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GENDER AND HEALTH: BARRIERS AND OPPORTUNITIES FOR WOMEN'S PARTICIPATION IN THE PRIVATE HEALTH SECTOR IN AFRICA

DISCUSSION PAPER

MAY 2015

Marguerite Monnet



WORLD BANK GROUP
Health, Nutrition & Population

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Summary of Case Studies of Seven African Countries:
Burkina Faso, Ghana, Kenya, Nigeria, Republic of Congo, South
Sudan, and Uganda



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HEALTH, NUTRITION AND POPULATION (HNP) DISCUSSION PAPER

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HEALTH, NUTRITION AND POPULATION (HNP) DISCUSSION PAPER

Gender and Health: Barriers and Opportunities for Women's Participation in the Private Health Sector in Africa

Summary of Case Studies Seven African Countries: Burkina Faso, Republic of Congo, Ghana, Kenya, South Sudan and Uganda

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Abstract: Despite their strong contribution to the overall world economic growth, gender gaps are wide in many countries in sub Saharan Africa and low representation of women in the private health sector is wider than in other sectors. While women and youth use the majority of health services both private and public, women are underrepresented as private health care providers and have limited access to financing to open their own private practices.

This landscape has prompted the HNP Global Practice to take a critical look at the factors which hamper the growth of female and young private health practitioners vis à vis their male counterparts (usually older and more experienced in their profession).

This assessment provides information on ways to close the gap which exists between male private service providers and female providers as well as recommends ways in which the existing gaps can be addressed. The assessment also provides the basis for further developing a strong public- private dialogue in health while providing avenues for building capacities for women to fully contribute to the development of the private health sector through the development of training module to be administered in private training schools as a pilot in Burkina Faso and Mali.

Keywords: gender, private health sector, health training, human resource for health

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FOREWARD

Why is the gender dimension in health, and in particular, private health care provision, so important?

Over the past 20 years, the private sector has been a key contributor to health care provision in Africa. While great strides have been made in creating a conducive environment for effective public and private dialogue, efforts to ensure widespread access to quality health services have been limited by inadequate consideration of gender issues. Indeed, without looking at this critical aspect in the private health sector, gains towards improving health outcomes will stagnate while gender issues are swept under the rug against competing priorities.

This report documents the extent to which gender plays a role in improving access to health services in all spectra of the social pyramid. It also exposes the limitations of government, training institutions and legislation in facilitating gender-friendly participation in health in seven Sub-Saharan Africa countries. The report, which is supported by the World Bank Group's Health in Africa Initiative (HiA), provides relevant recommendations that can be adapted to each country's specific context to inform policy development across the continent. Furthermore, it formulates recommendations which governments can easily draw upon to clarify the often opaque issue of gender equity in the health sector.

As a medical practitioner, wife, mother and strong advocate for integrating a gender dimension in all aspects of life, I recommend that all governments across Africa read this report with an open mind, and find ways in which the issues outlined can be addressed within their respective countries. Addressing the issue of gender equity in health will be the start of an open dialogue in clarifying the often obfuscated dimensions of health-specific businesses, with a focus on ensuring a level playing field for all genders. This report is only the tip of the iceberg in the quest for a more comprehensive solution in ensuring equal opportunities for all individuals in health.

Professor Awa Marie Coll-Seck, MD
Minister of Health and Social Action of Senegal

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EXECUTIVE SUMMARY

BACKGROUND

Delivery of quality health services for all citizens (universal health coverage) requires the engagement of all sectors beyond the public health sector; it includes the private health sector and gender is at the core of an effective and efficient health system. Such system will help Governments make significant progress towards attaining the Millennium Development Goals whose targets have not been achieved by many countries. Although progress is certain in some countries, the majority still face the daunting tasks of: (i) improving access to health goods and services; (ii) improving human resources as the limited number of health professionals cannot provide adequate and quality services; and (iii) increasing Government engagement with all stakeholders and enlisting the support of the private sector to improve provision of health services. Globally, there is a growing recognition—and an increasing consensus—that stronger health system issues are essential to improving health outcomes. This has been dramatically underscored by the recent outbreak of the Ebola virus in West Africa, which was exacerbated by weak health systems. Stronger health systems are essential for the delivery of quality health care, requiring input from not just government, but non-governmental sectors, including the private sector.

The Health in Africa Initiative (HiA) was created in response to the growing observation that the private sector plays a crucial role in the delivery of health services; in 2009, the World Bank Group (WBG) supported the establishment of this initiative, funded by the Bill and Melinda Gates Foundation (BMGF). The role of the private sector in health was further demonstrated by a study called Business of Health in Africa (BHA), published in 2007 by the World Bank Group. One of the major findings of the BHA study was that the private health sector (PHS) has a large growth potential to improve access to quality health services, to address the health needs of underserved communities, and to help African countries meet their health goals. The purpose of the HiA Initiative was to support African governments in harnessing the potential growth of the private sector in three key areas: investment, analysis, and policy and regulatory reforms. The objectives of the HiA were “*to provide information for decision making for both the private and public sectors; to provide policy and regulatory support to governments to enact essential country-specific reforms and create an enabling environment for effective Public Private Partnerships; and to provide access to credit through direct investments, funds, and local banks to private service providers.*”

The 2012 HiA Midterm Evaluation (MTE) revealed that HiA projects and programs failed to target the underserved adequately. The evaluation also found that the HiA Initiative lacked a gender approach; consequently, the factors hampering female health care providers from delivering effective health care are poorly understood. Gender analysis of the HiA Initiative was needed to document the disparities that prevent the equitable participation of men, women, and youth in the health sector in order to close the gaps between male and female participation in the PHS in Africa.

Lessons from this gender analysis are not just of interest to the health private sector, but to the public health sector and other sectors too, particularly at this point when many countries, including African countries, are making efforts towards achieving universal health coverage. As countries develop and review universal health coverage policies and regulatory mechanisms, it is essential that the needs of underserved, vulnerable and marginalized populations are taken into consideration from the outset. Hence the relevance of the broad findings of this assessment.

In response to the lack of gender data in the 2012 MTE, the HiA commissioned this *Gender and Private Health Care Sector Study*. An independent team of consultants was contracted in June 2013 to carry out surveys in seven Sub-Saharan Africa countries: Burkina Faso, Ghana, Kenya, Nigeria, Republic of Congo, Uganda, and South Sudan.

This report is a compilation and synthesis of the key findings from the seven country studies. For each country, the consultant did a literature review, held Focus Group Discussions (FGD), and conducted interviews with different categories of stakeholders from various organizations, including over 300 male and female health care providers and other professionals concerned with the PHS, such as the Ministries of Health and Gender, statistics bureaus, health professionals associations, health training schools, commercial banks, regulatory boards.

This *Gender Study* has two main objectives: (i) to document gender disparities that prevent the equitable participation of men, women, and youth in the PHS, and (ii) to provide recommendations to stakeholders on closing the gaps that exist between male and female private health service providers.

FINDINGS

In all seven countries, fewer female health professionals are engaged in the health private sector compared to their male counterparts. The studies reveal that this disparity is due to early gender socialization and, later, various barriers hampering women from fully participating in the sector. These findings are discussed below in greater detail.

EARLY SOCIALIZATION

- ❖ **Gender disparities appear very early in the life cycle.** Girls' socialization begins within the household and the community. Each country study remarked that families and communities have a *clear preference for giving birth to boys over girls*. The assumption is that a girl will get married and benefit her new family, while a boy is expected to continue to provide for his extended family as an adult. Gender disparities at the community level negatively affect girls' enrolment at school and their ability to pursue health studies. Girls are less likely than their brothers to acquire formal education, which restricts their employment opportunities. In all seven countries, whilst completion rates of primary education are low, those rates decline even more so progressively in middle and secondary school. For girls fortunate enough to attend school, completion rates are even lower. Because of early marriages and pregnancies, even those girls enrolled in school often drop out early. If girls are able to pursue a career, they are directed toward courses and professions deemed suitable for their gender. Only a small minority of girls graduates from high school and attends universities to pursue health studies. Combined, these inequities create a tremendous gender gap in health professionals.
- ❖ **Males are predominant in enrolments for health-care training institutions, except for nursing and midwifery schools.** In Kenya, more female nurses were trained than male nurses because Kenyan society believes nursing and midwifery are feminine jobs and that girls generally dislike the sciences. This societal attitude may explain why parents prefer not to invest in educating their daughters in science-related subjects such as medicine, dentistry, and pharmacy. The implication is that girls may not have the aptitude to excel in the sciences.
- ❖ Sometimes, **female university students reported being subjected to financial and sexual extortion** in order to register at university and in exchange for good grades. Female health professionals in Congo, for example, said they were sexually harassed repeatedly while they were undergraduates by male supervisors and health school administration. Because they feared retaliation by the perpetrators, none of the victims took legal action. The traumatization and victimization have a cumulative negative psychological effect on their careers, academic performances, and self-confidence.
- ❖ **The “infertility risk” often pressures females to forego university studies and careers and marry early.** Women are raised to become primary caregivers, as well as the health care providers in their families. Female students face familial pressures regarding their age and fertility period. Young women fear the “infertility risk” and, therefore, will marry while still students and start giving birth as soon as possible. While a female student accepts a second new role of caregiver for her whole family, including her family-in-law, her male counterparts are able to focus primarily on their studies. As a consequence, female students may be required to repeat grades or to drop out of university, while their male colleagues generally postpone marriage until they have completed their

studies. When male students do marry while still studying, the family prioritizes the husband's career over the wife's. Married male health students are therefore able to pursue a health specialization requiring four to five additional years at university, with the support of their wives and families.

- ❖ ***Certain health specializations are unavailable in local universities. Congolese students, for example, must pursue pharmacy or dentistry studies in foreign countries. The majority of families are reluctant to send their daughters abroad due to the enormous expense of foreign tuition and living expenses. Others may fear "what can happen to their daughters while they are far from home." In both cases, they often prefer, instead, to invest in their sons' higher education studies rather than their daughter's.***

GENDER BARRIERS TO PHS

Female health professionals have additional barriers to overcome in the PHS once they are practitioners. These financial and institutional barriers also are rooted in socio-cultural factors.

- ❖ **Inadequate access to bank loans.** Like any entrepreneur, to set up private health facilities, most health professionals need to access credit. While the credit regulatory system is not discriminatory per se, the lack of access to credit seems to be a major constraint for female health service providers, more so than for their male counterparts. In the absence of collateral, women tend more often to be disqualified from accessing credit. One similar reason across the countries is the inequity of existing property ownership. Through inheritance laws and by tradition, men have more property than women. Another possible method to access capital is bank loans. High interest rates for unsecured loans however are usually a discouraging factor for female health workers, who usually have a "low risk-taking attitude," compared to male colleagues. They often fear being unable to repay the bank loan and falling heavily into debt. So, female professionals prefer to stay in the public sector, which offers more employment security. They may also choose to be an employee in the PHS with less administrative responsibilities. For the more entrepreneurial among them, they may set up a smaller health entity, with the help of their spouse or a family member, without taking on a significant financial risk and burden.
- ❖ **Dual public and private employment to finance PHS business.** In the various countries surveyed, most health professionals working as owners or employees in the PHS are formally employed by the Ministry of Health (MOH). Although dual employment is not authorized, it is known that governments are "tolerant" on this issue. Therefore, a majority of primarily male health civil servants work part time in private health clinics. This allows them to earn more money with dual incomes, which they use to finance their private health facilities. In contrast, many of their female colleagues are fully occupied with work and family responsibilities.
- ❖ **Institutional barriers to PHS entry.** In all seven countries, professionals seeking access to the health private sector have to pay fees to acquire licenses authorizing them to operate as sole proprietors. While the requirements generally are gender neutral, survey results indicate that female health professionals tend to face more administrative constraints from regulatory bodies compared to male health professionals. Registering female-owned businesses takes longer and women reportedly are often forced to make informal payments to obtain authorizations.
- ❖ **Family constraints to PHS practice.** Male health providers experience fewer constraints to working long and odd hours in the PHS. Across the countries surveyed, specific family constraints

negatively affect female professionals' ability to perform their jobs. Like many health professionals, the career demands long hours and some night shifts. Female professionals are expected to meet these work requirements and, at the same time, be available at home to fulfill the demanding roles of mother and wife. These combined domestic and professional duties are notable factors discouraging women from working in the PHS, either as owner or employee. Even though the PHS offers an attractive environment in terms of better support service delivery, less workload, flexible hours, better salary, the opportunity to deliver better health care, and the ability to provide health care for underserved areas, the PHS is, nevertheless, much more demanding than the public sector in terms of managing time and human resources.

- ❖ **Conservative cultural perceptions of women's roles.** Some traditional African cultures offer very few opportunities to change the power dynamics of the household. Women are still considered responsible for taking care of the house, while men are considered the main breadwinners and bill payers. The country reports mention certain cultural practices that disempower women such as early and forced marriages, wife inheritance, and widowhood practices. During Focus Group Discussions and the validation workshops in Congo and Burkina Faso, it was clear that male health care providers expect women in private and public spheres to prioritize women's traditionally determined roles at home above their professional responsibilities. Interestingly, female colleagues expressed the same views as their males in the FGD, validating these stereotypical roles across gender lines.
- ❖ **The private health facility is a male-dominated area where “*men are doctors and women are nurses.*”** The few women working in private health facilities tend to be at the bottom of the hierarchy. Typically, men represent the role models to be emulated, even for female colleagues. Women have no choice other than to follow the example of their male colleagues to learn how to be competent and fulfill their responsibilities as health care providers. Because male professionals, in most cases, are not carrying the double burden of career and household, they cannot model effective ways to manage both personal and professional life. Women are often conflicted by the kind of work they would like to perform and the personal life they would like and are expected to have. Likewise, female professionals are always reminded by colleagues and family members that their first role is at home. Therefore, a health facility is not a secure place for women, either physically or psychologically.
- ❖ **Male clients prefer male health care providers.** Some cultural and religious beliefs play a role in male clients' selection of health service providers. While they prefer professional women for wives, they have an obvious preference for a male health practitioner rather than a female when making health service provider choices.
- ❖ **Women's fraught relationships in the work place.** Cultural stereotypes also negatively affect females' relationships at work. Male colleagues who share the same culture and values often have little interest in working with women due to negative perceptions and assumptions regarding females' possible absenteeism related to potential pregnancies or other family issues. Perhaps more surprisingly, the relationship among working women is also difficult. Because women share the same values and perceptions about one another as their male counterparts, women prefer working with male colleagues. As a result of both sexes' preference for male colleagues, women do not unite when they need support or encouragement. Consequently, female professionals working in private health facilities are discriminated against by colleagues of both sexes. As a way to take into consideration these negative perceptions, female medical doctors having their own facility often employ male doctors for balance.

In conclusion, the PHS can be more attractive to female health professionals than the public health sector because it offers some incentives that respond to their specific needs: well-equipped facilities offering a better working environment in terms of space, flexible working hours, favorable shifts, more quality time allowing the provision of better services, and better salaries are compelling reasons for female health care providers to be attracted to working within the PHS. Unquestionably, both male and female health professionals experience some of the identified barriers to participating in the PHS, particularly in regards to the difficulty of accessing credit and the administrative harassment in establishing private health facilities. Nonetheless, the country surveys indicate that some gender-based disparities are rooted in sociocultural factors. The main challenge for women health providers is how to mitigate and minimize the effects of the disparities and to balance their personal and professional life in order to effectively contribute to the PHS on a more equal footing with their male counterparts.

The sociocultural orientation of male and female roles is also reflected in the way male clients and healthcare providers perceive the duties of female health providers. Male health care providers have repeatedly resisted transforming the private health facility into a more mixed and equitable workplace for men and women. During Focus Group Discussions in all seven countries, men insisted on the importance to African households and communities of maintaining the traditional distribution of gender roles.

As a result of this seven-country assessment, strategies were identified to close the gaps between men and women working in the PHS.

What follows describes opportunities and strategies that have enabled women's entrepreneurship in the PHS to flourish. These successful approaches have contributed to creating a more enabling environment within the PHS for African female health practitioners, and these strategies are worth considering for replication in other countries.

OPPORTUNITIES TO EMPOWER FEMALE HEALTH PROFESSIONALS

The country surveys identified successful initiatives that have created opportunities to empower female entrepreneurs in the health sector. They include some initiatives aimed at reducing the effects of institutional, administrative, and sociocultural barriers resulting in gender disparities in the PHS, such as the following:

- ❖ Some government initiatives in countries like Kenya promote women's entrepreneurship, for example, the Kenyan Women and Youth Empowerment Fund; likewise, the Public Procurement and Disposal Act was amended to mandate both the national and devolved governments to set aside 30 percent of their procurement budgets for enterprises belonging to women, youths and Persons with Disabilities (PWDs). In Ghana, initiatives such as Women Award Programs, the Gender Responsive Skills Project and the Capacity Building Programs are illustrative of successful programs.
- ❖ The presence of gender-specific health professionals associations, such as the Nigerian Women Medical Association (NWMA), the Kenya Medical Women's Association (KMWA) and the Lady Pharmacist Association of Ghana, (LAPAG) all aim at building capacities and providing career support, information, and guidance to their members.
- ❖ In general, commercial banks' procedures have no gender differentiation. Some banks offer attractive conditions and services to access credit, such as in Ghana, where the Medical Credit Fund has been available since 2009. The Fund offers loans and credit facilities to health professionals in the private sector; 30 male and 45 female owners of health facilities have received credit through the Fund. One of their most attractive services for the female clientele is that the loan department of the commercial bank offers to help applicants assemble the required loan documentation, review for quality and accuracy, and then submit the completed package to the loan department for processing on behalf of the applicant.

RECOMMENDATIONS

Based on the findings of the seven-country survey, each consultant made recommendations to the HiA program to support African governments' health strategies to achieve the MDGs and to help specialized health associations. These recommendations should be considered as a prerequisite to achieving the health MDGs and the post 2015 sustainable goals. The recommendations for governments and professional associations are the following:

Governments to:

- Recognize that addressing gender disparities at all levels of society not only contributes to equity between men and women, but also to lowering of inequalities between populations within the countries and improved access to services by all.
- Develop policies to introduce gradual changes within African patriarchal societies at the household, community and national levels through gender-based budgeting and financing girls' education programs. These policies will promote more balanced gender roles and outcomes that contribute to social and economic growth;
- Develop health policies, particularly universal health coverage policies that take into account the deeply-engrained cross-sectoral and socio-cultural gender disparities that may hinder access to health services, particularly by vulnerable, marginalized and underserved populations.
- Create a more gender sensitive and enabling environment by reviewing the national gender policies, and, more specifically, the PHS policy to ensure that national gender policies result in more equitable and non-discriminatory access to the PHS by female health professionals, offering equal opportunities to all;
- Develop strategies to reduce the imbalance in the education sector to promote and encourage girls' enrolment in the sciences, university health disciplines, and professional health careers;
- Provide incentives to female and male health professionals in the PHS to jointly provide services in marginalized areas to reduce high rates of maternal mortality;
- Introduce a gender dimension in the Ministry of Health's advocacy activities to promote a positive attitude toward female health providers among the population and to dispel negative perceptions and attitudes;
- Ensure that policy development and review consultations should include critical socio-cultural gender analysis and awareness-raising to ensure developed and reviewed policies address gender disparities in a holistic and life-course manner that includes all affected populations.
- Encourage health training institutions to introduce a gender component module in the curricula of health sciences to get students to reflect on health investment ideas while in school, and take into consideration the gender dimension within the health sector (along with clinical aspects); and the implication of these gender dimensions in the universal provision of health care to all populations by both the private and the public sectors.
- Encourage commercial banks to mainstream a gender and youth perspective into their lending practices by encouraging partnership with local banks, particularly in regards to the two financing mechanisms: the Investment Fund for Health in Africa (IFHA) and the Africa Health Fund (AHF), as well as other available funds.

- Engage regulatory bodies to explore ways to reduce the administrative burden for the PHS, which is a source of chronic tension for health care providers;
- Encourage regulatory bodies to collect disaggregated sex and age data during registration for and the renewal of licenses. This information will assist governments in developing more adequate and gender-sensitive strategies and policies, including the introduction of a gender dimension in the training for health professionals. These should supplement or be additional to sex and age disaggregated data governments should have on all health professionals, in order to track specific disparities between the private and public health sectors.

Professionals Health Associations to:

- Attract more female health professionals to participate in association activities; identify the specific needs of youth and young female health professionals to address their concerns; explore other ways of collaborating with them by bringing more technical support; and include increasing capacity building activities;
- Support the creation of and/or strengthening existing female-specific Health Professionals Associations and their capacity-building initiatives for members involved in the PHS;
- Develop a series of strategies to empower and involve female colleagues more fully in the leadership, the management, and the delivery of health services. This may happen by recommending gender-sensitive working conditions to encourage the inclusion of female health care providers and to reduce stress in the management of their work and family responsibilities.
- Support government efforts towards inclusive healthcare delivery, at all stages of the healthcare delivery process, including the policy development, review and implementation stages.

RATIONALE

BACKGROUND

The World Bank Group (WBG) Investment Climate Advisory Services is helping Sub-Saharan African governments respond more effectively to the unmet needs for health services by assisting them in implementing climate reform investment in their health systems. By combining the comparative advantages of the International Finance Corporation (IFC) and the World Bank, the WBG is conducting activities to increase “access to health related goods and services by improving financing and provision of the private health services.”¹ This support is being provided through the Health in Africa Initiative (HiA), a five-year program established by the WBG in 2009.

The HiA aims to support countries reduce the regulatory compliance burden on businesses by:

- ❖ Simplifying business start-up procedures,
- ❖ Rationalizing business licensing and inspection regimens, and
- ❖ Reducing the cost and procedures involved in business transactions and simplifying taxation, particularly for small businesses and microenterprises.

In its landmark publication *The Business of Health in Africa’s Report: Partnering with the Private Sector to Improve People’s Lives*, HiA describes opportunities for developing, engaging in, and supporting a well-managed and effectively regulated private sector to improve the region’s health, especially in Sub-Saharan Africa. The report is based on six assessments of the private health sector in Burkina Faso, Ghana, Kenya, Mali, the Republic of Congo, and Uganda and complements the *Partnering with the Private Sector* report. One major finding of the six-country report is that the Private Health Sector (PHS), including the for-profit and not-for-profit service providers, has great growth potential to improve the respective population’s access to quality health services. The PHS already plays a major role in each country; on average, the private sector “delivers 50 percent of health care and 60 percent of the financing” from private sources (private sector assessments conducted by HiA from 2010-2012.) The PHS also delivers services to underserved communities.. Clearly, African governments need to develop strategies to better mobilize and leverage the PHS to maximize its contribution and create effective Public Private Partnership (PPP) in order to deliver comprehensive health services to the entire population, including underserved areas.

The HiA studies mentioned above highlight gender disparities in the PHS. Women health providers are underrepresented among owners and employees in PHS facilities. One recommendation of the HiA Midterm Evaluation (MTE) was to document gender disparities to better understand the factors that hamper female health care providers from fully contributing to the PHS, and then to recommend strategies to close the gaps between male and female participation in the PHS in Africa.

As part of the HiA Initiative, this *Gender and Private Health Sector Study* was undertaken to investigate the extent that gender disparities in the PHS exist and to determine how to minimize the disparities to strengthen African health systems. The HiA *Gender Study* was launched in Burkina Faso, Ghana, Kenya, the Republic of Congo, Nigeria, South Sudan and Uganda in May 2013. The seven country assessments were carried out between August and November 2013. The surveys were conducted by six consultants with local knowledge of each country s/he assessed.

¹ Herbert, Brad. 2012

THE GENDER AND PRIVATE HEALTH STUDY OBJECTIVES

The objectives of the *Gender and Private Health Sector Study* are aligned to meet the agreed Millennium Development Goals (MDGs). The study focuses on “*identifying issues and challenges faced by women private health care providers that hamper access to quality health services by women and youth users and recommending ways to address these challenges.*”

More specifically, the objectives of this study were to:

- Describe gender disparities that prevent the equitable participation of women and youth in the Health Private Sector;
- Explore the factors that hamper women's full contribution as PHS service providers;
- Describe the gaps that exist between male and female PHS service providers;
- Recommend strategies to reduce the existing gaps between male and female PHS providers.

To achieve these objectives, HiA organized two seminars with selected consultants - in Brazzaville and Nairobi in June 2013. During the seminars, the project team agreed on a common research methodology. Next, consultants conducted field research for each of the seven countries through Focus Group Discussions (FGDs) and questionnaires by targeting different stakeholders, and by undertaking a literature review.

WHY GENDER²?

For the basis of this assessment, it is critical to remember that the terms gender and sex are not synonymous or interchangeable.

More specifically, because gender relations are socially constructed, males and females from the same country may be raised differently due to localized cultural values, which may result in inequity. For example, in rural areas, conservative values may hinder girls' education and employment. Long-held gender beliefs may also have negative effects on girls' and women's reproductive health and other aspects of their lives. Differences in values will determine if a girl will be educated, have a career and formal employment; whether she is subjected to female genital mutilation, married early, and the number of children she will bear; and whether all these decisions will be made for her without her input or consent. Different variables other than education and culture may influence how boys and girls from the same country are individually socialized, including location, socioeconomic situation, ethnicity, and religion. Gender relations are based on ideologies that determine power, authority, and control of resources. Gender patterns are not easily renegotiated, particularly since women are socially constructed to accept and perpetuate power imbalances.

As gender roles and responsibilities are constructed very early in life and pervade the household, community, and national levels, boys and girls are raised to have socially acceptable behavior, expectations, attributes, and attitudes as adults. Gender is embedded in a society's social, cultural, economic, and political system; thus, gender attitudes influence how men and women perceive themselves and each other.

Gender roles and relationships between men and women require examination in all sectors of society to better understand underlying attitudes, as well as differences between men and women in terms of roles and responsibilities, the divisions of labor, access to and control of resources, and opportunities and benefits. By identifying gender gaps, it is possible to recommend gender-responsive interventions to amend and ameliorate disparities.

Each of the seven Sub-Saharan African countries assessed has a Ministry of Gender (MOG) or Ministry of Women's Affairs and they have integrated a gender dimension into their intervention strategy to improve

² World Bank Group. World Development Report 2012.

programs aimed at advancing the status of both men and women. While the respective governments are each signatories to various international instruments protecting women's human rights and supporting gender-sensitive development, in actuality, they fall far short on implementation. Surprisingly, Nigeria, which is economically strong compared to the other countries' studied, exemplifies the gaps between international law and customary practice that remains the status quo in the majority of African countries.

Box 1.1. Gender Issues in Nigeria

Over the past three decades, the worldwide social and economic development has not benefitted Nigerian women and girls. Nigeria ranks 118 out of 134 countries in the Gender Equality Index. Nigeria also ranks as one of the lowest countries in terms of progress in Africa and the world. This is a result of poor investment in health care and education for women, and their poor access to services, as well as legal and cultural barriers that restrict women's life decisions and options. Over half of Nigeria's population lives in rural settings. The majority of rural illiterates are women. The literacy level is about 61.3 percent: 72.1 percent males and 50.4 percent females (CIA World Fact Book 2010).

While the Government of Nigeria is a signatory to the UN Committee on the Elimination of Discrimination Against Women (CEDAW) and the protocol of Rights of Women in Africa, these international instruments have not been implemented. Although culturally diverse, Nigeria is a rigidly patriarchal society. Men dominate all spheres of women's lives, including marriage, politics, governing bodies, as well as religious, public, and private institutions. Nigerian women are underrepresented in the formal and public sectors: only 29.5 percent of women are employed in the public sector compared to 70.5 percent of men, and a majority of women spend their time doing unpaid work.

DEFINING THE CONTEXT OF THE STUDY

DEFINING HEALTH SYSTEMS IN THE SEVEN TARGET COUNTRIES

One of the major differences in the seven-targeted countries is that two of them are post-conflict nations. South Sudan and the Republic of Congo are still recovering from years of civil war and remain in a phase of rebuilding their infrastructure, including their public and private health systems. Nevertheless, all seven countries share similarities in key challenges to overcome in their respective health systems, including the following:

An inequitable distribution of health facilities

The capital cities and the main economic centers in each country contain a small number of large hospitals and clinics offering better quality services, while numerous small-scale health facilities and not-for-profit health private services are located across the country and particularly in rural areas where the majority of lower to middle-income people live.

Lack of incentives for staff deployment to rural areas

A major disincentive for health care civil servants is to be posted in the regions and more rural areas rather than in the capital city and major urban areas. They are distanced from family and social life that is concentrated in the larger cities and particularly the capital. Nonetheless, without health staff in the regional and rural areas, poorer and underserved communities are unable to access quality health care;

Lack of adequate quality public services in difficult working environments

Due to insufficient infrastructures poorly equipped facilities and working environments, public health professionals work long hours in difficult conditions. They are further burdened by the weight of onerous organizational bureaucracy, which diverts time from seeing patients;

Lack of local drug manufacturing

The cost of medicine exceeds the purchasing power of the vast majority of people in the assessed countries. The price point of medicines in private pharmacies could be reduced significantly if some drugs were manufactured locally. In the meantime, because costs are prohibitive, patients purchase medicines in illegal drug markets where they are cheaper - if they are indeed authentic. Nevertheless, self-medication increase the drug resistance of the consumers;

Employee hiring freeze in the public sector

Because civil servants' wages absorb an important share of states' budgets, many African governments introduced a series of reforms in the 1980s, aimed at reducing the government's role in economic development to rationalize the sector and provide better civil services. As a consequence, the public sector reduced its level of recruitment, and the private sector began recruiting more qualified health professionals. The Uganda country survey reported that the Government of Uganda hardly deploys health providers, and doctors are no longer deployed to the regions or rural areas. Employment opportunities are, therefore, subject to corruption. Job seekers pay bribes to obtain a position or to have someone push their candidacy.

Difficult to retain competent employees

Public health professionals, like other civil servants, are underpaid. Retaining competent staff is difficult when better salaries and working environment in the private sector lures them away.

Box 2.1. Compensation and Skills Improvements: Public vs Private

Until 2012, the public health sector in Kenya was characterized by poor pay and infrastructure. Male and female service providers were forced to work on the side to make ends meet. Ill-equipped health facilities made it difficult for health providers to deliver quality care to patients. Therefore, many male and female health practitioners migrated to private facilities for better salaries and to practice health care in an environment where they could remain clinically relevant. The private sector also faces the challenge of retaining good health care professionals if opportunities are not available for improving skills and knowledge – this is especially more apparent in small and medium-sized facilities.

Skilled and qualified health professionals' migration

International recruitment of health professionals is also becoming a solution for individuals who want to improve their medical skills and standard of living. No data is available about migration of health professionals in any of the countries studied. Nonetheless, African governments are aware of the negative impact of brain drain and flight of expertise has on their health sectors, which are already understaffed.

Dual employment is common

In all countries surveyed, the majority of health professionals are engaged in dual employment. They are employed full time in the public sector and, concurrently, they are running their own private practice or are employed part time in the private sector. In Kenya, for example, most male and female nurses with one-to-five years of experience are privately employed. In Uganda, dual employment is common: 54 percent of doctors working in the private sector also work in the government sector; more than 90 percent of private sector nurses, midwives, and nursing aides also work full time in the public sector. An estimated 9,500 health professionals are working exclusively in the Ugandan private sector, including more than 1,500 doctors. In Nigeria, the total number of doctors working part time and full time is the same as in the public sector. There are approximately 20,000 private health care workers in urban areas. There are about 60,517 full-time and part-time nurses employed by the private sector in Nigeria. In addition, available information shows that dental assistants, radiographers, and pharmacists work in both private and public health sectors concomitantly.

DEFINING THE CONTEXT OF THE PHS IN THE SEVEN TARGETED COUNTRIES

Curative and preventative health services are provided by a number of diverse stakeholders in the seven countries. They include those working in the public sector whose entities and facilities are managed by the governments through the Ministry of Health, as well as those working in the PHS. In the countries studied, the health public sector is the major employer of health staff. In Burkina Faso, for example, the public health sector employed 19,899 health employees in May 2010, compared to 1,800 in the private sector. Governments also own the majority of the health facilities in most of the seven countries. In Nigeria, as of December 2011, more than 66 percent of health facilities were publicly owned. The Government of Uganda owns 2,242 health centers and 59 hospitals compared to 613 health facilities and 46 hospitals which are owned by the Private Not-for-Profit (PNFPs), and 269 health centers and eight hospitals were owned by private for-profit health providers.³

The PHS plays an important role in each country's health system; the country studies found the following regarding the sector in each of the respective countries:

³ Government of Uganda. 2010.

The private health sector is a growing sector

The private health sector (PHS) plays an important role in delivering health services, mostly in clinics, maternity homes, and pharmacies. Private sector medical doctors, dentists, nurses, midwives, and pharmacists and other health professionals, provide health services for about 60 percent of the population in the Republic of Congo, 55 percent in Ghana, 50 percent in Kenya, and 70 percent in Nigeria. The PHS is perceived by Nigerians as more efficient than the public sector, which is probably due to the profit motive. It is also seen as a health market where goods and services are exchanged between health care providers and consumers⁴.

Box 2.2. Private Health Sector in Congo

In the Congo, the PHS includes commercial enterprises such as clinics, pharmacies, and not-for-profit entities. In 2005, the Ministry of Health identified 1,712 health entities, including 1,002 private ones (59%) nationwide. The majority of private entities are for profit (88 %) and are located in urban or semi-urban areas.

Box 2.3. Framework to Facilitate PHS Growth in Ghana

In Ghana, the private sector includes any non-government health business, private for-profit, private not-for-profit, and mission or faith-based facilities. The private sector is involved in direct delivery of health services, the supply of inputs, and the training of health professionals.⁵

In 2011, Ghana completed a Private Health Sector Assessment Report, with the assistance of the Health in Africa Initiative (HiA). The assessment drew attention to the important role the private health sector can play in achieving the country's health objectives. The report emphasized the need to improve the regulatory environment, promote an engagement between the public and private sectors, supports the private sector in policy dialogue, and open up space for Public Private Partnerships.⁶

The Government of Ghana acknowledges the importance of the private sector as a growing source of health services, providing about 42 percent of the healthcare services in the country.⁷ To facilitate and coordinate a private sector relationship with the public health sector, the Ministry of Health's private sector unit revised its 2003 Private Sector Policy. The new 2013 Private Health Sector Policy is aimed at providing a framework to facilitate the growth and development of the PHS, and monitoring and regulating private health care providers.

Before joining the PHS, health professionals tend first to work in the public sector

In all the countries surveyed, respondents acknowledged receiving foundational health care experience in their first years of practice in the public sector, exposing them to various aspects of the medical field. Eventually, this experience and these skills were used in the PHS. In 2010, 62 percent of Ghana respondents practiced for at least two years in the public sector before joining private practice. Owners of health facilities, on average, had worked for five years in public facilities before opening their own health establishments.

Reasons for working in the PHS

There are many reasons why the PHS has grown tremendously in the past two decades. Health professionals' desire to work in the PHS has been motivated by several factors, including various constraints in the public sector such as low salaries, restrictions on recruitment, work overload, and lack of

⁴ World Bank Group. 2011

⁵ World Bank Group. 2011

⁶ "Health in Africa Ghana Project in Brief", 2013.

⁷ "Five Year Program of Work, 2002-2006." Ministry of Health, Ghana.

job satisfaction in government facilities. In general, the PHS has fewer administrative procedures, is better equipped, and offers quality care and gives the necessary time for consultations with patients, as well as better salaries and working conditions. The majority of public sector health employees are already working in both sectors simultaneously, despite the practice of “moonlighting” which is officially unacceptable to governments. However, due to shortages of health providers and low salaries in the public sector, governments cannot strictly prohibit public sector personnel from working in the PHS after their shifts. If they enforce the rules, civil servants would opt to leave public health facilities altogether and work solely in the PHS (World Bank 2010).

Box 2.4. Good Working Conditions in PHS in Kenya

Private practice staff reportedly work together as a team and have a greater sense of accountability. The employees know they have to perform to maintain their jobs, and by carrying out their duties, they make everyone’s work easier. A male nurse working in a Mombasa NGO clinic observed, “I have to be extra careful here. In private practice, we offer quality not quantity care. We have to give our best. Otherwise, a client can report you to the boss.”

Some male and female health workers feel the private sector takes good care of the employees’ welfare and this motivates these employees to remain in their jobs. The employer accommodates their personal issues and sometimes sponsors their education. A female pharmacist working in Mombasa noted that whenever her daughter needed to see a doctor, her employer gave her some time off without requiring her to make up the hours.

A male employee and an owner of a pharmacy in Mombasa similarly observed that his boss trusted and employed him even when the boss knew he had his own practice. He said, “My boss trusts me. He knew I had my practice and still employed me. He trusted I would not have double standards.”

From the clients’ point of view, the PHS offers higher quality services

Private health facilities are smaller structures where the human dimension is valued. They also seem to be better equipped, and the personnel are more welcoming and provide better quality time with patients. Since user fees have been introduced in the health public sector, when affordable, patients prefer the PHS. (The World Bank, 2010.)

Private health facilities are inequitably distributed

Most private health facilities are concentrated in urban areas and provide mainly primary and secondary care services. Rural locations are undesirable because health care providers are away from their extended families.

Box 2.5. Staff Preference for Urban Employment in Ghana

Human resource patterns show that the unbalanced distribution of health facilities favoring urban areas is even more pronounced when health staffing is taken into account. Not only are there more hospitals and hospital beds in urban areas, but these urban hospitals are also more generously staffed than their rural counterparts, particularly by Ghana Health Service (GHS) doctors. The more generous staffing of self-financed private hospitals with laboratory and pharmacist personnel suggests that they provide more of these services than GHS hospitals.

The Private Not-for-Profit providers are more active in rural areas

They are the major health care providers for underserved communities.

Box 2.6. Private Not-for-Profit Role in Uganda

The Private Not-for-Profit (PNFP) sector is more structured and prominent in rural areas of Uganda. The PNFP is divided into two types of facilities: Facility-Based Private Not-for-Profits (FB-PNFPs) and the Non-Facility Based Private Not-for-Profits (NFB-PNFPs).

The FB-PNFPs provide both curative and preventive services while the NFB-PNFPs mainly provide preventive, palliative, and rehabilitative services. The FB-PNFPs account for 41 percent of the hospitals and 22 percent of the lower-level facilities that complement government health facilities, especially in rural areas. The number of PHS health facilities in Uganda accounted for 46 percent of the total.⁸ The estimated staff employed in the PHS sub-sector nationwide was 12.8 percent. The Government of Uganda and PNFPs together employ about 30,000 health workers.⁹

A male dominated sector.

Aside from the nursing and midwifery professions where females generally account for more than 80 percent of health care workers, there are more male health workers in the PHS due to the sex distribution of health workers in the overall practicing population. In Kenya, male professionals represent 75 percent of the doctors and 62 percent of the dentists, while in Nigeria, women comprise 35 percent of physicians and dentists, 99.9 percent of midwives, and 72.2 percent of occupational therapists across the country. The sex distribution of health workers in Nigeria is shown in Table 2.1.

Table 2.1. Percentage of Female Healthcare Workers in Nigeria, Public and Private:

Health Occupation Categories	% Male	% Female
Doctors	65%	35%
Nurses	5.4%	94.6%
Midwives	0%	100%
Dental Nurses	36%	64%
Dental Health Technicians	45%	55%
Dental Assistants	60%	40%
Pharmacists	64%	36%
Medical Lab Scientists	85.7%	14.3%
Medical Lab Assistants	60%	40%
Physiotherapists	33%	67%
Occupational Therapists	38%	62%
Speech Therapists	18%	82%
Radiographers	65%	35%
Optometrists	47%	53%
Chartered Chemists	70%	30%
Environmental and Public Health Workers	58%	42%
Public Analysis	75%	25%
Health Management Workers/ Health Records	44%	56%
Audiologists	44%	56%

Source: Federal Ministry of Health: A Directory of Health Facilities in Nigeria. 2011.

⁸ GOU, Ministry of Health, Health Sector Strategic Plan III 2010-11 – 2014-15.

⁹ Ibid.

One reason for this unequal distribution of providers is mentioned in the Nigeria report. Both clients and health workers perceive the duty of female health workers stereotypically. *“There is recognition among health professionals, but also among the population, that females tend to be predominately nurses, midwives, occupational therapists, and community health workers. Doctors, dentists, pharmacists, radiographers, physiotherapists, medical records, environmental health officers and medical laboratory scientists tend to be predominantly male.”*

These gender-based staffing inequities have implications for the health sector overall. Males are more likely to hold the highly skilled medical positions earning better wages. Consequently, they make the decisions as owners and/or employees of private health facilities—as well as for public health facilities. Male owned health facilities may not seem welcoming environments to women, unless the facilities are designed to meet both genders’ health needs.

Financing is the greatest constraint faced by private health facility owners

In all seven countries, financing was assessed to be the primary constraint to owning and operating a Private Health Facility (PHF). Operational expenses are enormous and include equipment, staffing and daily operational expenses. Because financing is difficult to obtain, health professionals are obliged to build private health facilities. According to the Nigeria report, *“Health care providers want access to credit to improve their services, but in many countries, banks are not interested in lending to this health sector. Financial institutions often view health as a public good, not a business. So they prefer to lend to more commercially viable projects like the trade and manufacturing sectors. Banks that require security may not be interested in the type of collateral that health care providers offer. The health businesses are often run by clinicians with little business experience and are unable to develop a good business plan to obtain financing.”*

Obtaining authorizations for the PHF is a major constraint

The administrative procedures to establish a Private Health Facility and obtain licensing are very time consuming and a main constraint for private practitioners who want to establish a licensed facility. In South Sudan, the clearance to start a business takes about four to 12 weeks and an additional two to four weeks to validate professional qualifications and the license to practice. Likewise, these credentials have to be renewed annually. For some, it is possible to circumvent the lengthy process. As one South Sudan respondent remarked, *“The [administrative] processes were equally determined by how well you were known by the officials handling the process. You also had to be known at the community level.”*

In Uganda, other bureaucratic factors can be the source of major constraints to PHS entry. Health professionals are required to navigate several approvals. *“To start up a health business, one has to fill the application forms, which are first approved by a District Health Officer. Then the request must be submitted to the District Council through the Standing Committee on Health for ratification. It is finally approved by the Chief Administrative Officer.”* The regulatory bureau responsible for accrediting and renewing licenses for private healthcare facilities has limited capacity and resources and, therefore, limited staffing to handle the volume of requests. The offices do not have a complete registry of private sector facilities. This lack of registry is found in all countries. A lack of respect for the procedures was mentioned in the Ghana assessment as another constraint to entry as described in Box 2.7.

Box 2.7. Registration and Licensing in the Ghana PHS

To regulate the private health sector in Ghana, statutory bodies register and license services. These include the Private Hospitals and Maternity Homes Board (PHMHB), which was enacted in 1958 and has evolved into the Health Facilities Regulatory Agency Act. Other agencies are Medical and Dental Council, Nurses and Midwives Council, Pharmacy Council, and Food and Drugs Authority. However, a regulatory framework for diagnostic centers and laboratories does not exist, which is critical, since these privately owned entities are proliferating in the country.

In Ghana, an estimated 50 percent of private facilities do not conform to current registration and licensing requirements. Stronger institutions with adequate capacity are required to regulate the PHS over larger geographic areas and with multiple stakeholders.

Client preferences for same-sex health care providers

One of the greatest advantages of seeking care in a private health facility is that the client can choose his/her health provider. Some clients are more comfortable being examined by a same-sex professional and feel more confident that the provider will be able to understand their specific needs and resolve their problems.

Clients' preferences have their sources in cultural and religious beliefs and are vital to appreciate in building a trusting relationship between clients and health care professionals. A women's preference for seeking care from female health professionals is an opportunity to empower female health professionals in African countries. This issue is discussed in more detail in section 4: key findings.

Public Private Partnership

All seven countries for this assessment have experiences with PPP. Below is an illustration of a PPP experience in health from Ghana (see box 2.8 which complements box 2.3).

Box 2.8. Health Private Sector Policy in Ghana 2013

In 2011, Ghana completed a Private Health Sector Assessment Report, supported by the Health in Africa Initiative. The assessment drew attention to the important role the private health sector can play in achieving the country's health objectives. It also emphasized the need to improve the regulatory environment, promote an interface between the public and private sectors, engage the private sector in policy dialogue, and encourage Public Private Partnerships.¹⁰

The Government acknowledges the importance of the private health sector as a growing source of health services in Ghana. The PHS provides about 42 percent of health care services.¹¹ To facilitate and coordinate the private sector relationship with the public health sector, the Ministry of Health's private sector unit revised its 2003 Private Sector Policy. The new 2013 Private Health Sector Policy is aimed at providing a framework to facilitate the growth and development of the sector and monitoring and regulating private health care providers. The vision of the Private Health Sector Policy is to facilitate the transformation of the private health sector into a viable industry by harnessing its unique competencies and comparative advantage in producing and providing healthcare products, infrastructure, and services that benefit the public at affordable prices.

The Private Sector Unit in the Ministry of Health has been established to forge linkages with the private health sector. However, the unit is small, relatively low in the administrative hierarchy, understaffed and under-resourced. The private sector is not sufficiently involved in health sector policy formulation, planning, or program implementation at the central or decentralized levels. The lack of collaboration between sectors prevents the sharing of best practices, efficient use of resources, minimization of duplication, effective distribution of facilities, and leveraging of the private sector's experience and expertise. Mutual suspicion and lack of trust between the public and private sector continues to hamper efforts at collaboration, however.¹²

This chapter has presented some of the similarities in the health systems of the different countries of the assessment. They may constitute barriers for health care providers to participate in the PHS. They may also explain gender disparities that hamper equitable participation by women and men in the private health care system.

¹⁰ *Health in Africa Ghana Project in Brief*, 2013.

¹¹ *Five Year Programme of Work, (2002-2006)* Ministry of Health, Ghana.

¹² *The Private Health Sector Development Policy*.

THE ASSESSMENT METHODOLOGY

This summary report is based on a seven-country assessment. Six consultants conducted a gender analysis of the PHS in seven African countries. In June 2013, two seminars with the two groups of country consultants (Francophone and Anglophone) were organized in Brazzaville and then in Nairobi, to develop a common approach and ensure consistency in collecting data. . The main outcomes of the two seminars included the identification of stakeholders to be interviewed and the main sources of information to be considered, as well as guidelines for data collection tools (*See Appendices 2 and 3*). The consultants defined their work plan, the scope of work, and the target groups. They then developed gender-specific draft interview questionnaires and an approach for focus group discussions, ensuring complementarity between both methods of data gathering.

To analyze the context of the health private sector environment in each of the countries, the consultants conducted a literature review of the different policies, laws, projects documents, and available statistics related to the two main issues of gender and the private health sector.

The data collection took place in each of the countries from September to November 2013. The consultants collected opinions from different stakeholders through focus group discussions and one-on-one interviews, mainly face-to-face, and sometimes by telephone. Respondents were selected using the availability sampling approach and the snowballing process.

SCOPE OF THE ASSESSMENT

Most of the data collected during the national assessments were qualitative data.. From the beginning of the process in June 2013, the consultants made the decision to seek information by targeting a small number of respondents in urban areas through interviews and focus group discussions. It was also decided to rely on literature reviews as a major source of information.

Target groups

The studies sought views from two information sources. First, different categories of health entrepreneurs were interviewed, including doctors, pharmacists, dentists, midwives, and nurses, all of whom are active in the PHS as owners or employees. The health professionals are associated with different categories of private health enterprises, including hospitals, clinics, pharmacies, and maternity homes of different sizes ranging from micro, small, medium, and large. Their associations, boards, and regulatory bodies were also part of the assessments. The second source of information included IFC project leader and team members, Ministry of Health, Ministry of Women Affairs or Ministry of Gender Affairs, health training institutions, health registration and licensing authorities, national statistics offices, and commercial banks. The consultants interviewed male and female health professionals, including young professionals, with a focus on female health service providers who own their practices, are self-employed or are employees in the private health sector.

Sample

The study sample was limited in each country to the two main cities, except for Nigeria where interviews were held in three cities and in only one city in South Sudan. The goal was to target the capital city and a second economically important city with an active PHS. The survey was conducted in the following cities in each country: Ouagadougou and Bobo Dioulasso in Burkina Faso; Brazzaville and Pointe-Noire in Republic of Congo; Accra and Kumasi in Ghana; Nairobi and Mombasa in Kenya; Lagos, Abuja, and Kano in Nigeria; Juba in South Sudan; and Kampala and Mbarara in Uganda.

Assessment Tools

The same methodology was used by all six consultants for a consistent approach across countries and to compare the different results. The first drafts of the questionnaire template were discussed in Brazzaville and Nairobi and then finalized through the consultants' email exchanges. Sample results of the first discussions are presented in Appendices 3 and 4, which show the agreed upon methodology for selecting

target groups and institutions to assess and their location. The three methods used to collect information are discussed below (*For more details, see Appendices*):

- ❖ **Desk reviews** were dedicated to collecting information from published documentation to frame the national context of the PHS in each country. Each country consultant reviewed policies and laws, available health related data focused particularly on the PHS and gender.
- ❖ In the seven countries, **more than 324 face-to-face interviews** (and some telephone interviews) were conducted to seek the opinions of health professionals who were considered the primary source of information about the conditions of the PHS conditions. The questionnaire template included in the Appendixes was collaboratively created by the consultants during the first preparatory meeting and is the basis for the interviews. The presidents of the different health associations, mainly medical doctors, pharmacists, nurses, midwives, and dentists, were involved in the preparation of the different assessments. They helped to develop the list of possible respondents and sent an introductory letter to their members, announcing the IFC Gender and Health Private Sector Project, and encouraging them to share their views with the IFC consultant and to attend the focus group discussions.
- ❖ In total, **14 Focus Group Discussions (FGDs)** were used to seek opinions from different health associations. FGDs were organized around small groups of the same category of health professionals; the discussion was facilitated by one or two facilitators. This method differs from a regular discussion because in a relatively short time, the discussion will focus around specific topics allowing people with a common interest and willing to participate in a focus group to share their opinions and feelings before making decisions on future action. The responses in focus groups are oral and diverse with some participants agreeing and others not. Qualitative responses with examples and stories are shared; the group interaction is very rich in openness and information.

Targeted information

The country assessments examined different aspects of the PHS to better understand the sector through the viewpoint of male and female and young professionals to understand their motivations for working in the PHS, the difficulties as well as the opportunities offered in the sector. The consultants also studied health schools admissions, government regulation procedures, and health sector loans from commercial banks to identifying gender-based barriers that might prevent equitable participation in the PHS by women and youth. To better understand the general investment climate in the PHS, particular attention was paid to the regulatory bodies in each of the countries. The Appendixes describe the kind of information reviewed.

Study limitations

Conducting the country assessments was not without challenges, which are discussed briefly below:

- ❖ **The sample size.** Because of limited time and funding, the decision was made to limit the assessment sites and the number of targeted categories of health professional groups. For example in Uganda, the survey targeted a sample of 32 respondents to represent a population of over two million for the cities of Kampala and Mbarara. Due to the small sample, the country studies have to be considered as rapid assessments. Even though the results cannot be generalized, they unquestionably are valid indications of some of the gender disparities existing among private health professionals.
- ❖ **Difficulty scheduling with respondents.** Working two jobs and balancing family life, health professionals were difficult to schedule interviews with. When appointments were finally made, the interview time was very limited, and cancellations and rescheduling were frequent due to

emergency calls. In Uganda and Burkina Faso, by the time consultants were able to arrange appointments with some health students for FGDs, the students from medical schools had to cancel because they were preparing for exams. In the end, all the consultants interviewed fewer people than planned. In Ghana, most care providers contacted for interviews declined because of the time factor. The facilitators reported that for the FGDs, several individuals who had confirmed their participation were absent because of conflicts or the short notice of the invitation to participate.

- ❖ **Limited access to accurate and updated data.** In South Sudan, for example, because the new state is in the process of establishing its infrastructure, data collection is understandably poor. In the other countries, however, the consultants experienced difficulty accessing PHS statistics and sex-disaggregated data from government institutions and from professional associations. In this case, the lack of information was often due to poor data management. In Uganda, most of the key informants provided only estimates or merged lists. The interviewers attempted to synthesize the information that was provided but not always successfully. It was difficult to determine the sex of individuals by their names or their ages based on the year of enrollment in medical schools, because of the numerous enrolments of adults into medical schools. The Nigerian consultant reported that because the nursing and midwifery and medical and dental councils were never audited for death, migration, and retirements, the records of membership may be grossly exaggerated.
- ❖ **Sensitivity of the assessments.** The consultants told the interview respondents that the contents of the interviews would be confidential. Despite reassurances, most interviewees were reluctant to provide information on their incomes, profits and about their relationships with government regulatory agencies. Their guarded responses may have partially affected the quality of the information recorded, but on other subjects, the respondents were generally more open in expressing their views.

KEY FINDINGS

GENDER-BASED DISPARITIES START EARLY FOR FEMALE HEALTH PROFESSIONALS

Gender disparities start very early in the life cycle. Though admission procedures to register for health training institutions are similar for male and female students, even before becoming a health professional, there are multiple factors which hamper women from fully participating in the health private sector. Some of these barriers are discussed below:

- ❖ **Gender disparities in the health education system.** Across the targeted countries, the assessments highlight that many more males than females are enrolled as students in health care training institutions, except for nursing and midwifery schools. The main reason that males are predominant is due to the imbalanced enrolment of boys and girls in primary and secondary school, then at college, and finally in higher education. African girls having less access to education than boys contributes to the gender gaps seen in the private health sector.

Box 4.1. Why Gender Disparities Exist in the Kenyan Education System

The Kenya country assessment established that nursing institutions enroll more female students compared to males, and therefore, Kenya trains more female nurses compared to male nurses. Whilst the reasons why most nurses are female are varied, research indicates that Kenyan society believes that nursing is a feminine job. Girls tend to take soft sciences, such as home science or home ethics, subjects that are featured in the nursing training. The majority of girls dislike mathematics and physics, which they describe as difficult. Girls generally tend to perform poorly in sciences compared to boys. The 2007 Kenya National Gender Policy and Development of Education notes that boys tend to perform better in English, mathematics, biology, physics, and chemistry, subjects that are tested in their national secondary examinations for the Kenya Certificate of Secondary Education (KCSE) (Mwaura 2011).

Since performance in the KCSE examinations strongly determines entry and the selection of disciplines in tertiary institutions, girls' relatively dismal performance in sciences explains their lower enrolment rates in medical, dentistry, and pharmacy schools.

- ❖ **Some cultural barriers widen the gap.** In poor families, parents will choose to invest in their sons' education rather than their daughters. Families assume that daughters will marry and as wives and mothers will care for their new families, whereas sons are expected to care for their own parents. Even in those African countries where gender equality is considered a development objective, female students are less likely than their male counterparts to acquire formal education, subsequently impacting their employment opportunities. In general, completion rates are low in primary school and even lower in middle and secondary school—particularly for female students. Due to early drop outs from school, and to early marriages and pregnancies among girls enrolled in school, only a small minority of young women graduate from high school and attend universities. Consequently, the pool of female high school graduates is small and few enroll in health studies.
- ❖ **Corruption and harassment.** At the university level, both male and female students in Congo and Burkina Faso shared stories related to financial bribery in exchange for registration or in exchange for good grades. Undergraduate and graduate female students said they were repeatedly sexually harassed by male supervisors during their training on leading university campuses, and later by professors and civil servants from the health school administration. Because they feared retaliation, none of the survivors took legal action. Nevertheless, the abuse and traumatization has a cumulative effect on their self-confidence and studies, as well as on their career.

- ❖ **Women's biological clock.** Most African women are raised to become primary caregivers and health care providers in their families. For female students, the extended period required for health studies means that they are likely to be in their mid-twenties when they complete their training.. Because of intense family pressure regarding their age and fertility period, and also fearing advanced maternal age and in consequence complications due to late childbearing, female students, during the course of their studies, often marry, start giving birth, and begin taking care of the whole family. Female students are therefore more likely than their male counterparts to repeat grades or to drop out of the university.

Male students tend more often to marry after they have completed their studies. Furthermore, when male students marry while still studying, the entire family gives priority and support to their careers. Therefore, male health students are more likely than female students to have the support to engage in a specialization that will require an additional four to five more years of university study.

When asked why females dropped out of health studies, female respondents to the Congo survey mentioned differences between female and male students. They explained that female students, while pursuing further studies, were more affected by their new responsibilities as mother and wife, which include multiple consecutive pregnancies, the lack of support from their husbands to raise their children, and sexual harassment from their supervisors, all while trying to master technical issues. Congolese male students were more concerned by a lack of financial support to pay university fees and inadequate working conditions as constraints to studying. Statistics from *Institut National des Sciences de la Santé (INSA)* indicate that at the health unit of Marien Ngouabi University, the only state-funded university in Brazzaville, Congo, female medical doctors were less represented in all specialties over a five-year period (see Table 4.1).

Table 4.1. Male and Female Students in Health at Marien NGouabi University, Republic of Congo

	2008	2009	2010	2011	2012	TOTAL
GENERAL PRACTITIONERS	39 M + 25 F= 39% FEMALES	50 M + 23 F= 31.5%FEMALES	44 M+ 24 F= 35.2 % FEMALES	44 M + 24 F= 35.2 % FEMALES	32 M + 19 F= 37.2 % FEMALES	207 M + 114F= 35.% FEMALES
SURGEONS	7M + 2 F = 22% FEMALES	13 M + 3 F = 23% FEMALES	M + 1 F = 50% FEMALES	12 M + 1 F = 7% FEMALES	----	34 M+ 7 F = 17% FEMALES
GYNECOLOGISTS	5 M + 3 F = 37,5% FEMALES	12 M + 3 F= 20 % FEMALES	8 M + 3 F= 27% FEMALES	5 M + 4 F= 44% FEMALES	----	30 M + 13 F= 30.2% FEMALES
ONCOLOGISTS	2 M + 0 F= 0% FEMALE	4 M + 0 F= 0% FEMALE	5 M + 0 F = 0 % FEMALE	5 M + 2 F= 28,5 % FEMALES	----	16 M + 2 F= 11% FEMALES
CARDIOLOGISTS	2 M + 0 F = 0% FEMALE	6 M + 4 F= 40% FEMALES	3 M + 1 F= 20% FEMALES	2 M + 0 F= 0 % FEMALE	----	13 M + 5 F= 27.7% FEMALES
PEDIATRICIANS	2 M + 0 F = 0% FEMALE	6 M + 4 F= 40% FEMALES	3 M+ 1 F= 25% FEMALES	2 M + 0 F= 0% FEMALE	----	13 M + 5 F= 27.7% FEMALES

Source: *Institut National des Sciences de la Santé*, Brazzaville, Congo.

- ❖ ***Some medical disciplines*** are not offered in any local ***university***. ***Therefore, some students require foreign study***. Congo, for example, has no college of pharmacy or dentistry. In Juba, South Sudan there are no medical schools either. ***To enroll in those specialties, students have to attend a foreign university for a lengthy period of studies. Because most families are unable to afford tuition expenses for seven years and more, when parents invest in their children’s higher education, they are reluctant to send their daughters abroad, and will choose to send their sons, who are perceived as being “less at risk.”***

While male and female health students may attend the same health schools, they do not experience the same constraints and opportunities. As professionals in a very demanding sector, the gender gaps due to their different status and social roles have long-term negative implications for female health professionals’ careers, while their male counterparts, favored by their dominant social status, will be able to dedicate more time, energy, and money to building their career. The next section analyzes the different barriers that prevent female health professionals from fully participating in the PHS.

GENDER-BASED DISPARITIES IN PHS

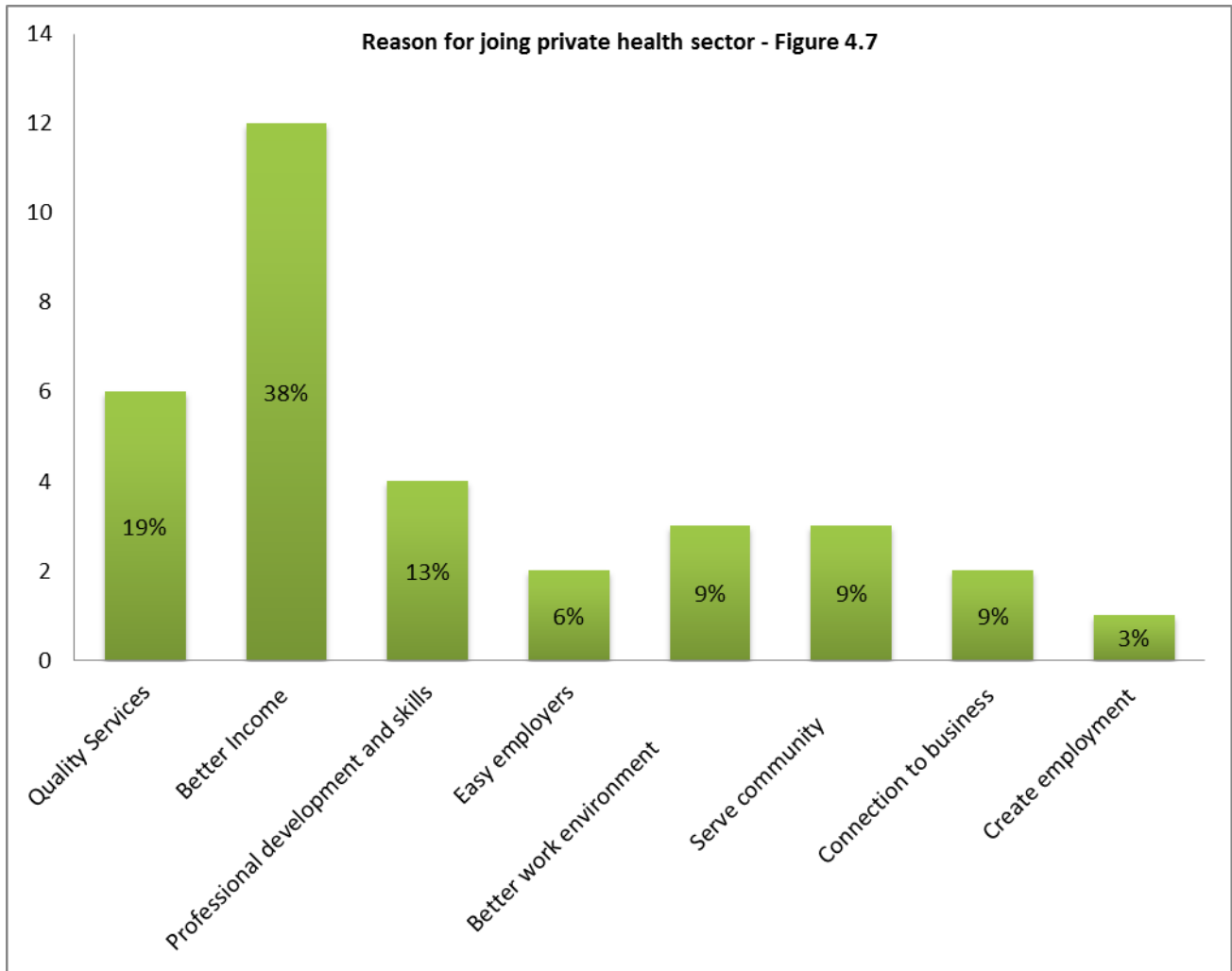
Male and female health care providers share some identical burdens working in the PHS, such as the sector’s competitiveness, the high cost of running a health facility, inadequate access to finance, administrative harassments, delays in insurance reimbursement, and high employee turnover. Nonetheless, the seven country assessments have identified additional unique gender disparities that females face in their path to becoming health care professionals. On the surface, the working environment seems similar and the same rules and procedures apply to both. Yet, female professionals’ reactions to the business environment and how they overcome common challenges are different. The coping mechanisms are all conditioned by gender norms: some are institutional while others are a result of socialization. The ways female health workers perceive and react to the PHS business environment significantly contribute to increasing gaps in productivity between men and women.

The country surveys assessed different issues faced by all private health professionals through a gender perspective and with a focus on the sex-disaggregated distribution in PHS. These included the specific reasons men and women chose to work in the PHS, their reactions to administrative requirements, accessing credit to finance a private health facility, participation in health associations, and management skills. As a result of the various targeted stakeholders’ responses, the survey identifies some of the factors which explain the existence of gender disparities in the PHS.

Male and female health providers join the PHS for different reasons

The surveys attempted to determine the reasons why health care providers are interested in working in the PHS in the various countries. The Uganda report highlighted some factors that respondents viewed as more attractive in the PHS than the public sector. Male and female health professionals appreciated the better salaries in the PHS, which are assured and paid without delay (38 percent); and the quality of services they could deliver to patients (19 percent), which was ensured by better equipment and the availability of prescription drugs. They both also appreciate the opportunity for continuous learning through ongoing medical education that is budgeted in some private health institutions as part of staff capacity building. The training allows them to continue improving their professional and skills development to grow their careers. The respondents also mentioned that the welfare of workers is considered in the PHS. Also, the flexible working time offered by the PHS is perceived as an opportunity to engage in dual or multiple employments. Figure 4.1 identifies some of the main reasons for preference for the PHS in Uganda.

Figure 4.1. Reasons for Working in the Ugandan PHS



Source: Teresa Omondi Adeitan. *Barriers and Opportunities for Women Participation in the Health Private Sector. Gender Assessment on Practice in Kampala and Mbarara, Uganda.* December. 2013.

While many of the factors attracting health workers both male and female to the PHS in Ghana were the same, there were other motivations. For example, male Ghanaian respondents seem to be much more attracted by the investment opportunity in the PHS than their female counterparts. As owners, they can manage their own business, determine the standards, monitor and oversee facility activities, create employment, be responsive to the high demands for their services. All these factors contribute to greater job satisfaction in the PHS.

Ghanaian female care providers perceived the private sector environment as being less bureaucratic and stressful than the public sector. They said the PHS provides more flexibility and allows them to allocate adequate time to their competing responsibilities. They are concurrently able to provide care to their families and manage their households while meeting their professional commitments in the PHS.

The Uganda country assessment report noted that some working conditions in Faith-Based Organizations (FBO) are very attractive to health professionals, especially to nurses and midwives. By providing housing close to the area of work for their health professionals, FBOs also “provide more room to reach out to the communities and address their specific needs. Such staff benefits are very attractive to female employees who have to balance work and family responsibilities.”

Some health workers participate in the PHS because after retiring from the public sector, they engage private sector work. This is apparently the case in Nigeria for midwives and nurses in particular. Some may have fewer family responsibilities, want to continue contributing to society or need more income. Therefore retirement can present an opportunity to have a new career in a friendlier environment. The various country studies only briefly mentioned retirement opportunities, which are discussed in the next chapter.

Credit and Regulatory Barriers to PHS Entry

All seven country studies reported that private health workers have difficulties accessing credit to set up a health private facility and completing the regulatory process to establish and maintain that facility.

Box 4.2 describes the challenging environment in which Kenyan pharmacists in tender business work.

Box 4.2. Difficult Business Environment in Kenya

Male and female pharmacists complain about the difficulty of starting a pharmacy in Kenya because of the business environment. Startups require an enormous sum of money. Funds are raised through tender, and the cost of bidding is high. Normally, a tenderer must raise an initial bid bond of between two-five percent of the value of the tender, and a subsequent 10 percent performance bond when the initial tender bid bond is successful. The performance bond is security paid to the procuring entity to guarantee the practitioner's ability to perform the tender, which is forfeited if the practitioner fails to perform.

In a focus group discussion in Nairobi, young male and female pharmacists indicated that smaller hospitals at the county and provincial levels, whose business ranged between Kshs 10 and 100 million (approximately USD 117,647 – 1.1 million), did not understand the inability of the young pharmacists to raise these high figures or access financing from the banks. A female pharmacist noted that, "Only Kenya Medical Supplies Agency (KEMSA)"reimburses quickly. And while KEMSA pays the practitioners within 30–60 days of performance, other institutions take as long as six months or more. Delayed payments disrupt the cash flow into the health practitioner's business. (See Box 4.4.).

The problem of accessing finance by female and male pharmacists may be partially solved by incorporating a 30 percent quota in public procurement for these groups.

Inadequate access to finance to set up a private health facility

To start their businesses and set up their own private health structures, most male and female health professionals need to access credit. Very few inherit their facility from their parents. As any entrepreneur, they apply for loans from financial institutions. For female health service providers—even more so than their male counterparts—the lack of access to credit seems to be the biggest constraint that disqualifies them de facto from being considered for loans due to the lending criteria.

In all seven countries, commercial banks have no gender discriminating criteria to obtain a loan. Aside from the banks' high interest rates and inadequate loan repayment modalities, women and youth are automatically excluded based on requirements such as minimum age and necessary collateral. Young health professionals, whether male or female, are also disqualified for lack of work experience, proof of income and saving, and guarantors. Women are additionally excluded because any existing collateral is traditionally in the husband's name, reducing even further their chance of getting a loan. Survey results indicate that employed health professionals are generally younger than facility owners who have several years of professional practice, an established clientele, and business connections. In Nigeria, 60 percent of the respondents said they financed their facilities through savings and investments.

Box 4.3. Youth Access to Credit in Kenya

The challenges faced by male, female, and youth health professionals in accessing credit determine the practitioners' level of participation in the health business and the quality of services they provide. When financing is inadequate, the businesses struggle or fail. Absence of financing also discourages startups. The lack of credit is not conducive to a business environment, which undermines the HiA's objectives of promoting the private sector and facilitating the provision of affordable health care to underserved populations.

A female doctor in Mombasa shared that she had not thought of opening up her own facility because "it is a financial burden." She said, "You need a one-stop facility with radiology, pharmacy, and a working lab—at least the essential services. Otherwise, it is cumbersome to send patients all about to get different services." Another female doctor in Mombasa whose business failed, forcing her to return to being an employee, expressed similar sentiments. She explained that she lost her corporate clients because they wanted a laboratory, an X-ray, and a pharmacy at the same place. Yet, she only had office space. Business, therefore, became so slow that she could not afford to pay rent. Eventually, she had to close shop.

In Nairobi, a woman owner of a retail pharmacy described the great effort it took her to start her own business while still working elsewhere. She explained that she had to depend on her family's savings, which added to her burdens by forcing her to be much more accountable to her family members.

Box 4.4. How I Started a Female-Owned Pharmacy in Kenya

"I went into business because I realized I was not making enough for the family—my parents, siblings, and child. I used my personal and family savings to start this business. I did not go to the bank because of high interest rates. The bank requires collateral and they assess the ability of a facility to repay the loan. Yet you need six months for a business to be able to repay the credit. I have kept my job as I run the business and I go to my pharmacy after work until late. But I have been burnt out lately because of the competing demands of my business and family.

"My family has suffered because I have to be in my facility on Saturdays and Sundays. I do not have trustworthy staff, and I cannot afford to employ full-time key professionals, such as an accountant. That is why my business does not yet have returns. I need capital of about Kshs 2 million (approximately USD 23,529) to start a wholesale business. If I do wholesale, I'll break even."

This female pharmacist's startup history emphasizes her attempt to fulfill her professional responsibilities working two full-time jobs. This dual burden of trying to balance her duties as a wife, mother, and a daughter has implications on her physical and mental health, financial situation, and time management. Already, the pharmacist admits to being "burnt out." Maintaining dual employment as well as a household becomes a major constraint, especially for women.

Her situation explains why some female health professionals prefer not to apply for a loan. It is not only a long process requiring numerous documents to apply for a loan, repaying a large loan necessary for a health facility requires working full time to run the business and reap adequate profits.

Box 4.5 includes a description of the loan application process for health professionals in Uganda.

Box 4.5. Standard Requirements to Access Credit in Uganda

To access credit for a health facility in Uganda, the proprietor must first have a practicing license and business registration license. In addition, the following are the standard requirements:

- ❖ Be above 18 years of age. One of the banks interviewed requires 21 years and above.
- ❖ Passport size photos (2-3).
- ❖ Valid Identification Card.
- ❖ The business must have been operating from six months to one year.
- ❖ Organizations providing microfinance to startups require a group of 5–25 persons to guarantee the loan.
- ❖ Have guarantors who hold accounts with the bank.
- ❖ Proof of income, providing at least three months of bank statements showing history of savings.
- ❖ For non-account holders, they must provide six months of statements and open an account.
- ❖ Be an account holder with the bank or microfinance organization.
- ❖ If employed, 10 percent of account holder's salary must be going through that account, especially for banks.
- ❖ Must show confirmation of employment, that is, a letter from the employer, address and status of employment.
- ❖ Must have collateral, for example, land titles, motor vehicle, household goods, and salary.

Additional requirements differ from one institution to another:

- ❖ Valuation report by the bank's approved valuers includes valuation of the business premises.
- ❖ Marriage certificate if couples are making a joint application.
- ❖ Credit reference history with other banks of business record such as business accounts and patient's register.

One requirement that was repeatedly mentioned as a disincentive for women to engage in the PHS is the absence of collateral. In African traditional families, it is likely that houses and lands are the husbands' property due to inheritance practices. This barrier was analyzed in the Kenya and Uganda reports.

Box 4.6. The Issue of Collateral in Kenya

The Kenyan country assessment highlighted that though gender neutral, the banks' insistence on collateral in fact indirectly discriminates against women because of the already existing property ownership inequities between men and women. Because women own only one percent of all titled lands in their names and five percent jointly with men, female health workers, particularly nurses, are unable to access capital from banks. Banks' high interest rates (15–18 percent) and the requirement to repay immediately also discourage women from seeking credit from commercial banks.

Youth are eliminated from financing opportunities through commercial banks because of their age and limited years of experience. Their lack of collateral remains a challenge too.

Male and female Muslim health professionals expressed their hesitance to seek capital from conventional banks because of the Islamic prohibition on taking and paying interest. Nevertheless, accessing financing from banks offering Islamic lending remain a challenge because they still require collateral and repayments are high.

However, the government has set in place policies and initiatives to encourage youth and women enterprises through a special fund and public procurement policy that mandates 30% allocation to this group.

All these lending requirements affect women's and youth's accessing credit from commercial banks and also their decisions to engage in the PHS.

Box 4.7. Implications of Access to Credit Requirements in Uganda

Respondents to the country surveys said that bank lending requirements impede their access to credit in the following ways:

a. "No one wants to lend money to someone who does not have money," one respondent from Burkina Faso explained. This statement is confirmed by the proof of income requirements such as employment, bank statements, and collaterals. One must have some funds and confirmation of income employment confirmation, bank statements, and collateral to get more funds. The requirements are difficult to fulfill in Africa where individuals have several dependents, salaries are low, taxes high, and where everything earned is spent and very little or no savings are made. This situation generally means that an individual is not credit worthy but that such individuals are least welcomed by credit institutions.

b. Young professionals who wish to start businesses immediately on being licensed are not eligible for the loans since the lending institutions do not support startup businesses unless through group guarantee. Group guarantee calls for partnerships with common objectives, trust, and a financial base among the group, conditions that are seldom achievable by the youth. The credit institutions prefer established businesses with a track record of success, not first timers in business.

c. Collateral requirements automatically exclude women from commercial bank loans. The majority of women have no property rights due to socio-cultural reasons. Most women's access to land is associated with male relations and titles are registered in the name of male partners. Male partners must approve the startup of a business and be willing to guarantee the loan or take the loan on behalf of the female partner. This situation is difficult to achieve in African society where women are viewed as dependents and men as the providers. Little societal value is placed on women owning and running businesses when they should be investing more time in taking care of their families.

d. Unwritten rules impeding access to credit include artificial delays by credit facility employees who expect kickbacks for having "fast tracked" documents, also referred to as "artificial favors." In instances where women are willing to take a risk, chauvinist tendencies are experienced. Credit institutions are reluctant to trust women with large amounts of money. Women are not considered household heads to be making weighty financial decision. A female pharmacist shared a personal experience with the bank asking for the names of others participating in her proposed business as a subtle indication that the bank needed to see renowned male practitioners as a director.

In Kenya and Nigeria, some religious stereotypes have been another factor contributing to women's difficulties accessing funds as shown in the following example.

Box 4.8. Gendered Impacts of Insufficient Financing

A Muslim female nurse in Mombasa observed that "I did not go to the conventional banks because my religion frowns upon interest. But when I approached one of the financial institutions offering Islamic products, I was asked for a title deed which I did not have. The repayments were also very high."

Relations with regulatory bodies

Female health workers react differently to administrative requirements. In the surveyed countries, several institutions regulate health system standards. Health councils and health associations are sector specific with different mandates. The Medical Council, Dentist Council, Pharmacist Council, Nurse and Midwifery Council are statutory governmental agencies overseeing the ethical aspects of their profession. They mainly regulate the health training system and practice. The councils usually register all health workers

from the private and public sectors, ensuring that all health workers are qualified to practice based on specific knowledge and skills. They provide registered health workers the license to practice in the public or private sector. The councils regulate the distribution of health facilities, and because they have disciplinary power, they have some control over the ethical behavior of their members and are mandated with enforcing discipline within their respective profession.

In Nigeria, the Midwives Board and the Nursing Council have merged into one unit, the Nursing and Midwifery Council, which is in charged with regulating and controlling the practice of its members.

Box 4.9. Education and Regulation of Nurses and Midwives

The Nursing and Midwifery Council of Nigeria (NMCN) is a parastatal institution of the federal government of Nigeria. It was established by Act Cap. No 143 laws of the Federation of Nigeria 2004. The primary objectives of the council are to maintain a high standard of professional practice and enforce discipline within the profession. The council approves training programs for nurses and midwives.

The NMCN licenses nurses and midwives. Nursing education is evolving in response to the dynamics of the society. Midwifery has a higher qualification for registered nurses.

Nurses and midwives must renew a practicing certificate every three years. To renew the certificate, nurses and midwives must attend one approved workshop once every three years. No list of registered nurses or midwives with practicing certificates exists. Any information about this group's size depends on getting data from public sector postings and collecting data from the government about licensed private facilities.

The professional associations of medical doctors, dentists, pharmacists, midwives and nurses usually provide capacity building and educational programs for their members. In Nigeria and Ghana, for example, there are some gender-specific associations, such as the Lady Pharmacist Association of Ghana (LAPAG);

Process to establish a private health facility

In each of the seven countries surveyed, applicants to the health private sector have to register their businesses. In general, there are no gender-specific requirements: all applicants must pay registration fees to a government registrar bureau, provide several official documents, such as a license to practice as a health professional and a registration certificate.

Box 4.10. Registering a Health Business in Ghana

In Ghana, the Office of the Registrar General is responsible for registering all businesses, including health businesses. During the registration process for sole proprietorship business, the applicant must provide an approval letter from the appropriate professional regulatory body because the sole proprietor cannot be separated from the business. For sole proprietors, their major barrier is acquiring the license from the appropriate regulatory body.

The fees for registration are 35.00GH (USD 15.43 exchange rate of 2.0695) for a sole-proprietorship business and 500.00GH (USD 220.44 exchange rate of 2.0695) limited liability company. Unlike other businesses that are required to have a certain minimum amount as start-up capital, such as micro-finance companies, healthcare facilities are exempted.

In all seven countries, acquiring the license and the business registration is the result of a protracted, time-consuming process.

Limited Capacities and Resources

In Uganda, respondents did not report any problem obtaining information and registering with the health regulatory authorities. Only nine percent of the respondents experienced difficulties in getting updates, following up on their registration and/or getting feedback.

Despite the written rules, in practice health workers have some unwritten challenges to overcome to register their health business and receive their practicing authorizations. The regulatory bodies have limited capacities and resources to accomplish their work in terms of accrediting, licensing, renewing licenses, monitoring and inspection of the activities of the health facilities. While their scope of work is broad, they generally have insufficient resources to accomplish their duties, resulting in lack of job satisfaction. The working conditions also result in administrative harassment, including demanding bribes, mainly from female professionals, as reported in the country surveys.

Box 4.11 describes the challenges in registering a health business in Uganda.

Box 4.11. Challenges with Registration, Licensing and Regulatory Authorities in Uganda

Respondents to the Uganda survey (32%) said that uncoordinated monitoring and inspection by regulatory authorities confuses private sector business operators and health professionals. The confusion also causes complexities and duplication of procedures and therefore delayed processing. Key certificates a business operator in Uganda must have for licensing include:

Medical Practitioners Certificate/Registration. This document is issued only once but requires the following documentation to obtain it:

- a. Annual practicing certificate for doctors and dentists, and every three years for nurses and midwives*
- b. Trading License*
- c. Certificate of Incorporation*
- d. Certificate of Suitability of Premises*
- e. Infection Control Approval*
- f. National Environment Management Authority*
- g. Municipal council documentation varying from council to council with graduated levels of payments*

For pharmacists, in addition to providing to the above documentation, they have four other authorities to comply with: Pharmacy Board, Pharmacy Society of Uganda, National Drug Authority, and National Medical Stores. Private facility owners are not permitted to supply prescription medicines.

1. Travel distance and cost (31%). *The regulatory authorities are based in Kampala and the service of registration/licensing is not decentralized. Health providers based in Mbarara have to travel at least 300km to Kampala. The Kampala-based health practitioners interviewed travel a distance of 3–8 kms to the regulatory bodies. The cost of travel from Mbarara to Kampala ranges from USD 40–80. The cost of the return trip varies depending on the mode of transport: 69 percent of the respondents use public transport (USD 20 return trip from Mbarara), 31 percent private vehicles (USD 40 return trip from Mbarara), and three percent travel by taxi/car hire (USD 80 return trip). The travel cost varies per professional depending on the number of necessary trips to Kampala. Follow ups or delays are some of the reasons leading to more than one trip to Kampala.*

2. High costs of registration and licensing. Though the cost of the practicing license is standard (USD 20–80), the 22 percent of respondents attributed additional costs to travel for follow up and delays, making licensing costs very expensive. (Nurses and midwives may pay less than USD 20. Business licenses vary depending on the size and services rendered by the business, the cost ranges from USD 40–120).

3. Unnecessary delays in issuing certificates/licenses. Private physicians applying for a license reported that the time necessary to get licenses varies from less than one week (44 percent of those interviewed), two-four weeks (47 percent), some respondent reported that in some cases it took 24 weeks (6 months) before an approval was given to start up her pharmacy. However, respondents attributed delays to a lack of proper information about the requirements (poor access to information), inadequate or frequently changing requirements leading to a lot of back and forth communication, delays in reviews by the approving boards, and artificial delays caused by officials waiting for kickbacks;

4. Requirement for bribes to facilitate licensing processes (3 percent);Female physicians report that had a pay a bribe to speed up their application;

5. Lack of transparency (6 percent). The use of the revenue collected from licenses and registration for other unintended purposes. Some respondents were concerned that the benefits of revenue collected were not realized by the health professionals or at least the benefits received are not commensurate to the revenue collected, creating lots of discomfort while attracting corruption (evading to pay the required amounts).

Administrative procedures are time and energy consuming, and female health workers more than male health workers have difficulties enduring this very long and complex process. To avoid this administrative and financial burden, some women will hesitate to officially join the PHS. Congolese midwives explained during a focus group discussion that “they can work informally in the PHS without being registered. The benefits of the PHS, they said, are working in a less demanding working environment for a salary, health insurance, and furthermore, it is an additional income.” The majority of the health professionals work in the private sector as owners or employees after having worked till the afternoon in a public hospital or they work part time in private health clinics. But compared to their female colleagues, men more often choose to be civil servants and at the same time be owners of health facilities, while women barely have enough time to do the same: having to also manage their family responsibilities, they will hesitate to have the full responsibility of heading a health facility and opt instead for being PHS employees.

To sum up the administrative challenges, a male Congolese doctor described a typical situation: “We are meeting lot of constraints, but after a while, for male health workers, it becomes a lifestyle.” While men adapt to the situation, their female counterparts often opt for being employed in the public or private sector rather than being self-employed.

Box 4.12. Self-Employment versus Traditional Employment in Uganda

All respondents shared the same preference for being self-employed. They seek employment first generally in the public sector to gain experience, while saving for self-employment. Each desires to own a business, although various factors such as access to finance, business skills, and years of experience, among other factors determine their success.

Female health professionals are admittedly risk averse and therefore reluctant to set up their own medical facilities, opting instead to continue working securely as employees. Women appreciate the certainty in being an employee with the responsibility as a wife and/or mother. Female health professionals equally have challenges to find the time needed to successfully run a business and at the same time respond to family responsibilities.

Women have a low risk-taking attitude

Female health care providers who want to start a business in the private sector are risk averse and reluctant to seek a loan from commercial banks. Male and female professionals have the choice of accessing funds through a commercial bank, friends or a family member. The female health professionals interviewed indicated that they avoided taking financial risks much more than their male counterparts. They did not want to start their business heavily in debt for fear of being unable to repay a bank loan. Their preference was to seek funding from a family member, mainly their husband or their father.

Box 4.13. Kenyan Women's Risk Averse Attitude

The majority of women in Kenya do not seek capital from banks because they fear defaulting on the loans. They fear giving business a try even after preparing a positive feasibility study. They fear being unable to face intense market competition. Women's tendency toward extreme caution in business is partly attributable to their socialization to nurture and to their protective natures.

Women would find it shameful for their business to fail and be devastated if family property used as collateral was lost by defaulting on a bank loan. Because of their low risk-taking attitude, women seeking credit from banks get less than what they apply for (women usually apply for less than they need). Financial institutions are wary of women-owned business and whether they would yield adequate returns to repay the capital. Even though male professionals admitted to being equally intimidated by the challenges of starting a health care business, they downplay their insecurity. Their persistence and self-confidence instill confidence in business partners and financiers.

Health Private Sector is a male-dominated area

One consequence of having fewer women enrolling in health studies is that fewer female health care providers are represented in the whole health sector and in health associations for public and private practitioners. Currently, women have the greatest representation in nurse and midwife associations. In Ghana the total number of registered pharmacists that were members of the Pharmaceutical Society of Ghana in 2013 was 2,852, of which only 890 were female. However, the total number of nurses registered in a Ghanaian association in 2013 was 20,055 nurses of which 15,643 were female and 820 midwives.

Despite the National Gender Policy in Nigeria, which requires a 35 percent minimum quota, female health workers are underrepresented in decision-making positions and are operating in the less profitable segments of the health profession. The Nigeria country report highlighted that males dominate the private health sector. Females only account for 35 percent of the 65,759 medical doctors. Females are dominant in certain specialties such as audiology. In pharmacy, 64 percent of pharmacists are females, and almost 100 percent of nurses and midwives are female.

In Pointe Noire, a major economic center in Congo, female professionals represent 14.5 percent of all general practice doctors, and 7.28 percent of specialists. The Pointe Noire Health Association data indicates that women are also less represented private health facility owners: only 11.60 percent of all private health facilities are owned by female health professionals.

Table 4.2. Male and Female Owners of Health Facilities, Pointe Noire, Republic of Congo

TYPE OF HEALTH FACILITIES	NUMBER OF MALE OWNERS	NUMBER OF FEMALE OWNERS	NUMBER OF ENTREPRISES AND NGO OWNERS	TOTAL
CLINICS	21	4 = 12,90%	6	31
MEDICAL OFFICES	27	4 = 12,90%	2	33
SOCIO-MEDICAL CENTERS	18	1 = 3,33%	11	30
NURSING HOMES	194	19 = 8,79%	3	216
PHARMACIES	53	16 = 23,18%	-	69
LABORATORIES	3	0 = 0%	-	3
TOTAL	313	44 = 11,60%	22	379

The Congo survey also reported gender disparities in the distribution of health workers in the PHS. Fewer female health care providers are registered in the health council of medical doctors in Pointe Noire. Table 4.3 provides obsolete data from the health council, which is apparently outdated since some of the health facilities were no longer operational.

Table 4.3. Male and Female Registered as General Practitioners and Specialists Pointe Noire, Republic of Congo:

No. of male general practitioners	No. of male specialists	No. of female general practitioners	No. of female specialists	Total
114	47	30 = 14.56%	15 = 7.28%	206

Source: Conseil Départemental de l'Ordre des Médecins de Pointe-Noire.

While these different statistics described an unbalanced enrolment of men and women in the PHS, the interviews also described situations where female health care providers face specific obstacles due to their male counterparts dominating the workplace environment.

In the seven countries assessed, the male-dominated PHS sector can affect women's level of motivation and performance at work. Because women are underrepresented in the PHS and in the professional councils and associations, female health workers face difficulties trying to adapt in an environment where there are few female role models. Male health professionals are often oblivious to the obstacles that a male-dominated environment presents to women. Nonetheless, when their attention was drawn to the disparities, some male health providers during interviews preferred to maintain the status quo in the PHS. During the feedback meeting held in Ouagadougou, a medical doctor said¹³, "... female health professionals cannot have the same kind of involvement as their male counterparts. They have to take into consideration that our society is actually very violent, and as mother, female health professional have to give priority to their caring role at household level if they don't want their children to be into trouble and go to jail..."

The Ouagadougou doctor's perception of female roles seems to be widely shared across countries. During the focus groups discussions in Brazzaville, a pharmacist challenged his male colleagues by asking, "Who in this conference room agrees on eating regular meals which are not cooked by their wives?" In Nigeria, a female health facility owner from Kano state, a predominantly Islamic society, has been facing immense pressure just from her colleagues. They twice tried to shut down her practice because they believed that even if she were to run a hospital, it should be in partnership with a male health professional, not on her own. A medical doctor from Ghana described the PHS as a difficult workplace for women: "When I first started work there, the whole place was filled with males and their egos." She also indicated that some

¹³ Burkina Faso focus group discussion, Yameogo, Victorine, Gender in the private health sector in Burkina Faso, 2014

healthcare facilities do not employ female medical officers because of the duration of maternity leave. As a consequence of their repetitive absences due to family commitments, it becomes challenging for female health facility owners to rely on employees. Not only may they lose respect for their manager but employees also may not have the required business skills to run the facility.

Despite the different levels of the health systems development of the targeted countries, the assessments show many similar gender disparities in the PHS. Youth and female health entrepreneurs who own their practices are more affected by the barriers to entry. They are often prevented from being self-employed due to the barriers including a difficult business environment, a lack of access to finance, family and socio-cultural constraints, and lack of opportunities to facilitate their involvement in the PHS. There are left with few options: be employed in the public sector, be employed in a private health facility, or practice dual employment as a public servant working and also working in the private sector, while the most entrepreneurial wait and save for an opportunity to improve their situation in the PHS.

OPPORTUNITIES FOR YOUTH AND FEMALE HEALTH PROFESSIONALS

One objective of the country studies was to identify opportunities countries that can be applied elsewhere. The country assessments show that all health care providers do not have equal access to participate in the PHS, particularly midwives and other female and young health professionals. A number of public and private initiatives are aimed at enhancing women and youth's participation in the PHS. These initiatives include financial, educational, legal, and policy strategies and actions to close the gap between male and female practitioners.

Some initiatives to correct gender imbalance in the education sector

- ❖ To correct gender imbalances in the education sector, in 2007 the Government of Kenya set up Affirmative Action (AA) policies to provide scholarships for girls from the Arid and Semi-Arid Lands (ASALs) to attend university, technical colleges, and national secondary schools. Data indicates that this AA policy has not been well implemented, however. The gross enrolment rate of girls in secondary schools is declining, and except for the field of nursing, men dominate the science-based courses in colleges and universities.
- ❖ In Ghana, the Ministry of Gender, Children and Social Protection has designed plans to promote female empowerment, including the *Women's Award Programs*. This incentive is awarded through nominations. The ministry's other projects include the *Gender Responsive Skills Project* and *The Capacity Building Programs*, which provide female health entrepreneurs in the PHS, Information Communication and Technology (ICT) business training.

Some initiatives to improve access to credit

Different initiatives have been developed to facilitate health professionals' access to credit to set up a health infrastructure; some have failed and others have succeeded; some had no gender differentiation, while others targeted female health professionals.

- ❖ In Republic of Congo, Laborex is the leading wholesale distributor of medicines. It also provides financial support to pharmacists that want to equip their facilities with medicines for an initial contract or more. To be eligible, a prospective owner of a pharmacy must submit a registered certificate and a license, a business plan, and a feasibility study, as well as a good location for the pharmacy with access to clients to substantiate the suitability of the business and that the pharmacist will be able to fulfill the terms of the contract for the loan repayment. Based on the results of the pharmacists' focus group discussions, many pharmacists received loans from Laborex for business startups, but unfortunately, sex-disaggregated statistics were unavailable about the number of male and female recipients successfully applied for Laborex loans, and how many were rejected and why.

- ❖ A similar initiative for pharmacists exists in Uganda. The Pharmaceutical Society of Uganda has arranged an agreement with drug manufacturing companies to provide pharmacists with some pharma and non-pharmaceutical goods on credit. This credit arrangement allows pharmacists to avoid the burden of taking cash loans but it “also reduces the risks of pharmacists putting the loaned cash to other uses rather than the purpose for which they borrowed the cash.”
- ❖ And in Nigeria, the Fidelity Bank has developed an innovative health program called the Fidelity Private Medical Support Scheme (FP-MEDSS). It offers duly registered private medical doctors the possibility of purchasing drugs up to USD 20,000 and acquiring medical equipment up to USD 67,000. The program is designed for practitioners with a license to practice from the Medical and Dental Council. To be eligible for the Fidelity Bank program, the health facility has to demonstrate business records of a well-managed infrastructure over at least five years. The Fidelity Bank offers the lowest interest rate in Nigeria.
- ❖ In Ghana, the Medical Credit Fund initiative is a health investment fund founded in 2009 by PharmAccess International.¹⁴ It has been successfully supporting private health facilities to access capital. The comparative advantage of PharmAccess International Group is in being a group of non-profit organizations sharing the same objective: working towards affordable and inclusive access to quality health care in Africa by stimulating investments through Public Private Partnerships. Its integrated approach consists of complementary initiatives that examine the supply and the demand sides of health care provision and combine establishing standards for quality improvement, and providing loans for healthcare infrastructures and health plan insurance.

Box 4.13. Medical Credit Fund in Ghana

The Medical Credit Fund in Ghana supports private healthcare facilities in Africa by obtaining capital to strengthen and upgrade their operations to enhance access to affordable quality healthcare. The Medical Credit Fund has given loans and credit facilities to health professionals in private sector practice in Ghana, including 30 male and 45 female health facility owners. According to the fund, more female facility owners apply for funding than males. However, the fund has no gender-specific requirements differentiating access to credit by men or women health professionals in the private sector. Loans are assessed based on selected quality and business related criteria. The loans are given to health facilities, not to the individual health professional. The Medical Credit Fund puts together the documentation needed to support a loan application and submits it to the bank on behalf of the applicant. Banks partnering with the fund in Ghana are HFC Bank, Merchant Bank, and UNIBANK. These banks have their own lending policies and there is no gender differentiation in the loan process. The maximum lending capacity is GHC 200,000 (USD 88,175.25)¹⁵ per health facility. Maternity homes have been the main beneficiaries from the credit facilities.

Business partnerships initiatives to overcome lack of access to finance

Business partnership in the PHS is one solution to accessing credit. Several programs have been put in place to encourage partnerships among health workers. In Kenya, some initiatives target female and young health workers in accessing credit. Beyond the problem of lack of collateral, however, religious issues can also be an obstacle for health professionals to get a loan.

¹⁴ <http://www.medicalcreditfund.org>, accessed 18/11/2013.

¹⁵ Bank of Ghana Exchange Rate, 21st November 2013.

Box 4.14. Youth and Female Health Workers Divisions in Kenyan Banks

In Kenya, some banks have set up youth divisions to assist them in obtaining credit and providing business advice to young sole proprietors about forming partnerships. Nevertheless, bank's requirement for collateral remains a challenge for youth. Both male and female Muslim health professionals expressed their hesitance to seek capital from conventional banks because of the Islamic prohibition on paying and accepting interest on loans. It is difficult accessing financing even from banks offering Islamic lending products¹⁶ because they still require collateral and the repayments are high.

Women and youth are likely to overcome the challenges to access finance and dual gender roles if they team up to conduct business. Financial institutions see less credit risk when youths work together, despite their lack of experience. Business partnerships also provide women with the ability to perform their jobs and run their businesses effectively as well as attend to their roles as wives and mothers. Women have successfully scheduled day and night work shifts and almost run a 24-hour facility, which also permits them to attend to their private family life.¹⁷ Reliable availability assures client loyalty and sustained income generation for the business. Moreover, government-sponsored economic Affirmative Action (AA) measures for women and youth prefer to support groups over individual enterprises. The newly-introduced 30 percent public procurement policy for women and youth is one such example.

Business partnership may be one solution to accessing credit from a bank since each partner contributes to the financial effort and guarantees the other.

Initiatives supporting female health providers

- ❖ The Government of Nigeria has a clear policy to reduce the high average Maternal Mortality Rate (MMR) of an estimated 840 deaths per 100,000, which varies across the different regions and between urban and rural areas. Several initiatives for midwives and nurses were developed to reduce the MMR rate, which is largely influenced by the availability of skilled attendants during birth. Box 4.15 describes one initiative by the Association of General Private Nursing Practitioners.

Box 4.15. Private Nursing and Maternity Homes in Underserved Areas of Nigeria

The Association of General Private Nursing Practitioners (AGPNP) is a professional Nigerian association of self-employed registered nurses and midwives in private nursing and midwifery practice. The AGPNP employs nurses and midwives and contributes meaningfully to the health care industry by complementing government efforts.

The AGPNP licenses nurses to open private nursing homes and midwives to open a private maternity home after five years of being registered and serving in the public or private sector. Each state issues the licenses for the private facility, and enforces standards beyond those set out by the National Nursing and Midwifery Council. Therefore, there are differences in standards between states in the country.

While these initiatives present an opportunity to nurses and midwives who are willing to open their own facilities, they also require nurses and midwives to pay the supervision fee to the physicians when

¹⁶ "... Islamic products are both profit and equity-based. The profit arrangement is found in asset financing. Here the bank buys or builds an asset and then sells or leases the same to the health practitioner at a mark-up. In case of a lease, the bank will later transfer the asset to the practitioner after it has realised its capital and the mark up. The equity-based arrangement occurs when the bank offers liquid money to the practitioner for investment. The bank would hence forth have a stake in the practitioner's business at an agreed profit/loss-sharing ratio until the capital invested is paid up..." (Jadeed, 2013)

¹⁷ This is a suggestion from the female health workers from Kenya. No evidence it has been put into play (Jadeed, 2013).

consulting their clients. “Unfortunately the lack of clarity around how much supervision is required constitutes a constraint for some nurse midwives wishing to establish their own practices. Such costs can hinder profitability. These arrangements appear to be completely open to negotiation between the proprietor of the nursing clinic and the physician, with the physician having an advantage in the negotiation because the clinic must have some arrangement to satisfy the supervision requirement.”

- ❖ In Nigeria, some opportunities exist to create a welcoming environment for female employees providing care to a female clientele. Two private Not-for-Profit health centers/female dominated facilities in Nigeria are considered as the best practices. They are described in Box 4.16.

Box 4.16. Female Dominated Facilities in Nigeria

St. Kizito is a very pleasant Not-for-Profit health facility in Lagos State, Nigeria. It is located in an underserved area within an urban setting, with poor roads and access to good sanitation. The archdiocese of the Catholic Church in Lagos manages the facility. Over 90 percent of the staff are females. There are no staff medical doctors currently. The patients prefer to see a female doctor at each visit, so the facility concentrates on employing female staff members. The facility offers primarily a general practice and mother and child health services to its patients.

The Nisa Premier Hospital in Abuja, Nigeria was originally established as a fertility center but over the years it has become a women and children’s hospital. “Nisa” means woman in Arabic. About 70-80 percent of the staff are females because most of the patients are female. The female staff includes the non-medical staff like the facility cleaners and security. Being located in the Islamic northern part of Nigeria, a majority female staff has many advantages when cultural and religion may influence female patients’ preference for female medical staff and even non-medical staff.

Opportunities to protect female health professionals

Box 4.17. Lady Pharmacist Association of Ghana

The Lady Pharmacist Association of Ghana (LAPAG) is a gender-specific association of the Private Sector Alliance of Ghana. It was established in 1993 and has a certified membership of 450 female pharmacists. The main activity of the group is to identify and address unhealthy and harmful practices in the Ghanaian society, especially women’s indiscriminate use of medicine.

Opportunities to create a more favorable learning environment for women

Box 4.18. Long Distance Courses for Female Professionals

In Kenya, women may opt to specialize in medical fields that can be learnt online or by distance learning, instead of being physically in class. Because of their dual roles as wives and mothers their time is less flexible. Female sole proprietors may lose clients and therefore business when they go on maternity leave or are absent frequently because they take their children for immunization or are attending a school function. But some female practitioners do not find family a strain on their business. They play a « flexibility card » (That is: they arrange which days to be physically at work and which ones to be at home, to enable themselves to give both family and business adequate attention.)

Each of these initiatives has been supporting some categories of health workers who are engaged or want to be engaged in the PHS. Another Kenyan program seems to have developed a more global approach; it is described in the Kenya country report as a best practice. Some credit institutions have been successful

in customizing lending products through partnerships to provide credit to health professionals at very favorable terms. This lending program has the comparative advantage of offering not only loans to entrepreneurs to open a facility and buy medical equipment; it also provides continuous nursing training.

Box 4.19. The Kenya Women Finance Trust: A Banking Solution to Create Nursing Homes

The Kenya Women Finance Trust (KWFT) is a local bank that has customized lending products for health professionals, such as nursing loans, which are provided in partnership with Deposit Taking Microfinance (DTM). The trust targets individuals interested in a nursing course. The loans are unsecured and allow the beneficiaries to train as they work. This would be beneficial for women who struggle with balancing family resources and professional development. KWFT also provides asset loans to purchase machinery, including medical equipment by health entrepreneurs.

A well designed training component could be a guarantee to improve the management of the health facility once opened, but also to ensure the loan can be repaid. More importantly, the KWFT training considers the socio-cultural aspects of society, which are the main constraint faced by women entrepreneurs. The Uganda report also emphasized the multiple benefits of this approach. It observed that women as a gender are strong in group savings. Various commercial banks with women groups as their largest clientele have grown. Female health professionals can take advantage of such associations to access loans from the credit institutions. The group-based credit approach provides guarantors, increases negotiating ability, and peer support to succeed.

DISCUSSION AND CONCLUSIONS

To contribute in achieving universal health coverage and sustainable development in their country, African women must be equal participants in all sectors of the society. With so many obstacles in various spheres of their lives, women cannot contribute to the development of their countries and health service delivery unless they are empowered to fulfill all their roles in society. To achieve their professional potential, and to contribute effectively to health service delivery and sustainable development, female health care professionals must overcome many constraints; the most important is changing societal perceptions and expectations of women's roles.

While governments can institute some economic, gender, and political policies to diminish gender disparities and improve universal access to health, the greatest strides forward will occur by awakening African societies to the benefits from women's full participation in every dimension of society, to the benefit of their families, communities, and nations.

Gender disparities in the PHS are an example of a lack of equality between men and women which are also similarly reflected in the whole health sector including the public health sector. The country study findings indicate that some categories of private sector health workers are more affected than others. These include youth and female health entrepreneurs who want to own their health businesses, mainly midwives and nurses, but numerous obstacles have prevented it. Lessons from the gender disparities observed in the private health sector are therefore likely to be of value to the public health sector, especially as governments seek to move towards universal health coverage.

The main obstacles to female participation in the PHS include difficulty obtaining financing due to a lack of collateral, complicated and time consuming administrative procedures, and family and socio-cultural constraints. All of these factors impede women's ability to work in the male-dominated sector.

Various studies on gender differences in the work place have shown that in male-dominated occupations, men have a tendency to "dominate in position and to legitimate power" by instituting a "male culture" in which men are highly visible, occupy the higher positions and salaries, make decisions, and impose long working hours. In such places, women usually feel pressure to go along with their male counterparts' views to prove that they are capable to "do masculinity." They are also more likely to be discriminated against because the PHS owners anticipate multiple pregnancies and absences. As a result, female health workers may feel a "cultural exclusion" when practicing in such an environment.¹⁸

Some innovative strategies have been put in place to reduce female and youth exclusion from the PHS, but evidence has shown that there is still room for improvement to ensure women and youth will effectively take advantage of these opportunities to benefit from the PHS more fully. By focusing on only one aspect to improve access to credit for example, the different stakeholders fail to have a systemic approach that encompasses the gender disparities in the entire sector.

These major constraints inhibit youth and female health workers to limited options: work in the public sector, the private health sector, or work in both sectors concomitantly, while the most entrepreneurially inclined bide their time for an opportunity to improve their situation in the PHS.

¹⁸ Watkins M. B and Smith. A.N. 2014.

RECOMMENDATIONS

Based on the findings from the seven country assessments, the following are recommendations for the Health in Africa Initiative (HiA) to support African governments reduce gender disparities in the private health sector. Specific recommendations are directed to governments, commercial banks, regulatory bodies, private health facilities owners, professional associations, females and young health professionals and donors. These recommendations, while focusing on the private health sector, are likely to be useful to governments and other stakeholders, as African governments, along with the rest of the global community, focus on efforts to provide good quality health services for all their populations (universal health coverage) as well as the soon-to-be-agreed sustainable development, which both require cross-sectoral collaboration, including partnerships between the private and public health sectors.

RECOMMENDATIONS FOR GOVERNMENTS

Gender disparities in the PHS are a consequence of inequalities starting at the household level where gender is constructed and then diffused into the society at large. In the workplace, women still bear the burden of gender inequalities. As a result, they are unable to reach their full potential, unlike their male counterparts. This gender disparity has a negative impact not just on women and girls but on the whole society and its ability to achieve international and national health and development goals, including universal health coverage and the upcoming sustainable development goals.

In the seven countries assessed, the respective governments have put in place gender sensitive policies which nonetheless have failed to keep girls in the education system. Consequently, without education, the majority of women toil in unpaid jobs and in charge of family chores. Different innovations are required to equalize the ongoing imbalance in the distribution of roles within the household and the community. The following recommendations for governments are based on the country surveys:

- ❖ Sensitize the public on the importance of girls' education and women's participation in their country's development by actively involving boys and men in the promotion of gender equality;
- ❖ Develop and implement effective strategies to reduce the imbalance in the education sector to keep more girls in primary and secondary school. Encourage girls to enroll in sciences and later in health schools. Offer health and science scholarships starting very early at school through university;
- ❖ Institute national policies to increase women's participation in the country's development such as Affirmative Action, gender budgeting, girls' education, and female entrepreneurship programs;
- ❖ Introduce new perceptions and behaviors at different levels (household, community, and nation). New changes will contribute in the promotion of more balanced roles and outcomes that better suit both men and women's contributions for social and economic growth;
- ❖ Introduce a gender business unit in the curricula of health sciences to get the students thinking about health investment ideas while still in school;
- ❖ Review the national gender policies, and more specifically for the PHS, to ensure that gender policies adopted by the states result in more equity and non-discriminatory actions to make female health professionals more centrally involved and offered equal opportunities to males;
- ❖ Improve access to information regarding existing opportunities, e.g., recruitment of staff, scholarship, subsidies, etc., provided by governments in the form of equipment or direct funding to open a health private facility;

- ❖ Recognize the existence of gender disparities in the health system, particularly in the PHS, by encouraging the collection of sex-disaggregated data to better measure the gender dimension of the health sector and develop adequate strategies to reduce the disparities;
- ❖ Recognize the contribution of the PHS and build strategies for an effective Public Private Partnership by boosting the PHS's working capital, mainly by providing subsidies to reduce the capital and operating costs;
- ❖ Provide incentives to health professionals, both women and men, to engage in the PHS in marginalized areas to contribute to reduce the maternal mortality rate. For example, governments may encourage initiatives that enable midwives and nurses to get credit with low interest to run their own facilities, including in underserved areas where access to sexual and reproductive health and maternal maternity are big problems
- ❖ Encourage health training institutions in collaboration with management schools to introduce a business component in their curriculum to develop business skills of health professionals willing to engage in the PHS;
- ❖ In South Sudan and in Congo, there are no pharmacy schools. By investing in national schools of pharmacy, the governments will reduce the burden on families struggling to pay the cost of foreign tuition fees and be often forced to choose to invest in professional school for their daughters or sons.
- ❖ Encourage health training institutions to introduce a gender component module in the curricula of health sciences to get the students think over health investment ideas while in school, and take into consideration the gender dimension of the health sector (as opposed to clinical aspects); and the implications of these gender dimensions in the universal provision of health care to all populations by both the private and public health sectors.
- ❖ Ensure that policy development and review consultations should include critical socio-cultural gender analysis and awareness-raising to ensure developed and reviewed policies address gender disparities in a holistic and life-course manner that includes all affected populations.
- ❖ Recognize that addressing gender disparities at all levels of society not only contributes to equity between men and women, but also contributes to the lowering of inequalities between populations within the countries as well as to improved access to services by all.

RECOMMENDATIONS FOR COMMERCIAL BANKS

Access to credit is a main obstacle to setting up a private health facility and to being self-employed. The large majority of youth and female health care providers lack collateral to secure a loan and are risk averse to long-term debt as well as concerned about repaying high bank interest. To improve access to banking products and services, the following recommendations for commercial banks should be considered:

- ❖ Mainstream a gender and youth perspective in lending products to make access to credit less intimidating while addressing youth and female health workers' lack of collateral (grace period? lower interest rate?);
- ❖ Consider instituting innovative approaches to lending and specific credit instruments designed for young and female health professionals, e.g., credit in form of stocks of medicines and medical equipment, creation of partnerships, capacity building programs, including financial management and life skills for private and professional life.

RECOMMENDATIONS FOR REGULATORY BODIES

In the health system, regulatory bodies are inevitable offices. Governments rely on them for oversight of the health profession. As such, they supervise and control the public and private health system. They are responsible for registering and renewing licenses, and inspecting and regulating the quality of health services to protect the public. But in all the targeted countries, the regulatory bodies lack human resources to fulfill their roles. The registration procedures are onerous and health professionals complain about accessing the relevant information to register and renew licenses and the time required to get clearance. The facilities' owners seem to be overwhelmed by the time necessary for the different regulatory bodies that lack coordination, are overly complicated and inefficient. One respondent described the process as a "regulatory maze." The recommendations for regulatory bodies are the following:

- ❖ Explore innovative ways to improve regulatory bodies' quality of services;
- ❖ Reduce and better coordinate the processes necessary for health care providers to get or renew their licenses and for inspection and monitoring;
- ❖ Make the process more transparent to avoid administrative harassment and financial bribes and other corruption, which will also contribute to accelerating the process;
- ❖ In liaison with the Ministry of Health, collect sex and age-disaggregated data from service providers including the sector they work for (whether public or private) during registration and renewal of licenses. This data is important to inform future policies and strategies as well as development initiatives.
- ❖ In conjunction with sex and age disaggregated data governments should have on all health professionals, this will help to track specific disparities between the private and public health sectors.

RECOMMENDATIONS FOR HEALTH PROFESSIONALS ASSOCIATIONS

Health Professionals Associations (HPA) member activities are an important way to participate in a network where decisions are taken and technical and moral support and training can be provided. Members get to better know each other, build formal or informal partnership, and have the opportunity to get relevant information and exchange ideas for problems and solutions. Members build a community of professions while improving technical skills, as well as uniting to support the association. But because the HPA are male dominated, their working conditions are currently unfavorable to female health professionals' agenda. Women, therefore, rarely attend meetings (only in the nurses and midwives' associations), and women are less represented in their boards. By not contributing to the HPA's activities, women are missing empowering professional opportunities. The recommendations for HPAs include the following:

- ❖ Encourage women and youth to participate in the associations' activities by developing more attractive products and services such as mentoring, guidance, and monitoring, to better develop their careers. For instance, develop financial literacy programs, e.g., training on how lending to this sector can be favorable for members who want to apply for loans to open a facility or increase the capacity of their health facilities;
- ❖ Explore innovative ways of doing business without collateral. For example, the health professional's practicing certificate may be more explicit when a member wants to access credit indicating the health workers competency and demonstrating his/her ability to run a business and to repay the loan;

- ❖ Create a more enabling environment for all members by identifying the specific needs of males, females and youth to better provide adequate services for them and developing deliberate initiatives to empower them and build more confidence in the workplace;
- ❖ Where needed, create women-specific health professional associations for members engaged in the PHS and develop capacity building initiatives for them;
- ❖ Develop a series of strategies to empower and centrally involve more female colleagues in the leadership, management, and delivery of health services. This may happen by adopting gender sensitive working conditions, mentoring, and partnership, allowing more inclusion for all female health care providers and resulting in less stress in the management of their work and family responsibilities.

RECOMMENDATIONS FOR OWNERS OF PRIVATE HEALTH FACILITIES

Owning a health facility has two main advantages: the owner is the main decision maker and is also responsible for the performances of his/her facility. As such, the owner is interested in creating an environment that serves the needs of the clientele in terms of quality of provided services, availability of necessary medical equipment, and competence of staff. Staff members have similar interests. They appreciate a good working environment as well as competitive salaries in exchange for their well-performed health services. Based on the country studies, the following recommendations are for owners of private health facilities:

- ❖ First of all, recognize that workplaces are generally male-dominated areas where women are/feel very often directly or indirectly discriminated against, which has important implications on the general performance of the facility. They have to be aware of the existence of gender disparities and make it known among the staff in order to make relevant decisions;
- ❖ Explore solutions that will suit both male and female staff with young children by adopting rules allowing for flexible but regulated working hours and night shifts. These decisions usually work better when taken through a consensual process, because they prove that specific needs have been identified and gender disparities discussed and recognized;
- ❖ Encourage a cooperative and supportive learning environment for their staff.

RECOMMENDATIONS FOR FEMALE AND YOUNG HEALTH PROFESSIONALS

Youth and female professionals encounter specific constraints working in the PHS. To be competitive, they have to invest in building their career in terms of time, energy, and sometimes sacrifice to succeed in the PHS. The following recommendations are for youth and female health providers:

- ❖ Identify possible obstacles in the PHS and also solutions. Women in particular have to find the right balance between their family and professional responsibilities;
- ❖ Participate fully in the health associations' activities to obtain relevant information, express opinions, participate in the decision making process, and contribute to specific activities, to build trust and credibility and become well established in the profession;
- ❖ Build their own capacities by taking advantage of relevant opportunities that are offered, including business and partnership opportunities, as well as improving their skills that may help them to develop their career.

RECOMMENDATIONS FOR DONORS

The donor agencies have been very active in mainstreaming the gender agenda in developing countries. Different stakeholders have been trained to integrate a gender perspective in their development programs, and with the long-term support of donors, gender sensitive policies have been adopted. Nonetheless, many countries are still struggling to apply the policies, which require long-term efforts to introduce sustainable changes in perceptions. The recommendations include:

- ❖ Continuously support inclusive programs to mainstream gender equality in all spheres of society and particularly in the health private sector;
- ❖ In partnership with health training institutions, support the education of health workers and students by providing scholarships to increase the number of service providers and specialized health providers in the country;
- ❖ Support inclusion of gender and youth perspectives in health and other socioeconomic policies, strategies, and programs at the national and local government levels.

CONCLUSION

In conclusion, these recommendations must be considered as a prerequisite to reducing gender disparities in the PHS and achieving the health MDGs and the post-2015 sustainable development goals. All sectors, including the private, 'not-for-profit' and faith-based sectors should support and/or supplement government efforts towards inclusive good quality healthcare delivery, at all points of the health systems and in all stages of the healthcare delivery process, including the policy development, review and implementation stages. As explained in the Nigeria assessment, *"The MDGs (and SDGs) require that gender equality no longer be seen as a women's agenda, so men's full participation, accountability, and partnership with women is crucial. Formulating innovative culturally sensitive programs will help to actively involve men and boys in promoting gender equality."*

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Despite their strong contribution to the overall world economic growth, gender gaps are wide in many countries in sub-Saharan Africa and low representation of women in the private health sector is wider than in other sectors. While women and youth use the majority of health services both private and public, women are underrepresented as private health care providers and have limited access to financing to open their own private practices.

This landscape has prompted the HNP Global Practice to take a critical look at the factors which hamper the growth of female and young private health practitioners vis à vis their male counterparts (usually older and more experience in their profession).

This assessment provides information on ways to close the gap which exists between male private service providers and female providers as well as recommends ways in which the existing gaps can be addressed. The assessment also provides the basis for further developing a strong public- private dialogue in health while providing avenues for building capacities for women to fully contribute to the development of the private health sector through the development of a training module to be administered in private training schools as a pilot in Burkina Faso and Mali.

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