EXAMINING GENDER INEQUALITIES IN COMMUNITY DEVELOPMENT;CASE STUDY: KUMI HOSPITAL, KUMI DISTRICT, EASTERN UGANDA

BY:
OJEPA ANDREW KOKAS
BSW/31201/102/DU

DISSERTATION SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF DEGREE OF BACHELOR OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

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DECLARATION

I **OJEPA ANDREW KOKAS** hereby declare that this study entitled examining gender inequalities in the health sector, a case study of Kumi hospital in Kumi district is original and has not been published and/or submitted for any award to any institution before. The views expressed herein are mine unless otherwise stated, and where such has been the case, acknowledgement or reference has been made. I have read the regulations of the university with regard to plagiarism and here declare that I abided by all of them.

Signed.....

Date.....

APPROVAL

This is to approve that this work has been done under my supervision and is now ready for submission for examination

Sign.....

Date .....

ACHODA DENNIS

University Supervisor

DEDICATION

With due respect I dedicate this work to my beloved parents, brothers and sisters for the moral and financial support they gave me since I started the struggle up to this time of writing this paper, they have made me who I am today.

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I do appreciate the invaluable guidance offered by my supervisors, Mr. Achoda Dennis for his technical support and motivational help; he ensured that the goals of this project were achieved.

I wish also to thank University administration especially department for the support it rendered to us students. I don't forget the recommendable work done by the entire University staff.

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AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Virus
HRH	Human Resource for Health
ILO	International Labor Organization
LSOM	Legislature Senior Official Management
MDG	Millennium Development Goals
WHO	World Health Organization
WHR	World Health Report
UN	United Nations

ABSTRACT

The study examined gender inequalities in the health sector, case study of Kumi hospital Ongino Sub County, Kumi district. The specific objectives were to find out gender inequality manifestations, to investigate the causes of gender inequalities, to assess the effects of gender inequalities among health workers of Kumi hospital and to establish the available mechanisms to promote gender equality among health workers of Kumi hospital, Kumi district.

The study involved 30 female and 36 male. A total of 66 respondents were selected where by key informant guide was administered, set of questionnaire was generated and administered too and the focus group discussion tools which helped to collected the necessary information about this study.

Chapter two consisted of the literature review, these are documents written by other authors that the researcher reviewed.

Chapter three explains the research methodology employed in this research. The study used across sectional survey design and employed both qualitative and quantitative research approaches for data collection, presentation and analysis. The instruments used for data collection include Key informant interview, guide, focus group discussion guide, and questionnaire.

The findings and conclusions highlight and revealed the causes of gender inequality which included; the education level, gender roles, preference of one sex for a specific department, inferiority complex. Effects included; poverty, reduced labor force in some departments, low performance, stigmatization, conflicts, and staff demoralization and available mechanisms to promote gender equality were affirmative action, women empowerment

The recommendations made focus on the health sector providing a staff development and mentoring for female staff in order to better them to compete for higher management jobs and the government needs to develop gender policies, strategy, implementation and guidelines for the health sector. This would help health employees to know their rights while at work.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

This chapter basically provides the introductory part with key components like background of the study, statement of the problem, objectives of the study, research questions, and scope of the study, significance of the study, justification of the study, variables, definitions of key terms and concepts and the conclusion.

1.1 Definition of key terms and concepts

Gender: Gender in relation to work is a collaboration of individuals committed to strengthening organizations to build cultures of equality and social justice, especially gender equality.

Gender is the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women

According to World Health Organization (2014); Gender is the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women.

Examining: Is to observe a situation carefully or critically in order to get facts about the situations

Gender Inequality: Is unequal treatment or perceptions of individuals based on their gender.

Gender inequality means unequal distribution of resources, employment, unequal opportunities to career building, unequal payment of staff that are performing the same task and unequal treatment by their superiors.

Gender inequalities are systems inefficiencies that contribute to clogged health worker educational pipelines, recruitment bottlenecks, attrition, and worker mal distribution in formal and non-formal health workforces as noted by (Constance Newman, 2013).

Gender inequality also refers to disparity between individuals due to gender.

Gender inequality varies tremendously in different organizations, it may include; losses in achievement due to gender inequality. Health organizations with unequal distribution of human resources also experience high inequality among health workers.

Gender stereotypes: Are widely-held beliefs about the characteristics and behavior of women and men.

Gender Stereotypes are fixed ideas about men's and women's traits and capabilities and how people should behave, based on their gender.

In gender stereotyping, people make inaccurate, overly simplistic generalizations of others based upon their gender. These assumptions are untrue because they do not take into account that everyone is an individual with unique thoughts, feelings, and aspirations.

Health sector: The health sector is made up of the people, institutions and resources, arranged together in accordance with established policies, whose primary purpose is to promote, restore and maintain health. It includes government ministries and departments, hospitals and other health services.

The health sector is complex, with many types and providers of services and a range of funding and regulatory mechanisms. Those who provide services include medical practitioners, other health professionals, hospitals, and other government and non-government agencies.

Gender blindness: Refers to the failure to recognize that gender is an essential determinant of social outcomes, including health. It therefore impacts assessment and management of health problems.

1.2 Background to the study

Globally, although gender based inequalities exist in the majority of the world's cultures, religions, nations and income groups, there are differences in the way these disparities manifest themselves and how they evolve overtime notes (Ricardo, 2010). The global gender gap index introduced by the world economic forum in 2006 is a framework for capturing the magnitude and scope of these disparities and tracking their progress. The index benchmarks national gender gaps on economic, political education and health sector Ricardo, (2008).

In many countries, men get priority over women in the distribution of health care services. Contraceptive use has risen in industrial countries, but in developing countries, complications in childbirth are still a leading cause of death for young women. AIDS takes an even more terrible

toll on women than men globally, since women's risk of becoming infected with HIV during unprotected sex is two to four times higher than in men. The World Health Organization's 2007 AIDS Epidemic Update reported that about 33 million people are living with HIV/ AIDS, and that half were women. Sexual politics influence the transmission of HIV/AIDS. Many women with HIV/AIDS have been infected through early sexual exploitation or by husbands who have multiple sexual partners but who refuse to use condoms as stated by Lober (2010).

Gender inequalities in the health sector have been a major area of research interest since the early 1970s. In Chapter 1, Ellen Annandale and Kate Hunt outline general trends in research on gender and health since the 1970s when second wave feminism inspired an interest in the subject, highlighting methodological and theoretical concerns. They describe widespread social change, concentrating on changes in employment, educational qualifications, and the household and family, using Britain as a case study. Ellen, (2000)

In Africa, recently published data showed that health inequality was rampant among 56 low-and middle-income countries representing 2.8 billion people in relation to the best-off 20 percent of the population in these countries. This data suggest that the health sector should allocate more resources to the poor. Yet, the data documenting these disparities also showed that the health sector was a contributor to the inequality as noted by Abdo (2009).

In East Africa, most women earn less than men and are more likely to be trapped in low-paid, low-skilled jobs-often in the informal economy as stated by Maurice, (2010). Since 1994, the participation of women in the labor force has declined by 1.6%. In sub-Saharan Africa, the number of women in high-status positions-called legislative, senior official or managerial (LSOM) jobs-has increased by nearly 3% over the past decade, reaching a level of 24.8%. When compared to the number of women in such positions throughout the world, which was estimated at 28%, the progress by African women was seen as encouraging. As stated by International Labor Office notes Maurice, (2010).

In Uganda, Gender inequality was acknowledged as the most pervasive form of inequality which include low salary wage among gender, unequal employment opportunities, professional

development and distribution of facilities. Failure to achieve gender equality, impacts on the rights of women and girls everywhere, slows growth and progress from a development perspective. Gender inequality is reviewed in the context of capabilities on health and education opportunities, employment access to economic services and levels of empowerment ownership of productive assets, participation in governance, and access to justice as stated by the Ministry of Finance (2006).

Gender inequalities operated in the workforce outside of the awareness of human resources for health leaders and managers, these inequalities may impede entry in health occupations or contribute to attrition, absences from work, lower productivity, poor health, and low morale of health workers. The result was a limited pool of formal and informal health workers to deal with today's health and development challenges. A sound Gender health Initiative health workforce strategy must address the critical issue of gender inequality as stated by Maurice (2010). At present, though, key forms of gender inequality were still out of the awareness of most human resource leaders and managers.

Before 1995, cultural and tribal influences in Uganda mostly favored the superiority of men who were already strong. Gender was distinguished many ways-through various foods that were culturally accepted as being eaten mainly by males or females, in marriages where women were seen s as inferior to their husbands, in the workplace where women did not pursue jobs, and other areas. Mr. Batema (lecturer at Makerere Business School in his presentation to students, 2010) went on to outline the changes in gender roles that have resulted from the new constitution, which focused on creating gender equality and condemns the cultural and tribal practices that differentiate between gender state Students of Makerere University Business School, (2010).

Inequality was common among health workers who have direct contact with people in distress, that it may be considered an inevitable part of the job which was often the case in the health sector. Inequality in this sector may constitute almost a quarter of all inequalities at work. While ambulance staff is reported to be at greatest risk, nurses are three times more likely on average to experience inequality in the workplace than other occupational groups. Since the large majority of the health workforce was female, the gender dimension of the problem was very evident.

Besides concern about the human right of health workers to have a decent work environment, there was a concern about the consequences of inequality at work. Vittorio di Martino, (2002) Health sector inequality has an impact on health providers' health, productivity and dignity throughout the world. It has an impact on individual, organizational and social levels. It was associated with inequity, stigmatization and conflict in the workplace as noted by Newman, et al (2008).

Just like other sectors, the health sector too was embedded with inequalities and the researcher intended in this work to focus on Kumi hospital, the biggest referral hospital in Uganda and employs over one thousand medical personnel and non medical staff. The hospital harbored a number of activities which include medical school, and other research institutions.

1.3 Statement of the Problem

Gender inequality in the health sector is still a major concern in today's society. The increase in cultural and gender diversity in the health sector has obligated employees from different ethnicities and backgrounds to work together to meet the goals of the health sector. Unfortunately, differences between people have tendency to lead to misunderstandings, and result in conflict and inequalities. Health workers have responsibility to protect their fellow workers from inequalities and unfair treatment in the health sector.

Gender inequalities exist in the health sector, but little is known about their presence in relation to factors examined in the health work settings. The aim of this study was to identify the working and employment conditions described as determinants of gender inequalities within the health sector.

Given the gender blindness in the health sector in Uganda, it is very difficult to find basic information at country or regional level on the gender breakdown of staff at different levels or grades in order to provide a basis for developing appropriate policies to address problems such as the under-representation of women in senior positions in the health sector. Case study evidence,

however, would indicate some typical ways in which inequalities operate, either directly or indirectly. A study of examining gender Inequality in the health sector: a case study of Kumi hospital. There was a general assumption that women do not want, or are not able, to advance their careers because of the inequalities by their fellow health workers.

1.4 Purpose of the study

The main purpose of this study was to examine the gender inequalities like unfairness in recruitment, dismissals, gender biasness and focusing on how such can be used to improve such vices in the society more particularly in Kumi hospital.

1.5 Objectives of the Study

1.5.1 General objective

To examine gender inequalities in the health sector with special focus on Kumi hospital, Kumi district.

1.5.2 Specific objectives

i. To find out gender inequality manifestations in Kumi hospital
ii. To find out causes of gender inequalities in the health sector
iii. To assess the effects of gender inequalities among health workers
iv. To find out the available mechanisms to promote gender equality among health workers of Kumi hospital

1.6 Research Questions

a. What are the manifestations of gender inequality in Kumi hospital?
b. What are the causes of gender inequalities in Kumi hospital?
c. What are the effects of gender inequalities among health workers of Kumi hospital?
d. What are the available mechanisms to promote gender equality?

1.7.0 Scope of the study

1.7.1 Conceptual scope

The research concentrated on gender inequality focusing on the report findings that is in this assessment. The assessment concentrated in examining gender inequalities in the health sector. The stakeholders that interacted with the researcher included the medical director, medical doctors, midwives, nurses, cleaners and Administrators. The assessment captured data on the causes of gender inequalities in the health sector.

1.7.2 Geographical scope

The study was carried out in the project area of Kumi Hospital in Kumi district. This study would enable the health sector to consider gender equity among its employees.

1.7.3 Time scope

The phenomenon of Gender inequality in the health sector with focus on Kumi hospital had been in existence for the period of ten years ago from 2003 to 2014. This was used for the study. The study was limited to patients, nurses, medical and administrative departments of Kumi hospital. The variables that were used included causes and effects of gender inequalities in the health sector with special focus on Kumi hospital.

1.8 Significance of the study

The knowledge generated would help to strengthen the intervention strategies for gender equality in the health sector as a way of improving the health sector working environment.

The assessment was to help policy makers in identifying the causes of gender inequalities in the health sector.

The information got from the study would enable the researcher to establish the effects of gender inequalities.

The research was to act as a data base for policy makers to put strategies of fighting gender inequalities in the health sector.

1.9 Justification

There is still rampant gender inequality in our country which was unnoticed. Rights, equal participation and equal distribution of resources are mentioned in other sectors but not in the

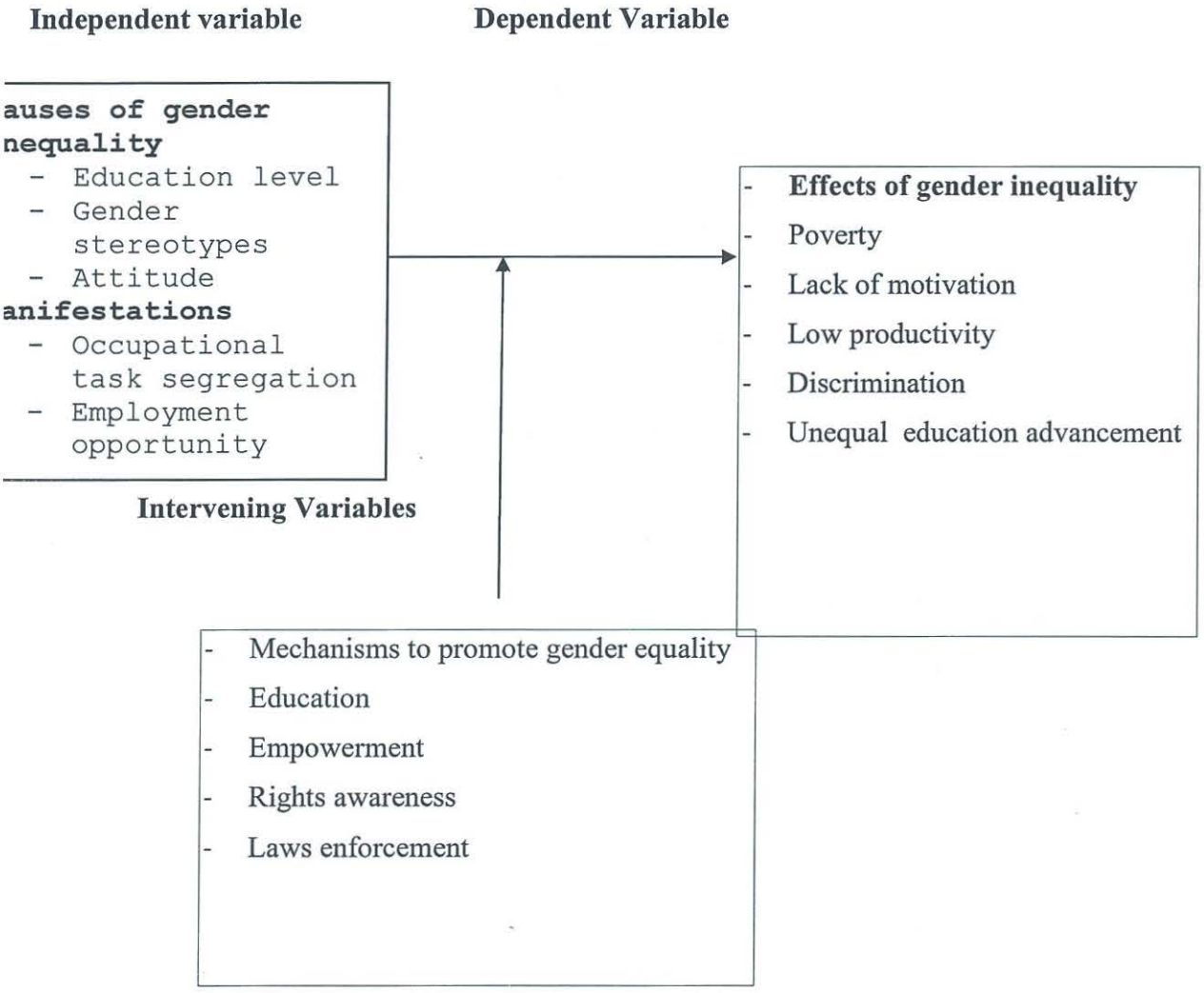
health sector. There is also no growing awareness and policy attention to gender participation and employment rights in the health sector

Relatively little data existed on the magnitude of gender asset gaps within and across countries, but these gaps are thought to be substantial.

The growing number of female health workers in the lower positions necessitated the researcher to carry out a research on examining gender inequalities in the health sector. Majority of health workers in Uganda are female (Uganda demographic health survey, 2012). Gender inequality may present significant barriers to achieving gender equality within the health sector, according to researcher's observation.

Figure 1: Conceptual framework:

1.10 A diagrammatic representation of research variables interplay



Source: Researcher's Conceptualization, July, 2014

From the conceptual framework in figure 1 above, the independent variable factors of gender inequality which include; Education level, stereotypes, Attitude the dependent variables are effects of Gender inequality, poverty, lack of motivation, discrimination, low productivity, Occupation and task segregation whereas the intervening variables include education, empowerment, rights awareness and law enforcement.

1.11 Conclusion

The consideration of a gender-based division of labor in occupational health studies not only implies separate analysis on the basis of sex, but must also take into account the potential different meanings of a given role for men and women in different social contexts. For example social classes and other dimensions of health inequalities, However; this research on examining gender inequalities in the health sector was to explain the complex pathways by which the social relations of gender may have an impact on the health sector employment of men and women. Therefore, with consideration of the roles of both sex and gender was required.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

In this chapter, the researcher reviewed the documents written by other authors, regarding the topic under the study. The study looked at gender inequalities in the health sector. The reviewed literature was done under the following subheadings got from the research objectives.

2.1 Gender inequality manifestations among health workers

Gender was a key factor operating in the health workforce. Recent research evidence points to systemic gender inequalities in health pre-service and in-service education and employment systems. Human resources for health (HRH) leaders' and researchers' lack of concerted attention to these inequalities is striking, given the recognition of other forms of inequalities in international labor rights and employment law discourse. If not acted upon, gender inequalities result in systems inefficiencies that impede the development of the robust workforces needed to respond to today's critical health care needs.

Fostering gender equality increases the likelihood of women and men having an equal chance of choosing a health occupation, acquiring requisite skills and knowledge, being hired and fairly paid, and enjoying equal treatment and advancement opportunities. Promoting no inequalities and gender equality in policy and planning can, for example, target gender stereotypes that kept men from entering female-identified jobs such as nursing and HIV/AIDS care and support as stated by Constance Newman (2013).

A 2012 systematic literature review of gender in health pre-service education and general tertiary systems in several countries identified 51 interventions to counter disadvantage stemming from pregnancy and family responsibilities and sexual harassment, as well as interventions promoting gender equality generally. The review recommended implementing a multilevel 'basic bundle' of interventions to target the roots of discrimination and violence, eliminate impunity for sexual harassment, and transform school and work arrangements so women were not disadvantaged by pregnancy and family care giving states Newman .C. (2012).

Inadequate health workers (disturbing statistics: doctor to patient ratio (1:24,725) and nurse/midwife to patient ratio (1:11,000). According to the 2011 Human Resources for Health Audit Report, with respect to the national level staffing, the proportion of the filled approved positions was found to be 58 percent and up from 56 percent in 2010. Out of 55,063 approved positions, only 31,797 are filled, leaving 23,321 vacant positions. The situation was worse at the level of HCIIs. Out of 4,905 posts in 1321 health centre IIs in the whole country, only 2,197 (45%) are filled. In addition, there were significant shortages of some specialist cadres like dentists, anesthetists, anesthesiologists, psychiatrists, and pathologists etc. Staff shortage was further compounded by absenteeism and inability to retain critical cadres even when health workers have been recruited.

Poor remunerated and de-motivated health workers which had resulted into health workers transferring their services to neighboring countries, moonlighting or taking up other jobs, absenting themselves from work, and to some extent stealing medicine and being rude to patients. It was in light of foregoing that the Health Service Commission has in the last 10 years has consistently recommended for salary enhancement and in 2010 specifically recommended to the President to consider a salary increase of 286 percent and other benefits such as transport, accommodation, risk allowances and Inadequate plans and salary to attract, motivate and retain super specialists to provide specialized health services in specialized health units such as the Uganda Cancer Institute and Uganda Heart Institute as noted by the parliament of Uganda (2012).

2.2 Causes of gender inequalities in the health sector

At a very root basis, gender inequalities happened when culture in a society was shaped to favor men or women as competent for certain roles. Things were just assumed to be done a specific way by men and women-neither of the sexes are questioned and it is simply accepted as the norm. Expectations of men and women are shaped by culture and how they fit into career roles is similarly guided by culture. For instance, careers that involve strong roles and dirty work' such as personal care and hygiene for patients was seen as women's work, while managerial, business- oriented positions were seen as men's work Ian M, (2013).

Gender inequalities occurred when sexes were treated unequally. Gender inequalities were not based solely on gender differences but on how people were treated differently because of their

sex. Employers who provided different working conditions and promotional opportunities for men and women violated anti-inequality laws. Leaders who offer better terms to one gender over another were in violation of anti-inequality laws. Gender inequality is illegal and several laws were in place to prevent and eliminate inequality practices, Sherrie Scott, (2014). Inequalities in the health sector were among the most debated issues around the world. There had been innumerous findings on and strong charges against inequalities.

In particular, gender bias had become a common occurrence everywhere in most of the developing countries. Some reports also showed that such inequalities happen even in developed countries, though the number of facts may be less compared to those in the developing and least developed countries. There were different forms in which inequality may be evident at workplaces. In spite of the number of findings and reported cases in governmental and non-governmental institutions, the issues still remained beyond control. Environment around the office, the socio-economic status of women, the religious values and restrictions and above all the social psychology of the people can be figured out as the principal causes behind biasness. Unwillingness and lack of attention and supervision by the government adds to this to a great extent. All these have led the issue being complicated more and more as stated by Afroza Bilkis et al, (2010).

Another common trend found in employers was their decision to reserve powerful and influential positions for men. Still in our society, women supervised fewer subordinates than men and were less likely to control financial resources. Dilok Phanchantraurai in his writing (2000), Gender Perspectives on The Workplace: Advanced Organizational Theory and Inquiry, states why men see women as threats to their advantageous position. According to him, men fear that their female colleagues may take over authoritative jobs and may thereby outperform men in the same job. Besides, they think that earning much will enable women to insist on greater equality in the family, community and national political life.

Mia Hultin also writes that women were being unduly restricted from attaining supervisory positions at work, primarily within the private sector. Furthermore, it was not just the level of

authority but also the type of authority where the differences between men and women emerge most clearly Reskin et al, (1992).

Inequalities can happen anywhere a power imbalance exists between groups of people, such as in education, in social and political contexts, and even health care. In particular, "inequalities in the health sector are disturbing as it violates the basic principles articulated by care providers." Generally, nurses experience inequalities based on their gender, race, lifestyle, and physical disability. In nursing, inequalities and oppression have lead to lower salaries, hostility from colleagues in the workplace, and unequal access to professional development training programs and career advancement opportunities an noted by Charissa .C (2014).

Women constitute the largest group experiencing inequalities. Despite recent increases in employment opportunities, the opening of new career paths, and advances in educational achievements, women are still subject to widespread inequality which affects their lives in the work world. For example, it was difficult for women to reconcile family duties with paid work without affecting their chances of promotion or skill enhancement. But even if they do, they still on average earn less than men. Also a significant proportion of employed women continue to be self-employed in the informal economy which was characterized by low pay, poor working conditions and lack of protection. Meanwhile more and more women are becoming involved in informal work in the domestic sector, partly as a result of female migration of labour as stated by Akpokavie, et al., (2007).

Women are thus seen as objects rather than subjects (or agents) in their own homes and communities, and this is reflected in norms of behavior, codes of conduct, and laws that perpetuate their status as lower beings and second class citizens. Even in places where extreme gender inequality may not exist; women often have less access to political power and lower participation in political institutions from the local municipal council or village to the national parliament and the international arena. While the above was true for women as a whole visa vie men, there can be significant differences among women themselves based on age or lifecycle status, as well as on the basis of economic class, caste, ethnicity etc. Much of the above also holds for transgender and intersex people who are often forced to live on the margins of

mainstream society with few material assets, who face extreme labor market exclusion leaving them little other than sex-work as a means of survival, and who are often ostracized, discriminated against, and brutalized Gita Sen et al, (2007).

The traditional public health approach is top-down rather than bottom-up, with experts identifying problems and formulating interventions while the problems and solutions as perceived by those at particular risk rarely constitute the base for action (Dahlgren, 1996). The power of change is then defined primarily in political and professional terms without the possibility of the targeted people to influence and control various determinants of health. Because of power imbalances and because of the low representation of women in decision-making bodies, women can seldom make their voices heard. As a result, health promotion programmes designed in a top-down manner will not necessarily correspond to women's health needs. Health promotion policies and activities are most meaningful when target communities and groups are involved in all aspects of policy and programme development, implementation and evaluation. For example, 'The Blue Nile Health Project' in Sudan with the objective to control water associated diseases was perceived as very successful, thanks to the particular emphasis in the programme on gender-related aspects that defined women's role and participation states A. Rahman et al., (1996).

Stereotypical views regarding gender can cause supervisors to engage in the illegal practice of passing a person over for promotion due to gender. While this could happen to both genders, supervisors most often pass over women for promotion due to preconceived notions about their roles and abilities. For example, a fire chief may repeatedly pass over a female fire fighter for promotion, due to resentment stemming from women applying to the force or due to a belief that men inherently performed better in these positions. Supervisors may pass over qualified males for promotions in industries that employ a high percentage of women compared to men, such as teaching positions or those industries involving care of children (Samantha, G. 2014).

2.3 Effects of gender inequalities among health workers

Inequalities could cause poverty and be a hurdle in alleviating poverty. Even in countries where there have been significant gains toward achieving the MDGs, inequalities had grown. The

MDGs had supported aggregate progress-often without acknowledging the importance of investing in the most marginalized and excluded, or giving due credit to governments and institutions which do ensure that development benefits these populations. Recognition of this shortcoming in the MDGs had brought an increasing awareness of the importance of working to reverse growing economic inequalities through the post-2015 framework, and a key element of this must be actively working to dismantle discrimination (Human rights watch, 2013).

Inequalities in employment and occupation often perpetuate poverty or make it worse. By excluding members of certain groups from work or impairing their chances of developing skills or capabilities, they were restricted to lower quality jobs. This enhanced their risk of becoming or remaining poor-which further reduced their ability to obtain jobs that could lift them out of poverty Akpokavie, (2007). Productivity was low when there was lot of partiality. Women were always beaten (not physically) but professionally, and men concentrated more on how to pull down other female colleagues than trying to climb the ladder themselves. Also, when a woman is hurt emotionally, the motivation and morale was highly reduced. This was very bad for any work environment. Therefore, they shall not be able to perform well at their job that makes productivity lower as noted by Tridiversity, (2014).

Victims of gender inequalities lose motivation and morale necessary to perform their jobs effectively. According to a report written by Jodi L. Jacobson of the World Watch Institute, gender bias also leads to a loss in productivity. Things that may lead to this loss of morale and motivation could include jokes about an employee's gender that imply inferiority, offensive jokes of a suggestive or sexual nature and jokes implying that an employee's work is sub-par due to his or her gender. Federal law prohibits this type of workplace harassment, whether by superiors or coworkers (Samantha .G, et al, 2014).

2.4 Available mechanisms to promote gender equality among health workers

The 2008 World Health Report and the WHA resolution 62.12 take forward the values pursued in the Declaration of Alma-Ata: social justice, the right to health for all, participation, equity and solidarity. The PHC policy directions aimed at achieving universal access and social protection; reorganizing service delivery around people's needs and expectations; securing healthier communities through better public policies across sectors; and remodeling leadership for health around more effective government and active participation of key stakeholders World Health Organization, (2010).

Hundreds of millions of people suffer from inequalities in the health sector. This did not only violate a most basic human right, but had wider social and economic consequences. Inequalities stifle opportunities, wasting the human talent needed for economic progress, and accentuate social tensions and inequalities. Combating inequality was an essential part of promoting decent work, and success on this front was felt well beyond the workplace. Issues linked to inequalities were present throughout the ILO's sphere of work. By bolstering freedom of association, for example, the ILO sought to prevent inequalities against trade union members and officials. Programmes to fight forced labor and child labor include helping girls and women trapped in prostitution or coercive domestic labor as stated by International Labor Organization (1996-2014).

The second Global Report on inequalities under the follow-up to the international labor organization (ILO), Declaration on Fundamental Principles and Rights at Work examines emerging issues in patterns of workplace inequalities and recent policy responses, and outlines the ILO's experience and achievements to date and the challenges it faces. It points to the need for better enforcement of legislation against inequality, as well as non-regulatory initiatives by governments and enterprises, and equipping the social partners to be more effective in making equality a reality at the workplace. The Report puts forward other proposals for future action, including making equality a mainstream objective of the ILO's Decent Work (Country Programmers' Programme for the Promotion of the Declaration, 2007).

Through international agreements, such as the Ottawa Charter for Health Promotion and the world health organization (WHO) Health for All Strategy, many countries had already committed themselves to health promotion. Likewise, most countries in the world had committed themselves to promote gender equity. These agreements stated that all women and men had the right to live without inequalities in all spheres of life, including access to health care, education and equal remuneration for equal work as noted by World Health Organization, (1981).

Many health promoting interventions with a gender perspective had focused mainly on strengthening women's and girls' capacity to better respond to, and control determinants of, health in the physical and social environment. They include gaining access to economic capital as well as social and cultural capital. The most effective interventions were those with an empowerment focus Sen and Batliwala, (2000). They aimed at helping women to: gain knowledge about, and access to, their rights; access micro-credit to start their own businesses; improve their access to essential services; address perceived deficiencies in their knowledge (including literacy and secondary education); acquire personal skills and thereby improve their health. Empowerment initiatives aim to encourage both sexes to challenge gender stereotypes. Such actions included, for example, training boys and men to reduce gender biases by promoting gender-sensitive behavior and reducing violence. Another example of such initiatives was raising awareness among young girls and their families about unfair inequalities against girls and thereby promoting the status and a value of the girl child. The Girl Child Project in Pakistan had, for example, made girls aware that unequal food allocation in the family is wrong Craft, (1997).

The internationally agreed Millennium Development Goals (MDGs) identified 'gender equality and empowerment of women' as the third of eight goals and a condition for achieving the other seven. Although, these and similar commitments had been ratified by most United Nations Member States, action by governments to bring national laws, policies and practices in line with the provisions of the ratified conventions has lagged behind United Nations, (2005).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter explains the research design, Area of study, population of the study, sample size and sampling techniques, data collection methods and instruments, quality control methods, data analysis techniques, ethical considerations, limitations of the study or anticipated constraints, references, bibliography, and appendices.

3.1 Research design

The research design that was used is cross sectional survey and the approaches that were used were qualitative where open ended questions were administered so as to get more data from the respondents and quantitative approach was basically used when it came to numbers of the respondents. During the research, both primary and secondary data was collected.

3.2 Area of the study

Kumi Hospital is a Private Not for Profit (PNFP) facility located in eastern Uganda, 300 km from Kampala. It is a rural hospital, which transformed from a leprosy centre to a general hospital in 1997

The Hospital was founded by the Church Missionary Society in 1929 as a leprosarium in response to the need for specialized work among leprosy patients.

The Hospital has grown to a 350-bed capacity providing a wide range of integrated services including Medical, surgical, rehabilitative, Primary health care, Community Based rehabilitation programmes and other specialized services such as AMREF Flying Doctor service offers VVF repairs and Reconstructive surgery. The Hospital also maintains a referral status for leprosy and TB in Eastern Uganda (Dr. Ruth Obaikol, 2012).

3.3 Population of the study

The researcher selected the medical director because he supervises daily functions at a health care facility, with the assistance of the human resource and support staff, including budgeting, patient care, and human resources needs. Medical doctors, midwives, nurses and Administrators will be selected because they are the bodies who carry out strikes whenever there is inequality in Kumi hospital.

3.4 Sample Size

The sample size was based on Kumi referral hospital. A total of 20 administrators (10 male and 10 Female), 10 medical doctors (5 men and 5 female), 10 midwives (5 female and 5 men), 20 nurses (10 men and 10 female), 20 cleaners (10 men and 10 female), 1 Medical superintendent and 10 patients (5 male and 5 Female)

3.5 Sampling Techniques

Due to the nature of the research, the researcher used purposive sampling technique on the medical superintendent and doctors because some of them were busy to attend to the researcher. Nurses, administrators and cleaners, random sampling technique was used because most of them were women and they had substantial knowledge on gender.

3.6 Data collection methods and instruments

3.6.1 Interview schedule

Key informant interviews were conducted among the doctors and the medical director using the interview guide because they were the top ranking health officials of the hospital.

The interviews that were conducted helped to get more information from the respondent through probing during the interaction between the interviewer and the interviewee. It also helped the researcher to get enough information about the topic in discussion.

3.6.2 Focus group discussion and observation

Focus group discussion and observation method was conducted among the nurses, administrators and the cleaners using the focus group discussion guide and a checklist because they were the most affected bodies in the health sector and the method enabled the researcher to get more information.

3.6.3 Questionnaire

The questionnaires were given to respondents to be self administered among the midwives because they provided services beyond their scope of care during pregnancy and birth and they

sometimes went ahead and gave medical treatment to other departments; so they were the best candidates to give views regarding the departments they were attached to.

The questionnaire enabled the researcher to collect large amounts of information and was collected from a large number of people in a short period of time and in a relatively cost effective way. The questionnaire was also used on patients, who were more affected by the effects of gender inequalities in the health sector.

3.7 Quality control methods

While in the field, the researcher took the responsibility of reviewing the questionnaires that were answered by the respondents for accuracy and completeness. This was done by the end of each day. Questionnaires with incomplete sections were sorted out and set aside to be reviewed by researcher.

3.8 Data analysis Technique

Quantitative data was collected, sorted, arranged and edited in order to identify the gaps that had been left while filling the questionnaires. It was then entered and analyzed using Microsoft excel. The data was then cleaned and analyzed in line with the research questions to seek for consistency, accuracy, reliability and relevance. The qualitative data was used to elaborate on more factual information and provided detailed examples to support the quantitative analysis.

3.9 Ethical Considerations

The researcher got consent from the respondent before involving them in the research discussions. The researcher thoroughly explained the purpose of the research to the respondents, got informed consent, voluntary participation, and guarantee confidentiality, safety and social wellbeing of the respondent.

3.10 Limitations of the study

The researcher was to conduct a study research from Kumi hospital but unfortunately she could not carry on with the research because Kumi involved along process to get an approved letter from the institution which could cause the delay of the research. The researcher therefore had to

seek for permission from her supervisor to change to another government referral hospital which was Kumi hospital in Kumi district.

Since the number of patients in Kumi was overwhelming, the medical personnel were too busy and this interfered with the research. The researcher made an advance communication with the medical personnel before going to the field.

Some respondents had unrealistic expectations which the researcher was not able to meet like money and other incentives. However, the researcher thoroughly explained to the respondents the purpose of the research and what they would expect of the researcher so that they don't expect a lot from the researcher.

The researcher expected to meet respondents who were willing to respond to some questions including others who were not willing to respond at all. The researcher informed the respondents that their participation was voluntary and very helpful.

CHAPTER FOUR

DATA PRESENTATION, INTERPRETATION AND DISCUSSION

4.0 Introduction

In this chapter the researcher presented, interpreted and discussed the research findings. Data obtained from the respondents has been processed and presented in frequency tables and figures and analyzed in percentages.

The study was based on four specific objectives which sought to examine gender inequalities in the health sector and identify strategies in place that can improve on gender inequalities in Kumi hospital, Kumi district.

4.1. Data presentation and discussions

4.1.1 Distribution of research respondents

The study had a sample size of 66 respondents who are all working in the study area. The categories of sampled respondents have been captured in the table below.

Table 1: Summary of findings on categories of the respondents of Kumi hospital

Categories of the Respondents	Frequency	Percentage
Male Administrators	10	14
Female Administrators	10	14
Key Respondent (Director)	1	4
Male medical Doctors	5	8
Female Midwives	10	14
Female Nurses	5	8
Male Nurses	5	8
Male support staff	10	14
Female patients	5	8
Male patients	5	8
TOTAL	**66**	**100**

Source: Primary Data, July, 2014

This table shows that more male than female respondents were involved in the research. This is because most female respondents were too busy attending to patients which prevented them from responding to the key informant interview guide.

4.1.2 Distribution of Respondents in terms of research instruments

The researcher used the methods captured in the table below to collect data from the field

Table 2: Summary of findings on methods used

Method	Frequency	Percentage
Interviews	46	70
Questionnaires (Patients)	10	20
Focus group discussion	10	20
TOTAL	**66**	**100**

Source: Primary Data, July, 2014

The table above shows that most respondents 70% were responded to the key informant interview and 20% responded to the questionnaire and while focus group discussion was conducted among some respondents 20%. This was because most of the targeted respondents were too busy attending to patients.

4.1.3 Distribution of Respondents in terms of research instruments

The researcher used the methods in the table below showing the research instruments given out, those which were returned and the total number that was not returned.

Table 3: Distribution of Respondents in terms of research instruments

Types of instruments	Total No. of respondents	Given output/ completed	Returned/ Involved	Total of questionnaires given out
Questionnaire (Patients)	10	10	0	10
Key Informant Interview guide	46	36	10	46
Focus group discussion	10	1	0	1
Total	**66**	**47**	**10**	**57**

Source: Primary Data, July, 2014

The target population was 66 respondents of which 57 questionnaires were given to the respondents and the 10 were returned un-completed and 47 respondents were interviewed and 10 respondents attended the focus group discussion out of 66. Therefore the researcher considered the data below to be viable for this research.

4.1.4 Distribution of Respondents in terms of gender

Table 4: Shows the distribution of respondents by gender (n=66)

Gender	Frequency	Percentage
Female	30	35
Male	36	65
Total	**66**	**100**

Source: Primary Data, July, 2014

Table 4 above indicates that 35% of the respondents were female and 65% were male. This was because the men were readily available due to their nature of seasonal/daily calendar (how the woman's daily activity schedule) which is critical in determining gender disparities and gender issues.

4.2 Gender inequality manifestations in the health sector

Under the above objective, the researcher looked at themes like; gender inequality manifestations in the health sector and the employees' opinion on gender inequality. Most employees gave their view saying that they had witnessed gender inequality in the health sector which included hiring only female in some positions such as midwives and nurses. Some gave an example of Kumi hospital where they have never had a female Administrator. The personnel at the director's office who requested to remain anonymous emphasized that they had to take deliberate move to start recruiting female employees for specific positions within the hospital to create an atmosphere for women and balanced work force.

Table 5: Existence of Gender inequality manifestations in the health sector
Respondents were asked to justify whether there are some manifestations of gender inequalities in their organization which required them to rate their response as 'Yes' or 'No' as seen in the following table

Options	Men /women		Key informants	
	Frequency	%	Frequency	%
Yes	40	95	30	100
No	26	5	00	00
Total	**32**	**100**	**30**	**100**

Source: Primary Data, July, 2014

According to the findings in table above, 95% of the medical workers and 100% of the key informants strongly agreed that several manifestations had led to the increase of gender inequalities in the health sector. 95% of the medical workers said that although most top positions in the health sector are managed by male, the health sector has concentrated so much on women empowerment and affirmative action which led to the increase of female medical employees in some departments like midwifery and nursing. This had created gender inequality because in the long run it leads to employment of undeserving or unqualified female staff that ends up being poor performers. A female respondent the researcher met in one of the wards said for time she has visited this hospital women staff were quite rare something that had created a bad picture among staff and patients but now things are much better and we hope for the best.
Affirmative preference has in reality too often been some form of corrupt decision making in which someone's personal got the job promotion. As a result an incompetent person from a designated group could find success through corruption, whereas a competent person might fail. All people from designated groups then suffered from the stigma created by affirmative action preference. It is essential that when affirmative preference is implemented, efforts be made to implement it effectively as stated by McWhirter, (1996). Susan not real name said when they applied for the current job she is doing she almost lost it because one of her fellow applicant had prior engagements with some of the "big" people in hospital something that is not fair and promote merit based competition.

Empowerment of persons who are vulnerable and excluded, promotion of social justice and equity are the main concerns of social policies, and this should transcend all aspects of society, including participation in governance and decision making. In spite of the pivotal role women in Ghana play within the family, they are invisibly represented in governance and decision making sector of the economy. This is because there are no concrete policy measures in place to ensure that the structural inequality between men and women are taken into account in promoting participation in policy decision notes Justine (2011).

4.3 Causes of gender inequalities in the health sector

Respondents gave different views on the causes of gender inequality. 33% said that affirmative action was the main cause of gender inequality in the health sector because women are looked at more than men hence leading to reverse discrimination, however an overwhelming percentage of 67% disagreed with the those who said affirmative action was the main cause of gender inequality.

During the focus group discussion, the male respondent said that, "education level, skills, and personal attitude where a medical staff develops a natural hate for a fellow and there he or she makes it difficult for a fellow staff to get a sponsorship opportunity to advance in education".

The key informant interview respondents, 60% of medical staff strongly agreed that that lower positions were occupied by women because men don't want to work in low paying departments and therefore, women take them up. This explains why lower departments in the health sector are occupied by female employees who have led to gender inequality in the health sector, difference in education level, inferiority complex by female staff, and some departments like maternity require female not male health workers.

Senior doctor (male) said, Women often work in sectors (for example in health, education, and public administration) where their work is lower valued and lower paid than those dominated by men. When we look at the health sector alone, 80% of those working in this sector are women. Another one added moreover, women are frequently employed as administrative assistants, shop assistants, or low skilled or unskilled workers-these occupations accounting for an important proportion of the female workforce. Many women work in low-paying occupations, for example, cleaning and care work. Justine, (2014)

Women entered the workforce in larger numbers since the 1960s; occupations have become segregated based on the amount femininity or masculinity presupposed to be associated with each occupation. Census data suggests that while some occupations have become more gender integrated (mail carriers, bartenders, bus drivers, and real estate agents), occupations including teachers, nurses, secretaries, and librarians have become female-dominated while occupations including architects, electrical engineers, and airplane pilots remain predominately male in composition argues Cotter et al, (2000).

Historically, gender relationships have usually been based on the subordination of women in various social spheres. Some of the mechanisms that tend to perpetuate poverty are connected with gender inequalities. For cultural and institutional reasons, often reinforced by public policies that lack a gender focus, the child-rearing burden is not distributed equally in the family and tends to fall disproportionally on women. This bias is one of the factors that reinforce the subordinate role of women and, consequently, gender inequality. According to much recent empirical research, one of the factors that most protects two-parent families against poverty are that the two members of the couple work. The greater and largely unwanted fertility of the poor is one of the obstacles of a gender system that tends to perpetuate the traditional roles of women and, at the same time, inhibits one of the main mechanisms for fighting poverty-the participation of women in the workforce as noted by UNFPA (2014).

4.4 Effects of gender inequalities among health workers

The question on the effects of gender inequalities presented to key informants, the respondents said that poor service delivery, harassment by top managers, staff demoralization and poverty which has greatly contributed to the effects of gender inequalities.

Discrimination is a lifelong tax on women's self-esteem and capabilities. Gender discrimination thwarts women's aspirations and restricts their opportunities. It denies them the experience that will build competence and self-direction, and enable equal partnerships with men. According to the woman councilor in this ward she said that, the nature and way our society is structured is biased because it is respects and responds to men not women. She added that it is a patriarchal society which gives men dominion over women something that denies women access to equal opportunities and services.

The restrictions placed on women can produce a state of "learned helplessness" typical of clinical depression. Women suffer disproportionately from depressive syndromes, which are the most important contributors to the global burden of ill-health notes Murray, C. et al, (1996). Gender inequality pervades the world. In considering the dimensions of economic gender inequality, women still make less than men in the formal work sector, are more likely to live in poverty, are less likely to participate in the formal work sector, and do a larger share of work in the household sector. The dimensions of political gender inequality include women's lower representation in elected office and lower representation in political and corporate appointments.

Social gender inequality has numerous dimensions, some of which are less favorable to men while others are less favorable to women: men are more prone to violence, imprisonment, and disability, while women are more likely to be the victims of domestic violence and sexual assault; in some countries men have lower educational attainment than women, while the pattern is reversed in other countries as noted Joyce (2011).

Table 6: Available mechanisms to promote gender equality among health workers of Kumi

Responses	Men /women	Questionnaire		
	Freq	%	Freq	%
Advocating for women empowerment	40	100	20	100
Advocating for men's empowerment	10	31.3	15	83.3
Advocating for equal opportunities	60	100	30	100
Considering gender equality when recruiting	50	100	40	100

Source: Primary Data, July, 2014

The findings highlighted different ways in which health sector employees are involved are in gender inequality and they want mechanisms to reduce inequalities to be set in Kumi hospital some of the mechanisms suggested by patients included; Advocating for men and women empowerment, giving equal opportunities to staff, considering gender equality during recruitment. Health workers also gave their views of promoting capacity building of the health staff and giving promotions on merit not according to sex, create rules and regulations that govern health employees in relation to gender as stated by IFAD, (2012).

It was noted that evidence demonstrates that, in economies where gender equality is greater in terms of both opportunities and benefits; there is not only higher economic growth but also a better quality of life. Addressing gender inequalities and empowering women are vital to meeting the challenge of improving food and nutrition security, and enabling poor rural people to overcome poverty.

4.5 Socio-demographic data

The study population was characterized by mainly medical staff and support staff because these were groups of people who were expected to give reasonable responses. Most of the respondents 80% were medical staff.

Most of the respondents were male 60% probably because most managerial positions are headed by male staff and they are the ones who are more affected by gender inequalities.

80% of the respondents said that gender inequality prevailed in the health sector most especially Kumi hospital where some departments like midwifery and nursing is dominated by women. 20% were in disagreement that gender inequality is at a minimal rate because women deserve to work in midwifery, nursing and more so lower positions because they are supposed to be managed by male employees.

A majority of the respondents were male health staff 60% and this is in line with characteristics of the health sector where most managerial positions are managed by male.

4.6 Conclusion

The findings indicate that women and men are concentrated in male and female jobs in the health sector. This includes the concentration of men at top occupational hierarchies and women at the bottom. The data collected from Kumi hospital shows that 70% of the top jobs are occupied by male and women occupied 30%.

There is evidence of unequal opportunity for career advancement for female health workers, positive beliefs about men as managers, negative beliefs about women as managers and perceptions of family responsibilities as factors hindering career advancement.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presented the summary of the findings, conclusions and recommendations of the study. The Summary of the findings, conclusions was drawn from the findings followed by recommendations on the study and suggestion for area of further research.

5.1 Summary of the findings

The summary of the findings were based on the research objectives as shown below. The study was based on four specific objectives which sought to examine gender inequalities in the health sector; a case study of Kumi hospital, Kumi district.

5.1.1 Gender inequality manifestations in the health sector

In reference to question two, data was collected from different respondents that were both the men and women and the patients. Research findings indicated that gender inequalities in the health sector do exist in Kumi hospital. 100% of the health workers 80% of the key informants agreed.

The findings also revealed that some health employees were aware of the gender manifestations in the health sector as stated by 95% of the key informant respondents who strongly agreed.

In a similar view gender equality in managerial positions and active participation in decision making during meetings, shows that men and women were aware of existing gender manifestations in the health sector. On the other hand 5% of the employees disagreed that they were not aware of any gender manifestations in the health sector.

However, the researcher summarized the following to Gender inequalities in the health sector in Kumi hospital; Education levels, experience and skills, salary, and recruiters being biased against certain workers. This may require un-biasness during recruitment, equal opportunities to further education because these are the issues causing gender inequalities in the health sector.

5.1.2 Causes of gender inequality in Kumi hospital

Research findings from Kumi hospital indicated that women are more employed in lower positions and earning low salary wage than their male counterparts' according to 60% of the

female respondents. Women are the largest number in the hospital but most of them work under the management of a man, and 80% of the key informants strongly agreed that the education level is the major cause of gender inequality in the health sector although 20% of the respondents disagreed with the low salary wage being given to women, they said that, salary is given according to one's position. And also when it comes to education advancement, all are given the opportunity. However according to Omoding Joseph who is one of the support staff, he said the education opportunities were given to some individuals not all as some few respondents had said. Other respondents also said that gender inequality was also caused because of lack of commitment by some medical staff, personal interest and attitude, some to managers my deny others opportunity for salary increment and promotions which made them to remain in the same positions for several years yet those who are newly recruited are almost promoted on a yearly basis hence leading to the increase n gender inequality in Kumi hospital.

The findings also indicated that gender roles is also another cause of gender inequality where 90% of the patients said that a female nurse has to first take care of her home before she comes to attend to them, this however did not mean that they reported late to work, despite of their gender roles they try as much as possible to keep time and attend to them. Unless one's child is sick which they as patients could understand.

In the questionnaire, 70% of the respondents who were patients said that despite the female gender roles, the nurses never showed any negative attitude towards them; they were very good and kind to them. 30% of the respondents disagreed saying that most female nurses first take care of their family needs before they come to attend to them and this caused their performance to be low.

The research finding also indicates that most female staff often take maternity leave, this leaves a lot of work undone. 80% of the male respondents said that female staff could not manage the top management positions because at least every year about 10% of female are on maternity leave; this affects their availability in the workplace.

5.1.3 Effect of gender inequalities among health workers

In reference to this question, research findings indicated that causes of gender inequality had effects which among them included poverty because unequal pay, lack of motivation and morale

necessary to perform the duties which leads to low or loss of productivity which is caused by low salary pay, no promotions and sexual harassment by senior staff.

According to research findings 50% of key informant respondents said that led to some health workers being marginalized discrimination and work overload to the junior staff which is caused by unequal treatment, this however demoralizes the employees hence leading to low performance and 50% of the respondents strongly agreed.

5.1.4 Available mechanisms to promote gender equality among health workers of Kumi hospital.

The respondents had different mechanisms to improve gender equality in the health sector. They included; promoting interventions with a gender perspective with a focus mainly on strengthening women's and girl's capacity through providing opportunities for further education; encouraging women to participate in various health functions so they can build their capacity, making all health sector jobs to be open to both sex, empowerment of both men and women; encouraging health staff to go for further training, employing staff on merit not basing on technical know who, and also giving them an opportunity of attending different workshops.

5.2 Conclusion

Kumi being an upcountry hospital, lower departments are dominated by female staff.

Medical staff had largely positive understanding that women empowerment provides the means to equalize opportunity and promote greater gender equality in the health sector workplaces.

Some health workers appear to experience work family-conflict, without a range of family friendly policies to mitigate it for instance, there may be a policy on pregnant women but one may take a leave for few days and opts to report to duty before she completes her leave because of heavy workload.

Uganda's policy and legal framework has not been operationalized in the district and health facilities, but could equalize opportunity and promote greater gender equality in the health sector workplace.

5.3 Recommendations

The health sector should provide a staff development and mentoring for female staff in order that they might better compete for higher management jobs.

The government should implement a gender policy, strategy and guidelines for the health sectors using a decentralized approach.

The health sector should develop a reader friendly "know your rights" booklet for health sector workers for increased awareness creation.

There is need for the health sector to integrate activities to promote equal opportunity and gender equality in the health sector action plan.

There must be a deliberate move to sensitize the communities to offer study opportunities to both boys and girls and to change society's perception on girl child education. To create deeper understanding of gender inequalities in society and the implications behind them

5.4 Suggestions for further research

The impact of gender inequality to patients in the health sector

The type of policies governing health workers in the health sector

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APPENDICES

Appendix 1: Focus Group Discussion (To be administered to nurses and cleaners)

Introduction

I am Ojepa Kokas a student of Kampala International University, carrying out a research entitled **"Examining gender inequalities in the health sector. Case study: Kumi Hospital, Kampala District.**

The purpose of this study is to examine gender inequalities in the health sector. This will help the researcher to identify various causes of gender inequalities and available mechanisms to promote gender equality in the health sector.

You have been selected as a respondent, the information you give will be handled with confidentiality. Please try to be as objective as possible.

Ice breakers for 5 minutes

Discussion Questions

1. Based on your experience, do you think employees are treated differently at the health setting?
   a) If yes, how are they treated differently?
   b) If no, how are they not treated differently?
2. What contributes to gender inequality at the health sector?
3. What are the effects of gender inequality among health workers of Kumi hospital?
4. What happens if it is noticed that some staff receive more pay than others yet they are in the same department and carrying out the same tasks?
5. Do the experiences of employees working in Kumi hospital differ?
   Please explain.
6. Do all employees of Kumi hospital have equal say during the meeting?
7. Do you think it is important that all employees have same opportunities at the health sector? Please explain why you think this way.
8. What are the available mechanisms for promoting gender equality in the health sector?
   Please give some examples.
9. What do you think the government could do to promote equality in the health sector?
10. Have you ever taken actions in health related problems in the health sector?

Appendix 2: Key Informant Interview Guide (To be administered to the medical director, medical doctors, administrators and midwives)

Introduction

I am Ojepa Kokas a student of Kampala International University, carrying out a research entitled **"Examining gender inequalities in the health sector. Case study: Kumi Hospital, Kampala District.**

The purpose of this study is to examine gender inequalities in the health sector. This will help the researcher to identify various causes of gender inequalities and available mechanisms to promote gender equalities in the health sector.

You have been selected as a respondent, the information you give will be handled with confidentiality. Please try to be as objective as possible.

Section I: General questions

1. Have you witnessed gender inequalities in case of other employees in Kumi hospital? If yes, in which form of gender inequalities? Answer: Yes/ No.
2. In your opinion, what factors do you think are mostly responsible for gender inequality in Kumi hospital? .....
3. Do you receive equal payment for equal work done? Answer: Yes/ No
4. Is gender equality considered during the staff recruitment?
5. What are the effects of gender inequality?
6. Does the Ministry of health make decisions to promote equal opportunities for all staff regardless of gender? Yes/ No. if yes how?
7. What mechanisms has the ministry of health put in place to promote gender equality?
8. How does your role provide opportunity for you to promote gender equality and equal opportunity in the health sector during recruiting and promotion of staff?
9. In your view, do employees have equal chance of being hired for a position of responsibility for which they are qualified?

Section II

10. Do you agree or disagree with this statement: if doctors devote most of their lives to their careers, then it is only fair that they should advance more quickly in their jobs than nurses.
    a) Agree ..... b) Disagree
    c) Please explain,

    .....
    .....
    .....
    .....

11. Do you agree or disagree with this statement: Male subordinates find it difficult to work effectively under women, so it is better to hire men into management jobs.
    a) Agree..... b) Disagree
    d) Please explain
    .....
    .....
    .....
    .....
12. Do you agree or disagree with the following statement: different treatment in hiring is necessary to combat past and present institutional inequalities in the health sector.
    a) Agree ..... b) Disagree .....
    e) Please explain.....
13. "Affirmative action is a form of reverse gender inequality".
    a) Agree ..... b) Disagree .....
    f) Please explain.....
    .....
    .....
    .....
14. "Affirmative action policy often puts managers in the position of hiring non- deserving or unqualified people in the health sector".
    a) Agree ..... b) disagree .....
    C) Please explain.....
    .....

Appendix 3: Questionnaire (To be administered to patients)

Introduction

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Circle the correct answer

1. Sex (a) Male (b) Female
2. How old are you?
   1.1.18-25
   1.2.26-35
   1.3.36- 45
   1.4.46 and above
3. How long have spent in this hospital?

a). 1-3 week b). 1-2 months c). 3 and more months

4. According to your condition, how fair have the medical staffs been treating you?

a). Extremely fair b). Very fair c). Quite fair d). Very unfair

e). Not sure

5. In your opinion, which of these statements is true?

a). Female nurses are denied access to further education

b). Female medical staff are taken up by family gender roles

c). Health sector gives unequal pay to medical staff who perform the same tasks.

6. Do you think gender roles like taking care of family issues makes female nurses to be low performers?

a). Yes, b). No

7. How true is this statement? "Women empowerment has increased gender inequality".

a). Very true b). True c). Not true 4. I don't know

8. Which of these statements is true?

i. The health sector advocates for women empowerment
ii. The health sector advocates for men empowerment
iii. The heath sector gives equal opportunity to its staff
iv. The health sector does not consider gender equality when recruiting

9. In cases where the nurses don't attend to you on daily basis because of gender related issues; have you ever taken action to tell the medical director?

a. Yes, many b. Yes some few c. Not at all

10. How much attention do patients pay to ensure respect with the medical staff?

a. Very much b. Sometimes c. Not at all