Workplace Violence and Gender Discrimination in the Health Sector in Rwanda

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I. Introduction

In order to ensure that men and women contribute to and benefit from social and economic development on an equal basis, we must address gender disparities in human resources for health (HRH) policy and planning, workforce development and performance support. By targeting these issues, we can better achieve the desired outcomes of all gender-related actions in HRH: equal opportunity and the elimination of gender discrimination at work; and improved service delivery and health—for workers and for the communities they serve.

As the Capacity Project has worked to strengthen HRH systems to implement quality health programs in developing countries, it has systematically focused on how differences and inequalities affect women's and men's opportunities for education, training and occupational choice. In Rwanda, the Project helped the government follow through on its national policy commitments to gender equality by conducting a study of workplace violence and gender discrimination as barriers to workforce participation. Project staff made use of a research-to-practice approach in design and dissemination to increase the likelihood that study results would be applied. This publication presents the research, summarizes results and lessons learned and describes how research was used to promote policy change and program response to workplace violence and discrimination[1].

II. Background and Rationale

Workplace violence is a severe problem that affects occupational health across the globe (di Martino, 2002)[2]. Possible effects may include depression, anxiety, physical disability, resignation, dismissal, transfer, absenteeism, lower quality of care by health workers who experience workplace violence and decline in workplace productivity. This violence includes incidents of physical or psychological assault or abuse that occur at work, though they may also occur outside the work setting, impeding workers' mobility to and from work or in the community. The scope of violence may consist of sexual and nonsexual physical assault, verbal abuse, sexual and racial harassment or bullying. These categories are overlapping rather than mutually exclusive.

A 2004 study of violence against women in Rwanda (International Rescue Committee [IRC] et le Ministère du Genre et de la Promotion de la Femme, 2004) described a form of sexual violence, termed "community violence," that consists of an expression of sexually "obscene words" perpetrated against women by people in the community other than their intimate partners, such as neighbors, police or employers. Of the Rwandan women interviewed for the 2004 IRC study, 33% reported that they had experienced community violence. Though the 2004 IRC study did not focus specifically on violence within the workplace, it did point

to the broader issue of sexual harassment in Rwanda, which had already been implicated as a problem for girls in school in the 2004 National Gender Policy. Based on anecdotal evidence, recommendations from the gender policy included further study in other sectors, which provided an entry point for the Capacity Project to study sexual harassment and other forms of violence in the health workplace. Rwanda provides a positive policy and legal environment for research and action, having not only a national gender policy, but also a national policy and a law against gender-based violence, and having ratified the International Labor Organization's (ILO) equal opportunity (nondiscrimination) and equal remuneration conventions.

Aside from issues of sexual harassment, most research on workplace violence prior to 2006 dealt with the topic in nongendered terms (Newman and Fine, 2006). More recent research suggests that certain types of violence may be gender-specific, to some extent. For example, male health workers seem to experience higher rates of nonsexual physical assault, and female workers are more often sexually harassed and abused than male workers (Mayhew and Chappell, 2007). There appears to be no clear gender pattern for bullying or racial harassment (Newman and Fine, 2006; also see Hatch–Maillette et al., 2007; Hegney et al., 2006), though perpetrators of violence in general are disproportionately young males (Mayhew and Chappell, 2007).

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Recent research has directly linked women's vulnerability to violence to the gendered division of labor and the types of jobs they occupy, "with women workers concentrated in jobs at greater risk of exposure to the hazard of workplace violence" including "exposure to clientele who are distressed, fearful or angry" (Mayhew and Chappell, 2007; Chen et al., 2008; Kamchuchat et al., 2008). A study of Canadian social service workers (Baines, 2006) drew several parallels between the gender segregation of tasks and gender-based violence. The study found that beliefs about male social service workers led to males being segregated into mainly recreational tasks with patients, while beliefs about female social service workers (formally and informally) assigned them to counseling and nurturing tasks, often with emotionally upset patients. This research also identified sexualized forms of violence and drew parallels between the gender dynamics of professional caregiving and intimate partner violence, and concluded that male social service workers were insulated from the more intense forms of stress, violence and exploitation at work. Others have observed that discrimination and violence are closely linked, that discrimination is one of the causes of violence and that equality in gender relations and the empowerment of women are crucial to the prevention of violence in the health sector (ILO, 2000).

The Capacity Project had previously worked in collaboration with the Ministry of Health to improve nurses' training, human resources planning, family planning and prevention of mother-to-child transmission (PMTCT) services delivery in Rwanda. The Ministry of Health sought ways to further improve the quality of patient care and health provider working conditions. With the Project's assistance, this research into health workplace violence and the relationship between discrimination and violence at work will benefit health and human resources policy development and human resources management practice.

III. Study Purpose and Methodology

The Capacity Project worked in partnership with the Ministry of Health, the Ministry of Public Service and Labor, the Ministry of Gender and Family Protection, the Ministry of Justice, the Rwanda Health Workers Union and other stakeholders to research the nature, extent, context and consequences of workplace violence in the health sector in Rwanda; to explore the gender dimensions of this violence; and to support institutions concerned

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with establishing human resources and other policies and programs that can improve health workers' safety, satisfaction and retention. Fifteen districts (three per province) were selected randomly for the study. The study sample included 297 health workers (205 women and 92 men) and 23 facility managers from 45 sites (three per district), 111 patients, 29 key informants and nine union and Ministry of Labor representatives. Data collection lasted 26 work days during June and July 2007. Using seven tools[3], researchers collected quantitative data on the prevalence of different forms of workplace violence and used qualitative and quantitative means to explore the relation between gender discrimination and violence at work.

The study measured gender discrimination in terms of occupational segregation by position grade and task; sexual harassment and discrimination in hiring, promotion and compensation; and discrimination based on marriage, pregnancy or family responsibilities. (See Explanation of Terms.) The utilization-focused research processes (Patton, 1986) involved stakeholders at crucial points in the study to increase commitment, understanding and ownership of the study and, hence, the likelihood that results would be used by individuals and institutions. Utilization-focused processes included:

■ Formative research with key informants and review of Rwanda's labor and gender equality policies

■ Creation of a multisectoral stakeholder steering committee with representatives of focal institutions including the Ministry of Health, Ministry of Public Service and Labor, Ministry of Gender and Family Protection, Rwanda Health Workers Union and Ministry of Justice. The Capacity Project study team held initial and periodic meetings with representatives to: 1) validate study relevance and identify a sponsor who would assume responsibility to champion the results; 2) select the forms of workforce violence to be studied—among which were verbal abuse, physical assault, bullying and sexual harassment; 3) review proposal and tools; 4) provide guidance on data sources and data analysis priorities; and 5) identify mutisectoral institutions' future roles in advocacy and use of results.

The research process also included activities to build stakeholders' technical capacity and expand policy dialogue, such as:

■ Training of focal institutions' representatives and Capacity Project/ Rwanda staff on workplace violence and

discrimination to increase understanding of these phenomena before vetting and validating study results

■ Internal briefings with focal institutions, followed by half-day results sharing and memo-writing to summarize institutional commitment to actions that will eliminate workplace violence and gender discrimination as well as identify recommendations for partners from different ministries and nongovernmental organizations

■ A national results dissemination workshop for 75 policy and implementing stakeholders from different sectors, which started with an orientation to workplace violence and gender discrimination, and concluded with the presentation of study results and discussion of concrete actions focal institutions would take to eliminate workplace violence and gender discrimination in Rwanda's health workplaces.

IV. Study Results

Violence is a severe problem in Rwandan health workplaces, and it is perceived as such. Approximately 39% of the 297 respondents reported experiencing at least one form of abuse in the workplace in the preceding year.

Table 1: Prevalence by Type of Violence (N=297)

Type of Violence	Prevalence
Verbal abuse	80 (27%)
Bullying	48 (16%)
Sexual harassment	21 (7%)
Physical violence	12 (4%)

The types of violence in Table 1 are not mutually exclusive.

Verbal abuse was the most prevalent form, and physical violence the least prevalent. The majority of perpetrators of workplace violence were health personnel—victims' colleagues, followed by hierarchical superiors. A smaller portion of perpetrators were members of the general public, including patients and their families. Both men and women engaged in acts of violence. Men committed most acts of sexual harassment, bullying and physical violence, while women in this sample perpetrated most acts of verbal abuse. Female health workers were twice as likely as men to be victims of sexual harassment. Many respondents held perceptions of the men "in charge" as perpetrators of violence.

In most cases of violence, especially cases of verbal abuse, bullying and physical violence, the victim disclosed the incident to colleagues. However in sexual harassment cases, 40% of victims did not disclose the occurrence to anyone. The impact of violence was felt primarily on

the worker's psychological health (e.g., feelings of trauma, loss of dignity, fear, frustration, obsessive thoughts), but other effects included absenteeism (an average of three days following an incident), lower energy, disturbed interpersonal relations at work or at home and a feeling of decreased productivity. Consequences also included thoughts of quitting or actually quitting, the latter particularly for female workers who had experienced sexual harassment and bullying.

Gender Discrimination

The study asked health workers whether they agreed or disagreed that various forms of discrimination occurred at work. Responses were analyzed with attention to the number of men and women in the top management jobs. According to both male and female respondents, various forms of gender-based discrimination did exist at work. Almost one-half of respondents agreed that women encounter different problems than men at work, and almost 41% agreed that women are more exposed to violence. In addition, 68% of respondents pointed to pregnancy, childbirth and family and child care responsibilities as factors that prevent women from fully participating at work.

> Prolonged absences…when a child is sick, when she has a pregnancy-related illness, when she takes maternity leave [are what keep women from fully participating]. (Health Workers Survey participant)

Almost one out of four service providers agreed that task assignments for male and female workers occupying the same job differed either in types or volume, which suggests some gender segregation of tasks. As one female study participant noted,

> Some people seem to think that certain activities are reserved only for men. (Key Informant Interview participant)

Some female workers perceived their career progress to have been adversely affected by the unique problems faced by women at work, including instances where these female workers thought promotion or evaluation had been influenced by maternity status, including demotion after pregnancy, not being hired because of future pregnancy and negative performance appraisal.

> When I had not yet delivered, I was deputy director; after my delivery I was demoted for no reason but I think it was because of my pregnancy. (Health Workers Survey participant)

> I passed my test but I was told it was impossible to hire me, knowing that I would be taking maternity leave. (Health Workers Survey participant)

> [My colleague] received bad evaluations because she did not come to work because of pregnancy-related illnesses. (Health Workers Survey participant)

These are common manifestations of pregnancy discrimination that would tend to weaken women's ties to the health workforce. Some workers also reported being victims of *quid pro quo* sexual harassment by their hierarchical superiors, or being offered a job, promotion or raise in return for sexual favors.

The Glass Ceiling

Forty-seven (about 16%) health workers in the survey sample (N=297) believed that women *do not* have the same chance as men of being hired for jobs for which they are qualified. However, despite this perception, women *do not* hold the top management jobs at the same rates as men. Even though men made up only 31% of the sample, they constituted 60% of directors in the sample facilities. These data demonstrate vertical segregation, a form of gender discrimination that is typically the result of multiple and accumulating discriminations during childhood, schooling and entry into a career.

Sexual harassment, discrimination based on pregnancy or family responsibilities and gender segregation of top management appeared to occur together with negative stereotypes about female health workers. Impressions regarding Rwandan women in the health workplace were largely characterized by negative attributes such as an unwillingness to speak up, weakness, indecisiveness and incompetence. For example, according to some workers, "Women prefer to keep quiet and are easily mistreated;" "They don't have the same resistance as men and they tolerate stress less well;" "They just don't know how to make decisions in a sure and certain way;" and "Women are not even capable of pulling out a tooth." Negative stereotypes such as these may be the foundation on which violence and other forms of workplace discrimination rest. According to a key informant, "There is a tendency to say that women are weak in the broadest sense (no physical strength, late in execution of work tasks, pregnancies, breastfeeding, giving birth which debilitates them, absences) and in some cases, the violence that women are subjected to stems from this situation."

## Perceptions of Gender Equality and Experience of Violence

Responses to questions about the existence of gender discrimination revealed that perceptions of gender equality are associated with decreased workplace violence. Overall 85% (249 of 292) of respondents perceived that men and women receive equal treatment at work. Figure 1 shows that perceived equal treatment at work is associated with a reduced percentage of health workers experiencing workplace violence. Sixty percent of respondents who perceived unequal treatment also indicated that they had experienced some form of workplace violence, compared to 36% of those who perceived equal treatment (Pearson chi2(1) = 9.388, P = 0.002). Using logistic regression modeling, it was found that for staff who perceived that there was *unequal treatment at work, the odds of being a victim of workplace violence were two and a half times greater* than those who perceived equal treatment (OR 2,59>1)[4].

Figure 1: Do Men and Women Receive Equal Treatment at Work?
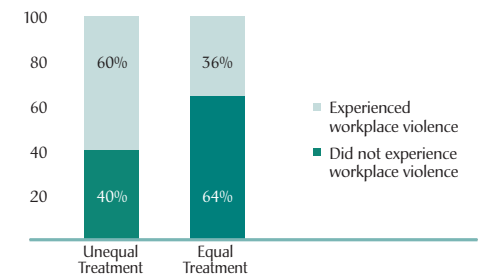
In addition, Figure 2 shows that the perception of an equal chance to get hired for jobs for which the worker is qualified is associated with a reduction in the percentage of health workers experiencing workplace violence. Sixty-two percent of respondents who perceived inequalities in the hiring process indicated that they had experienced some form of workplace violence, contrasted with 35% of respondents who had perceived equal chances for both men and women (Pearson chi2(1) = 11.639, P = 0.001). Further, logistic regression revealed that for staff who perceived *unequal chances in hiring, the odds of being a victim of workplace violence were three and a half times greater* than those who perceived equal chances (3.53>1).

Figure 2: Do Men and Women Have an Equal Chance to Get Hired for Jobs for Which They Are Qualified?

Legend:
- Experienced workplace violence
- Did not experience workplace violence

Unequal Chance: 62% / 38%
Equal Chance: 35% / 65%
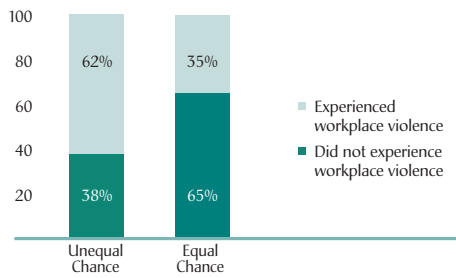
V. Study Conclusions

■ Forms of discrimination appear to occur together (i.e., sexual harassment, negative stereotypes, vertical gender segregation, task segregation, hiring or promotion decisions and negative evaluations linked to pregnancy and family responsibilities).

■ The perception of gender discrimination is related to increased odds of experiencing violence at work.

■ Negative stereotypes of women at work seem to justify violence.

■ *De facto* gender discrimination exists at work in spite of a positive legal/policy environment and public rhetoric that strongly favors gender equality.

■ Gender discrimination may exist but not be perceived, as in the case of the "glass ceiling."

■ Gender discrimination limits equal participation in work, negatively impacts female workers' career paths and weakens women's ties to the health workforce.

VI. Applying Research to Promote HRH Policy Change and Program Response in Rwanda

The Capacity Project strengthened HRH policy and planning to promote gender equality and contributed to supportive, equitable and safe work environments by engaging in dialogue with stakeholder institutions throughout the study. The Project also led two phases of validation before wider dissemination, which allowed for the growth of awareness and consensus about the importance of pregnancy discrimination as a central barrier to women's workforce participation. Focal institutions outlined the institutional and multisectoral actions required to eliminate workplace violence at a national dissemination meeting. The Project recommended that the Ministry of Labor advocate widely for the integration of already-ratified international labor standards in institutional policy and practice (i.e., C100: Equal Remuneration; and C111: Equality of Opportunity and

Treatment) and that two remaining gender-equitable labor standards be ratified and applied to national and health sector policies (i.e., C156: Workers with Family Responsibilities; C183: Maternity Protection). On the basis of the study results, the Ministry of Health decided to conduct an in-depth study on discrimination based on pregnancy, develop a policy on workplace violence in the health sector and create a training program to eliminate workplace violence and discrimination at health facilities. The Ministry of Labor decided to develop a national workplace violence policy and train work inspectors. Results later contributed to the revision of the national law regulating labor in Rwanda, with specific articles prohibiting gender-based violence and gender discrimination in the workplace.

The Capacity Project found that subjective research measures were credible and important for understanding perceptions and the experience of gender discrimination. However, because discrimination may exist but may not be perceived or known, perceptions should be linked to other measures (e.g., data on salary, training opportunities by gender or number of women and men occupying top management positions) where these data are available, or if observation of work tasks is possible.

Education and training programs should challenge myths about women's capabilities and dedication to work and strengthen female workers' ties to the paid health workforce over the course of their career. Workplace violence and gender discrimination should be addressed together in policy and planning, workforce development and performance support and involve stakeholders at different levels, in different sectors.

Explanation of Terms

Workplace violence: Any incident of physical or psychological assault or abuse that occurs in work-related circumstances and challenges a victim's safety, well-being or health. It includes incidents in which employees are abused, threatened, attacked or subject to other kinds of aggressive or offensive behaviors or actions in circumstances related to their work (including on the way to and from the workplace).

Types of Workplace Violence

Physical violence: Based on existing definitions, we defined physical violence as the use of force to cause physical or

psychological harm. It includes: hitting, biting, throwing objects at someone, strangling, pushing someone around, shoving, punching, kicking, dragging someone, pushing someone against the wall, beating someone with a stick, threatening an individual with a gun, a knife or any other kind of weapon.

Verbal abuse: Based on existing definitions, we defined verbal abuse as verbal behavior aimed at degrading or humiliating someone, as well as showing a lack of respect for someone's worth and dignity. This type of violence may include humiliating someone in front of patients or his/her coworkers. Humiliation is usually based on insults and sarcasm.

Bullying: Based on existing definitions, we defined bullying as psychological violence used to intimidate, marginalize, socially exclude or isolate another worker. Supervisor bullying involves repetitive abuse and oppression of a less powerful person (subordinate) by a more powerful person (hierarchical superior). Bullying may include verbal abuse, malicious allegations, blackmail aimed at making someone lose his/her job or face disciplinary actions, isolation and denigration of his/her work, giving someone an offensive nickname, onerous tasks, canceling earned days off, wrongfully punishing someone or slandering someone's reputation directly or indirectly. Bullying differs from verbal abuse and physical violence in that it is a *repetitive* behavior, occurring over time. Bullying may be perpetrated by an individual or a group of people. In the latter case, it is referred to as *"mobbing."*

Sexual harassment: Based on existing definitions, we defined sexual harassment as a type of violence consisting of comments or behavior of a sexual nature that are unwelcome and offensive, and detrimental to the person's human dignity at work. Sexual harassment may include verbal, nonverbal and physical acts. It may take the form of attempting to establish or force sexual relations, to threaten someone into having sex (sexual blackmail) or to offer money, gifts or privileges in exchange of sexual favors. Sexual harassment also includes sexist remarks or innuendos denigrating a person's work or competence, and may be a manifestation of resistance or hostility to women's entry into traditionally male-dominated occupations; i.e., it may serve to lessen competition from women. Examples of sexual harassment include: pornography in the workplace; forcing someone into having a conversation about sex; looking at someone in a lascivious

way; frequent requests for dates after refusals. Two types of sexual harassment are recognized worldwide, including "hostile environment" and "quid pro quo" sexual harassment:

- **Hostile environment harassment:** Sexual comments or actions that have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, offensive, hostile, humiliating work environment (Diversity and Equal Opportunity Office, 2009).

- **Quid pro quo harassment:** When work-related decisions or tangible job benefits (such as salary raise or promotion) are granted or denied based on an individual's rejection of or submission to unwelcome sexual advances (ibid.).

Sexual assault: An extreme type of sexual harassment used to have sexual relations without mutual consent between two parties. It may consist of intimidating someone in order to have sexual relations, as well as caressing or kissing someone without his/her consent or forcing sexual relations (rape).

Gender Discrimination

Gender refers to the social definition of what it means to be a man or a woman, including the social and cultural characteristics and the economic, social, political and cultural opportunities (or lack thereof) associated with being female and male.

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 (WHO, 2001). Gender discrimination also includes distinctions, exclusions or restrictions based on the biological characteristics and functions that differentiate women from men (e.g., pregnancy). Gender discrimination thus covers marital status, pregnancy, family responsibilities, occupational segregation and sexual harassment.

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

Gender stereotype: A rigid, oversimplified, generalized idea of the differences between women and men, their skills, psychological attitudes, ambitions and behavior (Johnson, 2000; ILO, 2008. See also Blau et al., 2006). Stereotypes are forms of social consensus rather than individual judgments (Online dictionary of social sciences, 2009). Gender stereotypes contribute to ideologies and norms of what constitutes appropriate behavior or aspirations for men and women (ibid.). Stereotypes can be negative and used to deny individuals respect or legitimacy, or positive, to maintain privilege, based on membership in that group. (The term "norm" is used to refer to a culturally established rule or standard of appropriate social behavior, as distinct from a stereotype, which is a socially constructed, oversimplified, generalized idea.)

Occupational segregation by gender ("gender segregation") is a pervasive and widely documented form of gender discrimination in which women "tend to work in jobs and occupations that are dominated by women and men in ones that are dominated by men [….] This segregation has been shown to be strongly related to inequalities in pay, career prospects, and employment protection. It has proved to be one of the most profound dimensions of labour market inequality (compared with, say, race or class) and the most enduring" (Scott, 1994). Occupational segregation prevents women from accessing jobs other than the ones they are traditionally given and do not pay as much, and effectively serves as a brake on competition in the labor market. Typically, women are confined to a narrower range of work, in insignificant, lower grade and less well-paid jobs ("horizontal segregation"); often hold caring and nurturing occupations, such as nurses, social workers, teachers; and remain at a lower rank ("vertical segregation") in nonmanagerial positions. In contrast, men are typically concentrated in technical, diagnostic, managerial or strength-based jobs or occupations for which they use physical skills: scientists, physicians, managers, police officers, fire fighters, coal miners. Men and women may be given different tasks in the same job.

- **Glass ceiling** ("**vertical segregation**"): The term refers to situations where "the advancement of a qualified person within the hierarchy of an organization is halted at a particular level *because of some form of discrimination*, most commonly sexism or racism. This situation is referred to as a "ceiling" as there is a limitation blocking upward advancement, and "glass" (transparent or invisible) because the limitation is not immediately apparent and is normally an unwritten and unofficial policy. Although this phenomenon may be illegal, it is still prevalent in most countries.

Pregnancy (maternity) discrimination: Exclusions, restrictions or distinctions at school or work made on the basis of pregnancy, childbirth or medical conditions. It occurs when expectant women or women of childbearing age are demoted or fired, or are not hired, promoted or rehired after maternity leave, have their pay docked, have working hours limited or are otherwise discriminated against due to pregnancy or intention or potential to become pregnant. Typically, pregnancy discrimination excludes women from jobs because of stereotyped notions that women are incapable of doing their jobs, will leave their jobs after childbirth or because employers are unwilling to pay the costs of maternity leave or believe women will require too many accommodations after return from maternity leave.

Wage/remuneration discrimination (or systematically paying lower wages to women or minorities): A gap or difference in salary and any additional benefits, whether in cash or in kind, based on gender and not on objective differences in the work performed, seniority, education, qualifications, experience or productivity. Wage discrimination has been tied to education, experience and seniority, but there is considerable evidence documenting differences in pay between women and men who have the same job, education and qualifications in the workforce, as well as for female employees with more seniority and better performance than male employees (National Committee on Pay Equity, 2009). Reasons for wage discrimination include the belief that men need higher wages because they have families to support (a "breadwinner" benefit) or that differences in pay are due to choice of work, rather than the belief that differences in experience, training and occupation reflect larger workplace and societal discrimination (Reed, 2001).

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1 The complete study report, *Study on Workplace Violence within the Health Sector in Rwanda: Final Report*, is available on the Capacity Project's website at http://www.capacityproject.org/images/stories/files/workplace_violence_health_sector_rwanda.pdf.

2 Also see Mayhew and Chappell, 2007; Hatch-Maillette et al., 2007; Hegney et al., 2006; Chen et al., 2008; Kamchuchat et al., 2008; Baines, 2006; and George, 2007.

3 Tools can be accessed in the complete study report, as referenced in footnote 1.

4 Based on global logistic regression model with experience of workplace violence as dependent variable and eleven independent variables, (Chi2(33)~99.95, p=0.00), Pseudo R-sq=0.25.

References

Baines D. Staying with people who slap us around: gender, juggling responsibilities and violence in paid (and unpaid) care work. *Gender, Work and Organization*. 2006;13:2.

Blau FD, Brinton MC, Grusky DB, eds. *The declining significance of gender?* New York, NY: Russell Sage Foundation, 2006.

Chen W, Hwu H, Kung S, Chiu H, Wang J. Prevalence and determinants of workplace violence of health care workers in a psychiatric hospital in Taiwan. *Journal of Occupational Health* 2008;50(3):288–93.

di Martino V. Workplace violence in the health sector: country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study: a synthesis report. Working paper. Geneva, Switzerland: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, 2002.

Diversity and Equal Opportunity Office. Sex discrimination- what supervisors need to know. University of South Florida, 2009. Accessed 2 Apr 2009 at: http://usfweb2.usf.edu/eoa/sex.asp

George A. Human resources for health: a gender analysis. Geneva, Switzerland: WHO Commission on Social Determinants of Health, 2007. Available at: http://www.sarpn.org.za/documents/d0002790/HR_health_George_Jul2007.pdf

Hatch-Maillette MA, Scalora MJ, Bader SM, Bornstein BH. A gender-based incidence study of workplace violence in psychiatric and forensic settings. *Violence and Victims*. 2007;22(4):449–62.

Hegney D, Eley R, Plank A, Buikstra E, Parker V. Workplace violence in Queensland, Australia: the results of a comparative study. *International Journal of Nursing Practice*. 2006;12(4):220–31. Available at: http://eprints.usq.edu.au/1618/2/Hegney_Eley_Plank_Buikstra_Parker_Author's_version.pdf

International Labor Organization. *Breaking through the glass ceiling: women in management*. Geneva, Switzerland: International Labor Organization, 2004.

International Labor Organization. Convention concerning equal remuneration for men and women workers for work of equal value. Geneva, Switzerland: International Labor Organization, 1951. Accessed 2 Apr 2009 at: http://www.ilo.org/public/english/employment/skills/hrdr/instr/c_100.htm

International Labor Organization. Decent work for women: an ILO proposal to accelerate the Beijing Platform for Action. St. Petersburg, Russia: International Labor Organization, 2000. Available at: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/event/wcms_080274.pdf

International Labor Organization International Training Center. *Break gender stereotypes, give talent a chance: toolkit for SME advisors and human resource managers*. European Communities, 2008.

International Rescue Committee et le Ministère du Genre et de la Promotion de la Femme. Rapport de Recherche sur la Violence Contre les Femmes au Rwanda: de Janvier 1998 à Mars 2003. Kigali, Rwanda: International Rescue Committee et le Ministère du Genre et de la Promotion de la Femme, 2004.

Johnson AG. *The Blackwell dictionary of sociology: a user's guide to sociological language*. 2nd ed. Malden, MA: Blackwell Publishers, 2000.

Kamchuchat C, Chongsuvivatwong V, Oncheunjit S, Yip TW, Sangthong R. Workplace violence directed at nursing staff at a general hospital in southern Thailand. *Journal of Occupational Health*. 2008;50(2):201–7.

Mayhew C, Chappell D. Workplace violence: an overview of patterns of risk and the emotional/stress consequences on targets. *International Journal of Law and Psychiatry*. 2007;30(4–5):329–330.

National Committee on Pay Equity. Examining the "women's choices" theory [website]. National Committee on Pay Equity, 2009. Accessed 2 Apr 2009 at: http://www.pay-equity.org/info-choices.html

Newman C, Fine A. Workplace violence in the health sector: a form of gender-based violence? Literature review from the Capacity Project, 2006 (unpublished).

Online dictionary of the social sciences [website]. Athabasca University and the International Consortium for the Advancement of Academic Publication, n.d. Accessed 3 Aug 2009 at: http://bitbucket.icaap.org/

Patton MQ. *Utilization-focused evaluation*. 2nd ed. Beverly Hills, CA: Sage Publications, 1986.

Reed A. Whatever you call it, it's still discrimination and it still affects women's wages. *Federal Reserve Bank of St. Louis Regional Economist*, 2001. Accessed 2 Apr 2009 at: http://findarticles.com/p/articles/mi_qa3678/is_200104/ai_n8948449/?tag=content;col1

Scott AM (ed.). *Gender segregation and social change*. Oxford, UK: Oxford University Press, 1994

World Health Organization. Transforming health systems: gender and rights in reproductive health Geneva, Switzerland: WHO, 2001.

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