Executive Summary of the Report on the Ministry of Health Sexual Harassment Formative Assessment in Uganda's Public Health Sector

BACKGROUND

This brief summarizes key findings and recommendations of a formative assessment of sexual harassment in Ugandan government health facilities conducted on behalf of the Uganda Ministry of Health (MOH) between August-November 2016 with assistance from the USAID-funded Strengthening Human Resources for Health (SHRH) project led by IntraHealth International. The objectives of the assessment were to:

- Describe forms of, reactions to, and consequences of sexual harassment in government health workplaces
- Describe patterns of interaction between men and women around the issue of sexual harassment
- Assess the adequacy of existing policy and law related to sexual harassment
- Identify current implementation status and feasibility of legal/policy guidelines relevant to sexual harassment at national, regional, district, and facility levels
- Identify implementation challenges and opportunities relative to sexual harassment law and policy
- Recommend elements of an effective sexual harassment prevention and response system
- Document the baseline for key measures related to a sexual harassment prevention and response system that are already being implemented at in government health facilities.

Methodology: The formative assessment used a multi-methods qualitative study design and rigorous social science methods in two phases: 1) initial data collection through document reviews, male/female same-sex focus group discussions with health workers, and key informant interviews; and 2) follow-up mixed-sex focus group discussions, in-depth interviews, observations, and baseline documentation. The sample included 294 health workers (including managers) from ten districts: Central (Mukono and Mubende); East Central (Bugiri, Namayingo); East (Tororo); Karamoja (Abim); North (Gulu); West Nile (Adjumani); West (Hoima); and South West (Rukungiri).

KEY FINDINGS

Categories, Forms, and Examples of Sexual Harassment in Public Health Sector Workplaces
Sexual harassment in government health workplaces appears to be *normalized* and following a pattern of male-on-female harassment. The assessment found evidence of the two major categories of sexual harassment defined in Uganda's *Sexual Harassment Regulations*: "hostile environment" and *quid pro quo* sexual harassment. Examples of *hostile environment* sexual harassment noted by respondents included sexualized physical, verbal, written/visual, and gestural behavior, predominantly by men towards their female colleagues, behavior clearly considered by targets or witnesses to be unwanted, intimidating, and/or humiliating. Most respondents agreed that *quid pro quo* sexual harassment started during recruitment of health workers, mainly perpetrated by men in positions of power (e.g., senior managers, medical superintendents, supervisors). According to respondents, some female applicants are promised or given

jobs after having sexual intercourse with men who are in recruiting positions. This behavior continues in the workplace, where some in-charges/supervisors offer unjustified incentives, such as an excuse from duty, exemption from night duty, working fewer hours, promising or providing opportunities for training, or promising promotion, in exchange for sex. *Quid pro quo* can also enter the process of performance appraisal. Refusal of unwelcome sexual advances was often met by harassers with hostility or retaliatory antagonism, ranging from verbal abuse to unfavorable employment-related actions, including negative performance evaluations.

Health Worker Reactions to Sexual Harassment

Leaving the job through transfer or absconding was the most frequent reaction to sexual harassment, tied with avoiding/resisting/ignoring the harasser and compliance with demands ("giving in"). Victims of sexual harassment often keep quiet due to fear of being disgraced, embarrassed, stigmatized, or retaliated against.

Causes of or Contributors to Health Worker Sexual Harassment

The most cited cause or contributor was misuse of power, an organizational-level cause that includes unclear expectations of professional behavior, unclear evidentiary and reporting requirements, facility conditions allowing no privacy or space, and lack of sanctions and regulating mechanisms that lets harassers operate with impunity. The second most cited factor was socio-cultural, in particular, a belief in "indecent dressing" that attributes the cause of harassment to the target. Ethnic stereotypes and cultural expectations of male-female relationships also figured as causes.

Effects/Consequences of Health Worker Sexual Harassment

Targets in hostile environments suffered psychologically from unwelcome touching, persistent requests, and sexual innuendoes. Unsafe abortion of unwanted pregnancies, sexually transmitted infections (including HIV), stress and depression (in some cases suicidal ideation or even death) were also reported as health consequences. The refusal of *quid pro quo* sexual advances was reported to lead to professional consequences, including punishment and retaliation by the supervisor and actions with professional and economic consequences such as delayed confirmation, deleting the victim's name from payroll so as to miss a salary, loss of job (victim quit or faced unjustified dismissal), punitive transfer, negative performance appraisals, or demotion (being relieved of desired responsibilities). The most frequently cited organizational consequences were low productivity and low morale among victims, perpetrators, and other health staff, including staff conflict, disruption of teamwork, absenteeism, and harm to the supervisor/supervisee relationship, resulting in a poor work climate. The findings strongly suggest that health managers are perceived to only take sexual assault and rape seriously, and will likely dismiss as not serious most of the other hostile environment and *quid pro quo* behaviors.

Other Categories of Perpetrators and Victims

Evidence of the sexual harassment of patients also emerged from the study. Irrelevant or unnecessary vaginal and breast exams and "bad touching" were reported to be the most common forms of sexual harassment by health workers, but forms also included displaying a patient's nude body or body parts in clinical exams, and sexual assault, including rape. Key informants stated that harassing patients results in perceptions of poor service quality, tainted reputations of MOH facilities and providers and the nonuse of government health services.

Uganda's Legal-Policy Framework on Sexual Harassment

The Ministry of Gender, Labor and Social Development (MOGLSD)'s 2012 *Sexual Harassment Regulations* and the MOH's 2014 *Guidelines for Mainstreaming Gender in Human Resources for Health Management* are the most comprehensive and useful documents as a basis for further health sector policy. The MOH 2009 *Joint Code of Conduct and Ethics for Health Workers* prohibits sexual advances towards patients and should be integrated into a health sector policy. Of district-level key informants, only half had ever seen the MOGLSD regulations and 65% had seen or read the Ministry of Public Service (MOPS) *2005 Code of*

Conduct and Ethics for Uganda Public Service. Health sector managers' lack of familiarity with these basic regulatory documents renders reporting or responding to incidents of sexual harassment problematic.

There was almost universal agreement among respondents that romantic relationships between supervisor and supervisee should be forbidden. Most respondents believed that sexual relationships among peers/colleagues should be permissible. Key informants were also asked to comment on whether nine criteria for a sexual harassment policy were feasible for Uganda's public health sector: clear definition, examples, zero tolerance, duty to report, protection from retaliation, complaint procedures, confidentiality, ongoing training, and penalties. Most criteria were thought to be feasible (above 70%), with zero tolerance (i.e., employees should feel uneasy even thinking of coworkers in sexual terms) at a lower level (57%). Some respondents believed zero tolerance might be "sabotaged" by supervisors who gain from the current system, or that managers, in committees or individually, might cover up evidence to protect colleagues.

Implementation Challenges and Opportunities Related to Sexual Harassment Law and Policy

Challenges

- *Gender power dynamics*. The assessment's finding that sexual harassment is *normalized* either as a cultural pattern or abuse of social and organizational power means that it is perceived as non-problematic by the harasser. The fact that the harasser may be one's supervisor or another senior manager is a deterrent to confrontation, refusal or reporting. Fear of retaliation exerts pressure to not report or even mention sexual harassment in many instances.
- *Victim-blaming*. The assessment found a strong tendency to "blame the victim." An example is the construct of "indecent dressing." Expectation of victim-blaming typically suppresses reporting and would impact the mechanisms for reporting or investigation (e.g., in committee processes).
- *Risk of secondary injury/victimization* based on beliefs, attitudes, and stereotypes about why sexual harassment occurs. Risks included fear of heightened scrutiny of the victim who reports; being subject to publicity, gossip, doubt or disbelief; victim-blaming; a feeling of shame; or experiencing stigma or lack of support by coworkers.
- *Potential opposition to or non-implementation of new policy*. While signing an oath of public service obliges government health employees to conform their behavior to government policy expectations, there are few incentives for perpetrators who gain by the system of sexual *quid pro quo* to dismantle it.

Opportunities

- Most respondents were aware that abusive and harassing relationships at work can compromise work output, recognized the need for a policy, and believed that an MOH sexual harassment policy can be implemented once put in place.
- Existing institutional frameworks, structures, and mandates represent opportunities to implement a sectoral sexual harassment policy. This includes the existing performance management committee and safety and health committees, which are mandated to handle workplace violence, including sexual harassment. The MOH also has human resource (HR) officers who can be trained to perform various roles related to sexual harassment prevention and response.
- The finding that the greatest contributor to sexual harassment is normalized abuse of organizational power may actually be an opportunity. This is because the MOH has the power to change its *organizational* expectations, culture, structures, norms and behaviors, and the criteria for who works in the health sector and how. The findings suggest establishing policy implementation mechanisms that do not rely on individual victims coming forward, but rather organizational measures to *prevent* sexual harassment before it happens through existing structures.
- The consistency of this assessment's results with other studies and findings in the MOH 2012 *Gender Discrimination and Inequality Analysis* point to the value of multi-sectoral coordination, especially

with MOGLSD, Ministry of Education and Sports, MOPS, public and private educational institutions, and communities to improve work climate and professional environments in health workplaces.

RECOMMENDATIONS

Short-term recommendations marked by (*) can be delivered in 3-6 months and are consistent with SHRH project workplan activities. Longer-term MOH interventions can be initiated in 6-12 months.

- **Stakeholders review and approve the sexual harassment formative assessment report** and seek input from MOGLSD and MOPS.*
- **Identify a gender-balanced institutional framework and implementation guidelines** for sexual harassment prevention and response in the public health sector, consistent with priorities described in the MOGLSD 2012 *Sexual Harassment Regulations* and evidence from this report.*****
- **Hold a *Consultation, Validation, and Visioning Meeting*** to reach consensus on design elements of a sexual harassment prevention and response system to be piloted in ten districts.*****
- **Design a sexual harassment prevention and response system** based on the formative assessment data and better practices, targeting both individual and institutional (culture and systemic) changes. Implementation guidelines, training health workers, establishing a reporting system, and disseminating communication materials are feasible within 6-9 months. Prevention interventions include communicating organizational expectations, changing men's and women's awareness and behaviors, and establishing or reforming organizational norms. Response interventions establish sustainable mechanisms that respond to, and end impunity for, *quid pro quo* and hostile environment sexual harassment in public health facilities.
- **Develop* and implement pilot interventions** in 10 districts.
- **Develop MOH sexual harassment implementation guidelines* and policy** within six months of approving the study report, and a sexual harassment policy within 12 months.
- **Update national policies and codes of conduct to reflect the findings of this assessment.**
- **Collect further evidence on sexual harassment of patients by health sector employees** to determine the magnitude of the problem and effective prevention and response strategies.

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