Making Non-discrimination and Equal Opportunity a Reality in Kenya's Health Provider Education System: Results of a Gender Analysis

Constance Newman, Senior Team Leader, Gender Equality, IntraHealth International, Inc., Chapel Hill, NC 27517

Anastasiah Kimeu, Training Program Manager, Capacity Kenya, IntraHealth International, Inc., Nairobi, Kenya

Leigh Shamblin, Senior Technical Advisor, Training Systems, IntraHealth International, Inc., Chapel Hill, NC 27517

Christopher Penders, Senior Program Manager, IntraHealth International, Inc., Chapel Hill, NC 27517

Pamela A. McQuide, Acting Director, Human Resources for Health/Systems Strengthening, IntraHealth International, Inc., Chapel Hill, NC 27517

Judith Bwonya, Senior Deputy Director of Medical Services, Ministry of Medical Services, Government of Kenya, Nairobi, Kenya

Correspondence may be directed to: Constance Newman, IntraHealth International, Inc., 6340 Quadrangle Drive, Suite 200. Chapel Hill, NC 27517; Tel.: 919-313-9157; e-mail: cnewman@intrahealth.org.

Abstract

IntraHealth International's USAID-funded Capacity Kenya project conducted a performance needs assessment of the Kenya health provider education system in 2010. Various stakeholders shared their understandings of the role played by gender and identified opportunities to improve gender equality in health provider education. Findings suggest that occupational segregation, sexual harassment and discrimination based on pregnancy and family responsibilities present problems, especially for female students and faculty. To grow and sustain its workforce over the long term, Kenyan human resource leaders and managers must act to eliminate gender-based obstacles by implementing existing non-discrimination and equal opportunity policies and laws to increase the entry, retention

and productivity of students and faculty. Families and communities must support girls' schooling and defer early marriage. All this will result in a fuller pool of students, faculty and matriculated health workers and, ultimately, a more robust health workforce to meet Kenya's health challenges.

Background

Gender equality in human resources for health means that women and men have an equal chance of choosing a health occupation, developing the requisite skills and knowledge, being fairly paid, enjoying equal treatment and advancing in a career. When gender inequalities and discrimination operate in the workforce outside of the awareness of human resource managers, they may impede entry into health occupations or contribute to attrition, absences from work, lower productivity, poor quality of care, poor health and low morale of health workers. In addition to being violations of employees' rights at work, gender inequality and discrimination result in a limited pool of formal and informal health workers to deal with today's health and development challenges (Newman 2010). Human resources leaders and managers in pre-service and service settings must be aware of and eliminate gender-based obstacles to entry, retention and productivity of students and faculty and, ultimately, of service providers in the health workforce.

The Government of Kenya is committed to improving accessibility and equity of essential health-care services. Kenya has established critical and ambitious targets for providing health services to its population, set forth in its policies, strategic frameworks and operational plans (see box). Achieving these service targets requires a well-managed, equitably distributed health workforce with appropriate skills.

Key Kenyan Frameworks

- Vision 2030 plan
- 2010 Proposed Constitution of Kenya
- National Policy Framework (1994–2010)
- National Health Sector Strategic Plan (NHSSP) II (2005–2010)
- NHSSP II Mid-term Review (2007)
- Kenya Essential Package for Health (2005–2010)
- e-Health Ministries' Strategic Plans (2008–2012)
- Ministerial Annual Operation Plans
- Employment Act of 2007
- United Nations Millennium Development Goals (2015)
- 2000 Gender and Development Policy

To address overall human resources challenges, the Ministry of Medical Services and the Ministry of Public Health and Sanitation developed the National Health Sector Strategic Plan (NHSSP II) (2005–2010), which spells out strategies to improve health services delivery and reverse declining health outcomes. To make progress, all health cadres must be prepared to perform and adapt to changing situations in the workplace at various service levels outlined in the Kenya Essential Package for Health. Understanding the performance of education systems requires consideration of all factors that influence performance, not merely provision of knowledge and skills. Therefore, the ministries of health (MOH), with support from the US Agency for International Development (USAID)–funded Capacity Kenya project, led by IntraHealth International, and in collaboration with a multi-sector stakeholder technical working group, conducted a performance needs assessment (PNA) in 2010. The PNA assessed health workers' competencies to deliver health services at different health system levels and the educational and training systems' capacities and gaps. One of these gaps was equal opportunity and treatment for women and men with respect to education, occupation and

employment in the health provider education system in the context of Kenya's strategic planning, equal opportunity and gender policy environment.

Kenya's Gender Equality Policy Environment

Understanding barriers to equal opportunity, access and treatment in pre-service education will increase entry into and retention in health delivery systems and ultimately yield a more robust health workforce to meet Kenya's health challenges. Kenya's National Gender and Development Policy establishes clear expectations regarding enrolment and retention in "women and men-friendly institutions" (Republic of Kenya 2000). There is also a supportive, evidence-based policy environment in the labour sector. Kenya has ratified the International Labour Organization (ILO) conventions on equal opportunity and non-discrimination in employment and occupation (C.111), human resources development (C.142) and equal remuneration (C.100); it may also soon ratify conventions related to maternity protection (C.183) and family responsibilities (C.156) (International Labour Organization 2011). Kenya's 2007 Employment Act states: "an employer shall promote equal opportunity in employment and strive to eliminate discrimination in any employment policy or practice," specifically acknowledging and prohibiting pregnancy discrimination and sexual harassment (Republic of Kenya 2007: 12-13). Importantly, it recognizes the distinctions between direct and indirect discrimination, which are relevant for this analysis. Direct or indirect discrimination against women, associated with pregnancy, marital status and family responsibilities, often results in occupational segregation and wage discrimination. Finally, the Proposed Constitution of Kenya states that "Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres" and

> "To give full effect to the realization of the rights guaranteed under this Article, the State shall take legislative and other measures, including affirmative action programs and policies designed to redress any disadvantage suffered by individuals and groups because of past discrimination" (Republic of Kenya 2010: 24).

Key Concepts

Direct discrimination occurs if an individual or group is treated less favourably than another in comparable circumstances because of a particular attribute, such as age, disability status or sex. This means that factors unrelated to merit, ability or potential of the individual or group are used as an explicit reason for excluding or otherwise discriminating against them. This form of discrimination tends to be more obvious, such as a student experiencing sexual harassment or a married employee being told she cannot be considered for a promotion because it is expected that she will be taking pregnancy leave. Some forms of direct discrimination may not be evident, such as when employers offer less favourable remuneration packages on the basis of race or sex. However, in some cases, a policy, rule, condition of work, procedure or practice may seem fair and neutral because it applies to everyone, though it can only be complied with by a higher proportion of people without an attribute or personal characteristic, such as age, sex or disability status (International Labour Organization 2006). An example of this would be that all tutor consultation times for a subject are held after 5 p.m. While this requirement applies equally to all students, it may have a disproportionate (negative) impact on students with family responsibilities. (In the United States, this would be called "disparate impact"). The requirement may therefore amount to indirect discrimination (Anti-Discrimination Commission 2007). This is a serious problem for workforce development and retention because it is typically unintentional and more difficult to recognize than direct discrimination.

In this report, the term *gender discrimination* refers to "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" (World Health Organization 2001: 43). These gender roles and norms are often associated with the biological characteristics and functions that differentiate women from men (e.g., pregnancy, childbirth or breastfeeding). Gender discrimination also includes gender

beliefs and stereotypes that result in sexual harassment and occupational segregation. These gender-related distinctions, exclusions or restrictions are typically experienced more by women than men in the workforce and can result in a negative educational or employment outcome.

In 2006, the President of the Republic of Kenya issued a decree … 30% of all recruitment, appointments and promotions in the public sector must be women.

Affirmative action is "a legal policy requiring employers to seek out skilled women and minorities and place them in valued jobs, educational programs and positions of authority in greater numbers than would otherwise occur" (Ridgeway and Correll 2000: 114). In 2006, the President of the Republic of Kenya issued a decree on affirmative action that 30% of all recruitment, appointments and promotions in the public sector must be women. This directive was intended to create equity in employment of men and women and promotion of women to senior positions in the public sector, including education. The purpose of affirmative action in Kenya is to address past discrimination by increasing the chances for marginalized groups such as women to participate in political, social and economic decision making and policy implementation. Affirmative action is not considered discrimination by the ILO, in Kenya's 2010 Proposed Constitution or in the 2007 Employment Act. However, enactment of legislation to implement affirmative programs and policies is surrounded by controversy in Kenya's male-dominated Parliament. One source of this controversy may be traced to culture and tradition, wherein "The subject of gender (equality) has … been misconstrued to mean replacing patriarchy with matriarchy or privileging women over men" (Kimani 2006).

Gender Analysis Method

This article focuses on an analysis of PNA data that identified gaps in equal opportunity and treatment for women and men with respect to training, education, occupation and employment in Kenya's health education system. Data were collected through focus group discussions, key informant interviews and an analysis of student and faculty numbers in various programs or faculty positions, respectively. During the PNA, various actors in health provider education were asked to share their views and understandings of the role of gender in the system. Students were asked whether they felt their learning opportunities were limited by gender and, if so, how. Respondents from the MOH and regulatory bodies, as well as school directors were asked to describe gender-based challenges that students face in the health training system. They were also asked how gender affects faculty recruitment, retention and advancement, and how to improve gender equality for both students and faculty. The analysis was not based on systematic measurement of discrimination with respect to how students and faculty are selected or hired or how students and faculty are treated in the health education system.

Results

When asked to respond to the statement, "My learning opportunities are limited by my gender," 87% of students disagreed. However, twice as many female as male students perceived learning opportunities as more limited by gender. Gender issues raised in student focus groups included the following perceptions: health training is not flexible with respect to age and family constraints; female clients do not want to be treated by male students; some female students left in male wards alone, especially at night, fear that male patients will attack them (a preceptor in a public mid-level training institution also expressed this perception); male candidates are not encouraged to pursue nursing; female candidates are favoured in nursing school admissions; and male students are given opportunities to learn more complex procedures than female students (e.g., males catheterize; females make beds). In the next section, we report on occupational segregation in the student and faculty bodies, sexual harassment, pregnancy and family responsibility discrimination, and then offer conclusions and recommendations.

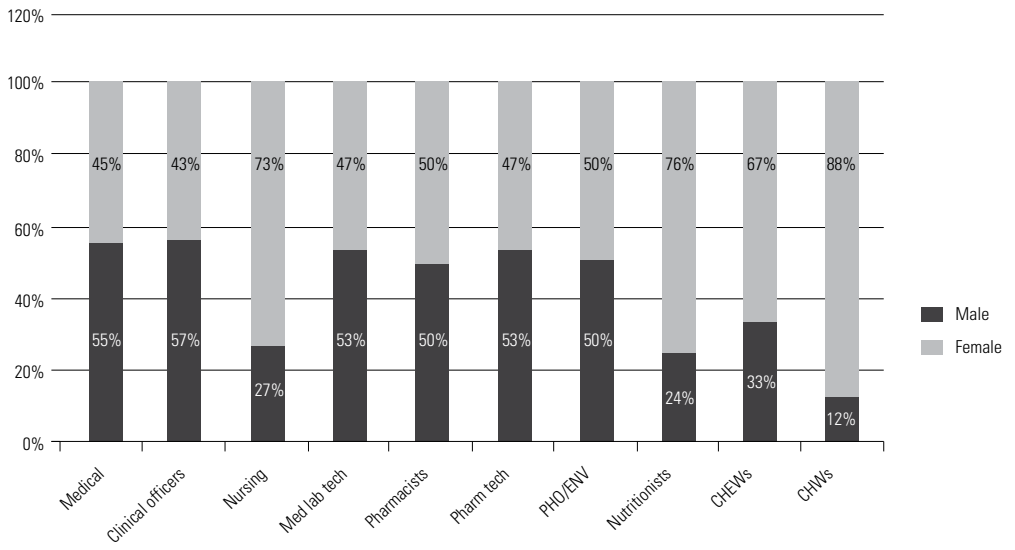
Occupational Segregation

Findings suggested occupational and task segregation in some training institutions. Occupational segregation by gender is a pervasive and widely documented form of gender inequality in which women and men are expected to work in culturally defined occupational roles (Anker 1997; Anker et al. 2003). Women are concentrated in marginal, lower-status, and/or less-well-paid caring occupations, such as nursing and teaching, horizontally segregated from men who are typically concentrated in technical, managerial or strength-based jobs such as physicians, managers and police officers.

Student Body

Because the qualitative results suggested occupational and task segregation, the PNA team analyzed the quantitative data to assess patterns of occupational segregation. Descriptive data show that within 42 training institutions sampled, and the 15,798 currently enrolled students based on total enrolment reported by sampled institutions, there was unequal distribution by gender in various career tracks (e.g., medicine, nursing, nutrition). Figure 1 shows differences in the concentration of female and male students in key occupational programs. For example, there were more women enrolled in nursing (73%), nutrition (76%), and community health worker (CHW) (88%) programs, while more men were enrolled in medicine (55%) and clinical officer (57%) programs. Percentages are based on data from those schools that provided a breakdown.

Figure 1. Student enrolment by gender and cadre



CHEWs = Community Health Education Workers; CHWs = Community Health Workers; PHO/ENV= Public Health Officer/Environmental

The data suggested that some occupations were "female jobs," with the most striking segregation appearing in the nursing and CHW occupations. A regulatory body director and a school director perceived this segregation, observing "Nursing is seen as a woman's occupation," and that a man is "lowering his dignity by taking it up." This position is consistent with findings of other research. For example, as early as 1987, researchers noted that performing jobs that are seen as "women's work" is considered demeaning to men and their manhood (Sen and Grown 1987). This sentiment has been documented more recently in Lesotho (Newman et al. 2011), in Soweto, South Africa, and Tanzania (Peacock and Weston 2008) and in Latin America, where Chilean men reported that they

clandestinely carried out tasks associated with women so as not to "ruin" their reputations (Barker 2009). Occupational segregation in health caregiving – whether formal or informal – usually reflects gender beliefs of male primacy and the denigration of jobs traditionally performed by women (Newman et al. 2011).

Faculty

Figure 2 shows that there are more male faculty (285) than female faculty (173) in 20 nursing schools that reported faculty and staff levels. This may seem surprising, given the female profile of the nursing occupation, but the finding is consistent with other research that found teachers are more likely to be men than women as one progresses from primary to tertiary level (International Labour Conference 2009).

Figure 2. Number of faculty by position and gender in 20 nursing-only education institutions

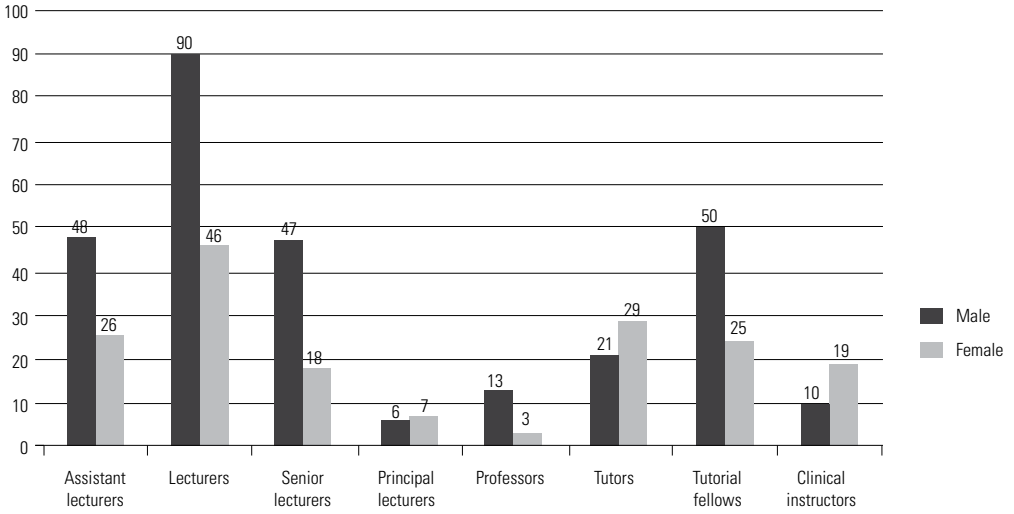
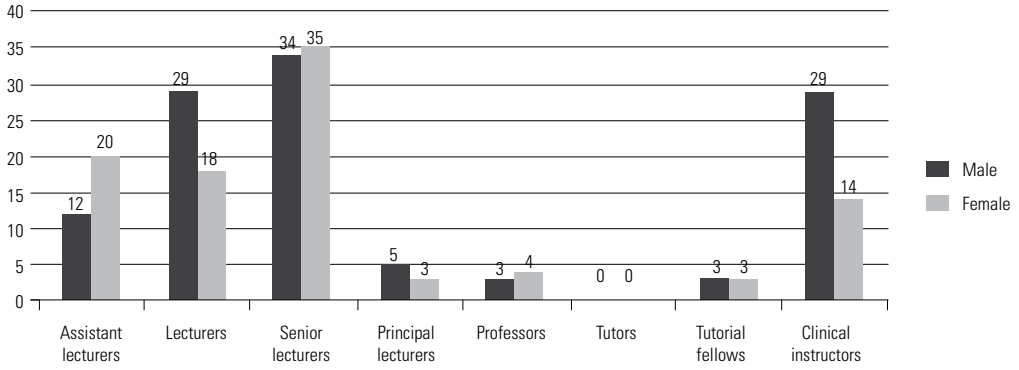


Figure 2 shows men more heavily concentrated in five of eight faculty positions such as lecturer (66% versus 34%), senior lecturer (72% versus 28%) and professor (81% versus 19%). Women hold more tutor (58% versus 42%) and clinical instructor (66% versus 34%) positions.

Figure 3 shows that in four clinical officer training institutions (*Clinical Officer* refers to a health provider who, having successfully undergone a prescribed course of training in clinical medicine in an approved training institution, holds a certificate issued by that institution, and is registered under the 2009 Clinical Officers Act), men are more concentrated in lecturer (62% versus 38%) and clinical instructor (67% versus 33%) positions. Women are more heavily concentrated in the assistant lecturer position (63% versus 37%). The other positions seem to be "equal opportunity" jobs.

In summary, PNA results suggest some "male" and "female" occupations in the Kenyan health workforce. The PNA provided a cross-sectional snapshot and did not capture hiring trends. Thus, it would be useful to examine trends in recent hiring to ascertain whether the gender imbalance in faculty positions is improving, remaining constant, or becoming further segregated. Likewise, it would be useful to examine trends in student enrolment by gender. In addition, the PNA did not collect data on vertical segregation in the workforce such as the percentage of men and women in management, leadership and administration jobs. This information may be useful in the future to training institutions and to nursing and medical councils that pursue equality of opportunity in career advancement.

Figure 3. Number of faculty by position and gender in clinical officer-only education institutions



Sexual Harassment

In the Kenya 2007 *Employment Act*, sexual harassment encompasses both quid pro quo and hostile environment sexual harassment (Republic of Kenya 2007). Kenya's *Sexual Offenses Act a*ddresses quid pro quo sexual harassment in educational institutions (Republic of Kenya 2006).

Students' Experience of Sexual Harassment

Students were asked to describe gender-related challenges in the learning environment, including sexual harassment. Two categories of sexual harassment have been recognized in the laws and policies of several nations: (1) hostile environment, which is conduct of a sexual nature that creates an intimidating, hostile or humiliating work environment for the recipient such as to change the terms and conditions of work; and (2) quid pro quo, where a person's rejection of, or submission to, such conduct is used explicitly or implicitly as a basis for a decision that affects that person's job. Despite a clear legal framework, female students participating in focus group discussions reported incidents of quid pro quo sexual harassment in educational institutions. Some female students reported harassment by male faculty, especially during exams, stating "there are 'sex engineered grades' whereby a male lecturer will require a student to perform sexual favours before being awarded a certain grade." Participants reported that some instructors requested female students to "give in" before they are assisted in their work and if the student did not comply, she would be given a failing grade. Female students who reported being harassed by male tutors also stated that they perceived there was no avenue for recourse. In some cases, students (in addition to school directors) reported having to pay a "demotion fee," which most students cannot afford. Male participants reported being involved in "love triangles" and being bullied or harassed by male lecturers who were interested in the same female students. Female students who were harassed were perceived by some as having an unfair competitive advantage, being favoured by male tutors and obtaining grades they would not otherwise have achieved, as when a male student remarked, "Where there are ladies, favouritism must be there … a girl is favoured since she can go to the extent of using herself."

Evidence from this assessment suggests that quid pro quo sexual harassment by male faculty is a problem for female students and constitutes unequal and detrimental treatment of women and an obvious roadblock to equal opportunity. Also, shortly after PNA data collection ended, a news article appeared reporting a wider systemic problem in that more than 1000 teachers in mostly rural primary schools had been fired for sexual abuse in the previous two years (BBC News Africa 2010).

Pregnancy, Family Responsibilities and Discrimination

Discrimination based on pregnancy consists of exclusions, restrictions or distinctions made on the basis of pregnancy, childbirth or related conditions. It often includes unwillingness to hire, promote or retain female students or workers who may get pregnant and leave the workforce or require maternity leave

and benefits (Newman 2009). Pregnancy discrimination may also be thought of in a larger category called "family responsibilities discrimination," in which discrimination occurs against workers who have family caregiving responsibilities, such as mothers and fathers of disabled children, and workers who care for family members (WorkLifeLaw 2011). Indeed, it is difficult to separate the two forms of discrimination, since exclusion from school or a job may be linked to the actual pregnancy, as well as to the risk of pregnancy and an expectation of subsequent caregiving responsibilities.

Students' and Faculty Experience of Pregnancy and Discrimination

During focus group discussions with students, there were reports in six of the 15 focus groups of the disruption to female students' studies caused by pregnancies. In some cases, students mentioned that female students had been forced to leave educational institutions or had experienced demotion and/or disruption of their studies because of family responsibilities. Quotes from students illustrate both the disruption and elements of discrimination:

"When the female student becomes pregnant, the attitude of the male lecturers is negative towards them."

"When [female nursing students] get pregnant, they will be given time off to deliver and nurse the baby for a few months, and then come back, but they have to pay the demotion fee of Ksh 50,000 (about 600 US dollars) on return."

When asked about gender-based challenges that students face, 21 of 37 school directors mentioned pregnancy. Twelve of these suggested that pregnancy was "not a problem now" because "previously girls who got pregnant could not come back but now [they] do." Nine of these directors indicated, however, that pregnancy continues to be a major cause of disruptions for female students. Illustrative perceptions include:

"Girls who are pregnant have to leave when delivery is due, while boys who impregnated them continue with studies" (school director, public middle-level institution).

"They become pregnant, and this hampers their learning and continuity with studies, and it affects practical lessons" (school director, public tertiary institution).

Faculty may also face discriminatory practices. As one mid-level school director noted, "They would rather employ a male lecturer than female because females need a lot of duty (i.e., maternity leaves)." Maternity leave poses long-term institutional challenges. A public institution school director notes that "Female lecturers go for long maternity leaves and this provides some sort of shortages."

Students' and Faculty Experience of Family Responsibilities

The qualitative data suggested that some students and faculty face challenges related to family responsibilities, which may constitute direct or indirect discrimination. Female students stated that they had to manage family responsibilities, such as household duties and childcare, while also studying full-time, implying that they could not pursue educational opportunities under the same conditions as their male counterparts (or female students without children). As one female tertiary student noted:

"We have different roles. If we go home the two of us, I make sure the baby is well fed, then asleep, husband taken care of … that affects my concentration … while [when] he goes home he expects food [to] be ready."

The qualitative data suggested that balancing work and family obligations was also perceived as problematic by faculty, highlighted in the quotes below:

"As a woman, domestic responsibilities become a major hindrance to advance my training because I have to seek consent from my spouse to go back to school" (clinical preceptor, public middle-level institution).

> "In most cases, women in this facility have not been interested in precepting. Most times precepting is conducted by men. Most theories classes (i.e., those taught in classrooms as opposed to practicum/placement sites) start at 2 p.m., but most women instructors would be breaking off for the day. So women find it inconveniencing to come back in the afternoon because they are busy preparing food for their families" (male clinical preceptor, rural health training facility).

A ministry respondent remarked that "women are disadvantaged because of commitments in caring for family."

Conclusions

These results add further evidence that equal opportunity for education, occupation and employment are constrained by gender in Kenya's health provider education system, including forms of discrimination based on pregnancy and family responsibilities, sexual harassment and occupational segregation (Kabubo-Mariara 2003; Onsongo 2006). PNA results are consistent with other available data from Kenya, including the 2000 National Gender and Development Policy, the National Commission on Gender and Development's October 2006 Desk Survey on Gender Issues in Kenya, and findings from other studies. The conflict between life cycle events and school or work requires a more family-friendly perspective in health training policy and planning. It also appears that some willing male candidates may experience cultural and institutional obstacles to entering nursing and other "female occupations." Evidence of these gender constraints points to the need to at least promote non-discrimination and equal opportunity and treatment in health provider education institutions with respect to specific barriers to entry, performance and retention of students and faculty (Gregory 2003). However, some believe a strict equal opportunity policy holds mothers to a model of competition in which they cannot equally compete. It is probable that existing laws have not been operationalized or disseminated effectively. Implementing non-discrimination and equal opportunity policies is a step toward a more equitable training system and, ultimately, a more robust health workforce. However, gender discrimination, whether cultural or situational, begins in the family and community. Girls must be able to attend school, have time to complete homework and get unbiased vocational counselling.

Recommendations

Gender inequality and educational disadvantage and poverty are key hindrances to achieving desired outcomes in healthcare provision in Kenya. These hindrances are experienced before students enter the health education systems and persist within the education system. PNA findings suggest the need to take policy, program and community action on occupational segregation and sexual harassment, and to further study the existence of and intersection between pregnancy and family responsibilities discrimination. There are five broad recommendations:

- Health and education ministries, regulatory bodies and training institution leaders should reach consensus on how equal opportunity and non-discrimination should be integrated into the health provider education system.
- The MOH should undertake a situational analysis to identify existing equal opportunity policies, and if they exist, create sector-wide awareness.
- Health ministries should convene a task force to develop a plan to develop, revise and implement non-discrimination and equal opportunity policies.
- These ministries should sponsor further research to document the forms and severity of sexual harassment, family responsibility and pregnancy discrimination.
- The Ministry of Education should build tomorrow's health workforce starting in primary and secondary schools.

Table 1 summarizes specific recommendations to health training institutions for making equal opportunity a reality.

Table 1. Recommendations to health training institutions for making equal opportunity a reality

Occupational Segregation
• Eliminate gender stereotypes in curricula.
• Develop institutional recruitment, admission and retention policies to assure non-discrimination and equal opportunity to pursue and advance in all occupations.
• Promote equality in recruitment, targeting male entry into "female" health occupations and vice versa.
• Provide dormitories for both male and female students.
• Offer social support to men and women who choose "non-traditional" health occupations.
• Ensure that male and female students demonstrate the same competencies prior to completion of training.
• Develop a communication strategy to change societal beliefs about essential male and female traits, the relative value of "women's work," and men's equal sharing of family responsibilities.
• Analyze the reasons for the concentration of men and women in certain faculty positions.
Sexual Harassment
• Develop or apply policies and programs to protect students from sexual harassment.
• Develop new, or enforce existing, codes of conduct that define and prohibit sexual harassment, including termination of faculty members who sexually harass students.
• Orient students and faculty on sexual harassment.
• Create a "safe space" to anonymously report sexual harassment without fear of reprisal.
• Assess risk of sexual harassment and assault in hospital wards; implement prevention and response measures accordingly.
Pregnancy and Family Responsibility Discrimination
• Through policies, enable students and faculty with family responsibilities to engage in education and employment without discrimination and, to the extent possible, without conflict between work and family responsibilities.
• End punitive policies or practices that target pregnant female students, and introduce alternatives to reduce dropout rates.
• Encourage male faculty and students to take paternity leave to relieve the burden of family responsibilities, taking into account cultural factors and expectations in educational and certification requirements such as bridging programs.
• Engage with professional bodies in advocacy to ratify ILO [International Labour Organization] conventions to ensure that maternity and family responsibilities are not sources of discrimination in access to education and employment.
• Assure unbiased vocational counselling in high school.
• Engage families and communities in support of girls' education and delayed marriage.

References

Anker, R. 1997. "Theories of Occupational Segregation by Sex." *International Labour Review*136 (3): 315–39.

Anker, R., H. Malkas and A. Korten. 2003. *Gender-Based Occupational Segregation in the 1990s.* International Labour Office.

Anti-Discrimination Commission. 2007, January. *Direct and Indirect Discrimination*. Queensland, Australia: Anti-Discrimination Commission. Retrieved March 2, 2011. <http://www.adcq.qld.gov.au/Brochures07/direct.html>.

Barker, G. 2009. *Capacity Building for Mainstreaming a Gender Perspective into National Policies and Programmes to Support the Equal Sharing of Responsibilities between Women and Men, Including Caregiving in the Context of HIV/AIDS.* Written statement. Commission on the Status of Women. New York: United Nations.

BBC News Africa. 2010, October 7. "Hundreds of Kenyan Teachers Sacked over Sex Abuse." Retrieved March 1, 2011. <http://www.bbc.co.uk/news/world-africa-11492499>.

Gregory, R.F. 2003. *Women and Workplace Discrimination: Barriers to Gender Equality.* New Brunswick, New Jersey, and London: Rutgers University Press.

International Labour Conference, 98th Session. 2009. *Gender Equality at the Heart of Decent Work Report VI.* Geneva: International Labour Office. Retrieved March 1, 2011. <http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_105119.pdf>.

International Labour Organization. 2006. *International Training Center, Gender Equitable Labour Standards Course.* Turin, Italy.

International Labour Organization. 2011. *Kenya: Ratification Status of Up-to-Date Conventions.* Retrieved March 1, 2011. <http://www.ilo.org/dyn/natlex/country_profiles.ratifications?p_lang=en&p_country=KEN>.

Kabubo-Mariara, J. 2003. "Wage Determination and the Gender Wage Gap in Kenya: Any Evidence of Gender Discrimination?" *AERC Research Paper 132.* Nairobi, Kenya: African Economic Research Consortium. Retrieved March 2, 2011. <http://www.aercafrica.org/documents/rp132.pdf>.

Kimani, J. 2006. National Commission on Gender and Development. Desk Survey on Gender Issues in Kenya.

Newman, C. 2009. "Conceptual and Practical Foundations of Gender and Human Resources for Health." Chapel Hill, NC: Capacity Project. Retrieved March 1, 2011. <http://www.capacityproject.org/images/stories/files/foundations_gender_hrh.pdf>.

Newman, C. 2010. "Gender Equality in Human Resources for Health: What Does this Mean and What Can We Do?" Chapel Hill, NC: IntraHealth International. <http://www.intrahealth.org/files/media/gender-equality-in-human-resources-for-health/gender_equality_hrh.pdf >.

Newman, C., L. Fogarty, L.N. Makoae and E. Reavely. 2011. "Occupational Segregation, Gender Essentialism and Male Primacy as Major Barriers to Equity in HIV Caregiving: Findings from Lesotho." *International Journal for Equity in Health* 10:24

Onsongo, J. 2006. "Gender Inequalities in Universities in Kenya." In C. Creighton and F. Yieke, eds. *Gender Inequality in Kenya.* UNESCO. Retrieved March 2, 2011. <http://unesdoc.unesco.org/images/0014/001458/145887e.pdf>.

Peacock D. and M. Weston. 2008 *Men and Care in the Context of HIV and AIDS: Structure, Political Will and Greater Male Involvement.* 2008. United Nations Division for the Advancement of Women Expert Group Meeting on "Equal Sharing of Responsibilities between Women and Men, Including Care-giving in the Context of HIV/AIDS" Held in Geneva, October 6–9, 2008.

Republic of Kenya. 2000. *National Gender and Development Policy. Ministry of Gender, Sports, Culture and Social Services.* Nairobi, Kenya.

Republic of Kenya. 2006. *ACT NO. 3 of 2006—Sexual Offences Act Sexual Offenses.* 24(4): 16. Retrieved March 2, 2011. <http://www.kenyalaw.org/kenyalaw/klr_app/frames.php>.

Republic of Kenya. 2007. *The Employment Act.* Retrieved March 2, 2011. Kenya Gazette Supplement; Acts, 2007. <http://www.hsph.harvard.edu/population/aids/kenya.labor.07.pdf>.

Republic of Kenya. 2010. *Proposed Constitution of Kenya.* Retrieved March 18, 2011. <http://www.primeminister.go.ke/DOCS/the_proposed_constitution_of_kenya.pdf>.

Ridgeway, C.L. and S.J. Correll. 2000. "Limiting Inequality through Interaction: The End(s) of Gender." *Contemporary Sociology* 29(1): 110–20. Utopian Visions: Engaged Sociologies for the 21st Century. American Sociological Association.

Sen, G. and C. Grown. 1987. *Development, Crises and Alternative Visions: Thirds World Women's Perspectives. New York: Monthly Review Press. WorkLifeLaw 2011.* A Center of UC Hastings College of the Law. "Family Responsibilities Discrimination Fact Sheet." Retrieved March 1, 2011. <http://www.worklifelaw.org>.

World Health Organization. 2001. *Transforming Health Systems: Gender and Rights in Reproductive Health*. Geneva: World Health Organization. Retrieved March 2, 2011. <http://www.who.int/reproductivehealth/publications/gender_rights/RHR_01_29/en/index.html>.