

Gender equality in the global health workplace: learning from a Somaliland-UK paired institutional partnership

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To cite: Keynejad RC, Mekonnen FD, Qabile A, *et al*. Gender equality in the global health workplace: learning from a Somaliland-UK paired institutional partnership. *BMJ Glob Health* 2018;**3**:e001073. doi:10.1136/bmjgh-2018-001073

Handling editor Stephanie M Topp

► Additional material is published online only. To view please visit the journal online (<http://dx.doi.org/10.1136/bmjgh-2018-001073>).

Received 23 July 2018
Revised 6 October 2018
Accepted 14 October 2018



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ABSTRACT

Worldwide recognition of gender inequality and discrimination following the #MeToo movement has been slow to reach the field of global health. Although international institutions have begun to address gender, the perspectives of front-line global health workers remain largely undocumented, especially in regions not captured by large-scale surveys. Long-term collaborative relationships between clinicians and educators participating in paired institutional partnerships can foster cross-cultural dialogue about potentially sensitive subjects. King's Somaliland Partnership (KSP) has linked universities and hospitals in Somaliland and London, UK, for health education and improvement, since 2000. We collaboratively developed an anonymous, mixed methods, online survey to explore workplace experiences among Somaliland and UK-based staff and volunteers. We adapted the Workplace Prejudice/Discrimination Inventory to address gender inequality, alongside qualitative questions. Somaliland (but not UK) women reported significantly more gender prejudice and discrimination than men (medians=43 and 31, $z=2.137$, $p=0.0326$). While front-line Somaliland workers described overt gender discrimination more frequently, UK respondents reported subtler disadvantage at systemic levels. This first survey of its kind in Somaliland demonstrates the potential of global health partnerships to meaningfully explore sensitive subjects and identify solutions, involving a range of multidisciplinary stakeholders. We propose priority actions to address pervasive gender inequality and discrimination, including wider engagement of academia with gender-focused research, institutional actions to address barriers, national prioritisation and nurturing of grassroots initiatives, through institutional partnerships and international networks. Without sustained, concerted intervention across all levels, gender inequality will continue to hinder progress towards the vision of good health for all, everywhere.

INTRODUCTION

From 'silence breakers' instigating the #MeToo movement¹ to legally mandating gender pay gap reporting,² high-income countries have begun to acknowledge the pervasive influence of gender inequality

Summary box

- Slow progress on gender equality has predominantly occurred in high-income countries. The long-term commitment of health workers and educators on both sides of health institutional partnerships can facilitate constructive, collaborative and interdisciplinary exploration of the potentially sensitive subject of gender inequality.
- Global health workplace gender inequalities are common in low-income and high-income countries alike. While overt gender prejudice and discrimination may be more prevalent in settings with limited education and awareness, subtler disadvantage persists at systemic levels in high-income settings.
- Priority actions include wider engagement of academia with gender-focused research, institutional actions to address barriers, national prioritisation of gender inequality and nurturing of grassroots initiatives, through institutional partnerships and international networks.
- Sustained, high-profile recognition by global institutions, non-government organisations, publishers, national governments, health and education systems is required to harness grassroots momentum demanding gender equality at every level.

and discrimination. Gender is an important social determinant of physical and mental health^{3 4} and mortality,⁵ increasingly recognised at international levels. The fifth sustainable development goal aims to achieve gender equality and empower all women and girls, end gender discrimination and gender-based violence and ensure women's leadership at all levels of decision making.⁶

Gender inequality in global health

Recently, work in Syria and Democratic Republic of Congo addressing sexual violence as a weapon of war received 2018's Nobel Peace Prize.⁷ However, slow progress towards gender equality in global health largely affects high-income countries.⁸ The World

Economic Forum's global gender gap report⁹ quantifies economic participation and opportunity, educational attainment, health and survival and political empowerment in 144 countries. Rwanda, Nicaragua and Philippines are unusual among low-income and middle-income countries (LMICs), being ranked in the top 10. The lowest rankings are occupied by countries currently or recently engaged in armed conflict, alongside more affluent nations that limit women's participation and empowerment. Postconflict 'success stories' such as Rwanda demonstrate how peace-building activities can create political and wider gender equality, although not without some negative consequences.¹⁰ A growing literature supports gender-sensitive approaches to state building in fragile and conflict-affected situations while emphasising barriers that can perpetuate entrenched gender norms.¹¹

Since only countries able to provide data for 12 out of 14 index domains are included in the Gender Gap Report, 49 United Nations member states remain unaccounted for. These nations risk falling behind the current wave of global support for gender equality. Their undocumented experiences may also offer important insights, relevant to global health practitioners and policy makers. Neither Somalia nor Somaliland (a peaceful, postconflict nation internationally unrecognised since 1991) was included in 2017.

Attempts by the WHO to prioritise gender inequality have been challenged for neglecting its interactions with other personal characteristics such as ethnicity, sexual orientation and disability.¹² Intersectional theorists¹³ emphasise that the impact of gender on health is determined by 'multiple axes of power relations' resulting from interactions between gender and other individual categorisations.

Somaliland

Somaliland, a former British Protectorate, is a self-declared independent state with an estimated 4.5 million population.¹⁴ Primary and secondary school enrolment is increasing, but in 2008/2009, one woman attended school for every three men.¹⁵ In 2007, enrolment was 73%–76% men at Amoud and Hargeisa universities, including medicine, nursing, business and law. However, enrolment at Burao University, including veterinary medicine, islamic studies and law, was 80% women. The majority religion is Islam and 55% of the population is nomadic or semi-nomadic.¹⁵ A constellation of factors influencing experiences of gender equality affects Somaliland, but data regarding practising healthcare staff, disaggregated by gender, are not available.

Paired institutional partnerships for global health

Long-term global health partnerships between healthcare organisations and educational institutions in different clinical and resource contexts facilitate mutual exchange of experience, skills and expertise.¹⁶ Their benefits were reflected in Millennium Development Goal

8¹⁷ and Sustainable Development Goal 17 to 'revitalize the global partnership for sustainable development'.¹⁸ In an ever-more globalised world, international, multi-disciplinary networks, aided by rapidly evolving online media and communications technology, offer advantages to global health not readily accessible to large institutional bodies.¹⁹ In particular, the benefits of 'boundary-spanning' practices that foster cross-cultural learning networks and communities of practice that build local and national health institutions in LMICs are increasingly acknowledged.²⁰

King's Somaliland Partnership (KSP)

KSP is one such link between universities and hospitals in Somaliland, and King's Health Partners, London, UK, which aims to improve healthcare and its outcomes by strengthening people, organisations and systems.²¹ KSP has collaborated on clinical education in Somaliland since 2000,²² using a combination of face-to-face and e-learning via the low-bandwidth MedicineAfrica website,²³ demonstrating knowledge and cultural exchange benefits.²⁴ Building research capacity is evidenced by publications coauthored by female and male clinician-educators in both countries.²⁵ A 'strategic partnerships for higher education innovation and reform' grant²⁶ has expanded KSP's work to multidisciplinary professionals.

Several founding members remain active in KSP to this day, and many volunteers have contributed for over a decade. The long-term commitment of health workers and educators on both sides affords working relationships in which potentially sensitive subjects, such as gender inequality, can be discussed. Responding to growing awareness of intersectional gender inequality, our predominantly, but not exclusively, female and Somaliland-based team of KSP volunteers agreed to survey diverse staff in both countries, exploring gender-associated barriers and facilitators in the global health workplace, focusing on solutions and best practice.

SURVEYING WORKPLACE EXPERIENCES

Procedure

A working group of interested KSP volunteers and staff collaboratively developed a survey before online dissemination. We used mixed-methods²⁷ to capture quantitative and qualitative data on diverse experiences. We adapted the validated 16-item Workplace Prejudice/Discrimination Inventory (WPDI)²⁸ to ask about gender using simpler language (online supplementary file 1). We developed five contextually relevant additional statements, about being listened to, expressing views, being encouraged, leadership and missing opportunities. We used qualitative questions to explore gender-based and intersectional workplace barriers, recommendations and good practice. We collected demographic information using broad categories and encouraged participants to contact RK to raise specific concerns.

Any staff member, volunteer or student aged over 17 years participating in KSP activities was eligible to participate.

Analysis

We used Stata SE V.15²⁹ to analyse adapted WPDI scores. Likert-scale responses scored between 1 ('strongly disagree') and 5 ('strongly agree'); relevant items were reverse-coded, yielding a maximum score of 80. We performed non-parametric tests due to small sample size. We compared median item, total WPDI and additional item scores, using Wilcoxon rank-sum tests.

We analysed qualitative responses using thematic analysis, following a stepwise approach.³⁰ RCK, FDM, JIMH, AQ, MMHR and MAD generated initial codes and searched for themes. RK collated and named themes, which were collaboratively reviewed. We employed reflexivity during this process, recognising our personal, intersectionally influenced biases.³¹ For example, as a female UK researcher, RK employed self-reflexivity when reading qualitative responses by participants with diverse experiences. Reflexivity was also employed within the analytical team, when collaboratively reviewing codes and themes generated by diverse research colleagues, whose experiences and perspectives influenced their interpretations. This approach has been advocated to enhance 'sense-making' when cross-cultural teams collaborate on research.³²

Demographics

Thirty-six Somaliland (58% women) and 17 UK-based participants (53% women) completed the survey between 18 January 2018 and 12 March 2018. Median age was 26–30 years (Somaliland; range: 19–60 years) and 31–40 years (UK; range: 19–61+ years). Somaliland participants' main professional roles were medical (42%), administrative (19%), teaching (11%), midwifery (11%), research (8%) and nursing (6%). Most UK participants were doctors (65%) or nurses (18%). Median experience was 5–10 years (Somaliland) and 10–20 years (UK; range: 1–20+ years).

WPDI scores

Online supplementary file 2 displays item responses; table 1 shows descriptive statistics.

When considered alone, Somaliland women and men differed significantly on total WPDI scores (medians=43/31, $z=2.137$, $p=0.0326$), unlike UK

participants (medians 32/41.5, $z=-1.109$, $p=0.2673$). Somaliland women agreed significantly more strongly than men with eight statements. These were 'at work, women receive fewer opportunities' (medians 4/2, $z=1.959$, $p=0.0501$), 'where I work, men are treated better than women' (medians 3/2, $z=2.687$, $p=0.0072$), 'at work, people are intolerant of women' (medians 2/1, $z=2.399$, $p=0.0164$), 'managers check women's work more closely than men's' (medians 2/1, $z=2.150$, $p=0.0316$), 'making jokes about gender is [not] common where I work' (medians 3/3, $z=2.042$, $p=0.0411$) and 'at work, I am treated poorly because of my gender' (medians 3/1, $z=2.871$, $p=0.0041$). Two non-WPDI items showing significant differences were 'I am not encouraged by my seniors to aim higher in my career' (medians 3/2, $z=2.002$, $p=0.0453$) and 'I miss out on training or teaching opportunities because of my gender' (medians 2/1, $z=1.967$, $p=0.0492$).

There was no significant difference between Somaliland and UK participants' total WPDI scores (medians=34/38, $z=0.105$, $p=0.9164$), nor between aggregated women and men (medians=39/33, $z=1.419$, $p=0.1558$). When considered together, Somaliland respondents agreed significantly more strongly that 'where I work, people of different genders [do not] get along well with each other' (medians 2/2, $z=2.195$, $p=0.0282$) and 'I am not encouraged by my seniors to aim higher in my career' (medians 3/2, $z=2.065$, $p=0.0389$). Women agreed significantly more strongly than men, that 'at work, I am treated poorly because of my gender' (medians=2/1, $z=2.553$, $p=0.0107$).

Workplace barriers

Forty-seven (Somaliland) and 65% (UK) of respondents described gender-related barriers in their field. Somaliland participants described men being disproportionately encouraged and widespread beliefs that women are weaker, less competent and reliable. One commented: 'my managers never encouraged me or appreciate. [I am] never being given opportunity of work or education if one come[s] out'. They highlighted difficulties for women in securing employment, scholarships, promotions and leadership positions. A top candidate was told she would not be appointed in case she married and became pregnant, and women were posted to inaccessible regions where they could not go outside unaccompanied. Women were interrupted by men in meetings,

Table 1 Median WPDI scores and IQRs by group

	Somaliland (n=36)		UK (n=17)		Total (n=53)	
	Median	IQR	Median	IQR	Median	IQR
Female, n=30	43	24–63	32	31–38	39	24–63
Male, n=23	31	21–40	41.5	41–42	33	21–51
Total, n=53	34	21–63	38	27–51	35	20–63

WPDI, Workplace Prejudice/Discrimination Inventory.

deprioritised against junior males and faced ‘all kinds of humiliation and under encouragement’. One recalled ‘during my study people were telling me I can’t be a doctor and when I became they said at least say am nurse; female can’t be a doctor’. Another noted that limited employment prospects influence emigration of women to high-income countries. Gender-based violence was a cause for concern: ‘every girl is afraid of being raped if they leave home at night, even evening, this is the greatest problem for women who cannot defend themselves’.

UK participants described gender pay gaps, unequal treatment, inflexible conditions, being bullied on-call, unequal representation in leadership and excess work (‘male colleagues giving females additional work, eg, pelvic exams, review[s] of young female patients as they feel uncomfortable’). One reported that US ‘females [are] subtly seen as less able to handle hard work hours, or being seen as selfish for wishing to breast feed’. One said stereotypically feminine women are better received, and another: ‘I consciously try to avoid what I feel are “female” attributes when applying for jobs or promotions’. A male participant said ‘I often feel I am treated with more academic respect than my women peers in the workplace’. UK participants also noted disadvantages for men (‘I am expected to stomach more abuse’), difficulty gaining exposure to women’s health and lower clinical pass rates ‘because of the perception that [women’s] approach is “softer”’.

In both countries, participants said patients may be more willing to see women and described women being unable to train in chosen specialties. Surgical theatres were highlighted: (Somaliland) ‘sometimes they did not give us sterile surgical gowns to participate in the theatre; sometimes they hide sutures while we are in there’. A UK respondent highlighted limited access to toilet facilities during on-call shifts.

Interventions

Somaliland respondents proposed a range of interventions. Themes included raising community awareness about gender equality, especially in remote areas, involving parents, elders, religious leaders, commercial sectors, and policy makers, seeking international attention, policies and legislation, fair recruitment, proportional leadership, advocacy, economic empowerment, positive discrimination, widening access, confidence building, peer support, case studies, workshops, seminars and radio and television broadcasts.

UK participants recommended better implementation of legislation and policies, quotas, more access and support of flexible working, equal parental leave, mentorship, role models, countering stereotypes, pay transparency, recognition of implicit bias and enhanced access to opportunities. Academics proposed proactively engaging women in research and returning to it from maternity leave, support with grant applications, mock interviews, publication and alternative routes.

Some expressed positivity. A Somaliland respondent said ‘I try to change many problems that I see... I am hopeful that the world will recognize the power of women’. A UK respondent stated ‘healthcare is ahead of many areas of work in terms of equal opportunity, but we need to actively recruit more women into senior leadership roles and develop young women’s leadership skills in a way that does not just replicate the current very ‘male’ leadership style’.

Existing positive practice

Several Somaliland respondents noted improvements in prejudice against women in the workplace and recognised government efforts. Female senior surgeons and physicians, hospital matrons, managers, academics, entrepreneurs and business leaders were cited as role models. Others emphasised rising school enrolment, university graduation and work participation among women, especially in urban areas. One noted that mixed-gender clinical placements improved respect for female students, compared with segregation. Another noted more gender discrimination outside the workplace than within it. Several respondents noted that national and international organisations employing female staff enable role modelling of gender equality, including equal pay. One respondent referred to Islamic scripture advocating women’s rights, and others emphasised the roles of elders and the wider community in recognising women’s contributions.

UK respondents recognised employer initiatives, including paid maternity leave, shared parental leave, less than full-time training, female leaders, role modelling, retention efforts and implicit bias training. One highlighted the benefits of KSP’s flexible, remote electronic technologies, widening access for staff with caring responsibilities. However, one stated ‘gender bias is such a problem in my area that I do not know of any positive examples of which to share’.

Intersectional barriers

Fifty per cent of Somaliland and 77% of UK respondents acknowledged barriers arising from other characteristics. Somaliland participants especially emphasised clan membership, younger age and disability as influencing career progression. One highlighted early marriage, when husbands may prevent women from continuing to work. Sexuality was acknowledged to be a taboo subject in Somaliland. UK participants emphasised intersectional barriers for ethnic minorities: ‘social stereotypes of those with certain age, race, religion, disability and sexuality manifest as psychological and practical barriers to opportunities’.

Somaliland participants recommended addressing intersectional barriers through similar initiatives but emphasised the need to involve cultural, religious and government leaders in addressing clan, disability and age-related discrimination. Suggestions included preventing clan being identified during recruitment,

national policies protecting characteristics, education about implicit bias, role modelling by international organisations and funders and collecting more routine demographic data. UK participants suggested employer actions, including quotas, enforcing policies, encouraging diverse applicants, discussing implicit bias, school-age and early career mentorship.

IMPLICATIONS

Benefits of health institutional partnerships

Our study built on nearly two decades of cross-cultural global health partnership between Somaliland and the UK. It demonstrates how culturally sensitive subjects can be constructively explored in the context of long-term health partnership between differently resourced settings. In distinct ways, persistent hierarchies and entrenched power differentials affect the worlds of research, university education and clinical practice in both countries, consistent with low rates of female leadership across top international universities.³³ This study overcame these barriers to collaborative research leadership and academic authorship, building on KSP's legacy to unite a diverse team of junior and senior, female and male, Somaliland and UK contributors to address this still-taboo subject.

Academic engagement

Medical publishing is increasingly prioritising the neglected field of gender inequality³⁴ and the need to consider gender in global health practice and research.^{35 36} The Gambia women in science working group argues that in sub-Saharan Africa, 'women and men need to perceive women as intellectually equal'.³⁷ The current climate of prioritising gender equity in global health³⁸ inspired our diverse group to spearhead the first study of its kind in a country unable to contribute data to the gender gap report. More vocal prioritisation of such research is required, to meaningfully harness current momentum for global gender equality. The dangers of inertia are clear, with emigration of skilled female staff and withdrawal of female expertise from the workforce highlighted by our study.

International commonalities

While overt gender prejudice and discrimination were more frequently reported in Somaliland, UK respondents described subtler disadvantage at systemic levels. While many recommendations for Somaliland already exist in the UK, they have not eliminated unequal pay, hostility in surgical theatres, bullying, harassment or intersectional barriers. Transparency and discussion are crucial steps, making recent global publicity of pervasive sexual harassment,¹ pay inequality³⁹ and occupational segregation⁴⁰ particularly welcome. WPDI scores among female Somaliland respondents were higher than those of male or UK respondents and similar to a recent study among Muslim American women,⁴¹ underscoring the severity of workplace discrimination and prejudice in

selected low-income and high-income settings. Recognition of intersectional barriers and the need for them to be approached with sensitivity in Somaliland supports calls for recognition of intersectionality in global health.^{12 13}

Institutional action

Our findings support evidence-based action at global, national and institutional levels.⁴² This includes conceptual frameworks for gender in healthcare human resources, research guidance, integrating gender equality into health systems strengthening, applying international human rights and equal opportunities laws to national policies, anticipating health workers' life cycle needs, restructuring education and work settings to integrate family and work and reflect the value of caregiving by both genders. Of note, a health workforce survey in Rwanda found that the odds of health workplace violence were reduced by gender equality.⁴³

National prioritisation

The encouragement of the Somaliland ministry of health development for this study, in requesting to receive its results, deserves special mention. Government bodies can tackle systemic gender inequality in collaboration with health, education and voluntary sector organisations. Improvements in workplace attitudes, educational enrolment and female leadership in Somaliland demonstrate how much can be done, even in resource-limited contexts.

Grassroots initiatives

Despite challenges, respondents were hopeful about Somaliland's future global health workforce. Somaliland's Female Medical Doctor Organization was founded in 2016, to exchange knowledge through discussion and seminars, empower female doctors through education and contribute as equals to their community. A key benefit will be building support networks for isolated clinicians outside urban centres, providing support during challenging, isolated posts. Institutional support of such unfunded organisations and similar initiatives for nurses and allied health professionals could be developed in collaboration with institutional partnerships, such as KSP, which conduct interdisciplinary capacity building. The work of grassroots initiatives in collaboration with paired institutional partnerships could be further enhanced by international networks such as Women in Global Health,⁴⁴ providing support, mentorship and promotion on a world stage.

Limitations

Our results were limited by the self-selecting nature of participants: we did not capture views of individuals lacking literacy, English language or internet access. As such, more severe prejudice and discrimination could have been missed by this brief survey. A broader range of responses would be obtained by triangulating these data with Somali-language interviews, with diverse staff.

CONCLUSIONS

This first study of its kind in Somaliland demonstrates the potential of global health partnerships to meaningfully explore sensitive subjects, involving stakeholders across international, governmental, educational, clinical and voluntary sectors. Understanding responses alongside those of UK participants using cross-cultural mixed methods indicated relevance outside this region, missed out of key international surveys. We hope that colleagues in diverse global health settings will explore gender in their own context,⁴⁵ taking the crucial first step of starting a conversation, from which a theory of change⁴⁶ can be built and multifaceted interventions planned. We look forward to reading their findings and sharing the outcomes of our own in years to come.

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Acknowledgements We thank Dr Sharon Markless, Dr Stephani L Hatch, Dr Billy Gazard, Dr Peter Hughes, Mr Daniel Jones, Dr Gudon Adem, Dr Hodan M Osman and Professor John Rees for their kind and instructive feedback on the survey design. We would also like to thank Somaliland's national research committee and staff of the Somaliland Ministry of Health Development for their support of and interest in the results of this research.

Contributors RCK coordinated survey inception and design, applied for King's College London ethics committee approval, coordinated thematic analysis, performed statistical analysis and led writing up. FDM contributed to survey design, applied for Somaliland Ministry of Health and Development approval, led survey dissemination, performed thematic analysis and contributed to writing up. AQ, JIMH, MAD and MMHR contributed to survey design, performed survey dissemination, thematic analysis and reviewed the final manuscript. CR provided senior advice on survey and study design, partnership working and ethics procedures and contributed to writing up. EAI provided senior advice on survey and study design, senior input to application for Somaliland Ministry of Health and Development approval, performed survey dissemination and reviewed the final manuscript.

Funding KSP receives funding from UK Department for International Development (Education), via British Council.

Disclaimer The funder played no role in study design, data collection, analysis, interpretation, writing-up or publication.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval King's College London's research ethics subcommittee (Ref: LRS-17/18-5508) and Somaliland's national research committee and Ministry of Health Development director general (Ref: MOHD/DG:2/167/2018) approved the study.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement All available data have been summarised in this article.

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