

Promoting women's leadership in the post-conflict health sector in Cambodia

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Although women account for the vast majority of the global health workforce, they are under-represented in leadership positions. Gender inequity in the workforce can restrict entry into the health sector, career progression, access to professional education opportunities, and motivation.

Gender disparities in health leadership are also prevalent in post-conflict settings, where incentives to motivate health workers, particularly women, to continue working during and after a crisis have been overlooked. During conflict, abduction, injury, displacement, and lack of support can deter health workers, especially women, from taking on a leadership role. In Cambodia, civil war and conflict lasted almost 30 years, from 1970 to 1998. Health workers were among the 3.3 million professionals who were executed during the Khmer Rouge regime (1975-1979). After the fall of the Khmer Rouge, it is believed that only 40 doctors were left in the country.

Now, after a 20-year period of strengthening the health system and developing human resources for

health (HRH), over 19,000 people are employed in the health sector in Cambodia. Women make up most of the health workforce, and yet rarely hold senior roles, and have fewer opportunities than men to re-train for new positions. Only one in five leadership positions in the Ministry of Health are held by women. Just 16% of senior health workers (such as doctors) are female, compared to 100% of midwives. This is problematic for several reasons. Women's concerns, for example, are not reflected in health policies, including HRH strategies. Human resource policies, such as those related to career advancement, do not take into account women's life course events, such as childbearing and childcare. And, finally, in a country where most women prefer to be cared for by female health workers, the shortage of female doctors limits women's access to health services.

Research on gender equity in human resource management for health in post-conflict settings is limited. To fill the gap in the evidence base, ReBUILD and RinGs, carried out qualitative research in Battambang province, Cambodia.

METHODOLOGY

In-depth interviews were conducted in February 2016 with 14 female and six male health managers in two districts. A life history approach was used to record health workers' views. This approach enables researchers to capture personal perceptions and experiences over time, and can empower participants by giving them the opportunity to tell their own stories.

Participants who started their career in the 1980s or 1990s were chosen, in addition to one younger health manager. All had advanced their careers. Interviews were recorded and transcribed in Khmer and translated into English. Transcripts were analysed to identify the impact of gender on motivation and barriers at the individual, household, community, and institutional levels.

The study has some limitations. More women than men were selected for interview on purpose in order to explore women's views, perceptions and experiences. As there was just one young interviewee, it was difficult to explore the views of young managers in the post-conflict period. Finally, the life history approach relied on people's memory of past events.

KEY FINDINGS

Female and male senior health workers' views of their career progression was explored, from the period of conflict to the present day. Researchers sought to understand how gender has influenced their entry into the health sector, their career path and development of technical skills, and what this means for women in leadership positions today. While they evolve over time, gender norms shaped women and men's engagement in the health sector. This was especially true for women.

1980s (the government began to rebuild the health system after the fall of the Khmer Rouge)

"There was also a Khmer social tendency that girls should not study much as they would still become someone's wife in the future." (64-year-old married man)

- In general, women were encouraged to stay at home rather than study at medical school. This was due to safety concerns as well as gender roles.
- Female and male health workers' decision to go to medical school was not only based on personal or financial reasons, but also shaped by the wider social and political context, such as wanting to avoid military conscription.
- During conflict, female health workers faced challenges, such as risks to their personal safety, travelling long distances on poor roads, lack of contact with family, and nowhere to stay. Women who worked in remote conflict-affected areas were, however, motivated by the recognition they received from the community, as well as peer support.
- In most cases, the women who pursued further studies were single, did not have children, or were supported by husbands and family members.

1990s (health sector reform started in 1996, but civil conflict did not end until 1998)

"My aunt was also a doctor and this also pushed me more to love this position. Wearing white uniform was what I dreamed about when I was a child." (44-year-old married woman)

- The importance of role models was highlighted, for example, a successful senior health worker who inspired participants to study medicine and enter the health sector.
- Women were constrained by gender norms in carrying out their jobs, for example, facing the disapproval of family and community members when they worked a night shift. They reported feeling undervalued by male colleagues, however, they welcomed support from other women.
- No participants pursued further studies at this time. Barriers to education included traditional gender responsibilities – women's role childbearing and caring for children, and men's role as the breadwinner – as well as lack of encouragement from managers.

2000s to present day (peace was restored in Cambodia in the early 2000s)

"My husband's salary was enough to support me when I was studying... My husband also agreed to let me study." (46-year-old married woman)

- Gender equality advanced, and it was widely accepted that young women could study at medical school - often far from home.
- Female health workers were expected to look after the children and home, as well as work. Some women were supported by their husbands and family members, and others hired help.
- A gender working group was created to support female members of staff, and gender training helped build women's skills and confidence.
- Women who had children valued their partners' support in being able to continue their studies, in spite of challenges. Some men shared responsibility for housework and childcare. Participants were motivated by role models, such as women who combined further studies with motherhood.

Women currently in health leadership positions

Barriers

"For me, I was often in a hurry when I went out and soon after I finished doing the injections, I often returned home and breastfed my children..."

(59-year-old married woman)

Female health managers identified constraints which affect their leadership role:

- Juggling work with looking after older family members, breastfeeding and housework. Some women, however, considered this an inconvenience rather than a barrier.
- Many women felt that, as leaders, they were treated with less respect than men. On the whole, men had developed their technical skills to a higher level, but even when women were sufficiently qualified, they were still not considered suitable for leadership positions.

Enablers

"My husband is often the one who cooks the rice... Once we finish eating, I do dishes and return to work... It does go against the gender norms, but my husband understands my condition."

(58-year-old married woman)

Female health managers identified the following factors as furthering their career progression:

- Support from their partners and family.
- Support from the head of the local health institution, particularly early on in their leadership position.
- Drive and determination to succeed, hard work, and a willingness to take on new challenges.
- Qualifications and skills in order to gain respect from male and female colleagues.

CONCLUSIONS

"...I always perceive that whatever men can do, women can also do it. I always want to show my output and results to others."

(58-year-old married woman)

After the defeat of the Khmer Rouge, government HRH policies focused on recruiting and training health workers, while failing to address barriers to gender equality. Female health workers made a substantial contribution to saving lives during the crisis and rebuilding the health system. Their needs, experiences and the challenges they faced were different to men's. Without gender-sensitive policies, women's potential to fully engage in the health sector cannot be realised. This study underlines the need for government policy to acknowledge and act upon the impact of gender on health service delivery both during and after conflict.

The study captures the voices of dedicated female health workers who stayed in their jobs during the violent conflict, despite risks to their safety. Recognising the factors that empowered them to continue working – namely, social recognition, managerial support and backing from their peers – is important, and may be relevant for staff retention policies today.

Since the conflict, gender roles and responsibilities have evolved in Cambodia. Women are increasingly aware of their right to study and work outside the home. Some men share household tasks. The government has strengthened its policy and support for gender equality, and respect for human rights. Nevertheless, gender norms and expectations perpetuate the division of traditional roles, with domestic tasks largely assigned to women and decision-making to men. Women are still significantly under-represented in health leadership positions.

In order to promote women's leadership in the health sector, an understanding of the obstacles faced by female health professionals in Cambodia, and how they overcame them, is valuable. A number of factors contributed to their success. The women are highly motivated. Support from partners, family members and managers is crucial, illustrating the importance of achieving gender equity at home as well as at the workplace. Finally, skills and qualifications are necessary.

The career path of today's female leaders was forged not only by their own history but also by the social and political context. Therefore, to accelerate progress in advancing female leadership within the health workforce, the collaboration of a wide range of stakeholders at various levels – individuals, organisations, institutions and society – is required. This is a long-term process that begins with increased access to education for women.

Gender should be mainstreamed within health workforce policy. Key actions include: combating gender bias at the workplace, promoting role models and mentoring, providing supportive supervision for woman leaders, and generating commitment for quotas for female candidates.

Increased political will is required to advance gender equity in the health workforce. This is an ambitious goal. The benefits, however, are far-reaching. There is some evidence that, as decision-makers, female health managers are better able to respond to the needs of the entire population, especially women. Promoting women's leadership can improve health system resilience and responsiveness, ultimately advancing equity and improving health outcomes.

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