Policy Brief 4

International Labour Organization
Regional Office for Arab States

Women and Men Health Care Workers in Yemen: Rights, Needs, and Responsibilities[1]

This policy brief aims to contribute to the ongoing debate on health care reform in Yemen by focusing on health care workers. It identifies key problems and opportunities for women and men working in health care, emphasizing their rights, needs, and responsibilities. It also analyzes the link between the rights of health care workers and the rights of health care beneficiaries. Based on this analysis the policy brief formulates seven recommendations.

I. Context

Health profile

It is widely recognized that health care reform in Yemen is necessary to meet the rights of all Yemeni citizens to health care that meets the needs of women, men, girls, and boys equally. Key health indicators suggest that there is still some way to go before the health needs of the population are met (World Health Organization (WHO), 2008). In 2006, life expectancy at birth was 62 for women and 59 for men, and healthy life expectancy at birth was 51 for women and 48 for men. In 2005 the maternal mortality ratio was 430 per 100,000. In 2006, infant mortality rate was 75 per 1,000 live births, and under-five mortality rate was 102 per 1,000 live births. Prevalence of underweight children (under five) was 41.3 per cent in 2000-2006 (ibid.). Estimates put the annual incidence of malaria between 800,000 and 900,000 cases. Tuberculosis is one of the major communicable diseases, with a prevalence rate of 0.08 per cent of the population causing 2,500 death cases annually (Ministry of Planning and International Relations (MoPIR), 2005, p. 27). Health care coverage is low, and basic living conditions are not conducive to good health. In 2006, the proportion of the population with access to improved drinking-water sources was 66 per cent, and the proportion of people with access to improved sanitation was 46 per cent (WHO, 2008).

Government commitments

Given this health profile, the government faces important challenges to fulfil its commitment towards the improvement of the health status of the population. The Yemeni constitution (Articles 30, 32, and 55) grants all citizens the right to health care (Women National Committee, 2006). The government has reiterated its commitment to health care provision in different ways over the years, most recently in the Third Five-Year Health Development Plan 2006-2010. In it, the government provides a guarantee for all citizens to receive full health care services easily and at the least expense, and commits to place health care at the core of the government's development programme and to ensure a just distribution of resources (MoPHP, 2006, pp. 43-44).

The government also has commitments towards achieving the Millennium Development Goals (MDGs), three of which target improvement of the health of the population, namely reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, and other diseases. Another relevant MDG, Goal 3, targets the promotion of gender equality and the empowerment of women.

Health expenditure

Despite its declared commitment to health care as central to national development goals, in 2005 general government expenditure remained under

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42 per cent of total expenditure on health, which is among the lowest government contributions in the region (WHO, 2008). Out–of-pocket contributions from users of health services made up 95 per cent of the private expenditures on health, by far surpassing government expenditures. Total expenditure on health is low, reaching 5.1 per cent of the Gross Domestic Product in 2005. The small budget dedicated to health is seen as a main obstacle facing the full implementation of the Third Five-Year Plan. Some experts and MoPHP staff members point out that it is not the budget size that explains health care deficiencies, but inefficient management and spending. Thus, it is important that more resources go towards health care; it is also essential that they are used in a more effective, efficient, transparent, equitable, and sustainable way.

Inadequate system of provision

The health care system suffers from serious systemic problems including lack of strategic planning, lack of coordinated management, and weak monitoring and evaluation. Problems with the distribution of human resources have also been identified, especially in the organizational structure of the health care system, in different specializations and in rural/urban areas. There are also dissatisfactions among health care workers in terms of remuneration, incentives, and working conditions. The deficits are reflected in poor availability, access, and utilization of health services. Only 35 per cent of the rural population is covered by essential health services, compared to 80 per cent of the urban population, with 58 per cent coverage overall (Al Mutawakel, 2007). Primary health services cover only 30 per cent of the rural population and 45 per cent of the whole population. There are 2099 health clinics, of which only 1,700 are in operation. There are 569 health centres, and 180 hospitals with 12,252 beds. There is on average one medical doctor for every 2,000 citizens. These statistics demonstrate that Yemen is one of the countries with a very low health coverage rate in the world (ibid., p. 9). User fees, official and unofficial, are charged for most health services. Despite the fees, the low quality and frequent lack of adequate drugs and equipment in public facilities leads patients to seek services in the private sector. This means that a large proportion of poor women, men, girls and boys to various degrees, have little or no access to health services. This is particularly serious given the high levels of poverty in the country, creating a situation where income poverty and poor health reinforce each other in a vicious circle of deprivation (ibid.). This works against stated government commitment to reach all citizens and to guarantee minimum expense.

Initiatives under way

Health care policy makers, planners, and providers are fully aware of the situation and are working in various ways to address it. Among the initiatives under way is the Joint Health Sector Review of 2007, which aims to assess the heath care sector in setting a vision and strategies for implementation of the Third Five Year Health Development Plan (2006-2010). The review is part of the process of the formulation of the Health Sector Reform Strategy and it is set out to reinforce the political commitment to the reforms and dedicating sufficient resources to implement those reforms as well as to create consensus among stakeholders on the mechanisms and approaches to implement the strategy (Ministry of Public Health and Population (MoPHP), 2007). This policy brief is a contribution to such efforts.

The situation of health care workers

Central to health care reform is addressing the rights and needs of women and men health care workers, for them to enjoy conditions that motivate them and improve their capacity to meet the health needs of the population. The questions to answer include:

1. Are the rights of women and men health care workers met?
2. Do women and men health care workers get equal and regular access to training?
3. Do women get the same access as men to all medical specializations?
4. Are men as involved as women in providing and taking responsibility for reproductive health and family planning?
5. Do women and men health care workers feel secure that their health needs and their families' are met?
6. Is research conducted and used by policy makers in a way that helps to diagnose and meet women and men's needs as both the users and providers of health services?
7. To what extent are monitoring and evaluation systems observed?
8. Do they take into account the needs of both women and men?

II. Problems and opportunities

1. Are the rights of women and men health care workers met?

Women and men health care workers are low-paid, as is the case in government jobs. The necessity to raise government wages has been debated since 1990 with no resolution. With this problem unresolved, it is imperative that health care workers enjoy an environment where the organizational structure, laws, and regulations are solid and clear in their design and enforcement. It is also crucial that both women and men workers feel respected and valued in a system where equality and transparency prevail.

There is general discontent among health care workers regarding employment laws and regulations dealing with recruitment, contracts, job security, training, promotion, incentives, overtime, and allowances. Two main arguments prevail in this regard. The first argument is that all necessary employment laws and regulations are in place, they are fair and treat all employees equally, but the problem is in their implementation. The second argument is that the laws and regulation themselves are problematic and need revision. There is some agreement that legislation is written at such a general level that it is open to wide interpretation and manipulation, leading to inequalities, promotion of self-interest, and nepotism.

Recommendations on rights of women and men health care workers

Better meet the rights of women and men health care workers through:

- Strengthening the link between employment laws and their enforcement in a way that safeguards the rights of both women and men as employees in the health sector, providing equal opportunity and transparent procedures and practices with respect to:
  - Recruitment, including in advertisements, selection criteria, and interviewing
  - Wages and incentives
  - Promotion and equal access to decision-making positions
  - Grievances
- Improving working conditions of women and men workers and ensure equal access to
  - Equipment, including computers and medical equipment
  - Nurseries
  - Lodging, rest rooms, toilet facilities, and canteens
  - Transport

While there is recognition that current practice has resulted in inequalities among women and men workers respectively, there is less recognition that inequalities are most blatant between women and men. While a number of indicators provide evidence to make the case, lack of or unsystematic recording and monitoring of the implementation of employment regulations makes it difficult to document and more importantly to address this issue (see points 3 and 7 below).

Women represent 28 per cent of health care workers. Of these women, 25 per cent are doctors, mostly paediatricians and gynaecologists, 39 per cent are nurses and midwives, 21 per cent are technical staff, and 17 per cent are administrative staff, mostly as lower and mid level administrators and secretaries (Women National Committee, 2005, p.63). In terms of decision-making positions, there are two women ministers, one woman undersecretary of State among five, and four women out of 15 director-generals (ILO, 2006). The manifestation of inequalities is most apparent when it comes to the promotion of women to decision-making positions and the constraints they face once in power. Women with similar qualifications to men are rarely considered for responsible positions (Martin, 2001, p. 24). Once in a position, although their competence might not be questioned by their men colleagues, women often find themselves working in a hostile environment where rules and regulations are not applied to protect them from undermining of their authority (ibid.). For example, decision making often takes place after working hours during informal men-only gatherings.

The organizational structure of the health sector is seen as another, but related, area in need of reform. The Third Five-Year Plan clearly states among its commitments to "[c]reate an organizational structure that better serves the health objectives of the country" (MoPHP, 2006, p. 43). Meanwhile, MoPHP struggles to reform its management structure and procedures (Martin, 2001). A main manifestation of the weakness of the organizational structure of the MoPHP is that staff members under the minister, the undersecretary of State and general directors, do not have clear job descriptions. Roles and responsibilities are assigned to the directorates and not to directorate staff members (see Government of Yemen, 2005, pp. 73-98). This leads to clashes and overlaps in roles and responsibilities within each directorate and between the different directorates.

In addition, decision-making structures and authority lines are unclear and cause problems in the relationship between the centre and local administrative organizations, and between the public and private sector. These problems have become even more urgent since the introduction of decentralization and privatization reforms. Attempts to reform the organizational management problems are in place, among them is MoPHP training for senior staff (see point 2). Bad distribution of human resources causes an over staffing in the Ministry and in cities, leaving local level administrative organization, and above all service provision in rural and remote areas, understaffed. This problem of distribution is often blamed on women staff members who, it is argued, refuse to work or travel away from home. In fact, again there is no evidence that men are not as reluctant as women to comply to placements that require them to be posted away from home.

Another area in which the rights of health care workers are not met is related to inadequate or non-existent facilities and services such as access to transport, computers, and a comfortable physical work environment. Women and men health care workers also suffer from lacking or inadequate housing facilities, resting rooms in hospitals, and incentives for night shifts. Women are especially presented with an impossible situation where there are no appropriate and clearly segregated toilet facilities, dressing rooms, or resting rooms (ILO, 2006, p. 6).

2. Do women and men health care workers get equal and regular access to training?

Capacity building is both a right and an important need for workers. As stated in the Third Five-Year Plan, the government is committed to continuous training and education and the provision of technical and managerial cadres (MoPHP, 2006, p. 43).

Recommendations on building capacities of women and men health care workers

Continue efforts in building the capacities of women and men health care workers while ensuring:

- Equal opportunities to both women and men
- Equal access to training through more attention to location, timing, transport, and quality of lodging (including safety and privacy)
- Content of the training takes into account the differences in access to and control over resources, and needs of women, men, girls, and boys as users of health services

Concerns are first about quality, content, and frequency of training, and second about the extent to which women and men have equal access to such training. The overall consensus from reports and interviews, is that in the absence of a staff development plan, training is often ad hoc with mixed results (ILO, 2006, p. 6). The Directorate of Human Resources Development in the MoPHP and the Training Centre in the Ministry are primarily responsible for planning and delivery of capacity building. Training is also carried out at the level of directorates for their own programmes, and independently of MoPHP at the local level. While there might be no problem in decentralized training, lack of coordination and cooperation results in duplication and waste of resources. It also means that some staff members, mostly those working in donor-funded programmes, are favoured in accessing training.

Inequalities in access to training do not only contribute to the unequal advancement of knowledge and skills among staff members, but also to unequal opportunities for promotion and wage increases. Women staff members are at a disadvantage when it comes to access to training. For example, key training targeting higher levels or specializations that are dominated by men exclude women who have potential to work in these areas. Currently, the Management Training conducted by the Ministry Training Centre is targeting high-level administrators, mostly men. Women who are as qualified, but are in second-level management positions, are not considered for such important training that could contribute both to the quality of their work and to their professional advancement.

More generally, social norms restricting some women's ability to travel for training within the country, and more problematically abroad, are seen by most decision makers as a constraint that is the responsibility of the women themselves to solve. In fact, where there is true political commitment to women workers' rights, institutions have been able to find solutions to problems of access to training by choosing accessible location, providing transport, secure and appropriate residency and even giving support towards a man companion or 'mehrem' when necessary. The content of training itself often lacks a gender perspective. In the content of training in health management, budgetary issues, and health care provision, there is generally no examination of the different access to and control over resources and needs of women, men as workers and users.

3. Do women get the same access as men to all medical specializations?

While available statistics as well as general opinion show that women do as well as men in medical school and in other medical related institutes, women end up working in limited medical specialities. Women represent 28 per cent of specialists in the public sector, and 30 per cent in the private sector. Among general practitioners, their share is 30 per cent men in both the public and private sectors. Also 19 per cent of anaesthetists in the public sector are women. Women constitute 24 per cent of pharmacists in the public sector and 11 per cent in the private sector. They constitute 28 per cent of dentists in the public sector and 35 per cent in the private sector. Among nurses, women's share is 37 per cent in the public sector and 62 per cent in the private sector (MoPHP, 2006). Although statistics are not available, it is generally believed that among specialists most women are restricted to gynaecology and paediatrics. Few women are surgeons, neurologists, cardiologists or oncologists (ILO, 2006).

Recommendations regarding women in medical specializations dominated by men

Support and encourage women to enter medical specializations that are dominated by men through

- Supporting and encouragement of women to enter specializations dominated by men in teaching and training institutions
- Creation of a mechanism to protect women from resistance and discrimination once they are specialized in men-dominated areas (including quotas, incentives, etc.).

Some women may chose to be in areas of work seen as 'appropriate' for women. More generally, women are not provided the institutional support to venture into men-dominated specializations. This lack of encouragement starts at the university level and continues more clearly during specialization training, as for example at the Yemeni Council for Medical Specializations. Reports and interviews show that women working in men-dominated specializations feel at best a lack of support from their men colleagues and superiors, and at worst are actively discouraged from fulfilling the professional role that they have the qualifications to perform.

This situation means that not only are women unable to fulfil their potential, but as importantly, are unable, to fulfil the needs of women patients to receive medical help. Of the Yemeni women 35 per cent do not receive health care (MoPHP, 2003). The low percentage of women doctors and nurses is one of the main obstacles to women's access to health care (MoPIR, 2005, p. 63). If there are not enough women to meet health needs of women in a culturally sensitive manner then how effective is health service provision? Attempts to address the needs of women patients focus on reproductive health and family planning neglecting the other health needs of women. In order to better address this situation it is necessary to increase the numbers and capabilities of women medical staff in all specializations. There is an absence of an overall strategy to coordinate and cooperate with relevant institutions, including medical institutes, to produce the women cadres necessary to meet women's health needs.

4. Are men as involved as women in providing and taking responsibility for reproductive health and family planning?

The absence of men as providers of services in population and reproductive health is another indication of poor coordination between health service needs and organizational structure of the health sector, namely capacity building and assignment of job descriptions. It is a given that in the context of Yemen women who seek reproductive health services are seen by women practitioners. However, it is also imperative that men are a target group in their own for reproductive health and population services and campaigns. This can be best achieved through the involvement of men as health care providers. Even though the National Strategy for Reproductive Health 2006-2010, sets high targets for improving the status of reproductive health in Yemen, it does not explicitly mention the roles and responsibilities of men in this process.

As currently implemented, the reproductive health service for of women suffers from a number of problems. The Family Health Survey shows that prenatal care coverage was 45 per cent, 77.2 per cent of deliveries were home deliveries, deliveries assisted by trained practitioners were 26.8 per cent, and postnatal care was given to 12.6 per cent of women (MoPHP, 2006, p. 4).

The National Strategy for Reproductive Health 2006-2010 recognizes the gravity of the

situation and sets a number of targets to improve the reproductive health of women. The Millennium Development goal on reducing maternal mortality aims to half it by the year 2025 (Some international sources such as WHO and UNICEF put the level of MMR much higher at 870 per 100,000).

Recommendations regarding men in reproductive health and family planning

Strengthen the role of men in reproductive health and family planning as providers and as target group through:

- A more effective allocation and training of men nurses in order to engage Yemeni men as part of the target group for reproductive health and family planning by:
  - building g the capacity of men nurses in the diagnosis and treatment of sexually transmitted diseases
  - men medical staff delivering health education concerning men's contraception to Yemeni men
- Revision of the terms of references of midwives to allow their referral of men to men doctors and nurses when it comes to sensitive issues[0]
- Design of health education and awareness-raising campaigns addressing men's needs and responsibilities in family planning and sexually transmitted diseases

Prerequisites to reducing maternal mortality and morbidity are the availability, accessibility, affordability and quality of reproductive heath services. Even where such services are available, for the majority of cases, women do not have control over decision making. They are often constrained by cultural norms that dictate their level of mobility and access to medical care. They also have serious concerns about being seen by a man doctor. In addition, priorities given to spending limited resources on their health needs, is not always left to them. The introduction of health services fees has meant that the majority of poor women can no longer have access to health care.

The National Strategy for Reproductive Health, 2006-2010 shows that 7.5 per cent of women suffer from some kind of sexually transmitted diseases (STDs). It does not mention any statistics around the percentage of men inflicted by STDs.

There is no strategic planning or programming of health awareness campaigns or preventive and curative services targeting men.

There are also no programmes targeting men as health care workers to implement such services. These issues are largely left to women nurses and midwives (as noted in their Terms of References). When a woman is afflicted with an STD, the responsibility is left to the women medical staff to examine the husband and prescribe treatment, which nearly never gets done. Treating women only while the husbands are inflicted, therefore, makes the treatment partial and ineffective.

Family planning is not a decision or responsibility that should be left to women alone. Statistics show a fertility rate of 6.2 per cent per woman, one of the highest in the world with 17 per cent use of contraception (MoPHP, 2003). The percentage of men using contraception is not mentioned in the statistics. Family planning, health education and campaigns mostly target women. Contraception advice is by and large given by women health providers to women.

A number of initiatives are in the making toward changing this approach. The MoPHP is currently reviewing its code of ethics for reproductive health. A conference on population and family planning entitled 'Men have a Responsibility' was held in Yemen in October 2007. Discussions and recommendations coming out of this conference need to be included in the Health Sector Reform. There is also a discussion among health care policy makers concerning fee payments as a constraint to affordable health care services. Suggestions include the re-introduction of free services for the poor, and providing free birth deliveries .

5. Do women and men health care workers feel secure that their health needs and their families' are met?

Third Five Year Plan committed to introducing a health insurance system for health care workers (MoPHP, 2006, p. 44). Health insurance for health care workers is still under discussion and no serious plan has been put forward as yet. A fair and effective health insurance for health care workers and their families would contribute a great deal to recognizing their rights and needs as workers and citizens. Looking into the terms and conditions of such a scheme will have to take into account of the different needs of women and men staff their family members.

6. Is research conducted and used by policy makers in a way that helps diagnose and meet women and men's needs as both users and providers of health services?

There are a number of issues of concern when it comes to the information system in terms of health care workers, as well as research carried by the MoPHP on the health issues of the Yemeni population generally. One of the objectives of the MoPHP is to "build a comprehensive and modern health information system" (ibid, p. 43). When it comes to the information system regarding health care workers, while some basic statistics are available, they are not compiled or presented in a very useful way, and are often inaccessible. While there are some available tables on the human resource distribution, these tables are incomplete and inconsistent. For example, some tables from the MoPHP provide information on public and private sector workers by specialization, but not by rank, wage, or location. Recently, most data are disaggregated by sex, with the exception of MoPHP staff. The availability of good and comprehensive data is closely linked to laws and regulations and their implementation (see point 1 above). While key documents may be kept by the Personnel Directorate regarding information such as recruitment and promotion of particular staff members or grievance cases when they occur, this information is not compiled in a systematic way that could be informative about how laws and regulations are being implemented. It was suggested that such data could be compiled on request. In fact the systematic production of such data and its accessibility to all is crucial for achieving transparency and for identifying possible areas of inequality.

The Documentation and Statistics Directorate in the MoPHP has started to introduce sex-disaggregated data in its work since 2003. This was an initiative that was accompanied by training and the revision of all its data collection and documentation forms at the district level. Advanced computer statistical packages for data analysis where also used accordingly. Given that the MoPHP uses national level samples for its research, and has updated its methodology in data collection and statistical analysis, is potentially a real asset for the health sector.

An examination of samples of research reports of the directorate shows that although most statistical data is now disaggregated by sex, this is not always done consistently. For example, statistics on infant and child mortality rates, nutrition, and morbidity are not disaggregated by sex. The reports do not include in-depth analysis of findings and their implications. The existence of disaggregated data is an essential prerequisite for such analysis but is not enough. Research that is based on sex disaggregated data could make a key contribution to explaining the link between gender relations and health, and help to better identify the health needs of women, men, boys and

Recommendation on health insurance for health sector planners and providers

Ensure that the planning process for the Health Insurance System equally takes account of the needs of women and men employees as well as their spouses and children.

Recommendations on research, policy, monitoring and evaluation

Strengthen the research and information systems in the MoPHP through:

- Mainstreaming gender in both research and information systems by:
  - More consistency in disaggregating all data by sex
  - Raising the capacities of research staff in gender analysis
  - Creating sex-disaggregated health indicators
  - Increasing the commitment of senior MoPHP staff to the importance of collecting and compiling sex-disaggregated information that is well organized and accessible
- Strengthening the mechanisms that link the Directorate of Statistics and Research in the MoPHP and the gender disaggregated data they produce, to policy makers and planners in the Ministry to:
  - Ensure the design of the policies, planning and programmes better meet the health needs of women, men, girls and boys in their diversity.
  - Ensure the design of organizational policies, laws and procedures to better meet the needs of both women and men employed in the health sector.
- Create a gender-responsive monitoring and evaluation system for health care by:
  - Putting in place monitoring and evaluation mechanisms that examine the link between the observance of equal rights for women and men workers and workers' performance in meeting the health needs of women, men, girls and boys;
  - Putting in place a gender budgeting process to monitor the allocation of resources in the health sector.

girls in all their diversity. It could provide policy makers with better evidence of the link between users' needs and the contribution that women and men health care workers could make to meet these needs. It could also highlight the necessary employment conditions different health care workers require in order to perform their roles and responsibilities in the most effective way. Family planning under this kind of research would greatly increase its efficacy and equity.

The most important use of applied research is the extent to which it informs and guides policy makers and planners. Ministry staff members and health experts point out that there is lack of coordination and cooperation between the Statistics and Documentation Directorate and policy makers and planners in the ministry. Research is seen by most as an end in itself rather than part of the policy making process.

Staff members in the Statistics Directorate are not invited to important Ministry meetings and are therefore unable to contribute the important information that they do have. According to staff in other directorates, the Statistics Directorate also does not do a very good job in packaging and presenting the findings of its research strategically for it to be accessible and effective in influencing decision making.

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