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Gender in Nepal's health sector

Mahesh Puri and colleagues find little gender equality or transparency surrounding gender in the health sector in Nepal

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Gender means different things to different people. At its crux, gender is a construct to bring order to social relationships and institutions, and most often to rationalise and perpetuate the unequal distribution of power. It is a building block in the structure of our social and political systems. Health is no exception.[1]

As professionals who have spent decades researching, reporting on, and raising the issue of gender inequality in forums from the local to the global levels, we're still regularly dismayed by how often gender and health gets ignored—both in terms of its influence on health outcomes and impact on the health workforce.

Health systems around the world share a range of gendered characteristics—in divisions and valuations of labour based on gender, in reinforcing male dominance-female submission dynamics between practitioners and patients, and in its body of knowledge in which gendered assumptions, language, and categories are deeply embedded. We know too that the dynamics of power and privilege in the health sector are compounded by other social stratifiers—including class, origin, ethnicity, caste, and nationality—with the result that leadership of the sector is frequently not as diverse and inclusive as the populations it seeks to serve.[2]

The Nepalese health sector, as in many other contexts, has a highly gendered division of labour: women make up 99.8% of all nurses in the country, but just 30% of doctors. While not governmental staff, by definition all of Nepal's Female Community Health Volunteers are women, a critical yet unremunerated role, thus further widening the gender pay gap resulting in a health system which functions in part on the basis of women's unpaid labour.[3] Although women hold around 41% of the local government positions, most women are in subordinate positions with little access to decision-making power. In the civil service, women hold just 25% of all positions.[4]

There are high opportunity costs to a lack of diversity in leadership. Women's leadership can expand programming for issues that have the greatest impact on women and girls.[5] Organisations with diverse leadership outperform non- or less-diverse competitors.[6] This goes beyond representation—diverse and non-discriminatory leadership can improve health policies and outcomes for everyone.

How can we as practitioners, researchers, and advocates demand attention and action on gender equality? A recent report on the health sector in Nepal, conducted by the Center for Research on Environment Health and Population Activities (CREHPA) and Global Health 50/50, sought to answer that question.[7] Specifically, the report responded to calls from national policy-makers for an accountability framework to fully understand the state of gender equality in Nepal's health sector.

Nepal has a supportive legal and policy environment to promote gender equality in the health workforce. For example, the Civil Service Act 1993 and Nepal Health Service Act 1997 provide the legal basis for increasing the participation of women employed in the civil service and in government health facilities, but our analysis finds that 89% (25/28) of the senior management of the Ministry of Health and Population are men.[8 9] Women's careers may be protected in law, but over half (17/30) of the maternity leave policies assessed do not meet the legal minimum entitlement 14 weeks of paid maternity leave, including 10 of the 11 national NGO policies. These findings suggest that commitments—or even law—do not necessarily translate into actions or equitable outcomes for men and women.

Beyond gender, two-fifths (11/29) of the Nepal offices of global health organisations are led by Nepalese nationals and only two are led by Nepalese women. This represents a failure to fulfil commitments towards national ownership of health systems as set out in the Paris Declaration (2005) and Accra Agenda for Action (2008). As Seye Abimbola and colleagues have written, "All global health organisations (in the global North or global South) must [...] ensure that their leadership and staff are diverse and gender balanced without which global health organisations are bound to fail in their mission.[10]

Despite our efforts to better understand whether and how organisations in Nepal are addressing goals of equality and diversity we were thwarted in fully doing so due to a lack of transparency—the crucial documents are simply not in the public domain. Of the 30 national NGOs surveyed, only two had workplace gender equality policies that were publicly available. No reference to policies or programmes for the advancement of women in the workplace were found in 13 of the 30 NGOs.

Without gender equality and a more diverse and representative health leadership, health for all will remain an elusive goal. Achieving that goal requires more than good laws and policies—these are the bedrock, but implementation relies on transparency and accountability which are the cornerstones of good and effective governance for state and non-state institutions whether at the global, national, or local levels. Transparency ensures that the decisions and actions made by elites in the name of population

health and wellbeing are available for public scrutiny. Independent monitoring, as reflected by our research, can play an important role in improving transparency, promoting accountability, and leading to organisational change. Many global health organisations have begun to engage in action to promote equitable change at the global level, this report shows that calls for equity, transparency, and accountability cannot go unheeded at the national level too.

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