

Violence against female health workers is tip of iceberg of gender power imbalances

Tackling gender power relations is key to ensuring the safety and wellbeing of health workers and the ability to deliver quality care, say **Asha George and colleagues**

Twenty five years ago the Beijing Platform for Action for Women advocated for women's rights to health. In doing so, it recognised women as important providers of healthcare and not just as users of it. Since then, attention to the predominantly female composition of the health workforce and the central role of health workers to global health, and to economies more broadly, has increased.¹ Nevertheless, the potential contribution of female health workers to advancing global health remains inhibited by several factors, including those underpinned by gender power relations. One of the more extreme and harmful forms of abuse of gender power relations is the violence perpetrated against female health workers. Such violence continues even as health workers respond to the covid-19 pandemic.²

A joint task force on workplace violence in the health sector, set up nearly two decades ago by the International Labour Office, International Council of Nurses, World Health Organization, and Public Services International, emphasised that workplace violence is a structural problem rooted in social, economic, organisational, and cultural factors.³ As well as responding to and mitigating individual incidences of workplace violence in healthcare, it is therefore essential to also tackle the underlying gender power dynamics at a broader organisational and societal level if we are to protect women health workers.

KEY MESSAGES

- Violence against female health workers is an extreme form of abuse of power within the health workforce
- Tackling underlying gendered power dynamics is key to stopping violence against female health workers
- Achieving good quality healthcare worldwide requires the rights of the women responsible for delivering care to be acknowledged, protected, respected, supported, and promoted

Overlooked problem

Violence in the workplace is defined as "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health."³ Workplace violence affects all health workers, but it is particularly harmful to women. Gender power relations and their intersectionality with other factors, such as age, ethnicity, and income, are associated with the form and source of violence experienced by female health workers but are often hidden like the base of an iceberg (fig 1). Despite the structural causes of violence against health workers being recognised over two decades ago, the widespread prevalence of the problem throughout the health workforce hierarchy and its gendered roots continue to be ignored (box 1).

Violence against female health workers in the workplace undermines their confidence and undercuts their ability to progress in their careers or be promoted to the leadership positions from which they could prevent and curtail abuses of power. The long term effect of violence against health workers is burnout and moral distress, which leads to absenteeism and attrition. In addition, fewer women may not choose to pursue health occupations if workplace violence is not adequately addressed. Eventually this could impede efforts to meet the global shortfall of health workers. The resulting vacancies place additional stress on remaining health workers and can further undermine their ability to provide quality care.

Gender power relations underpinning the violence

We build on Batliwala's feminist analysis¹³ to focus on five key dimensions of how gender power relations undermine female health workers and heighten their vulnerability to violence in the workplace (fig 1). This includes what is known (visibility), who has what (resources, policies), who does what (division of labour), who is val-

ued (social norms and discourse), and who decides (agency, leadership).

What is known?

Although tools have been developed to measure workplace violence, they are not routinely used in health facility surveys. Under-reporting within existing efforts to measure workplace violence is also a problem, creating a misperception that sexual harassment cases are rare.¹⁴ Violence against female health workers may be under-reported because of stigma around reporting or because it is perceived as normal practice. The lack of visibility undermines the ability to champion reform.¹⁵ Insufficient data on violence against female health workers echoes a broader lack of prioritisation to measurement and acknowledgement of women's experiences and contributions to healthcare.¹⁶

Who has what?

Even when women who experience workplace violence overcome the stigma or normalisation of their victimisation, trusted mechanisms for reporting and addressing such violations may not exist.¹⁷ In India, mechanisms set up to handle sexual harassment incidents in hospitals were often overseen by management staff who were not neutral or were implicated in cases themselves.¹⁸ Organisational mechanisms may also lack legislative backing. In 2019, 59 countries did not have laws prohibiting sexual harassment in the workplace, 100 countries had no civil remedies for sexual harassment in the workplace, and 110 had no criminal penalties for sexual harassments in the workplace.¹⁹

Safety in the workplace has varied meanings and requirements for women and men across the health workforce. Different occupations may be exposed to different physical and psychological risks across diverse healthcare settings. For example, informal community led care is predominately provided by women, who are often from poorer communities with less access to education or paid employment. They are less likely to have

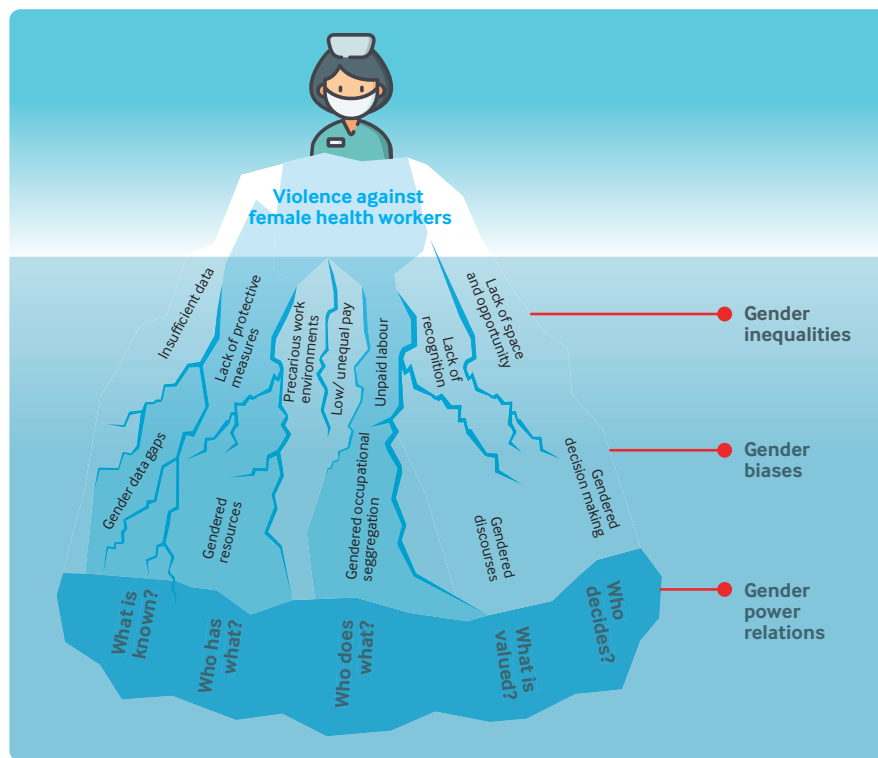


Fig 1 | Gendered dimensions of the health workforce underpinning violence against female health workers

access to personal protective equipment than surgeons in a tertiary hospital, who are more likely to be men. In addition, the male norm used for designing protective equipment is an example of bias against all female health workers and for male health workers who don't fit the norm. The importance of access to protective equipment for health workers is evident in crises such as the covid-19 pandemic and Ebola outbreaks.

Who does what?

Another reason why female health workers fail to report violence or advocate for safe working conditions is the gendered economic risks they face. Female health workers, particularly those from marginalised groups, are often in more precarious or part-time contracts with lower remuneration and benefits, even when in the same occupational group as men.^{20 21} Strikingly the gender pay gap in the health sector is larger than the average of all labour sectors combined.²¹

The nature of the health labour market can also reinforce particular gender dynamics. In countries with low ratios of health workers to patients, such as Pakistan, the high demand for their skills means women find it easier to switch jobs

than report victimisation.²² In contrast, in Mexico the increasing numbers of trained health workers and a restrictive policy of permanent positions in the public sector make it more difficult for nurses to get and maintain jobs.²³ Female nurses may therefore fear the ramifications of reporting workplace violence.

Not only are female health workers placed at greater economic risk than male health workers, they also tend to work in more precarious and unsafe settings. Midwives and specialist primary care nurses often work night shifts by themselves in patient's homes.²⁴ Female health workers, particularly community and other field health workers, are responsible for outreach services or are based in remote locations, which also exposes them to violence.^{10 25 26} This occupational vulnerability is heightened by the broader gendered occupational segregation that occurs in healthcare.²⁷

Who is valued?

The professional and economic hierarchies that constrain all female health workers, but particularly those from marginalised backgrounds, normalise and mask a broader lack of recognition of female health workers' needs or even disrespect for their

skills and expertise. For example, in South Africa, female community health workers' gendered professional and personal needs were not articulated by policy makers.²⁸ At a broader level, the discourse around many female dominated health occupations, such as nursing and midwifery, as a caring versus curing profession, has historically justified its subordination to medicine and ignores the importance of caring for physical and emotional healing. Nurses and midwives tend to lack professional autonomy within the health workforce²⁴ because their capacities and skills are generally not recognised or valued by medical and institutional hierarchies.^{15 29 30}

Who decides?

Gender power relations are further reinforced by the constraints placed against female health workers in terms of their agency, leadership, and ability to mobilise collective action to defend their interests. Discriminatory gender norms make women feel they are not of equal merit, which can lead to self-censorship.³¹ Additional layers of social stigma exist within the health workforce in countries such as Pakistan, where women opting for nursing are usually from lower income groups and religious minorities. In our experience, this adds to the occupational hierarchies faced by female health workers. Lack of investment in women's professional development and leadership skills, even when they are included in decision making forums, inhibits them from advocating their case.³²

Empowering change

Following Batliwala's categorisation of power,¹³ if female health workers are to wield power to transform the gendered nature of workplace violence, they require several other forms of power. They must have the "power within" to believe in their capabilities and expertise despite the many forms of hierarchy they face in their workplace. They must have "power with others" to build effective coalitions to support collective action to address their interests. Finally, they must have "power under" their control, rather than being used or drawn into broader power dynamics. Given their experiences of marginalisation, female health workers are not inherently agents of transformation^{29 33} unless supported and held accountable for being such agents.

Action is needed in three areas to break up the iceberg of gender power relations that interferes with female health workers' rights, responsibilities, and roles in global

Box 1: Violence against health workers: a worldwide problem

Health worker surveys show that female health workers are greatly affected by violence:

- In a US survey of 1066 academic medical staff, 30% of women reported experiencing sexual violence in the workplace compared with only 4% of men⁴
- In the Republic of Korea, of 970 female nurses surveyed, 64% reported experiencing verbal abuse in the past year and 42% threats of violence⁵
- In Rwanda of 297 health workers surveyed, 39% had faced at least one form of workplace violence, such as verbal abuse, bullying, and sexual harassment, over a year, with women disproportionately represented and affected in all categories⁶
- In Nepal, 42% of 190 female health workers who participated in a survey on sexual harassment reported experiencing sexual harassment in the form of verbal and physical abuse, and almost two thirds reported being harassed by senior male colleagues⁷

Qualitative research suggests that many female health workers feel unsafe:

- In Bangladesh, where all midwives are women, a qualitative study found that the mobility of midwives after dark was perceived as “inviting sexual assault”⁸
- In Malawi and Ghana, young unmarried women who provide midwifery care and live in rural areas without secure accommodation report being concerned for their personal safety⁹
- In Kenya, community health workers report experiencing threats of violence from husbands of women they are providing with HIV testing. Cases of rape were also reported, leading to calls for security services to accompany community health workers¹⁰

Reports suggest that health workers are targets during emergencies:

- Attacks on health workers are even more prevalent in settings affected by fragility, conflict, and violence, with examples from the Ebola outbreak in the Democratic Republic of the Congo, polio vaccination workers being targeted in Pakistan, and doctors killed in the Libyan conflict¹¹
- In Mexico, since the start of the covid-19 pandemic, violence has spread to hospitals, where the public blames health workers, particularly nurses, for disseminating the disease¹²

health and exposes them to violence. Firstly, building an understanding of the shared nature of the problem is critical. Violence against female health workers, like all women's issues, is not just important for women. It affects all health workers, all healthcare environments, and our ability to effectively expand and improve healthcare services to rise to the challenge of universal health coverage. More resources dedicated to understanding the extent, nature, and basis for change are required. Apart from better reporting, participatory initiatives that use other ways of understanding and reframing the problem are also needed to tackle ingrained gender biases.³⁴

Secondly, professional associations, organisations, and regulatory bodies that govern healthcare and the health workforce require leadership that is more representative of gender, occupation, and other relevant social backgrounds. Most countries have a chief nursing and midwifery officer,³⁵ and governments need to expand these roles and ensure they are coupled with leadership training enabling the officers to advocate for reducing gender imbalances. Professional associations, UN agencies, and non-governmental organisations must coordinate action, give visible support, and enforce zero

tolerance for workplace violence. This includes supporting the International Labour Organisation's 190th convention, which recognises everyone's right to a world of work that is free from violence and harassment, including gender based violence and harassment.³⁶

Finally, we must empower women in the health workforce to find their voice and participate in this coordinated action. Now is a good time in which to focus on this problem as 2020 is the International Year of the Nurse and the Midwife, celebrating 200 years since the birth of Florence Nightingale, an extraordinary woman who challenged the status quo and advanced the professionalisation of nursing and midwifery. The ILO Convention 190 has been ratified and the Beijing+25 event marking the anniversary of the Platform for Action for Women provides an opportunity for health and social sectors to advance the various gender reforms required to honour the calls for women's empowerment and gender equality. We must support these currents of change. The ambitious goals set to achieve universal health coverage, especially given the realities of covid-19, cannot be met unless the rights of women who are responsible for delivering such care are acknowledged, protected, respected, supported, and promoted.

In this article “female” is used as an adjective for women; it does not denote sex, but rather highlights a linguistic gap that remains outstanding.

Contributors and sources: ASG and FM led the conceptualisation of the paper. ASG led the drafting and finalisation of the article with FM, MM, GN, and SS writing various sections. All authors read the final version and approved it. The authors are researchers and practitioners engaged in various ways with health workers and draw from our collective experience and knowledge of the literature. We appreciate inputs from Avni Amin, Michelle Remme, and Berit Kieselbach, and thank Natalie Trout for help with the design of the figure.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare. ASG is supported by Countdown 2030, the Health Systems Extra Mural Unit funded by the South African Medical Research Council, and the South African Research Chair's Initiative of the Department of Science and Technology and National Research Foundation of South Africa (Grant No 82769). The content does not represent the official views or policies of the authors' organisations or funders.

Provenance and peer review: Commissioned; externally peer reviewed.

This article is part of a series commissioned by *The BMJ* based on an idea from the UN University International Institute for Global Health (UNU-IIGH) and World Health Organization to mark the 25th anniversary of the adoption of the 1995 Beijing Platform for Action. UNU-IIGH paid the open access fees. *The BMJ* retained full editorial control over external peer review, editing, and publication.

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Cite this as: *BMJ* 2020;371:m3546
<http://dx.doi.org/10.1136/bmj.m3546>