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47

THE PUBLIC HEALTH WORKFORCE

ITS CHARACTERIZATION AND DEVELOPMENT FROM A GENDER PERSPECTIVE

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1. INTRODUCTION

In early 1997, the Pan American Health Organization/World Health Organization (PAHO/WHO) began to place new emphasis on analyzing and systematizing the functional dimensions of public health practice. In this process, which resulted in a regional initiative endorsed by its Governing Bodies, the Essential Public Health Functions (EPHF) are understood as “the series of actions that must be specifically undertaken to achieve the primary objective of public health, which is to improve the health of populations. *Essential* is understood as that which is fundamental and even indispensable to achieving public health objectives and defining public health.”¹

The EPHF performance evaluation that was conducted in 41 countries and territories in Latin America and the Caribbean in 2001-2002 revealed that EPHF #8 “Human Resources Development and Training in Public Health” was the second most deficient category among the 11 EPHF examined. This finding coincides with other trend assessments in what has come to be known in the developed world as the current crisis in human resources for health. In this regard, various forums have recommended that greater attention be paid to the immediate future of the Public Health Workforce (PHWF) with a view to strengthening the EPHF and contributing to the attainment of the Millennium Development Goals (MDG). The PHWF “... consists of all people working in health who are responsible for contributing—either directly or indirectly—to the performance of the EPHF, regardless of their profession and the institution in which they actually work.”¹

With the object of taking a comprehensive approach to the PHWF, the World Federation of Public Health Associations and PAHO called together experts from the Region (San José, Costa Rica, 16 -18 August 2005) to hammer out the basic elements of a proposal for the characterization and development of the PHWF.² Recognizing that mainstreaming gender and ethnicity into the approach is essential to achieving a proposal for characterization and development of the PHWF that is responsive to the specific needs of the different population groups, the Human Resources for Health and Gender, Ethnicity, and Health Units of PAHO decided to examine the impact of these social determinants of inequity on the PHWF.

Under this approach, a technical meeting was convened to determine the elements that a proposal for characterizing the PHWF from a gender perspective should contain to promote and improve development planning. The participants included experts on human resources for public health and gender and health, representing a variety of institutions and sectors and lending a multidisciplinary character to the advisory group. Its contributions made it possible to determine the basic elements that should be included in a proposal to characterize and develop the PHWF from a gender³ perspective. These elements should reflect the link between the productive and reproductive roles assigned socially to men and women, as well as the unequal distribution of resources and power.

¹ Pan American Health Organization. Public Health in the Americas: conceptual renewal, performance assessment, and bases for action. Scientific and Technical Publication No. 589. Washington, D.C.: PAHO, 2002.

² Organización Panamericana de la Salud. Consulta sobre “Fortalecimiento de la capacidad de la fuerza de trabajo en salud pública en apoyo a las Funciones Esenciales de Salud Pública y a los Objetivos de Desarrollo del Milenio. San José, Costa Rica, agosto 16-18, 2005. Documento Final.

³ Pan American Health Organization. Advisory Group on “The Public Health Workforce: Its Characterization and Development from a Gender Perspective”. San José, Costa Rica, 11-13 October 2005.

2. FRAME OF REFERENCE

2.1. GENERAL CONSIDERATIONS

Characterization and development of the PHWF require drastic changes in *the public health paradigm*. Notwithstanding the progress made, the current paradigm still has a very individualistic biological orientation that limits mainstreaming of the gender perspective and the interdisciplinary approach as an integral part of a model that provides a social and cultural context for health. Every change in policy requires a change in culture, and mainstreaming the gender equality perspective will make this change possible.

Education for health professionals is considered very limited and specialized, geared to personal curative care, with serious shortcomings in contextual and cultural aspects of health, where essential public health issues such as health promotion, disease prevention, or health threats and risk factors come into play.

Human resources education in its current form creates a fragmented and inconsistent workforce, which adversely affects overall performance of the EPHF. The deregulation of training and professional practice does not facilitate central planning at the national level or the mainstreaming of key performance principles. *Human resources education in public health* should be consistent with the particular needs of women and men at the individual and community level, with citizen participation linked to PHC. When talking about community, we recognize the existence of cultural differences that should be considered in the work of public health; each community has the right to its own culture and beliefs, which must be respected. Furthermore, *public health research* should be geared to the practice of public health, where community participation is vitally important for research projects that meet the needs of the most affected groups.

Labor flexibility, in turn, is a trend in globalization that emphasizes greater productivity, often at the expense of labor rights. It will be necessary to consider job stability and to move in the direction of cooperative labor relations between employers and workers; it would also be worthwhile to stress areas related to investment in training and innovation, with PHWF participation.

2.2. THE PHWF: SITUATION ANALYSIS

In recent decades, shortcomings in public health practice have frequently been documented in the Region of the Americas. In the 1970s, the spotlight was on problems in the schools of public health, for example, the instructors, and human resources began to be viewed as the main problem in the crisis and in public health's disconnection with the needs of the population. In the late 1970s, the Primary Health Care (PHC) initiative began to gather ground. PHC was defined as "...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford..."⁴ The initiative seeks to eliminate the vast inequalities and inequities in access to health services, and PHC is considered essential for achieving a level of health that permits the social and economic development of each country.

⁴ Declaration of Alma-Ata. 1978.

Ten years after Alma-Ata, widespread awareness of gaps or weaknesses in both the theory and practice theory of public health led to the perception of a crisis that was acknowledged even in the developed countries.

As mentioned earlier, a recent PAHO evaluation of EPHF performance in the Americas revealed several deficient areas in terms of the EPHF. Significant among them was the poor performance of the national health authority in the matter of human resources for health (EPHF #8). Although the countries of the Region reported that the basic characteristics of the workforce are evaluated, only a small proportion of them defines its manpower needs to ensure good performance in public health activities. The weakest areas identified in this measurement are lack of information and the lack of criteria for assessing needs for the future growth of the PHWF.

In describing the impact of the current challenges, the developed countries have stressed the notion of a contemporary crisis in human resources for health, questioning the ability of public health systems to respond to the endemic and catastrophic situations of recent years, which have revealed growing weaknesses in these systems.

Health sector reforms, in contrast, especially those related to decentralization, service delivery, and financing have had a significant impact on human resources in the sector. For example:

- The changes in service delivery and financing with private sector involvement led to new types of employment and working conditions, increasing the complexity of estimating labor needs;
- Greater community participation requires local staff to possess greater administrative, managerial, and planning capacity;
- Staff reduction policies have had a greater impact on women;
- Transferring health care for the sick, the disabled, and older adults who cannot take care of themselves from the formal system to the home environment has meant an increase in the demand for unpaid labor, performed mainly by women.

When the reforms are vertical, the workforce could be adversely affected by lower participation and less of a sense of “ownership” of the reforms among its ranks and, at the same time, by a greater distancing from community realities, becoming disconnected from the problems in most need of attention. If, moreover, the reforms are abrupt, human resources are left behind, because there is no opportunity to absorb the change; furthermore, policy changes in these reforms are limited, and human resource problems are considered secondary. If there is a lag between the reforms and human resources management policies, the quality of employment and work schedule suffer from the inadequate supply and distribution of staff, as well as from unregulated intrasectoral flows of workers. In that case, the trend is to introduce flexibility in the labor market, leaving not a few workers without protection or labor guarantees, an area where women are over-represented.

The EPHF must be adapted to the needs created by sweeping economic, social, cultural, and political changes. These new needs call for a characterization of the PHWF that permits the strengthening of human resources to respond to current needs, defined by a specific economic, social, cultural, and political context.

From the standpoint of strengthening the EPHF, mainstreaming the gender perspective will lead to better performance and, at the same time, will facilitate attainment of the MDGs on health and appropriate responses by public systems to alerts and emergencies. It should be recalled that the achievement of MDG-3, on gender equality and the empowerment of women, has widely been recognized as a prerequisite for achieving the other MDGs.

2.3. GENDER: GUIDING PRINCIPLES

The term *gender* refers to the social constructs of “masculine” and “feminine” and to the way these constructs are linked in power relationships. As a historical and social phenomenon, the unequal access and distribution of resources and power, whose roots lie in the biological differences between women and men, is reflected in the structures, practices, and behaviors that characterize the organization and dynamic of a society.

In health, *gender equality* means “that women and men are in an equal position to exercise their full rights and realize their potential to be healthy, contribute to health development, and benefit from the results. Achieving gender equality will require specific measures to eliminate gender inequities.”⁵

Gender equity, in turn, means “fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men. The concept recognizes that men and women have different needs and different access to and control over resources, and that these differences must be addressed in a manner that rectifies the imbalance between the sexes. *Gender inequity in health* refers to inequalities between women and men in health status, health care, and participation in health work that are unjust, unnecessary, and avoidable. Gender equity strategies are used to eventually attain equality. Equity is the means, equality is the result.”⁶

As part of a gender equality approach, *diversity* means recognizing that “women and men are not a homogenous group. When addressing the problems of gender and health, the differences between women and men from the standpoint of age, socioeconomic status, education, ethnicity and culture, sexual orientation, ability, and geographical location must be taken into account.”⁷

Gender mainstreaming is “...the process of assessing the implications of any planned action for women and men, including legislation, policies or programs in any area and at all levels. It is a strategy for making the concerns and experiences of both women and men an integral dimension in the design, implementation, monitoring, and evaluation of policies and programs in all political, economic, and social spheres, so that inequality between men and women is not perpetuated. Gender equality is the ultimate goal.”⁸

The following *dimensions of gender equity in health* have been considered from a gender perspective:

- *Socioeconomic determinants of health*. This refers to access to and control over material and nonmaterial resources, as well as the distribution of power, which make it possible to exercise the right to health;
- The *health situation*, in which gender equity would be reflected in comparable levels of health and well-being for women and men, not only between them, but in terms of the more privileged population groups in specific contexts;
- *Health care*, where gender equity implies that:
 - ♦ resource allocation is based on the specific needs of men and women, and the services received are based on the particular needs of each sex, regardless of the ability to pay;

⁵ PAHO/ CD46/12. Proposed PAHO Gender Equity Policy. Page 4.

⁶ Canadian International Development Agency. Gender Equality Policy of CIDA, Québec, 1999. From PAHO/CD46/12 Proposed PAHO Gender Equity Policy. Page 4.

⁷ PAHO/CD46/12 Proposed PAHO Gender Equity Policy. Page 5.

⁸ E/1997/L.30 (para. 4), adopted by the United Nations Economic and Social Council on 14 July 1997. From PAHO/CD46/12 Proposed PAHO Gender Equity Policy. Page 5.

- ♦ contributions to the financing of health services for women and men are based on their ability to pay and not the risks or needs characteristic of each sex and each stage of the life cycle;
- *Participation in health management*, where gender equity demands a fair balance in work (paid and unpaid) between the sexes, in compensation for that work, and in decision-making power. With regard to the workforce, it should be emphasized that this participation covers both paid and unpaid work, the latter of which is done mainly by women in the home and community; it also refers to volunteers who perform recognized work in the formal system without payment.

2.4. THE PHWF FROM A GENDER PERSPECTIVE

2.4.1. *Women in the Labor Market*

Women's disadvantages, specifically in the world of work, are derived from the sexual division of labor, where women have the main responsibility for unpaid domestic work, which limits their opportunities in the labor market. Their participation in the labor market has not necessarily meant the redistribution of domestic responsibilities, giving rise to the so-called "double shift." It should also be noted that women's work in both the home and the labor market is undervalued. In Latin America, over 50% of women do not participate in the paid workforce; unemployment rates among women are higher than among men; women, when they do perform paid work, are for the most part concentrated in low-paying occupations or are paid less than men for the same work. Women earn some 57%-79% less than men; women are over-represented in occupations not covered by social security because they work primarily in the informal sector and part-time jobs; women's access to health insurance and retirement plans is much more limited; their reproductive role creates gaps in their work history because of pregnancy and child care.⁹

According to studies by the International Labor Organization (ILO), the growth in employment between 1990 and 2003 occurred mainly in the informal sector. An estimated 6 out of 10 newly employed people were working in the informal sector during that period. The greatest increase in informal employment was observed among men, but women exhibited a higher degree of informal employment. Currently, one out of every two working women works in the informal sector. As to the reduction in social security coverage, the ILO reports that roughly 5 out of 10 salaried workers, including those in the PHWF, had social security benefits, while only 2 out of every 10 new salaried workers in the informal sector had that coverage in 2003. This decline, according to the ILO data, was seen among women and men alike.¹⁰

Unemployment among women is growing in the Region. The ILO data indicate that in countries where unemployment is falling, the situation for both women and men varies; however, in most of the countries where unemployment is growing, women are worse off than men.¹¹

The ILO studies indicate that significant numbers of jobs for women are still a long way from what could be described as "decent work," as they lack social protection, adequate pay, and respect for the right to organize. Another matter yet to be addressed in employment policy is guaranteeing women and men the right to balance work with family life. The tension between family and work responsibilities affects all women, including those in the PHWF; thus, particular attention should be paid to guaranteeing the necessary

⁹ Gómez, E. Género, equidad y acceso a los servicios de salud: una aproximación empírica. Revista Panamericana de Salud Pública, junio del 2002.

¹⁰ OIT. Panorama Laboral 2003. Lima. Regional Office for Latin America and the Caribbean, 2004. pg.14.

¹¹ Idem, pg. 11.

balance between family and work responsibilities, making efforts to lower the barriers that keep women from fully participating in the labor market.

Employment policies should promote genuine equality of opportunities for women and men. "Neutral" policies are not enough, since they ignore the different characteristics, conditions and roles of women and men, especially those of women heads of household who must assume productive and reproductive responsibilities in the home. In order to promote equal opportunity in the workplace, consideration should be given to policies and programs that include measures such as daycare services and special areas for breast-feeding, flexible work hours (in the case of salaried employment), and initiatives that reduce occupational segmentation, such as training and access to jobs consistent with their skills and competencies.

Strengthening human resources for public health requires intervention at several levels. At the national level, the policies, planning, composition, distribution, and regulation of human resources should be considered; at the institutional level, it is important to intervene in the areas of personnel management, organization of the work, negotiations, labor relations, working conditions, and competency development; in the overall management of the services it is necessary to assess and encourage performance, productivity, motivation, teamwork, continuing education, commitment, and quality, among other things.

2.4.2. Challenges to Mainstreaming the Gender Perspective in Addressing the PHWF

The definition and characterization of the PHWF are critical to planning its development. It is not enough to propose standards, expressed as a ratio between the number of professionals and the total population, given the current deregulation of human resources education, unequal geographical and demographic allocation of these resources, gender inequities, and limited access to public health services.

The challenge to defining, educating, and training human resources for public health is adapting the health services workforce to the differential health needs of women and men in different population groups. That is, putting the right people in the right places, achieving equitable distribution of health workers in the different regions, as needed; regulating the movement of health professionals, both inside the country and internationally, keeping the health services in operation for all the population; forging ties between health workers and health organizations that will foster commitment to the institutional mission to offer good health services to the entire population; developing mechanisms for interaction between professional training institutions (universities, schools) and health services institutions that will make it possible to modify training for health professionals to ensure an equitable, quality model of care.¹²

From the gender perspective, an area of vital importance is the unpaid work in health care performed by women in the home. As mentioned earlier, the term PHWF refers to the people that contribute directly or indirectly to the performance of the EPHF. Thus, it is essential to make the contribution of many women to public health visible and recognize the work that they do in caring for children, the elderly, and sick or disabled family members who cannot take care of themselves. This unpaid work has remained invisible and, as a result, is not a policy consideration, and while these women are recognized as part of the PHWF, this work continues to be regarded as part of their "natural history."

Cost reduction and efficiency policies conceal profound gender biases—transfers of costs from the paid economy to the economy based on the unpaid work of women. This transfer of services from the public to the private domain has an enormous impact on women, especially because they must sacrifice time that could be used for personal development. To comprehensively address the issue of the PHWF, its characterization should include those who labor without pay to provide health care in the home. Nevertheless, this first phase in characterizing the PHWF will center on the paid workforce.

¹² Pan American Health Organization. Human Resources for Health Unit. Regional Consultation on Human Resources in Health: Critical Challenges (June-July 2005).

In short, cross-cutting issues such as gender, ethnicity, and generation, within the framework of human rights, are closely linked to principles, attitudes, and values.

Characterization of the PHWF implies a dual responsibility on the part of national and international, public and private institutions: the first, a technical one involving the definition of the functions and performance of human resources for public health, and the second, a response to a political-social undertaking that provides a context for cross-cutting¹³ issues. Addressing gender as a cross-cutting issue in the characterization and development of the PHWF is essential for achieving an efficient response to the health needs of the different population groups, reaffirming the principle of nondiscrimination contained in the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The characterization of the workforce should include a gender perspective in order to define and execute a human resources initiative based on universal values: nondiscrimination, equity, and sensitivity to the situation of the different groups and individuals that make up that workforce.

¹³ Gardián Fernández, A. Perfil curricular, temas transversales y derechos humanos. Universidad de Costa Rica.

3. CHARACTERIZATION OF THE PHWF: CONTRIBUTIONS FROM A GENDER PERSPECTIVE

3.1. CONCEPTUAL ELEMENTS OF THE DIMENSIONS

Characterization of the PHWF implies the identification of new dimensions, categories of analysis, and variables that describe the trends and characteristics of this occupational group in health service facilities and their work processes.

An important way of addressing inequalities and gender inequities, heightened by the current difficult working conditions, is to study the distribution of resources, responsibilities, and power between women and men, in both the unpaid domestic dimension and the paid employment dimension.

Concerning the situation of working women, it is often argued that there is no discrimination in the workplace; nevertheless, when gender considerations are ignored, the gaps that separate women from men in different areas of the labor market remain in place¹⁴.

3.1.1. Labor Laws and Regulation

Characterizing the PHWF becomes very important in the face of the growing global trend toward flexibility in the world of work and the determinants of globalization. Regulations are for general application in a national or regional context and are put in place to protect and/or improve conditions for workers, or people who aspire to a job and an income.

In this regard, at the international level, specific labor standards are already found in the regional and subregional¹⁵ integration mechanisms. The four regional integration blocs in Latin America and the Caribbean have adopted labor standards to a different extent and with differing scope. Aspects of labor have been addressed by specific or complementary instruments. Some aspects of basic rights refer, for example, to the guarantee that the integration agencies in general, with the exception of the Central American Integration System (SICA), have instruments and declarations with express references to the freedom of assembly and the right to unionize, the right to collective bargaining, the elimination of forced labor, the abolition of child labor, the elimination of discrimination, and equal remuneration. In the case of the Andean Community (CAN), it is recommended that compliance with the fundamental agreements of the ILO be improved and that a new instrument on occupational safety and health be developed. In the case of SICA, there is reference to nondiscrimination and, regarding working conditions, to fair and adequate remuneration.

It is recommended that in characterizing the PHWF, some labor standards be included that will make it possible to determine the quality of working conditions and respect for labor laws in order to assess institutional equity and gender equity in particular. Likewise, their effects on socially disadvantaged groups, i.e., women, low-income groups, migrants, and other ethnic groups, should be closely scrutinized.

¹⁴ OIT. *Panorama Laboral 2003*. Lima. Regional Office for Latin America and the Caribbean, 2004. pg 70.

¹⁵ The four integration blocs are MERCOSUR (Southern Common Market), CAN (Andean Community of Nations), SICA (Central American Integration System), and CARICOM (Caribbean Community and Common Market).

One of the main components of labor laws, and the fairest, is the possibility of obtaining what the ILO has called “*decent work*”¹⁶. This is probably the social dimension closest to working people. The hope of obtaining a good job is the most important issue for women and men alike; obtaining one means not only that working people have a job but that their basic rights are respected and that they can secure a living wage for themselves and their family, thus meeting their basic needs in the areas of food, housing, health, social security, and education.

With regard to the *working conditions of the PHWF*, it will be necessary to consider the following from a gender perspective: the work week, leisure time, fair and adequate remuneration, job stability, opportunities for promotion, conditions for workers with disabilities, maternity leave, opportunities to breast-feed and to care for terminally ill patients (family members), vacations and holidays, occupational safety and health, and mechanisms for settling labor disputes, among other things.

With regard to *social security*, the following should also be included: compensation for accidents in the workplace or occupational illnesses, indemnity for injuries or work-related illnesses, medical care, funeral benefits, unemployment insurance, old age insurance, and survivor’s benefits.

With regard to the *labor contract*, signature by the employer and employee is key, since it determines many of the characteristics of the job. The existence of a written labor contract makes the labor relationship more formal and visible, increasing the likelihood that the legal standards governing employment are complied with, among them those that grant workers labor rights and social protection.

In the field of health, the recent trend has been toward the outsourcing of professional services. In this type of contract, although a particular service is agreed upon at a certain price, the contract is not subject to the provisions of the labor laws; a professional who provides services under this type of contract does not enjoy the same rights as professionals who work under a work contract. In this regard, Labor Law is governed by specific special legal principles, among them the Principle of Protection, which implies the existence of a specific, previously recognized situation and determines that the law should be interpreted in the manner most favorable to the worker; thus, any changes that are introduced should expand and not take away the rights of the people.

In contrast, *salary* as one of the basic labor rights under the different labor laws, varies with the job and type of work. Here it is important to make a brief reference to the concept and right to a minimum wage, which is the national minimum value paid on average to working people of legal age, specified in the laws of each country and aimed at meeting basic needs and preventing exploitation. There is evidence of income disparities between women and men, a gap that widens as educational levels increase, with women at a disadvantage.

With regard to the *work week and working hours*, doctrine defines the work week as the number of hours per week that a worker by law is permanently obligated to spend on work activities. The work week in the health services should be analyzed from the standpoint of the service providers, but also adapted to a schedule that facilitate access by both women and men, considering their different productive and reproductive roles and responsibilities.

Given the time obligations that every working individual must fulfill each work week, labor laws have generally set limits on work hours that cannot be exceeded. Thus, the Labor Codes have recognized three types of ordinary work week—day shift, night shift and mixed—establishing regulations for the maximum number of work hours for each.

With regard to work, quality regulation implies an evaluation process aimed at verifying compliance with the established criteria and standards.

¹⁶ OIT. *Panorama Laboral 2003*. Lima. Regional Office for Latin America and the Caribbean, 2004. pg 70.

3.1.2. Health and Work

With regard to working conditions, occupational health should be taken into account, and thus, measures should be adopted that are appropriate to the characteristics of public health service delivery. In particular, there should be adherence to the guidelines for occupational health, policies against discrimination for health reasons, especially where workers with HIV/AIDS are concerned, and the adaptation of the workplace for people with disabilities, in different types of work. This, in search of equal employment opportunities, ethics, and the protection of human rights, in addition to the prevention of physical or mental stress from working conditions detrimental to health. Of particular importance is a health surveillance system for health workers, especially those who deal with survivors of domestic and sexual violence, as well as people with terminal illnesses.

3.1.3. Sociodemographic Dimension

Family structure is key to an integrated approach to the characterization of the PHWF. Many of the categories and variables in this dimension are directly and indirectly related to performance of the functions. It is surprising how little knowledge there is on the impact of this dimension on the workforce, and responses that come closer to the reality of a characterization may be limited by ignorance of this category.

The growing independence of women in recent years has contributed to greater freedom and definition of their personal and family relationships; however, the increase in homes in which women are heads of household, the principal sign of the social changes under way in nearly every country, puts women in a critical position in terms of obtaining resources while having greater responsibility for supporting the household. This picture is worsening with the cutbacks in social spending and the intensification of domestic work, especially because of the greater responsibilities in caring for sick people, older adults, and the disabled in the home.

As mentioned earlier, the growing participation of women in the workforce has sparked a public debate on the relationships between productive and reproductive work that differentially impact the work of women and men, both paid and unpaid. New social practices shared equally by women and men in the home are beginning to emerge; nevertheless, women retain the responsibilities of their traditional role, making it easier, in their search for ways to reconcile their productive and reproductive roles, to enter the informal sector of the labor market.

Information about the number, conditions and characteristics of the people who live in health workers' households will make it possible to analyze their participation and development in the workplace, as well as their performance of health care practices.

3.2. STRATEGY

Characterization of the PHWF with broad, nontraditional approaches that generate democratic environments in institutions requires:

- *Active participation by workers*, who express their views about the work they do, focusing on technical matters, as well as attitudes and skills. This social and human dimension facilitates an about-face and reorientation of the classical concept of the individual performance evaluation, in which this characteristic is merely a formality.

- *Information sources.* The proposed approach calls for creativity in the search for the existing data sources in each country situation. In addition to quantitative data sources, qualitative information must also be gathered.
- *Techniques and instruments.* The acquisition of data for analysis and information gathering to characterize the PHWF implies the design of the instruments that consider the suggested dimensions with their categories, variables, and data disaggregated by sex; instruments for the qualitative information survey; and the definition of techniques for gathering quantitative and qualitative data in protocolized research processes. The use of cases that draw out views and attitudes makes it possible to elicit the knowledge possessed by the workers about technical work situations that might generate discrimination and affect gender equity. The goal is to strategically capture the subjectivity of workers, which is the product of their life story, experiences, and knowledge about their day-to-day work environment.

3.3. METHODOLOGICAL ELEMENTS

Characterization of the PHWF from a gender perspective requires an integrated approach that goes beyond the traditional human resources survey in health institutions. Thus, account should be taken of factors that are a source of unfair and avoidable inequality in the hiring, recruitment, and retention of health workers and the quality of the services that they provide in the performance of their job. To this end, different entities and information sources, objective and subjective, should be tapped that reflect the reality of public health workers.

One of the clearest difficulties that must be resolved is understanding how the definitions of positions or jobs have been adapted up to now to the EPHF, and how these definitions have contributed or failed to contribute to the achievement of the goals pursued.

It should be emphasized that the data on the PHWF should be disaggregated by sex at all levels of the organizational structure. The following steps are considered strategic for achieving this.

3.3.1. Successive Approximations

For the definition of new dimensions that conceptually integrate the cross-cutting gender issue for characterizing the PHWF, three areas of exploration have been identified:

- The *first area* is the “structure and distribution of the public health workforce.” In this area, the employer—institution or organization—is consulted. In addition to the structure and distribution of personnel, criteria for the work process, policies, programs, and standards—including among the latter standards for quality in service delivery—are explored.
- The *second area* is “the function and quality of performance.” In this area, workers will be consulted, obtaining their perceptions of what they do and the knowledge they possess for their performance—that is, how they do it.
- The *third area* is “quantity and quality of work outcomes.” The links of the production and productivity of the system with the PHWF development planning will be assessed. On the other hand, the users of the system will be consulted to obtain their perceptions on the providers’ performance and their satisfaction with the services received.

3.3.2. Dimensions of the Characterization

We begin by linking the domestic and productive dimensions, through the identification of factors that are classically invisible in the working life of people. In each dimension of the levels, we propose basic categories and variables to be considered in the characterization of the PHWF. The identity of the institution is an element in the characterization that indicates the context of the work activities of the staff employed and the types of work processes involved.

For each area explored, the results of the consultation are detailed in Annex 1.

4. DEVELOPMENT OF THE PHWF: CONTRIBUTIONS FROM A GENDER PERSPECTIVE

4.1. CONCEPTUAL ELEMENTS OF THE EDUCATIONAL DIMENSION

Professional training calls for special attention in the characterization of the PHWF. Institutional modernization, the product of health sector reforms in the countries, usually promotes a regulated market of training and educational services that is not necessarily planned with equity in mind or based on the epidemiological profile of the population spaces, where the institutions that provide services carry out the EPHF, and contribute to development are found.

It is essential in this regard to consider the characteristics and needs of the workforce when designing and implementing training programs—schedules, scholarships, alternative modalities such as tutorials, virtual classrooms, etc.—with a view to inserting women into the labor market with equal opportunities and closing current gaps. The same holds true for continuing education in institutions as a strategy for staff development, based on job responsibilities and the competencies that should be developed to ensure good practices in the framework of health situations that workers face and the population groups receiving the care.

Educational regulation implies a process of evaluation to ensure that criteria and standards previously established for institutions and professionals are met.

Institutional accreditation, which is done at the national level, is an area that is beginning to be viewed as a need. It would not replace the accreditation of professional credentials or programs but be a complementary instrument that would put those results into perspective. This type of regulation is understood as the policies, mechanisms, procedures, and actions established to determine whether an institution or program is actually achieving its goals and objectives, ensuring that academic standards are met and continuously improving the quality of the services that it provides.

Recertification helps ensure that the competencies that professionals acquire in their training are suited to the needs of women and men in specific population groups and society as a whole. The goal is therefore to guarantee levels of quality in training, preserve the interest in quality at training institutions, and furnish users with information about quality levels.

This proposal underscores the need for mechanisms that contribute to better professional training, particularly in terms of evaluation systems, content relevance, and quality work. It also emphasizes transparency in evaluations in order to develop the new and necessary professional competencies, and the creation of incentives for training in the organization.

4.2. PROFESSIONAL COMPETENCIES IN PUBLIC HEALTH

It is important to underscore that the basic reference point for human resources education in public health (in academic, technical, and other institutions) must be human rights theory. The mainstreaming of

gender equality and human rights should permeate the different intervention levels considered in the strengthening of human resources: national, institutional and of management of services.

The central problem for the development of the PHWF is definition of the competencies required of the workforce. Health development requires encouragement and incentives for good performance, but also adequate knowledge and skills for displaying good practices and obtaining quality performance, thereby achieving work objectives and contributing to better health care. The demands of the 21st century and the challenges of globalization, the MDGs, the strengthening of the EPHF, together with the advances in science and technology and demographic change call for workers with the capacity to make decisions, adapt to changing situations, and guarantee respect for the rights of individuals, in addition to a good command of the technical aspects of their job.

Therefore, definition of the functions, capacities, or competencies of the PHWF is at the heart of promoting better performance. Thus, characterization of the workforce includes strategies and methodologies for assessing the situation of the different working groups in terms of the processes that they execute and the institutional context in which they perform.

In 1994, the Latin American and Caribbean Public Health Education Association (ALAES) established the following professional functions for public health education:

- Historical-political analysis
- Value added
- Knowledge management
- Strategic management
- Strategic mediation
- Advocacy

Regarding the definition of competencies, an approximation can be reached through what has been called “universal competencies for public health professionals¹⁷”, namely:

- Analytical
- Communication
- Policy development /program planning
- Cultural
- Basic sciences in public health
- Planning and financial management

Another suggested approximation is “general competencies” and “specific competencies”, outlined below.¹⁸

General competencies:

- Cultural
- Analytical
- Educational
- Communication

¹⁷ The Public Health Faculty/Agency Forum in the United States, 1993, cited in Ruíz Luis. “De la realidad a las disciplinas: Estructuración de las respuestas educacionales con base en las competencias de las instituciones y de la fuerza de trabajo.” In: *Educación en salud pública: Nuevas perspectivas para las Américas*. Pan American Health Organization. Washington, D.C.: 2001.

¹⁸ Ruíz, Luis. “De la realidad a las disciplinas: Estructuración de las respuestas educacionales con base en las competencias de las instituciones y de la fuerza de trabajo.” In: *Educación en salud pública: Nuevas perspectivas para las Américas*. Pan American Health Organization. Washington, D.C.: 2001. pp 134-159.

- Information management
- Public health sciences

Specific competencies:

- Analysis and monitoring of health status
- Disease prevention and control
- Health promotion
- Social participation and empowerment
- Service to vulnerable populations
- Environmental health promotion and protection
- Improvement of equity and quality in the health services
- Legislation and regulation
- Policy development /program planning
- Public health management
- Planning and financial management
- Human resources development

The definition of professional competencies is very important for PHWF development. Some of the implications for competency-based education that have been noted are monitoring and surveillance of the external environment, performance evaluation, analysis of the available structural or curricular adjustment options, identification of the competencies to be developed, the redefinition of educational contents and modalities, and its testing against institutional and professional needs.

The *core competencies* in public health reflect the knowledge, skills, and abilities common to all professionals working in that field. They cut across the boundaries of the specific disciplines in public health. Those competencies should be independent of the work programs, so that they will reflect the approximation of public health contents to health issues; also, these competencies should have the potential to relate or disaggregate more in close linkage to the organization of the health services, and be directly related to the target population (users, patients, organization, or community) and to the social pertinence of public health activities.

There is no doubt that defining the competencies required for PHWF performance helps to identify the population's perceived needs so that the PHWF can do its work better and create incentives that promote good practices.

Groups of experts, like those who gathered in August 2005 in San José, Costa Rica during the consultation on strengthening the PHWF, and those in the present *ad hoc* advisory group, which met in October 2005, indicated and supported new domains for consideration in the definition of competencies. These domains are related to capacity building in the PHWF as it relates to cultural aspects, especially gender, ethnicity, and generation.

The demand for new capabilities in the PHWF to ensure good performance of the EPHF, which promotes attainment of the MDGs, involves new elements in capacity building and the definition of competencies, such as the political capabilities of the PHWF, inasmuch as there is now greater involvement and closer ties with new individual and corporate social actors; recognition of public health as an intersectoral and international area, which implies capacity building to mobilize society to demand better living conditions and the right to health; and mediation between the public and private domains in public health actions.

The competency approach should be employed to assess and develop the performance capabilities in health systems; in this regard, new competencies should be identified to answer the following questions: How do members of civil society participate? How much activity involves democratic participation in health

and how is the development and implementation of this activity strengthened? How is citizenship in health promoted? as well as other related questions.

It was suggested, moreover, that the approach to and definition of competencies requires flexible methodologies and clear frames of reference, such as the EPHF in the framework of the countries' own reality; and that the competencies should be linked to the social and institutional context and be directed toward the political aim of public health.

Thus, development of the PHWF implies the definition of public policies and strategies, and most importantly, the identification of the core competencies for facilitating the strengthening of the capacities required of the PHWF. Only in this way will it be possible to guarantee better performance in the exercise of the EPHF and the attainment of the MDGs.

4.3. PROPOSED DIMENSIONS, CATEGORIES, AND VARIABLES

Annex 2 presents a table with the information from this Consultation, supported by the conceptual elements of the key dimensions in this aspect of PHWF development.

5. FINAL CONSIDERATIONS

One of the main goals of this summary, derived from the Consultation on the characterization and development of the PHWF from a gender perspective, is to circulate the information obtained among specialized groups that can enrich it. During the meeting, a video produced by the University of Costa Rica's School of Public Health, the REDET group, and the International Health Unit of the University of Montreal, was shown, with interviews of gender experts, instructors, investigators, and political authorities about the vision and aspects of gender in health situation analysis: public policy, adolescence, information systems, masculinity. This video could be offered for circulation to disseminate the knowledge of the different gender experts, as their contributions were highly useful to the advisory group.

The objective is ultimately to eliminate inequities following the basic political and philosophic principles of modern health systems: equal rights for all people without distinction of sex, age, ethnic origin, or sexual orientation, as well as the right of all members of a society to participate in the management and direction of the health systems.

Policies and programs should promote equal opportunities; to this end, they must consider gender roles in their concepts and practices, as well as employment conditions. We must emphasize the paradox in the argument for "neutral" policies; we recognize that although unintentional, in practice, omitting gender considerations means perpetuating the gaps between women and men in the different dimensions of health and its determinants.

The PHWF should have human resources that are competent, motivated, adequately paid and protected who perform efficiently in adequate health services, where and when they are needed.

It should be clear that institutional capacity and a State with active citizen participation are needed, where guaranteeing the right to health and responding to the demands of the population are the objective pursued by health policies. To this end, strategies for developing the PHWF should focus on the worker on the one hand, and on the employer, on the other. An important point to consider is the strategy of interdisciplinary teamwork in the public health practices needed for good performance of the EPHF.

When defining a work agenda to further the characterization of the PHWF, other consultations will be necessary to incorporate ethnicity and generation, with the participation of professionals, academics, and staff from the ministries of health and other agencies. It is important to review and expand the classical professional categories that make up the PHWF, since the traditional biologist image persists in public health work processes. Professions and occupations in the social sciences and other areas related to health should be given visibility to reveal the complexity and interdisciplinarity of this field.

This proposal is simply an attempt to highlight some criteria that should be included; it is neither a project nor a protocol. Tools and instruments should be designed for that purpose, mainstreaming the gender equality perspective.

ANNEX 1:

CHARACTERIZATION OF THE PHWF: PROPOSED DIMENSIONS, CATEGORIES AND VARIABLES FROM A GENDER PERSPECTIVE

1. CONTEXT

	INSTITUTIONAL AREA		
	DIMENSION	CATEGORIES	DATA
WHERE ARE THEY?	A. Institutional profile	Name and geographical location	Name of the institution; address; location (urban or rural area); work process
		Type of institution	Institution's level of care (primary, secondary, tertiary, special); nature of the institution (services, research, etc.)
		Human resources development policies, programs, and initiatives	Training programs; promotions; incentives and encouragement to workers
		Health services for workers	Existence of disease prevention and occupational health protection for workers Existence of an adequate environment for workers with disabilities Programs for monitoring workers' health
	B. Labor Laws	Type of contract	Working women and men with fixed-term, permanent, specific task or project, or professional service contract and without a contract
		Job security	Women and men serving in an interim, substitute, or other capacity
		Work period	Women and men by work week (full time, half time, part time); and type of work week (day shift, night shift, mixed, overtime)
		Regulation	Professional or institutional
		Remuneration and retirement plans	Salary in dollars and other components, such as specie, per diem, bonuses, incentives, overtime, professional career, exclusive dedication, prohibitions, zoning, for women and men
		Cultural aspects	Existence of labor laws consistent with freedom of religion

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	INDIVIDUAL AREA *		
	DIMENSION	CATEGORIES	DATA
WHO ARE THEY?	Socio-demographic	Marital status	Married, single, divorced, widowed, cohabiting
		Nationality	By birth or naturalization
		Immigration status	Documented, undocumented
		Ethnicity	Ethnic group
	Homes	Position in household	Head of household
		Type of household and dependents	Nuclear, blended, extended, one-person family; presence of people under 18, older adults, and disabled people who cannot care for themselves
	Schooling	Education	Basic, intermediate, higher education
		Profession	Medicine, nursing, odontology, laboratory worker, nursing auxiliary
	Employment	Work areas	Management, administration, operations, miscellaneous
		Job	Profession or trade
		Seniority	Years of service, age individual began working
		Job promotions	Job training, promotions received, date of last promotion, number of promotions
		Workload	Number of jobs currently held, type of employment, number of hours per work week (for all jobs), type of contract in each job
	Health	Disabilities	Disaggregated by type of disability
		Chronic diseases	Disaggregated by disease

HOW MANY ARE THEY? This will be obtained using the methodology for characterizing the PHWF.

* Disaggregated by sex

2. FUNCTION AND QUALITY OF PERFORMANCE

	DIMENSION	DESCRIPTION
WHAT DO THEY DO?	Type of function Job functions Functions performed	Taxonomy of the job; professional profile for the job; professional or vocational training
HOW DO THEY DO IT?	Allocation of their time Compliance with standards Quality of performance Interdisciplinary work	Availability and use of standards and techniques; performance gaps and educational needs observed or perceived (note 5 tracer examples to confirm what they do)

3. QUANTITY AND QUALITY OF RESULTS

	DIMENSION	DESCRIPTION
WHAT DO THEY OBTAIN ?	Production and productivity Satisfaction of demand	Number of activities carried out by type; geographical and population coverage; links to programs and plans; participation in planning activities

ANNEX 2:

DEVELOPMENT OF THE PHWF: PROPOSED DIMENSIONS, CATEGORIES AND VARIABLES FROM A GENDER PERSPECTIVE

DIMENSION	CATEGORY	DATA
Human Resources Management	Human Resources Education	Training: Women and men who have received in-service training, disaggregating by the study schedule (day, evening, night), training modality (presential, tutorial, virtual), payment method (scholarship/grant, loan, own resources) Orientation: Women and men who have received formal orientation when they start their jobs, or when they are promoted or transferred to other positions Training areas: Techniques, personal development, associativism Opportunities: Taken advantage of, declined, lost Obstacles
	Promotion at work	Criteria for promotion: Whether they have a procedure (competitive internal selection process): participation in promotion processes Age, sex, place of residence, immigration status, formal education, training and upgrading of skills, languages, performance, seniority, health status, disability Number of promotions: Women and men who have received promotions in the past ... years
	Planning	Cadres for replacement or brief substitution
	Incentives	Recognition for years worked, professional career, medical services, prophylactic vacations, leave for: maternity, breast-feeding, care of terminally ill family members, etc. PHWF satisfaction with services received.
Performance	Utilization of standards	Complies with them, knows them; they are clearly established, they are available and accessible to all individuals
	Interdisciplinary work	With other disciplines and professions; working group or team; frequency of interdisciplinary work
	Planning	Participation in the process; participation in decision-making; community participation
	Perceptions and attitudes	Respect for differences and diversity; gender sensitivity and equity
	Quality of performance	Satisfaction with his/her performance, strong and weak work areas in his/her performance.
	Job satisfaction	Remuneration appropriate to the function; practice consistent with the job profile; motivation to perform; commitment to the organizational mission; organizational climate and culture; adequate training