Gender norms and medical workforce across the lifecourse
Eswatini example

Methods

We constructed the vignette describing the role of gender norms across the lifecourse for the health workforce in Swaziland primarily as a narrative literature review. We selected literature based on our personal knowledge of Swazi research in both the academic and grey literature, as well as current ongoing projects. Our lens and the contextual details throughout were guided by our experiences conducting qualitative and ethnographic research in Swaziland. Dr. Shabalala is a trained medical anthropologist, certified nurse midwife, and lecturer at the University of Swaziland who has led and coordinated over 27 ethnographic and qualitative studies of adolescent health, HIV, and health systems in Swaziland for both programmatic and academic purposes. Prior to obtaining her PhD she served for over a decade as a public health community nurse and psychiatric health nurse for the Swaziland Ministry of Health, followed by seven years managing health systems and services for both the Ministry of Health and international non-governmental health service organizations in Swaziland. In addition to coordinating and leading multiple qualitative studies of HIV risk, gender, and social-structural determinants of health in Swaziland, Dr. Fielding-Miller is a founding member of the Swaziland AIDS Research Network, an organization dedicated to disseminating and promoting HIV research from and about Swaziland. She served as a scientific advisor for the 2014 Swaziland HIV/AIDS conference and later guest edited a special issue of the African Journal of AIDS Research highlighting Swazi authors and research entitled "What the World Can Learn from Swaziland".

Vignette

Below we describe the ways in which gender norms can affect the health workforce across the life course in sub-Saharan Africa by following the example of a single, imagined woman in Eswatini/Swaziland. We have constructed this imagined narrative based on a literature review of ethnographic and quantitative research conducted in Eswatini, combined with government documents and reports. It is not a systematic review of all gender or health systems research in the region, instead it is intended to demonstrate the broader contextual pathways that influence women's career choices and opportunities in the medical field as they might manifest in a single woman's life:

Simphiwe was born in a rural area approximately one hour outside Mbabane, the capital of the Kingdom of Eswatini (Swaziland). She was the third of four children. She lived with her mother and siblings on a homestead where the family grew most of the food they ate. Her father periodically traveled to South Africa for extended periods of time to earn money on farms or engage in other forms of migrant labor[1]

Simphiwe enjoyed school and had many friends. Boys and girls were equally able to attend her school and were essentially equally successful[i]. As she continued in her studies, she and her female friends slightly outnumbered the boys in secondary

school[ii], however her brothers and the other boys were much more likely to take the hard sciences courses that were prerequisites for careers in medicine or pharmacy[2].

Simphiwe and her siblings would frequently travel to the local clinic with their mother. The clinic was always full of women – women waiting for contraceptive services or antenatal care, mothers holding children there to get vaccines, the nurses in crisp uniforms providing healthcare, the sister in charge overseeing the daily administration. Simphiwe very rarely saw men in the clinic, either patients or nurses[3] . She also rarely saw Swazi medical doctors, but the few she knew of were male[4]. She did know other children who were living with HIV and who would sometimes travel to a specialty a pediatric HIV clinic in Mbabane that was financially and technically supported by a network of hospitals based in the United States[5]. Many white female doctors from Europe or the United States worked at the pediatric HIV clinic[4]. Simphiwe and her friends had never seen a Swazi female doctor, although there were a few in the country[4].

Simphiwe's family paid her secondary school fees with the money her father sent home and the support of a local sponsor - some of her friends were not so lucky and had to drop out to find work or support their families[6]. Moreover, even some of Simphiwe's female friends whose families could afford school fees often felt bullied or shamed as a result of poverty and would hide or withdraw during class[7]. Most of her friends who dropped out did so because they became pregnant and either left voluntarily or were forced to do so by school policy[6iii].

After secondary school, Simphiwe decided she wanted a career in health care. She briefly considered what it might be like to work as a doctor, but there weren't any medical training institutions available in Swaziland and she worried it would be too expensive to pursue her studies in neighboring South Africa. Moreover, she hadn't completed the necessary perquisites for a training course in medicine or pharmacy[2]. Many of her friends had completed their degrees in nursing and teaching, and she knew that the coursework was relatively short and that the job prospects were relatively good. Besides, she admired the nurses in the local clinic and wanted to care for people the way they did.

Simphiwe enrolled in University and completed her bachelors in nursing with a certificate in midwifery. She enjoyed her studies and the other women she got to study with in the predominantly female program. Unfortunately, she struggled to find a position after she graduated – unemployment for women in the country was about 50%[8] - and she didn't want to move too far away from her mother and siblings.

While looking for work, Simphiwe decided to volunteer her time with a local home-based care group run by a church in her community. She enjoys caring for her neighbours and friends, but sometimes it causes her distress to see the circumstances in which they live[9]. She shares food or money when she can, but her volunteer stipend is often late or delayed and she also needs the money to support

her family[9]. She also feels frustrated that the people she works with are sometimes reluctant to share important medical details with her due to local perceptions that women are more likely to gossip than men[10]. She is also frustrated by her low pay, which sometimes comes late or not at all[9,11].

Simphiwe, and her real life colleagues – nearly all of whom are female[4] – play a crucial role in the Kingdom of Eswatini's healthcare system. Unfortunately, there are still far too few: Less than half of Swazi households report receiving a visit from a community health worker[11] and the Kingdom struggles with a shortage of nurses, doctors, and specialists[4]. As we have attempted to demonstrate in this imagined vignette, gendered experiences in early education, exposure to role models, employment opportunities, and low pay for the opportunities that are available likely play a large role in creating and maintaining this shortage. Improving gender equity in health human resources would enhance not only individual women's access to a wider array of career paths, but would likely improve health systems and health outcomes across the Kingdom as a whole.

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[i] Approximately 96% of boys and 97% of girls enroll in primary school in Eswatini[1].
[ii] Net attendance ratio in Eswatini is 52% for girls and 42% per boys[2]
[iii] Approximately 50% of female secondary school dropouts in Swaziland/Eswatini are due to pregnancy[6]