

## Alleviating the Burden of Responsibility: Men as Providers of Community-Based HIV/AIDS Care and Support in Lesotho

Constance Newman, IntraHealth International/Capacity Project

### I. Introduction

The desired outcomes of all gender-related actions in human resources for health (HRH) are improved service delivery and health equity<sup>1</sup>, both for workers and for the communities they serve. As it worked to strengthen HRH systems to implement quality health programs in developing countries, the Capacity Project—a USAID-funded global project that focused on planning, developing and supporting the health workforce—examined how gender inequalities affect women's and men's opportunities for education, training and occupational choice and participation in the health workforce.

Occupational segregation by gender has been recognized worldwide as a major source of inequality, labor market rigidity and inefficiency (Anker, 1997; Anker et al., 2003) that impedes the development of robust health workforces. In the era of HIV/AIDS, this makes for inequities, inefficiencies and missed opportunities by creating barriers to health workforce entry and limiting the possible pool of formal and nonformal health workers. In Lesotho, as in many other countries, the HIV and AIDS care burden falls on the shoulders of women and girls in unpaid, invisible household and community work. This gender inequity in HRH needs to be addressed to ensure fair and sustainable responses to the need for home- and community-based HIV/AIDS care and support. The Capacity Project addressed these issues through a study of men as providers of HIV/AIDS care and support.

### II. Background and Rationale

Many men in Lesotho have been attracted to mining jobs in South Africa, but as these jobs have disappeared, and as the demand for more workers to respond to community-based HIV/AIDS care and support needs has increased, the Government of Lesotho has increasingly become aware of the need to move beyond traditional divisions of labor and multiply the number of hands to do the work of caregiving. Lesotho has the third highest HIV prevalence in the world, at 23%, and the fourth highest rate of tuberculosis incidence, with a growing problem of multi-drug-resistant tuberculosis. These high rates create an enormous caregiving burden on both the formal and nonformal (mostly female, volunteer and unremunerated) health workforces of Lesotho.

Lesotho's Gender and Development Policy (Government of Lesotho, 2003) identified the problem of *gender stereotyping* as a limiting factor for boys' and girls' career prospects as well as for HIV/AIDS caregiving. The policy recommended that "[t]he government should advocate for the improvement and expansion of gender-sensitive home-based health care service delivery with particular attention to HIV/AIDS affected and infected persons to alleviate the burden of responsibility on women." At a 2007 national symposium on community-based worker systems, the first lady of Lesotho noted that 92% of community-based workers are women, which "points to the challenges and gender dynamics of the subject of community-

based work in Lesotho, a situation I hope will be addressed in the nearby future." The Capacity Project assisted the Lesotho Ministry of Health and Social Welfare (MOHSW) to strengthen its capacity to respond to the HIV/AIDS pandemic by conducting a study<sup>2</sup> to understand the gendered division of labor and the dynamics of caregiving in three districts of Lesotho and to identify sustainable, *gender redistributive*<sup>3</sup> approaches to recruit, train, support and retain men in jobs traditionally considered the province of women.

#### Why Is Occupational Segregation a Problem for HRH?

Occupational segregation by gender usually reflects unequal opportunities and has been shown to be "strongly related to inequalities in pay, career prospects, and employment protection." It has also "proved to be one of the most profound dimensions of labour market inequality (compared with, say, race or class) and the most enduring" (Scott, 1994). Occupational segregation is particularly detrimental to women in terms of how they are perceived and how they perceive themselves, their educational and training opportunities, their status and salary, income inequality and ultimately, poverty (Anker, 1997).

Despite the fact that women generally comprise the majority (between 65%–85%) of workers in the health sector, they generally occupy lower-level cadres, usually in the informal care economy. They also often experience gender hierarchies in management, which result in differences in pay



*The burden of HIV and AIDS care has dehumanized women; it has feminized poverty and turned women into workhorses in the name of volunteering and caring for the community.*

—Augustine Chella, Voluntary Service Overseas (VSO), Zambia

### Key Term

**Occupational segregation:** *A pervasive and widely documented form of gender discrimination that concentrates women and men in different occupations, jobs and tasks. It refers to "the division of labour, in the context of paid employment, as a result of which men and women [...] are channeled into different types of occupational roles and tasks, such that there are two (or more) separate labour forces" (Marshall, 1998). Women are confined in a narrower range of insignificant, low paid jobs, often so-called caring or nurturing occupations such as nursing, social work or teaching (horizontal segregation) or in lower grades of work (vertical segregation). Men are typically concentrated in technical, diagnostic, managerial or strength-based occupations such as scientists, physicians, managers, police or firemen. Men and women may be given different tasks in the same job.*



and promotion (Ogden et al., 2006). Gender inequalities are particularly acute in HIV/AIDS care (90% of which is provided in the home), with women and girls making up the informal (invisible and mostly unpaid) care workforce (ibid.; Sen et al., 2007). It has been estimated that two-thirds of primary caregivers in households in South Africa are female, one-quarter of whom are over 60 years of age, and 7% of whom are under 18 (Steinberg et al., 2004). Researchers have noted that "Although the role that men and boys may be playing as providers of care in the context of the HIV/AIDS epidemic has been poorly documented and inadequately understood, it is generally recognized that women and girls are the principal caregivers in the vast majority of homes and bear the greatest degree of responsibility for the psychosocial and physical care of family and community members" (Ogden et al., 2006; see also Lindsey et al., 2003). Greater responsibility for care is accompanied by greater social, physical and psychological/emotional stress, and lost opportunities for education, careers and income (Lindsey et al., 2003; Sen et al., 2007; Ogden et al., 2006). Community health workers and other women who assume HIV/AIDS care and support responsibilities have found that their jobs are not seen as legitimate *vis à vis* the formal health system, resulting in less access to support and training (Reichenbach, 2007). It should be noted that the women who are engaged in volunteer, unpaid caregiving have less access to social protections such as insurance, social security, leave or pensions because these are typically tied to paid employment status (Sen et al., 2007).

### Occupational Segregation and Stereotyping

Occupational segregation is sustained by stereotypes and prejudices concerning the roles of men and women which are embedded in and promoted by policies, laws, custom and educational curricula. Gender stereotypes that characterize women as nurturing or not suited for leadership, and men as breadwinners or natural leaders, have been documented in many parts of the world. Such stereotypes rationalize the gendered division of labor in households and in formal and informal work (ILO, 2004; Newman et al., 2008, ILO International Training Center, 2008).

In the global literature, researchers differ about the intractability of the gendered division of labor and its related masculine and feminine stereotypes. There is evidence that "both sexes appear to possess sufficient psychological flexibility to accommodate a wide range of socio-economic roles" (Letuka et al., 1998; also see Wood and Eagly, 2002) and that "each sex's behavior is [...] responsive to contextual influences."

Yet there is also evidence to suggest that women are more likely to test and assume new gender roles (e.g., integrate into "male" occupations or assume male-identified gender tasks like "breadwinning") because, for them, this usually represents an improvement of status (England, 2006) and because women may be forced to assume new roles for economic reasons (personal communication with Michal Avni, United States Agency for International Development, January 2009).

Research demonstrates that because "women's jobs" are undervalued and undercompensated, men are less likely to want to enter these occupations. Beliefs, stereotypes and behavioral norms<sup>4</sup> about what constitutes appropriate work for men and women further impede the crossover of women into male-identified occupations and men into female identified-occupations.

HIV/AIDS caregiving is a gender-segregated job in which unpaid "women's work" in family structures translates into unpaid care for others in the community (England, 2006).

Since society appears to devalue women's work, there seems to be little incentive for men to enter such female activities. Both recent international discussion (UN Department of Economic and Social Affairs, Division for the Advancement of Women, 2008) and sociological research point to a "greater resistance to change that involves men taking on traditionally female activities (care of children) than to change that involves women taking on traditionally male activities" (England, 2006).

Some argue that gender plays such a powerful role in the organization of social relations, and is such a *fundamental* "organizing principle of (status) inequality in society" (Ridgeway, 2006) involving the devaluation of women—and, by extension, the activities and characteristics associated with women—that gender desegregation<sup>5</sup> of female-associated health jobs will fail if men lose respect, status and money for doing "women's tasks" (England, 2006). While there is evidence to suggest that men's entry to female-dominated occupations may be most directly influenced by the possibility of social mobility (Lupton, 2006), others argue that men's full integration in both family child care and caregiving jobs such as nursing or HIV/AIDS care and support would require early, deliberate and sustained public education, and that interventions to transform men's and women's gender roles would likely meet with resistance unless particular kinds of social support are brought to bear to effect and sustain transformation.

Men's entry into HIV/AIDS caregiving offers an important opportunity to mitigate health workforce shortages. The value of

bringing more men into the workforce is clear, especially for societies with high HIV prevalence (Reichenbach, 2007; see also Ogden et al., 2006). However, little actual data are available on the *willingness* of men to perform this role, and long-term results from interventions to increase the number of men in caregiving are elusive, even though there is positive evidence that some men do enter the gender-segregated HIV/AIDS caregiving job<sup>6</sup>.

Careful evaluation of the impact of increasing the number of men in female-dominated professions is essential. Women may be subject to greater and unfair competition for leadership roles and job openings (Standing, 2000; see also Anker et al., 2003). Men sometimes carry gender privileges and status advantages with them into female-concentrated occupations. Advancement into management (Warming, 2005) and higher pay may accrue faster for men than women in female-dominated occupations. This may be especially true in societies where women have not made inroads into male-dominated occupations and must continue to rely on "female" jobs to make a living<sup>7</sup>.

### III. Study Purpose and Methodology

The goals of the study were to strengthen the capacity of Lesotho's health system to address the HIV/AIDS pandemic at the community level by increasing the active engagement of men as providers of community home-based health care (CHBC), alleviate the burden of care on women and provide a model for employment alternatives to men laid off from the mining industry.

The specific objectives of the study were as follows:

1. Determine the need to bring men into community home-based care and support for HIV
2. Determine the feasibility of engaging men as providers of community home-based HIV/AIDS care and support, especially the gender-related and cultural factors that need to be addressed to increase male involvement in community-based care, based on an analysis of gender relations in Lesotho
3. Identify factors that facilitate or hinder substantive and sustained male involvement in community home-based HIV/AIDS care and support.

Data collection took place during February and March 2008 in villages, health clinics and hospitals across three districts in Lesotho chosen to represent two ecological zones (lowland and highland), to contain both rural and urban sites and to achieve MOHSW and Christian Health Association of Lesotho representation. The study used qualitative methods, including 25 key informant interviews with village chiefs, nurse clinicians

and hospital administrators and 31 focus group discussions with community health workers, community men and women, miners and HIV-positive men and women. Of the total 244 study participants, 70% were women (n=171) and 30% were men (n=73).

We obtained consent from all participants before data collection. Interview questions focused on the need for and feasibility of involving men in CHBC and the facilitating and hindering factors. Interviews and focus group discussions were audiotaped, transcribed, translated and coded for analysis. All interview and focus group texts were coded according to thematic categories. The results were also analyzed by gender analysis domains, particularly the beliefs, attributed knowledge, perceptions and stereotypes regarding men and women in caregiving; household and domestic division of labor and caregiving practices; and the use of time and space, including whether some spaces were “off limits” to men as HIV/AIDS caregivers.

#### IV. Study Results

##### Objective 1: The Perceived Need for Men in CHBC

Respondents uniformly agreed there was a need to increase the corps of CHBC providers to deal with the heavy workload from increasing numbers of patients, and that because of insufficient labor power, the current volunteer force was overloaded. Some villages had one health volunteer or none at all, leaving large gaps in care provision. Respondents said that young volunteers often got “fed up” from being overworked and undersupplied. Respondents who were CHBC providers themselves noted that it took a great deal of time to care for the sick, leaving little time to earn money or provide for their own families. They expressed the need to increase the number of people involved in caring for sick people, including people affected by HIV/AIDS—a need for “more hands to do the work.” There was recognition that changing times require a change in caring practices. From the community men’s focus group came this observation: “In our tradition, there are things which are the responsibility of women, and caring for sick people is one such thing. It is obvious, though, that because of changing times and new diseases, both men and women should unite against HIV/AIDS.”

##### Objective 2: Feasibility of Engaging Men as Providers

**Gender stereotypes and status beliefs related to caregiving.** Beliefs about essential male and female traits and gender status reinforced the inequitable division of HIV/AIDS caregiving labor in Lesotho. Both male and female respondents cast women as “natural” family caregivers with inherent traits of nurturance, altruism, sympathy, patience and self-sacrifice

that extended into voluntary community care. According to female focus group respondents, women are “able to bring up a child...able to sweet-talk patients” and “good at begging...submissively till he does what he is asked to do.” According to male key informants, “Women in nature are nurturing” and “have courage, sympathy and patience. They do not choose people, but help anybody who needs care.” Some respondents recognized that women are socialized to be caregivers in the context of family life, while men are not socialized for this role. Respondents saw HIV/AIDS caregiving as a natural outgrowth of caring for children and families. Caregiving provided a source of competence, power and identity for Basotho women<sup>8</sup>.

It is important to note, however, that the community health worker (CHW) job in the era of HIV/AIDS is also felt as an unsustainable burden that makes it unattractive to younger women.

That workload is heavy, because as it is we also serve that other village because there are no CHWs there. Let me mention the tasks and problems we usually have to handle. You could be called to go and assist a delivering woman, while you are still dealing with that, you are told that a group of men were involved in a quarrel and sustained injuries which require quick attention. Your family needs have to be attended to as well. Then in the end, one is overloaded that none of these tasks is completed satisfactorily. (CHW focus group participant)

An expectation that men be money-earners served as a barrier to men’s participation in CHBC, even in times of unemployment. While women may work for free, men will not, and voluntary caregiving is to be avoided because it is inconsistent with an ideal conception of men as breadwinners. According to a participant from the village men’s focus group, “the job without incentives is a mockery.”

Men are expected symbolically to fulfill their role in the home, or in caring for the sick, by “donating” money, even if it is a small amount.

The results also suggested that voluntary HIV/AIDS caregiving is associated with undesirable tasks that lower the status of women’s unpaid domestic labor.

Women do many things to such a person. They wash him or her, they put on gloves when they handle patients’ dirty blankets. (Village women’s focus group participant)

When my stomach is running a man will not wash those clothes but women can do that. Men run away. (Village men’s focus group participant)

However, “first aid” constituted a form of men’s caregiving that was perceived by men as superior to women’s family caregiving. Men’s first aid experience, related to mining in South Africa, was associated with saving lives and assumed “masculine” traits of courage, dignity, bravery and discretion. First aid was a male-identified technical skill distinct from women’s natural caregiving in the domestic sphere—something that men do better than women and that gave men superiority over women. According to some ex-miners, “men even know ‘First Aid’ which is why they know which blood vessels to close in order to control bleeding. That way they save lives;” and “Women know nothing about ‘safety’ so we are above them.” Caregiving as first aid was a source of competence, apparently compatible with the gender identity of Basotho men who had worked in the South African mines.

**Acceptability of men as caregivers.** While much of the data reflected both male and female respondents’ perceptions that men are fully capable of doing various CHBC tasks and that men would accept the caregiver role under certain conditions (i.e., being selected, paid and trained), there was a widely held perception that the extent to which men would be *accepted as caregivers* was circumscribed by tradition and culturally defined “male” traits. For example, men face traditional prohibitions against entering the room of a nursing mother, providing care to a daughter-in-law or entering the place of women’s traditional dance—spaces where “women need to be alone.” Equally important, both male and female informants appear to mistrust men’s motives. Female respondents revealed a tension between men’s perceived unbridled sexual appetite and women’s intense feelings of sexual modesty and decorum. Female respondents placed themselves in the role of the patient when considering men’s participation in HIV/AIDS caregiving and expressed a high degree of anxiety about their bodies being exposed to men, and women’s vulnerability to sexual exploitation in particular, since men are perceived as capable of dishonesty, hypocrisy, untrustworthiness and unscrupulousness when it comes to sex.

It is not acceptable, really, because men are not trustworthy people because he can pounce upon you irrespective of your condition, no matter how sick you are. (Village women’s focus group participant)

When he gets to the patient if he finds her recovering and in a better situation he can be attracted and then creep into the patient’s blankets. (Village women’s focus group participant)

A female patient will not be comfortable with male home-based caregivers reaching

for her private parts in any way. (Village women's focus group participant)

Men have promiscuous minds. They think of nothing but adultery when they see women. (Village women's focus group participant)

However, men's perceived womanizing would not necessarily preclude men's intimate caregiving inside their own families, nor would it preclude men working with women on tasks for which there were no cultural prohibitions. The perceived advantages and disadvantages of men as caregivers included men's physical strength to lift, turn and transport patients, the notions that male patients feel more comfortable being bathed by other men, that men keep secrets, that men communicate better with men, that men have courage, can venture into dangerous places and some men are skilled at first aid. There was a strong preference by both men and women for involving men as same-sex providers for men, and for not involving men as providers of intimate care for women outside their families.

Male respondents did not report being *unwilling* to participate in CHBC, but cited as impediments women's traditional caregiving responsibility, their own reticence to intrude on the women's preserve of community health work and their interest in paid work and incentives.

No man wants to work without incentives...If only some small amount of money could be given, I am sure men would be interested. (Village men's focus group participant)

Female respondents were aware of the importance of pay in men's caregiving:

It looks like men have a problem because caring for the sick is done by volunteers. Men want to be paid for whatever work they do. At present there is no pay. People are working for nothing. (Village women's focus group participant)

The data suggested a pattern of recruiting practices that may have inadvertently excluded some willing men from the voluntary CHW position, though national-level stakeholders did not agree that men had been excluded from CHW recruitment. It seems probable that women have been selected as CHWs not only because they are seen as naturally equipped for caregiving, but because women have volunteered these services, or at least have not refused to work for free. Generally, communities appear to expect women to work for free and to exempt men from voluntary CHW work even if they are unemployed.

**Gendered division of labor.** The study demonstrated differences between beliefs about the appropriate work of men and

women and the real gendered division of labor in households, especially tasks that may be associated with CHBC. Some male focus group respondents reported high rates of doing household tasks such as obtaining water and firewood, preparing food and washing clothes. Fewer men reported providing child care and even fewer reported being engaged in caring for the sick in the family, but overall the data showed that men were *already* involved in some female-identified domestic and household activities associated with CHBC. The data also showed that women engaged in tasks associated with CHBC at higher rates than men, and that despite the widely held belief that earning money was "men's work," more women than men reported earning money (i.e., were "breadwinners"). Together, the data suggested that there is some gender integration for domestic and household tasks associated with CHBC, which represents an opportunity to reinforce men's practice and skills in these areas.

### **Objective 3: Hindering and Facilitating Factors in Men's Participation**

Both men and women cited public ridicule as a response to men's public displays of caregiving. First, men were said to be masquerading as nurses ("Some people in the villages ridicule them saying they are inquisitive and pretending to be nurses who are not paid, who cannot provide medication for them. Such sayings de-motivate them."). Second, men were seen as effeminate for being involved in tasks associated with "women's work." Peer pressure stigmatized men who crossed into the "ridiculous" feminine social identity of caregiving and were no longer available for masculine pursuits like beer drinking. From the CHW focus group came the observation that "I once heard men ridicule another for taking 'under 5' child for immunizations. 'What have you done with her mother, where is she?' and they were laughing." Women's ridicule suggested that some might be resistant to men's appropriating women's legitimate social identity ("Other women ridicule them saying they take women's work and it is theirs.").

The lack of sufficient resources to care for people affected by HIV/AIDS emerged as a critical hindering factor for women as well as men. Respondents named lack of money, the inadequacy of necessary supplies, water, unreimbursed travel expenses and food as hindrances. From the female focus group of people living with HIV came the observation that "It is very hurting to look after someone who does not have food. I do not have enough food myself, but most of the time I am forced to share the little that I have with people I care for in the village." Many perceived that not believing

in HIV and AIDS, lacking knowledge about prevention and care and fearing stigma hindered men's greater and sustained involvement in HIV/AIDS caregiving.

While respondents cited numerous factors that hinder men's involvement in CHBC, respondents nevertheless identified training, supervisory support and financial incentives as the main factors that would facilitate men's participation. The study did not find a difference in these priority incentives for women. In fact, after the study team completed data collection, the MOHSW established a financial incentive for CHWs at \$43 per month, which presumably will attract both more men and women into this job.

## **V. Study Conclusions**

- Caregiving is not gender-neutral. A nexus of gender stereotypes about essential male and female traits, status beliefs and perceptions of men and of caregiving kept women in voluntary HIV/AIDS caregiving and kept men out of it.
- It is feasible to involve men in CHBC, since the Basotho men and women in the study sample seemed to demonstrate psychological and social flexibility in taking on the domestic and household tasks ascribed to the other gender. Male respondents emphasized the technical aspects of caregiving, identified with more powerful male tasks and groups (first aid, miners) and represented this first aid as more "masculine" by using male-identified traits, such as bravery, courage, dignity and discretion.
- Training can mitigate negative stereotypes of men, assuage women's fears about men's potential tendency toward sexual exploitation of patients while in caretaking roles and increase men's skills. Training for male and female caregivers should involve critical reflection on gender stereotypes, roles and responsibilities.
- Men stand to lose discretionary time by entering CHBC, but the MOHSW decision to remunerate this work at \$43 per month will make men's participation more likely. It will also retain and attract women for whom the CHBC is felt to be an unsustainable burden. This remuneration communicates that CHBC is a valued service to the community, and will improve the image, the gender equity and the long-term sustainability of community-based HIV/AIDS caregiving in Lesotho.

## **VI. Strengthening Health Workforce Policy and Planning and HIV/AIDS Programs in Lesotho through Research**

The study reinforced the MOHSW's capacity to plan for a more gender-desegregated HIV/AIDS workforce by implementing Lesotho's Gender and Development Policy, which promotes men's sharing the burden of HIV/AIDS care through "gender redistributive"

actions within the context of the national HIV/AIDS strategy. The Capacity Project convened a two-day results dissemination meeting in September 2008 with national and district partners to discuss study findings and validate recommendations for recruiting, training, supporting and retaining men as HIV/AIDS caregivers in ways that did not disadvantage the women who still carry the burden of care. The meeting included capacity-building in gender concepts through examples of gender discrimination in HRH; presenting the national Gender and Development Policy before the study findings and recommendations; and reaching consensus on policy and program actions at national and district levels, elements of which would constitute the foundation of a strategic plan for the national CHW program. The MOHSW approved the results and following study recommendations:

1. To reduce occupational segregation by gender, policies for national health, HIV/AIDS and CHBC and human resources should be gender redistributive and explicitly promote a more equal division of responsibilities between women and men, in general and in the context of HIV/AIDS care and support. The Lesotho government and other stakeholders involved in CHBC should make an effort to recruit more men as CHWs, and simultaneously continue to strengthen women's capacity to care for those affected by HIV/AIDS through gender-responsive policies, budgets and initiatives.

2. Gender-redistributive HIV/AIDS and CHBC policies should be promulgated through training curricula, job descriptions and protocols. The national CHBC training curriculum should include skills training, critical reflection on masculine and feminine gender roles and gender equality in caregiving, communication, HIV/AIDS education, service ethics, gender-based violence and an introduction to male role models already engaged in CHBC.
3. Organizations should adopt a "Volunteer Charter" for CHWs and home-based caregivers to address conditions of work, including standardized resources and protections such as standardized working hours and remuneration; training and psychosocial support; response to harassment and violence; tangible protections such as pensions and child-support grants; and supplies needed to cope effectively.
4. CHBC programs operating at district or village levels should be designed or redesigned to be gender redistributive. They should explicitly promote the equal sharing of responsibilities between women and men in training and supervision and in the recruitment of men. Recruitment and compensation strategies should not be based on assumptions about the real division of labor in families or reinforce "masculine" stereotypes such as "men as breadwinners" or "men as protectors" since women in

this study acted as "breadwinners" and protectors of their families.

5. The government and civil society should make men's participation in CHBC a priority to reduce the transmission of HIV/AIDS by altering personal, social and cultural views surrounding HIV/AIDS care and support for healthy and socially and economically viable communities. HIV/AIDS and domestic caregiving should be made more attractive to men and boys through early childhood education and public campaigns that communicate the value of HIV/AIDS (and all) caregiving to society.

The study results were later disseminated to the UN Theme Group on Gender, which plays an advisory role to the government of Lesotho's Ministry of Gender, Youth, Sports and Recreation (MGYSR). The MGYSR then reported that the study contributed to proposed revisions of The Gender and Development Policy of 2003, which will address HIV/AIDS care and support as an area of priority under Gender and Health, serve as a basis for advocacy programs to promote the value of caregiving and set a stage for educational or capacity-building programs to educate men and boys on sharing of care responsibilities as well as promoting positive images of men and boys engaged in care work. Finally, the study has also contributed to discussions between the MGYSR and the National Curriculum Development Centre on the need to improve the gender sensitivity of health provider training curricula.

## Explanation of Terms

**Gender discrimination:** Any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights (WHO, 2001). Gender discrimination also includes distinctions, exclusions or restrictions based on the biological characteristics and functions that differentiate women from men (e.g., pregnancy). Gender discrimination thus covers marital status, pregnancy, family responsibilities, occupational segregation and sexual harassment.

Gender discrimination constitutes a barrier to equal opportunity and treatment in employment and occupation, access to education, training, development and social benefits.

**Gender stereotype:** A rigid, oversimplified, generalized idea of the differences between women and men, their skills, psychological attitudes, ambitions and behavior (Johnson, 2000; ILO, 2008. See also Blau et al., 2006). Stereotypes are forms of social consensus rather than individual judgments (Online dictionary of the social sciences, n.d.; Wikipedia, 2009).

Gender stereotypes contribute to ideologies and norms of what constitutes appropriate behavior or aspirations for men and women (Online dictionary of the social sciences, n.d.). Stereotypes can be negative and used to deny individuals respect or legitimacy, or positive, to maintain privilege, based on membership in that group. (The term "norm" is used to refer to a culturally established rule or standard of appropriate social behavior, as distinct from a stereotype, which is a socially constructed, oversimplified, generalized idea.)

1 PAHO has identified four aspects of health equity: fairness in health status, health access and use, health financing and participation in health care production. The latter includes the fair distribution of responsibilities and power and placing value on nonremunerated work (Pan-American Health Organization, n.d.).

2 The complete study report, *Alleviating the Burden of Responsibility: Report on a Study of Men as Providers of Community-Based HIV/AIDS Care and Support in Lesotho*, is available on the Capacity Project's website at [http://www.capacityproject.org/images/stories/files/study\\_of\\_men\\_as\\_providers\\_of\\_care\\_lesotho.pdf](http://www.capacityproject.org/images/stories/files/study_of_men_as_providers_of_care_lesotho.pdf).

3 The Lesotho Gender and Development Policy defines "redistributive" approaches as "Interventions intended to transform existing stereotypes to ensure gender equity and equality by a more even redistribution of resources,

responsibilities, and power between and among men and women, girls, and boys."

4 The term "norm" is used in this study to refer to a culturally established rule or standard of appropriate social behavior, as distinct from a stereotype, which is a socially constructed, oversimplified, generalized, idea (Online Dictionary of Social Sciences, Athabasca University and International Consortium for the Advancement of Academic Publication, n.d.).

5 Policies aiming to reduce or eliminate segregation are referred to as "desegregation policies" (ILO, 2007).

6 Research from Zambia (Esu-Williams et al., 2004; see also International HIV/AIDS Alliance, 2003) demonstrated that trained male and female caregivers provided similar types of care to people living with HIV and AIDS if given adequate training, support and incentives. Other recent success stories on male involvement in HIV/AIDS care provision include those from

Zimbabwe (USAID-PVO Steering Committee on Multi-sectoral Approaches to HIV/AIDS, 2003), Botswana (Lindsey et al., 2003), Ethiopia (personal communication in June 2008 with Deborah McSmith, IntraHealth International consultant, about a SAVE CHBC initiative in Ethiopia) and South Africa (Akintola, 2006).

7 Ben Lupton's research in the UK found that male nurses engaged in "identity work," or coping strategies used when crossing gender boundaries into "female occupations," in order to deal with a challenge to sexuality or to affirm their masculinity. These strategies tended to construct masculine identities and "reinforce the gender order rather than subvert it."

8 The term "Basotho" refers to the people of Lesotho.

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**The Capacity Project**  
 IntraHealth International, Inc.  
 6340 Quadrangle Drive  
 Suite 200  
 Chapel Hill, NC 27517  
 Tel. (919) 313-9100  
 Fax (919) 313-9108  
 info@capacityproject.org  
 www.capacityproject.org

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**Research Team:** Constance Newman, IntraHealth International; Ntabiseng Makoae, National University of Lesotho; Erik Reavely, IntraHealth International; Linda Fogarty, Jhpiego.

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