themselves in any serious way in the design of training and career paths. Users' views and concerns about health service delivery

1 It is recognised that this varies from country to country. Anglophone countries may be more female dominated than Francophone ones. The point still remains that the health sector is one of the few major formal sector employers of women in sub-Saharan Africa.

are only now being acknowledged as important. Provider stakeholders (whether individuals or associations) have also not been conspicuously consulted about human resource development strategies. HRPP must find ways of meeting the needs of users and also of satisfying the legitimate aspirations of providers.

So far, very little systematic attention has been paid to the gender dimension of human resources in the restructuring of the health sector[6].[2] This accords with a more general gender blindness in the human resources area. Whilst the disaggregation of the health workforce by sex is sometimes part of human resources data collection[14], this information rarely seems to be used or factored into policy making. Indeed, it is not at all clear why it is collected in the first place. Yet, in the health sector, occupations such as nursing and midwifery are very gender defined. There may also be imbalances in the representation of the genders at different levels of the structure, with women disproportionately represented at lower levels and in certain front line positions. Women may also be targeted specifically for paramedical roles in the health sector at local level, such as in family planning or maternal health programmes and as unpaid community health workers[15].

Where such targeting occurs, it is usually a recognition of a) the importance of recruiting from the locality in order to circumvent the frequent problems of health worker exit through e.g. promotions, transfers or dislike of "remote" postings, b) a more general tendency for "caring" work to be considered "women's work," and c) preference by users for women providers in certain kinds of services. Much evidence also suggests the importance to many women of access to female providers in relation to health needs where intimate physical contact or examination is involved[1,16].

Sufficient evidence exists, therefore, to suggest the need to take gender seriously in human resources planning. Rather than assuming that all health staff are formally interchangeable, this article starts from the proposition that women and men may be positioned differently in terms of the kinds of contracts which are optimal for their circumstances, and within which they can best deliver services. For instance, rather than assuming a full time norm of employment, it may be that part time contracts are more useful for some women health staff. Similarly incentives may operate differently for men and women because of differences in their relationship to the locality.

2.1 Gender awareness in human resources policy

The importance of gender awareness in HRPP can be understood in relation to three levels of institutional practice:

- It refers to an understanding of the significance of gender in the positioning of people in the health sector workforce, and a recognition that gender affects occupational choices, career patterns and working practices. It therefore indicates a practical need to consider the relationship between the gender composition of the health workforce and the kinds of recruitment strategy, terms, conditions and contracts which will make the most effective use of health human resources.
- It relates to the need to provide more gender sensitive health care services, particularly in the area of reproductive health. The more encompassing understanding of reproductive health which came out of the Cairo Declaration emphasizes the importance of involving men in reproductive health matters, and of taking into account the context and constraints within which women make health choices. There is also the

2 A recent exception is the recent Round Table Discussion[12] on the inequitable distribution of qualified medical staff in Thailand.

important issue of provider-client relations and the sensitivity of providers, particularly to female clients. This implies the need for gender issues to be incorporated into health worker training.

- It relates to the low representation of women in decision making in health care[17]. This is both in the context of the low numbers of women at senior levels in the professions and in policy roles, and in the context of the absence of women's voices as stakeholders in the services which are provided.

The gendered nature of health care production therefore has policy significance for human resource planning in the following two areas, which are discussed in turn:

1. The quality of health service provision.
2. Preventing or reducing inefficient use of human resources through tackling gender discrimination in HRPP.

2.2 Quality of health service provision

The Plan of Action of the Fourth World Conference on Women[18] endorsed the need to "increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services." (Strategic Objective C.1:63). It also called for health information, services and training to be redesigned in more gender sensitive ways. This includes both an understanding of the specific health needs of women, and an understanding of gender relations and the ways in which women may be disadvantaged in their access to health care[3].

This stance requires little justification in the context of the heavy burden of preventable morbidity and mortality borne by women in poor countries. This is particularly an issue in many rural areas where services are inadequate or dominated by poorly regulated informal sector providers. Both technical quality of services and, often, the interpersonal and communication skills of providers may leave much to be desired[19]. In the public sector, poorly motivated and remunerated health workers are rarely likely to provide adequate, "user-friendly" services. There has also been a general recognition by governments, donors and planners of the need to shift the focus to quality issues in service provision[20].

In the context of most developing countries, this entails addressing the following issues:

- access and under-utilization, such as the ways in which women may be disadvantaged by the location of the facilities;
- the content of the services - are they appropriate to the health needs of women?
- the training of providers in appropriate and sensitive health care (including addressing men's reproductive health roles and health needs);
- the views of user stakeholders on services, particularly the views of women which may not always be represented by "community" organisations such as local health committees[21].

A number of factors predispose women to manage their health needs as locally as possible. Constraints on women's time, such as family and child care, affect their utilization of clinic and hospital based services and mean that they rely more on home based care and local practitioners[22]. Women are also usually the first line carers of sick family members and thus tend to have proportionately more contact with health services than male household members. Pregnant women are also major users of primary health care facilities[23]. This means that the health service needs of women and children are *de facto* substantially met by other women, particularly midwives, traditional birth attendants and some cadres of community based paramedics (e.g. family planning and MCH workers).

From a HRPP point of view, this underlines the need, first, to consider carefully how best to

meet these needs within existing constraints. Given the difficulties of recruiting and retaining qualified staff for rural and remote areas, what kind of incentives might change this, and how does the gender of the provider affect the take up of incentives? Can the old model of the multipurpose community health worker be revitalized to provide a reasonable quality of service in terms of meeting basic health needs, and should the focus be on developing female cadres in particular, on the grounds that they may be a more stable workforce?[3] Second, human resources planning should ensure that training for health staff is gender sensitive in order to cater to the needs and preferences of users.

2.3 Gender and discrimination in health sector employment

Antidiscrimination arguments have several different provenances. The micro-economic analyses outlined above provide strong backing for promoting equal opportunities for women (or indeed positive action) purely on an efficiency basis. Investment in women's human capital has a significant impact on national economic development.

Antidiscrimination can also be argued from an equity perspective: promoting equality of opportunity between the sexes is a social and political good in its own right. A strong antidiscrimination statement is found in the Beijing Declaration[(18)], which calls for "regulations to ensure that the working conditions, including remuneration and promotion of women at all levels of the health system, are nondiscriminatory and meet fair and professional standards to enable them to work effectively." (Part of Strategic Objective C.2:72).

Probably the most persuasive case for "equal opportunities" is the way in which it can be shown to be highly cost effective to the individual employer. Recent debates about equal opportunities have stressed the importance of the "business case" approach to equal opportunities. Whilst an earlier generation of equal opportunities policies was often seen as bureaucratically cumbersome and too focused on "equal rights," more recent thinking has emphasized the fit between business goals and equality goals. This stresses the "value added" of having diversity in the workforce. It notes that differences between one group of workers and the next can be valuable assets to employers (e.g. women's experience in managing multiple tasks simultaneously can be an excellent basis for managing in the workplace). It also stresses the importance of equal opportunities for retaining and motivating qualified staff[(24-26)].

Many equal opportunities policies put in place by employers thus reflect a pragmatic concern to retain valuable skilled workers (who may have been trained at considerable cost, or who may be scarce) by creating an environment within which women and other minorities are not disadvantaged in their work and career advancement goals. This means thinking more imaginatively about the constraints faced by women in formal employment and how to provide more employee friendly terms and conditions.

As a major employer of female labour, "equal opportunities" or antidiscrimination action is not a luxury but a necessity for the health sector. The Government of Uganda, for instance, has said that it will not support any further increase in the health sector workforce. It is vital, therefore, that the productivity of its existing workforce, of which a very high proportion is female, is developed to its maximum potential. This is a particular need in the context of the high rates of HIV prevalence in several countries of sub-Saharan Africa, where many health staff have already been affected.

Equal opportunities issues in relation to gender may arise at a number of levels:

3 A study from Haiti[(15)] found that the most successful ones were literate females with extended family ties which meant they remained within the community.

- Through terms and conditions for existing staff which set requirements which one sex is less able to meet than the other because of structural or familial constraints (e.g. a promotion requirement for overseas training).
- In workforce restructuring, such as the retrenchment of particular cadres of staff who happen to be mainly female (an important but unacknowledged issue in public sector reform).
- In recruitment, where there are significantly lower numbers of women taken on than men.
- A "category bias" in which a whole group of workers, which happens to be predominantly female, is treated less favourably than another group, which happens to be predominantly male. For example, in most of Anglophone Africa, nurses are mainly female and are the front line providers of health care at primary level. In many of these countries, salaries for health staff have fallen to levels which do not provide a living wage. Whilst doctors have been able to supplement their public sector earnings by private practice, nurses may be prohibited by law from doing so.

There is currently a serious under representation of women as policy makers and at senior level in the health sector in sub-Saharan Africa. This is due both to failure to improve women's participation in higher education, and to an absence of policies or mechanisms to address gender issues within human resources policy[27]. In Zimbabwe, women hold only 9% of the most senior positions in the civil service[10]. In Uganda, only 3.7% of all employed women are employed in professional, technical, clerical and managerial occupations[28].

This points to some wider issues in human resources policy. One of the difficulties seems to be the relatively narrow remit of what is included under the heading of human resources. This means that there is generally, for instance, a lack of integration between education policy and human resources planning.[4] A further problem is the absence, for the most part, of any representation of stakeholders in negotiations about HRPP in contexts of major restructuring of the health sector.

Given the gender blindness of HRPP, it is very difficult to find even basic information at country or regional level on the gender breakdown of staff at different levels or grades in order to provide a basis for developing appropriate policies to address problems such as the under-representation of women in senior positions.

Case study evidence, however, indicates some typical ways in which discrimination operates, either directly or indirectly. A study of Sudanese women doctors found complaints of pervasive discrimination against women in promotions and the award of scholarships for overseas study. There was a general assumption that women did not want, or were not able, to advance their careers because of family responsibilities[29].

Nearly half of the female medical graduates sampled were not undertaking postgraduate training. Common reasons given for this were the problem of completing their hospital experience because of the pressures of family responsibilities, and having to travel abroad with their husbands when they were undertaking training. These graduates also believed they were discriminated against through common stereotypes of women doctors as "inefficient" and lacking motivation because they were more likely to work part time or take career breaks.

A recent UK study[30] provides an illuminating account of the ways in which the restructuring of a profession dominated by

4 Although there have been some attempts to address the gap. For instance, the Government of Uganda has experimented with reducing the university entrance requirement for women candidates.

women, without regard to possible gender implications, can operate to disadvantage them. In Britain, nursing historically was not a linear, bureaucratic ladder of opportunity, but a command hierarchy presided over by a (female) matron. This was essentially a female chain of command within the (male) doctor dominated institution of the hospital, which gave the matron sole jurisdiction over her staff of ward sisters and staff nurses.

The health service reforms of the mid-1970s replaced this with a career hierarchy of posts from ward level up through the hospital and through the newly constructed administrative tiers to the Regional Nursing Officer. One result of this was that by the mid-1980s, senior nursing management was increasingly masculinized. Nearly 50% of these posts were held by men, despite the fact that men constitute only 10% of the profession.

This new career hierarchy is described as "stratification on the basis of motherhood." It occurred because of the clash between women's need for career breaks when their children were born, and the rigid logic of career progression where qualifying time periods were built into progression, and "time out" sent a nurse back into a lower grade. There was no allowance for them to remain on the same grade but to work part time. Returning mothers got shunted into what are seen as the "dead zones" such as night work. As night sisters were placed at lower grades than day sisters, it was then difficult to move from nights to days. As a result of this indirect discrimination, whilst men took 8 years on average to reach Nursing Officer grade, women who took career breaks took 23 years.

However, even women with no career breaks took an average of 15 years, suggesting that there were also other discriminatory factors operating. Comments from respondents in the survey suggested a great deal of gender stereotyping. Female nurses were seen as intrinsically not good at management, and as less motivated or concerned with their careers than men. This fed through into e.g. differences in the numbers of women and men applying for promotion at given points in their careers.

While the contextual details are obviously specific to the UK case, these examples do indicate significant ways in which women can be disadvantaged by ostensibly neutral occupational restructuring. In both the Sudanese and the UK case, family responsibilities constrained women's options in furthering their careers. Both cases also demonstrate the significance of stereotypical assumptions about women's capacities or motivation in perpetuating discrimination. They underline the inefficiency of discrimination. In the UK, a serious shortage of nurses has developed in recent years, as young women look elsewhere for careers and older staff leave the service for better remunerated jobs with better career options. In the Sudan, there is a high rate of exit from medicine by women graduates.

Equal opportunities policies are an important recognition of the way the private world of the home and the public world of work are interrelated in reality. Although this is true for both sexes, it is of particular significance for women, who bear the major responsibility for child care and whose capacity to act as independent sellers of their labour is frequently constrained by marriage, motherhood and cultural hostility to, or ambivalence about, their employment status.[5]

However, the accommodation between the public and private worlds generally rests on implicitly male assumptions about the nature of working life; in particular that it is always full time, uninterrupted etc. In practice, women's work lives are often not like this. Marriage or motherhood can have highly determining effects

5 A study notes that nurses at Mulago Hospital in Uganda sometimes faced difficulties from husbands in retaining their jobs since the serious decline in public sector funding. Husbands would "hide their uniforms" to try to force them to work in (better remunerated) family businesses instead[(9)].

on women's work and career patterns. This then results in a tendency to see women as "the problem" rather than the male employee based norms around which employment is generally structured.

For example, problems of recruiting qualified staff to rural areas and retaining them there are common across the developing world[12]. Women health staff are often seen as particularly recalcitrant in not being prepared to work outside towns or cities. Most attempts to deal with this assume (a) that it is best to concentrate on getting staff to spend time in rural areas at the beginning of their careers, and (b) that financial or career progression based incentives work best in motivating employees to move to or stay in rural areas. These assumptions are again implicitly based on "typical" male career patterns. Yet, in contrast to men, women in early career are generally precisely the most constrained by either family and marital demands, or by cultural difficulties in living away from families. A more imaginative approach might test whether and with what incentives, older women with no longer dependent children might be prepared to work for periods in rural areas.

For example, in Zimbabwe, there is a very high drop out rate from nursing among women staff with over 15 years experience. This represents a serious loss of experience and expertise. HRPP needs to examine (a) the reasons for this high exit rate and (b) what might be needed to be redeploy such staff so that their skills are not lost to the sector.

Recent studies in Malawi and Zimbabwe on how nurses are responding to the crisis make sobering reading[31,32]. Morale is extremely low. Strikes are endemic. Many have left government employment, some work privately as nurses, some have left nursing altogether and others have left the country. Nurses remaining in public employment increasingly augment their salaries through legal and illegal means. This may include moonlighting in private facilities, attending to nonmedical businesses and requesting informal payments for services.

This is partly due to rigidities in the demarcation of professional territory. In some countries where prescription medicines can be bought by anyone over the counter, nurses can face professional misconduct charges for prescribing common drugs which both doctors and paramedics supervised by nurses are allowed to prescribe. Nursing associations have generally found it difficult to assert professional autonomy vis-à-vis the much more powerful doctors' associations or to be heard in any negotiations. Gender has been an important dynamic in the politics of professional representation, reinforcing the lack of voice of this critical group of health workers[13,33].

The structural crisis in public sector employment in much of sub-Saharan Africa affords an opportunity to think more imaginatively about the deployment of health human resources in ways that might begin to satisfy equal opportunities and optimize the contribution of female health staff. This means looking critically at existing working practices, contracts, incentive structures and stereotypical assumptions about how health care tasks should be divided. Policy makers also need to pay the same attention to nursing stakeholders as they do to other powerful medical stakeholders.

3. Current models for human resource planning

HRPP has been criticized for its gender blindness. This occurs not just when an assumption is made that all individuals are formally substitutable, regardless of gender, but also when there is an unrecognized bias that these individuals are "male." Thus, working hours, conditions of service and career structures are predicated on what are really typically male patterns of employment. Women then become seen as a "problem" when they cannot or do not accommodate to these patterns. This gender blindness is part of a more general problem in HRPP whereby there is a failure to consider life cycle issues and their relationship to the patterns of work and career decisions which people make.

HRPP rarely addresses the needs of women employees which relate to their different life cycle experiences. For instance, women who leave the workforce for family reasons may need special attention if they are to return later. Their skills will need updating and they may need encouragement to re-enter employment in the area in which they were originally trained. Yet few employers keep records which would enable them to track differential retention and loss rates and the patterns of entry and exit of staff.

Whilst the official discourse of HRPP is ungendered, there is considerable evidence, already referred to above, of other "gendered" discourses which operate in the HRPP field. One of these is at the level of stereotyping, where generalized attributions are made concerning women's unsuitability for particular positions or promotions. Respondents in the study of Sudanese women doctors[29] complained that they were regarded by health planners as females rather than as professionals. As noted already, this is an unhelpful discourse, not just because it is unfairly discriminatory but also because it is inefficient. It detracts from the optimal deployment of valuable staff. It reinforces what are seen as "problems" with women as employees.

The other is a pragmatic discourse which does recognize and attempt to deal in an ad hoc way with the issues thrown up by gender differences. For instance, in Democratic Yemen, very directive measures were taken to overcome the problems of getting health staff to work in rural areas. In the face of cultural difficulties in recruiting women, a system of compulsory health service for women was established[14]. As noted, considerable practical use is made of women as community level paramedical staff, in recognition of their frequently greater acceptability to local users and their ties to the locality. Here, gender is being used in a very explicit way to promote a solution to a practical problem.

There are some indications that the technicist bias of HRPP is beginning to be challenged. A WHO Consultation in 1992 drew attention to the problems in linking planning to policy and policy to implementation. It noted an excessive concern with the production of new staff rather than with improving the effectiveness of existing ones; and a confusion between policy with its attendant goals, and procedures and regulations for managing staff[34]. In other words, the quantitative and technical have dominated over the qualitative and strategic.

It also pointed to the importance of making qualitative assessments of efficiency and performance. Effort needs to be focused on such issues as what workers do, how tasks and functions are distributed, how performance is monitored and rewarded, and the quality of care which is provided. These are all questions which may have a significant gender dimension to them.

There have been other critics of the narrow focus in human resource development (HRD) on staff numbers and training and pleas for more attention to the contextual factors which determine or influence this goal[35,36].

Gender can thus usefully be thought of one of these key contextual factors. In the health sector, skills are not randomly distributed - they are frequently gender specific or gender dominated. Gender may also combine with another important contextual factor, namely age. Younger and older women health staff may be situated differently in terms of what constitute optimal terms of service, working hours etc. for them. With increasing emphasis on the importance of flexibility in working practices, this provides an opportunity to develop a wider menu of options, taking into account gender and life cycle needs.

Motivation may also have a gender aspect. In all the concern about how to improve staff motivation within the health sector reform debate, no attention seems to have been paid to this. Yet the example of the frequent lament about the difficulty of getting female staff in particular to work in rural areas suggests that it may be important to find out whether a different incentive structure is needed to attract or retain women. In

the Sudan, for instance, it was noted that the primary concern for women doctors in moving to rural areas is with adequate housing and security, not with salary compensation[29].

The arguments for taking gender seriously in HRPP are not, therefore, based on special pleading for women (or on a unilateral view that women employees always have different needs or interests than men), but on the need to develop a much more effective way of using the health human resources that exist to meet the considerable challenges of providing competent health care in resource poor settings. This means enabling qualified women to operate effectively as workers while avoiding the pitfalls of stereotyping women as a "problem." This entails incorporating gender as a key contextual factor into HRPP frameworks.

3.1 Factoring gender into Human Resource Planning and Policy

In the above discussion, an attempt has been made to sketch out the main ways in which gender issues enter into HRPP. Key points from that discussion are as follows:

The health sector in sub-Saharan Africa, as elsewhere, employs significant numbers of women and is one of the only parts of the formal sector where women have established a major presence. At the same time, women tend to be concentrated in certain occupations and to be poorly represented in management positions and at senior levels in the professions. National governments, the World Bank and other agencies have all expressed concern about the low representation of women in senior positions.

There are important efficiency, service quality and equity arguments for taking gender seriously in HRPP. However, HRPP has tended towards a very narrow remit. It has been concerned with numbers and training at the expense of qualitative and strategic issues. Recent calls to incorporate contextual factors into HRPP, provide an opportunity to take on gender issues.

HRPP also contains hidden biases - personnel are assumed implicitly to be male and male patterns of work and career development are the norm. This has resulted in women employees being seen as a "problem" rather than as a resource to be used more imaginatively. At the same time, gender differences are often used pragmatically to resolve ad hoc problems in staffing services. There has been a general failure to take the life cycle needs of employees into account.

The gender blindness of HRPP has meant that there is a lack of basic information on the gender composition of the health sector workforce and little recognition of the need routinely to collect this information. HRPP has also not sufficiently consulted key stakeholders, both users and providers, as to how services can be improved and health workers' own needs and concerns addressed.

Similarly, whilst there is much current concern over quality of service issues, there has not been much formal attempt to link supply side issues with the demand side. HRPP needs to take much more account of what is happening on the ground in terms of demand side behaviour. Health worker training should address user needs for gender sensitive skills and programmes.

The paper suggests reasons for considering the content and targeting of training programmes quite closely. First, do they reflect the needs of users for sensitive (including gender sensitive) health care services? Second, are they targeted on those groups or individuals who will be most likely to use the skills obtained, and what is the role of gender and age in this? Third, what kinds of skills are most appropriately taught to health workers, given the restructuring of the public sector workforce and the near demise of stable, well paid public sector careers?

3.2 Methodological issues

The discussion has drawn attention repeatedly to the lack of information available for understanding the significance of gender in human resources, and thus for monitoring gender issues in HRPP. This has important implications for developing a framework within which gender

can be incorporated. It means a) that the data sources on which HRPP is based are not adequate to understand the role of contextual factors in provider behaviour, and b) that there is need for methodological innovation if such factors are to be integrated. Thus, stakeholder consultation needs to be much more central to the policy and planning process.

In section 2.1, attention was drawn to the specific ways in which gender blind HRPP can produce discrimination and reduce the effectiveness of human resources. These are now considered from the point of view of the data collection needs they would generate. For all of these, gender and age disaggregated data on the health sector workforce are required in order to understand its demographic structure, and thus provide a basis for taking account of life cycle factors in the disposition of the workforce.

- Terms and conditions for existing staff which set requirements which one sex is less able to meet than the other because of structural or familial constraints (e.g. a promotion requirement for overseas training).

Data on the gender composition of personnel taking up different types of training or career opportunity, data on gender/age of those leaving a) the public sector, b) the health sector. Qualitative data on female and male provider views of opportunities and constraints and on how barriers might be dealt with.

- In workforce restructuring, such as the retrenchment of particular cadres of staff who happen to be mainly female.

Data on the gender composition of different categories and grades of workers. Consultation with user and provider stakeholder representatives on implications for service delivery.

- In recruitment, where there are significantly lower numbers of women taken on than men.

Quantitative and qualitative data on educational and other barriers to female recruitment. Data on the proportions of men and women in senior positions. Qualitative data from stakeholders on reasons for gender imbalance.

- A "category bias" in which a whole group of workers, which happens to be predominantly female, is treated less favourably than another group, which happens to be predominantly male.

Consultation with provider stakeholders on implications of restructuring policies for specific groups and potential for indirect disadvantage, e.g. policies on private practice and professional regulation

3.1 A framework for incorporating gender into HRPP

The aim of this framework is to offer ways of bringing gender issues into human resources thinking in the context of health sector reform. Building on the work of Martineau and Martinez[36], it uses their four main headings for categorizing human resource issues, but with gender included as a key contextual factor. The final column notes additional data collection needs which would stem from a decision to incorporate gender issues in planning, monitoring and evaluating human resources policy.

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Table 1 Reduction of costs and increasing efficiency

Contributory factors	Gender issues	Data collection needs
Accurate information on the staffing situation	To feed into service planning and equal opportunities, what is the gender breakdown of staff in different occupations and at different grades?	Routine data to be collected on gender composition of health staff and trainees
Coordination between supply and demands of the health sector	Need for co-ordination with education sector to produce sufficiently qualified women for training. Do terms and conditions of training impose any barriers to women? Do terms and conditions of employment present barriers to women/are they "family friendly?"	Trends in female education Monitoring of exit from training and from public sector by gender Survey of barriers to female participation in training/ health sector employment
More flexible employment arrangements, new types of terms and conditions	Do proposed changes in contractual arrangements affect women employees differently from men (e.g. part time working)? Does HRPP need to take account of this in offering a wider menu of options? Can qualified and older women who have left the health sector workforce be attracted back by specific conditions to suit their circumstances (e.g. by legitimising private practice activities?)	Information from employees and professional associations/ trade unions
Reducing staff numbers	Will this disproportionately affect categories of staff where women dominate? What will be the effect on the quality and type of service delivered?	Gender breakdown of different staff categories. Information on access and utilisation of services, user views and health seeking behaviour.

Table 2 Improving staff performance

Contributory factors	Gender issues	Data collection needs
Providing suitable incentives for staff	Do male and female employees respond differently to different types of incentives? Should a wider menu be provided which would cater to any differences?	Survey of male and female employees and trainees
Changes in skills/skill mix and working practices	Are the categories of workers who are likely to be affected female or male dominated? Will the changes proposed result in widening or narrowing of the skill base for female dominated occupations?	Gender disaggregated data on occupations and grades
Designing appropriate skills mix	Meeting the needs of users for high quality reproductive health services	Studies of user health seeking behaviour and preferences
Impact of reforms on career paths and new forms of career development	Do new career structures impose conditions which can discriminate against female employees (e.g. training requirements which are difficult for women with family responsibilities to meet)?	Information from employees and professional associations/ trade unions
Style of human resources management	Developing a more contextually focused and consultative mode of managing human resources in which issues such as gender can be addressed directly	Treating consultation of stakeholders as routine

Table 3 Improving equity in the distribution of services

Contributory factors	Gender issues	Data collection needs
Effective mechanisms for staffing facilities in rural/ remote areas	Do female employees face different constraints from male employees in working in these areas? Are there ways of using these differences more effectively (e.g. by greater flexibility in timing of rural postings, or more specific use of locally based female paramedics?)	Information from employees and professional associations/trade unions.
Improving the quality of basic health services, especially in MCH/FP, and tackling under-utilisation of services	Providing services that are sensitive to women and their health needs, and that accommodate any expressed preference for same sex providers	Studies of demand side health seeking behaviour and preferences
Decentralising services closer to the point of delivery	Who takes responsibility for monitoring of "equal opportunities"? How is data collected, managed and used in decentralised systems?	
Contracting out of services to private sector/NGOs	Ensuring "quality control" for gender sensitive services	User satisfaction surveys

Table 4 Development of HRPP capacity

Contributory factors	Gender issues	Data collection needs
Information on staffing for planning and monitoring purposes	Should be disaggregated by gender at all levels	
Liaison with education ministry on HRD requirements	Addressing women's disadvantage in educational opportunity	Monitoring of school drop out rates and studies of reasons for lower educational attainment among girls
Effective and efficient use of qualified staff	Shortage of women in senior management positions	Case studies of barriers faced by women
Planning methodologies	Greater consultation with stakeholders, particularly female users	

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