

POLICY REPORT

#HEALTHTOO

HER STORIES: ENDING SEXUAL EXPLOITATION, ABUSE AND HARASSMENT OF WOMEN HEALTH WORKERS

December 2022



Women in Global Health Series: Gender Equity and the Health and Care Workforce



WGH | WOMEN IN
GLOBAL HEALTH

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DEDICATION

This report is dedicated by the **WGH** movement to the millions of women in the health sector who work every day to keep us healthy and safe. We acknowledge their expertise, dedication, the value of their work and their right to work with dignity free from violence, sexual exploitation, abuse and harassment.

As a movement, **WGH** advocates for a new social contract for all women health workers based on safe, decent and equal work, including equality in leadership and decision-making and fair pay. We call for an immediate end to work-related sexual exploitation, abuse and harassment and all forms of violence against women working in the health sector.

We thank the women health workers from all over the world who shared their stories with us for this policy report. This is their story.

ABBREVIATIONS

ARSF: Action pour la Reinsertion Sociale de la Femme

CSO: Civil Society Organization

DRC: Democratic Republic of the Congo

FEMNET: African Women's Development and Communication Network

GBV: Gender-Based Violence

GEH: WHO Gender Equity Hub of the Global Health Workforce Network

ICN: International Council of Nurses

ILO: International Labour Organization

ILO190: International Labour Organization Convention 190

NGO: Non-Governmental Organization

PSEAH: Prevention of Sexual Exploitation, Abuse and Harassment

PSI: Public Services International

PTSD: Post Traumatic Stress Disorder

SEAH: Sexual Exploitation Abuse and Harassment

SDG: Sustainable Development Goals

UHC: Universal Health Coverage

UN: United Nations

WGH: Women in Global Health

WHO: World Health Organization

WRVH: Work-Related Violence and Harassment

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EXECUTIVE SUMMARY

WOMEN'S TESTIMONY AS DATA

Women, as 70% of health workers globally,¹ were widely applauded for the exceptional contribution they made to health service delivery and saving lives during the pandemic. Yet behind the apparent respect paid to the women who deliver health services to around 5 billion people globally, is a dark story that often remains untold – significant numbers of women health workers experience violence and harassment in the course of their work. Health workers of all genders can face violence related to their work but women disproportionately face sexual exploitation, abuse and harassment (**SEAH**), perpetrated primarily by male colleagues, male patients and men in the community. This has to stop.



“Stories have a transformative power to allow us to see the world in a different way than we do if we just encounter it on our own. Stories are an entry point to understanding a different experience of the world.”

CLARE PATEY,
Director of the Empathy Museum²

Too often the **SEAH** experienced by women in the health sector is unreported, unrecorded and therefore not sanctioned. Where data is collected it is often not comprehensive or comparable. Despite anecdotal reports from women in the health sector that such abuse is significant and widespread, the safety and well-being of women health workers is not given sufficient priority to drive routine collection of sex-disaggregated data on SEAH. As more countries ratify **ILO Convention 190**⁴, which launched in 2021 and is the first global convention to address work-related violence and harassment specifically, we hope this will change. **SEAH** occurs in all sectors of the economy. However, since women are the majority of workers in the health sector, there is both an urgent imperative to end **SEAH**, as well as an opportunity for health to be an exemplar sector generating wider good practice.



“...the bottom line is that harassment is more about upholding gendered status and identity than it is about expressing sexual desire or sexuality. Harassment provides a way for some men to monopolize prized work roles and to maintain a superior masculine position and sense of self.”

VICKI SCHULTZ ET AL,
Open Statement on Sexual Harassment from
Employment Discrimination Law Scholars, 2018³

In the absence of comprehensive data, **Women in Global Health (WGH)** launched the **#HealthToo** platform in 2022 for women in the health sector to lodge their stories of **SEAH** anonymously, shine a light on this largely invisible abuse and drive accountability. In this report we analyze 235 stories from women in the health sector and draw upon existing research, information and data from partner organizations, and perspectives gained from global and regional multi-stakeholder dialogues on **SEAH** convened by **WGH** in 2022. Launched during the 16 Days of **Activism against Gender-Based Violence**, women's stories of **SEAH** in the health sector, in their own words, are the subject of this policy report.



KEY FINDINGS

SEXUAL EXPLOITATION, ABUSE AND HARASSMENT OF WOMEN HEALTH WORKERS IS SERIOUS, WIDESPREAD AND PREVENTABLE

The stories of the women health workers under #HealthToo, many harrowing to read, confirm earlier studies that SEAH is widespread in the health sector and the victims mainly women.

The key findings from this report are:

- Women in all parts of the world in the health sector experience work-related SEAH that includes sexualized verbal abuse, sexual assault and rape. This is unwanted and unprovoked by women.
- Vertical occupational segregation (the clustering of women in lower status, lower paid roles) in the health sector by gender, with women being 70% of health workers and holding 25% leadership roles, creates an enabling environment for SEAH.
- The risk of SEAH is increased by wider gender inequities in the health workforce where women are marginalized in leadership, earn less than men on average and are in less powerful roles.
- Women face SEAH from male colleagues, patients and men in the community. #HealthToo received only one report of a woman employee sexually harassed by a senior woman colleague.
- A pattern emerged of men in higher status positions abusing power to coerce and force female employees into unwanted sexual contact in a cycle of 'grooming', threats and retaliation.
- Many male perpetrators appear to be serial abusers, enabled by 'silent bystanders' supporting a patriarchal culture that legitimizes, downplays and perpetuates SEAH against women.
- Certain groups of women – trainees, interns, migrant women, women of marginalized races, castes and ethnicities – are at higher risk of SEAH in health due to unequal power dynamics.
- Many stories describe sexist behavior that belittles and demeans women, motivated by reinforcing power differentials and stereotypes of women's subordinate position, and less by sexual desire.

- Women's experience of SEAH and trauma is downplayed in the health sector and is even normalized.
- Women's responses vary with the type of SEAH and their personal circumstances; there is no 'right response'. No judgment is made in this report. The victim is not responsible.



"The vaccinator and the driver arrived and the attackers kidnapped all of them and took them to a large house in a deserted area.....Then they took 'M' to another room where two men raped her... 'M' was so scared that she did not report her rape... She believed that if she disclosed the truth her husband would leave her."

MONIZA INAM

in

'Breaking the silence: sexual harassment of community health workers in Pakistan.'¹⁵

- The majority of women reporting to #HealthToo did not make an official complaint or report SEAH. Some lacked a reporting mechanism, others feared disbelief, stigma or retaliation.
- Without victim-centered reporting mechanisms, SEAH is unrecorded, unsanctioned, and has a cost primarily for the victim, while the perpetrator is enabled to continue the pattern of behavior.

- #HealthToo stories record the trauma of women victims from SEAH in the health sector, including post traumatic stress disorder (PTSD) and suicidal thoughts. Employers are failing in their most basic duty of care.
- SEAH hinders women's career progression and retention in the health workforce, affecting morale, mental health, sickness, absenteeism, turnover and therefore, increasing staff shortages.
- SEAH improves the career progression opportunities for men in the health sector, creating a toxic working environment and reducing competition from women who may leave the role or the workforce.



"...I was afraid nobody would believe me since he is well loved by his colleagues and appreciated for his hard work by his supervisors. So I kept quiet. Even if I report, it will lead to a drama with no concrete outcome so why bother? I kept silent for 3 months and waited it out. It was the most frustrating experience of my life."

Doctor, Ethiopia



"...As far as I know nobody has told him anything and when I tried to raise the issue with some colleagues they laughed and said they had experienced the same but 'poor him, he can't resist'."

Health Researcher, Spain



"...He told me that I need to show him a good nightlife in Nairobi. When I said no, he said, 'How can we work together with this attitude of yours? It means you don't want your promotion that much which I can give you in 5 minutes.' I still said no. Then after a couple of days, he informed me that I didn't qualify for the role and that I had performed poorly over the past couple of months."

Health Administrator, Kenya



CONCLUSIONS

SEXUAL EXPLOITATION, ABUSE AND HARASSMENT HARMS WOMEN HEALTH WORKERS, AND IT HARMS ALL OUR HEALTH

SEAH of women in the health sector is a human rights abuse and part of a much bigger global picture of violence and harassment of women at work and outside work, perpetrated by men. World Health Organization (WHO) describes violence against women as a major public health problem and rights abuse, and estimates that globally, 30% of women have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.⁶

Concluding Points

We are working blind without comprehensive data:

We do not claim that the stories submitted to the #HealthToo platform are a representative sample of women's experiences. Until governments and employers routinely collect such data we will not know how representative our stories are of the health sector globally or locally. It is unacceptable, however, that even one woman health worker should experience such abuse.

Gender inequities in the health workforce multiply risk for women:

The hierarchical nature of medicine, status differences between professions and clustering of women in lower status, lower paid and even unpaid roles, all leave women more vulnerable to abuse. Women's concentration in patient-facing roles, such as community health workers and nursing, brings them into more contact with patients and their visitors, who can be perpetrators. The nature of health care as a 24 hour profession can also enable perpetrators to take advantage of unsafe infrastructure, such as shared duty and changing rooms, not designed with women's safety in mind.

Gender norms and culture:

The experience of SEAH by women health workers varies with their country, cultural and institutional context. Conservative cultures that restrict women's mobility may increase SEAH of women health workers, who are

perceived as breaking gender norms of 'respectability'. SEAH is legitimized by gender norms that socialize men into being sexually assertive and dominant, and women into sexual submission and passivity. Gender norms, stereotypes and cultures are formed outside the workplace but clear rules with accountability at work can change behavior.

Why do they do it?

Women's voices are often silenced when it comes to reporting SEAH but the truly silent voices are those of the perpetrators themselves. Only some men take advantage of power imbalances and other enablers to abuse female colleagues. We would be in a better position to design laws and policy solutions to stop SEAH if we understood more about why men abuse women health workers.

The toll on victims is high:

The #HealthToo stories are clear about the damage being done to women by SEAH in the health sector. SEAH and burnout are factors driving the 'Great Resignation' of health workers, especially women, currently underway in high income countries. Violence and harassment of health workers is reported to have increased in many countries during the pandemic. Workplaces where the culture of SEAH is tolerated are intimidating for women who may be driven to leave health altogether. This loss of trained health workers is adding to the projected shortfall of 10 million health workers by 2030, mostly in low- and lower-middle-income countries.⁷

The cost of inaction is high:

Health workers working under unsafe work conditions, including work-related SEAH, are more likely to make medical errors, provide a lower quality of work, and avoid patients. Absenteeism and staff turnover are also common problems in organizations with a high prevalence of SEAH. In addition to staff and care quality losses, organizations may face financial and reputational loss if a sexual harassment case does go to court. In 2015, sexual harassment charges filed with the U.S. Equal Employment Opportunity Commission cost organizations and perpetrators \$46 million,⁸ excluding monetary damages awarded through litigation. At the country level, the cost of inaction is also measurable. In 2018, the McKinsey Global Institute estimated that India could boost its GDP by \$770 billion in seven years by getting more women into the workforce.⁹ SEAH is one of the risks deterring women.

Women's leadership is a game-changer:

Although women are the majority of health workers, they hold only 25% of senior leadership roles. The #HealthToo stories confirm that men are the majority of perpetrators of SEAH to women. Equal representation of women in health leadership would reduce SEAH against women health workers. Gender parity in health leadership is therefore an important first step. Beyond gender parity, it is critical that leaders in health of all genders are gender transformative leaders and intentionally address all forms of gender inequity in the health workforce, including SEAH.

Women health workers are trained and skilled professionals. They go to work to save lives and deliver health services, and should be able to do their jobs free from unwanted sexual advances and violence. Join WGH in working to end SEAH against women health workers. Ending SEAH is everybody's business because health services are largely delivered by women and health is everybody's business.



PART 1: BACKGROUND TO THIS POLICY REPORT

1.1 GLOBAL HEALTH: DELIVERED BY WOMEN, LED BY MEN

In March 2019, World Health Organization (WHO) launched a landmark report, *Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce*.¹⁰ The report, authored by Women in Global Health (WGH) and a product of the WHO Gender Equity Hub (GEH) of the Global Health Workforce Network, was the first comprehensive literature review and compilation of evidence on gender equity in the global health workforce. Violence and sexual harassment was one of the thematic areas covered in the report, along with gender equity in leadership, pay and occupational segregation (key messages from the report are below).

The report called for urgent action to address gender inequities in the health workforce as matters of economic and gender justice, and also to build the foundation for strong health systems needed to achieve Universal Health Coverage (UHC) and other Sustainable Development Goal (SDG) targets.



“Sexual exploitation, abuse and harassment, like other forms of gender-based violence, is rooted in gender inequality.”

DR. POONAM KHETRAPAL SINGH,
Regional Director, WHO South East Asia

The report found, as many other reports had concluded earlier, that a large percentage of women in the health sector had experienced sexual harassment but that the major gaps in data and evidence obscured the prevalence and impact of this abuse. Since the report's launch in 2019, WGH has advocated for, collected and published policy evidence on the four thematic areas, including ending sexual exploitation, abuse and harassment (SEAH) in global health. In 2022, WGH established the #HealthToo platform to collect women's stories to build the evidence base.

Key Messages on SEAH from *Delivered by Women, Led by Men, 2019*

- A large percentage of women in the global health workforce face discrimination, bias and sexual harassment.
- Women are more likely to face sexual harassment in the workplace than men. For example, in the United States, 20% of female medical academics reported accounts of sexual harassment compared to 4% of men.
- Many countries, particularly low- and middle- income countries do not have a legislative framework to support gender equality at work, including laws to prohibit sexual discrimination and sexual harassment at work.
- While the #MeToo movement has encouraged more open discussion of sexual harassment in some countries, it remains a serious and widespread abuse causing attrition, loss of morale, stress and ill-health for survivors.
- Women health workers in conflicts or emergencies or working in remote areas can face violence in the course of their work, with a number of health workers severely injured or killed every year.

1.2 GLOBAL AND REGIONAL MULTI-STAKEHOLDER DIALOGUES ON ENDING SEAH IN GLOBAL HEALTH

Alongside the collection of SEAH stories through the #HealthToo platform, WGH convened stakeholders in a series of global and regional town halls to further understand the prevalence, challenges and ways to end SEAH in global health. The idea for the town hall series emerged as part of a civil society response to WHO's release of the Independent Commission's report^{10.1} in September 2021, investigating allegations of Sexual Exploitation and Abuse during the Response to the 10th Ebola Outbreak in Democratic Republic of Congo (DRC). Twenty-three of the perpetrators identified were WHO employees.

In December 2021, WGH, African feminist network FEMNET and DRC-based NGO ARSF co-authored a letter on ending SEAH in global health in response to the Independent Commission's report. The letter was signed by more than 210 civil society organizations (CSOs), two-thirds from the Global South.

In line with its recommendations for CSOs' engagement in SEAH prevention and response, WGH collaborated with DRC-ARSF and FEMNET to organize a CSO-led virtual town hall meeting on March 30 2022. Representatives from WHO, UN and other stakeholder CSOs participated. One major conclusion from this global town hall was that regional level coordination and accountability were critical in responding to SEAH in the health sector, and that the issues should be taken up in regional town halls.

Consequently, under the theme of Collective Responsibility, Collective Action in the Prevention of Sexual Exploitation, Abuse, and Harassment, WGH hosted four regional town halls, inviting actors from government, regional WHO and UN offices, national and regional level CSOs, as well as independent experts to participate in a dialogue on ending SEAH.

Women in Global Health PSEAH Town Halls 2022



Key Messages from regional town halls on SEAH:

- SEAH intersects with and can be multiplied by individual factors such as (dis)ability or the context, with humanitarian conflicts increasing risk.
- There is a need for better coordination between governments and CSOs working locally within affected communities.
- Taking a survivor-centered community-based approach is necessary to tackling SEAH.
- Social norms can normalize violence, even where legislation is in place.
- Education must be used as a tool to combat PSEAH, especially incorporating a gender perspective in training for health professionals.
- ILO Convention 190 on the Elimination of Workplace Violence is important in recognizing and addressing the widespread problem of SEAH in health.
- Effective solutions to PSEAH must be resourced. CSOs, especially community-based women's organizations, are an essential part of the solution but generally under-resourced

1.3 COMMITMENTS HAVE BEEN MADE

Commitments by Governments to address violence and harassment against women date back to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)¹¹ 1979, ratified by all but 6 UN member states. Since 1979, commitments have been made in a range of global, regional and national political agreements, including the 1995 Beijing Declaration and Platform for Action¹² and the SDGs 3, 5 and 8,¹³ the Global Strategy on Human Resources for Health,¹⁴ the joint WHO, ILO and Organisation for Economic Co-operation and Development “Working for health” five-year action plan (2017–2021).¹⁵

Regional conventions and protocols have also been put in place on gender-based violence, such as The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol, 1995), The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Belem do Para Convention, 1995) and The Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention, 2011).¹⁶

Closer to the present, the landmark ILO Violence and Harassment Convention 2019 No. 190,¹⁷ came into force

on 25 June 2021 and is the first Convention to address work-related violence and harassment (WRHV) specifically. To date it has been ratified by 23 member states.

In 2021, The Government of France, the World Health Organization and WGH partnered on the launch of the Gender Equal Health and Care Workforce Initiative (GEHCW)^{17.1} to increase visibility, dialogue, and commitment to action on gender equity in the health and care workforce, alongside the UN Women Generation Equality Campaign to accelerate gender equality and mark the 25th anniversary of the Beijing Declaration and Platform for Action.

GEHCWI, now led by France and WGH, addresses four pillars, one of which is Protecting women in health and care against sexual harassment and violence at work. Additionally, WHO’s Global Health and Care Worker Compact¹⁹ was adopted by the 74th World Health Assembly in May 2021 and focuses on protecting, safeguarding and investing in the health and care workforce. Global and regional commitments to end violence against women, including SEAH, have been made by governments, delivery and accountability need to be accelerated.

C190 - VIOLENCE AND HARASSMENT CONVENTION 2019 (No.190)

For the international trade union movement, the adoption of Convention 190 and Recommendation 206 on Violence and Harassment in the World of work by the Centenary International Labour Conference in 2019 represents a milestone to celebrate and challenge for its future work.

THIS AGREEMENT IS ESSENTIAL FOR THE LABOUR FORCE BECAUSE IT:



1.4 DEFINITIONS

Drawing conclusions on prevalence of SEAH and designing policy solutions is made more complex by the different terminology used in research and policy for the range of behaviors covered by work-related violence and harassment (WRVH). Terminology used to describe forms of violence and harassment has evolved over time. It is critical to establish common terminology and to be specific since a common excuse given by perpetrators of SEAH is that they did not understand their behavior was serious or offensive.

This report uses the terminology in ILO Convention 190²⁰ on Violence and Harassment which came into force in 2021 and is the first global convention on work-related violence.

In this report, under the umbrella of WRVH, we will also use the term sexual exploitation abuse and harassment (SEAH) as defined by the UN below.

International Labour Organization Convention 190 uses the term work-related violence and harassment (WRVH) and defines it as:

“Violence and harassment” in the world of work referring to a range of unacceptable behaviors and practices, or threats thereof, whether a single occurrence or repeated, that aim at, result in, or are likely to result in physical, psychological, sexual or economic harm, and includes gender-based violence and harassment and defines the term gender-based violence and harassment as “violence and harassment directed at persons because of their sex or gender, or affecting persons of a particular sex or gender disproportionately, and includes sexual harassment”

In line with the Convention, it also includes behavior that occurs outside a place of work, for example, whilst the health worker is in transit to and from a place of work. The Convention 2019 came into force in June 2021 and applies to all workers in all sectors.²¹

United Nations' Terminology²²

SEXUAL EXPLOITATION: Sexual exploitation is any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including threatening or profiting monetarily, socially or politically from the sexual exploitation of another.

SEXUAL ABUSE: Sexual abuse is the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. Sexual exploitation and abuse include sexual relations with a child (18 years old or younger), in any context.

SEXUAL HARASSMENT: Sexual harassment refers to prohibited conduct in the work context and involves any unwelcome sexual advance, request for sexual favors, verbal or physical conduct or gesture of a sexual nature, or any other behavior of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment.



PART 2: WHAT THE #HEALTHTOO STORIES TELL US

To understand an often hidden abuse like **SEAH**, we must look beyond numbers and statistics and analyze the lived realities of women health workers. For this report, work-related **SEAH** stories were collected from women anonymously via the online **#HealthToo** platform and from **WGH** Chapter members. Stories were also gathered from the public media of organizations that have worked on the topic, such as **Surviving in Scrubs, Survivor Stories, and Mandela Ethiopia Doctors**. In addition, case studies published in journals, the media, and gray literature were also included, such as from **Nursing times, ABC News and Public Services International**. All stories have been anonymized to protect the women who submitted their stories. *(More detail on methodology can be found in the report Annex).*

In total, 235 stories of **SEAH** from women in the health sector were analyzed in this report, submitted in 10 languages from 40 countries. The four major themes emerging from the stories are summarized below.

Summary of broad themes emerging from the #HealthToo stories

THEME 1	Pattern of SEAH	Refers to a common pattern of abuse starting with 'grooming' or gaining confidence of the victim	<i>Fig 1</i>
THEME 2	Nature of SEAH	Type of incidents reported	-
THEME 3	Responses to and impact of SEAH	Immediate trauma responses plus long run trauma responses	<i>Fig 2</i>
THEME 4	Reasons for not reporting	Why survivors are not reporting SEAH	<i>Fig 3</i>



2.1 PATTERNS OF WORK-RELATED SEAH

Sexual exploitation, abuse and harassment are persistent issues for women and girls all over the world, occurring at work, in education, in the community and even at home. It occurs in all economic sectors, including the health and care sector. It is, by definition, unwanted and includes a range of sexualized behavior including both non-verbal, verbal and physical abuse. It is sexual behavior that causes physical and mental harm, damages a woman's career, undermines her performance at work, and diminishes her sense of self-worth by fostering a hostile work environment.

Figure 1 below shows the typical SEAH pattern of abuse emerging from the narratives shared by women survivors in the health sector from across the world. **The stages are:**



STEP ONE: 'Grooming' or gaining the confidence of the intended victim.

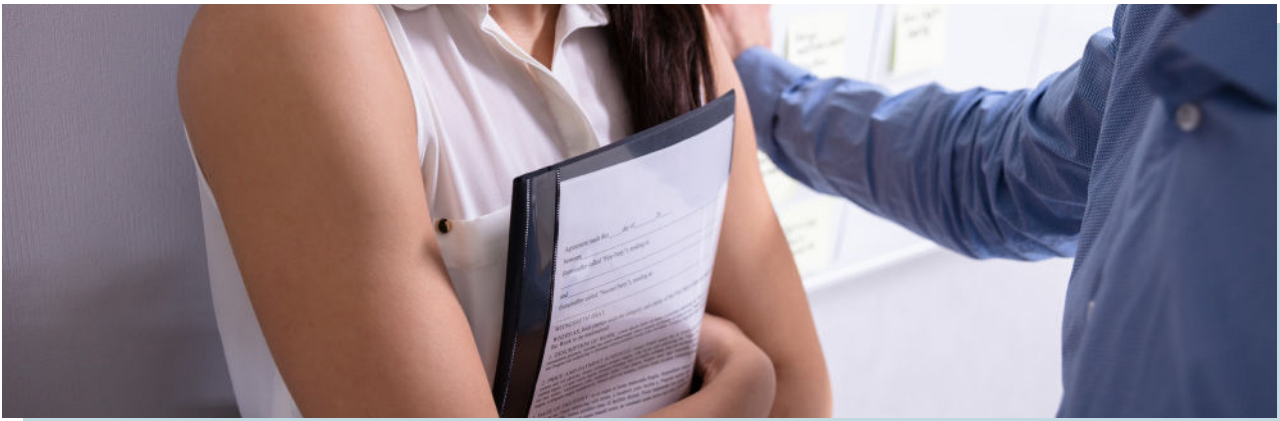
The perpetrator behaves in a cordial manner initially. They may appear to help the intended victim with their work or career so that they can gain their trust.

"Once a surgeon saw me crying and very kindly said some words of comfort to me and from then on, he greeted me every day by kissing me on the cheek, which made me feel very uncomfortable to the point that I hid from him so that he would not greet me." (Doctor, Mexico)

STEP TWO: Friendliness misunderstood.

The intended victim learns to trust the perpetrator and misunderstands their cordiality to be well-intentioned.

"I was so eager to learn and would latch on to any doctor willing to teach me. One senior doctor took a shine to me and went out of his way to help me. He was a fantastic teacher, I felt so lucky. He took me home one night after a work dinner. I trusted him because he was my senior. He kissed me. I didn't know what to do." (Doctor, UK)



STEP THREE: Growing unease.

The survivor may feel a growing sense of unease but due to the unequal power relationship or previous cordial behavior may ignore the first signal of harassment or be uncertain how to respond. Harassment may be couched as humour or 'a joke'. A Swiss intern from an international agency wrote:

"I had barely spoken to him before and had no personal connection to him. I was very embarrassed, when he jokingly presented me as his new wife there and flirted with me in front of everyone. I did not know how to react to that..."

STEP FOUR: Act of abuse or harassment.

Feeling of discomfort in survivors is soon followed by the actual act of abuse or harassment and realization by the victim that the perpetrator cannot, after all, be trusted. Women health workers from different countries gave examples ranging from sexual innuendos to staring at breasts and attempts at sexual molestation.

"I was harassed by one resident for three months. He is an amazing doctor and a good teacher loved by everyone. But he made inappropriate remarks about my body, and my hair, smiled and told me I am too cute to be a doctor. He even once touched my neck sexually saying he would want to bite it one day." (Doctor, Ethiopia)

A nurse from Ghana reported:

"On that fateful [sic] day, I was on duty alone when he walked into our nurses' room and called me to come see something. He immediately shut the door and pushed me against the table rubbing his erect penis against my buttocks."

STEP FIVE: Abuse of power.

A perpetrator in a senior position may then abuse his power to silence or coerce the victim. This is reflected in the story from a woman doctor from Senegal:

"I felt his erection against me and kicked him hard before trying to get out. The door was locked so I turned to him. He calmly sat behind his desk and said without looking at me 'remember that I have already succeeded in the profession and you are only a student. If you talk, you risk harming yourself,' before getting up and opening the door for me."

STEP SIX: Silent bystanders.

Sexual exploitation is facilitated by the presence of bystanders who may see abuse or hear about it and keep quiet. Some of these bystanders may be men in senior positions with sufficient power to challenge the perpetrator. Inactive bystanders enable SEAH. This was the experience of one health researcher from Spain:

"As far as I know nobody has told him anything and when I tried to raise the issue with some colleagues they laughed and said they had experienced the same but 'poor him, he can't resist'."

STEP SEVEN: Retaliation.

When a perpetrator is thwarted or threatened with exposure, their behavior may become more abusive and they may respond with violent behavior or passive aggression. A dentist from Kenya shared such an experience:

"One day, he shut the door closed and asked me to kiss him and I said no. He slapped me across my face."

STEP EIGHT: Tolerating SEAH.

The power imbalances that lead to SEAH may back women into a corner where they are afraid of losing their income, jobs, career advancement or their honour and reputation and therefore tolerate and try to manage SEAH.²³ An English doctor tolerated the abuse which ultimately increased its severity. She recalled:

“The perpetrator was meanwhile staring at me intensely from across the table. This made me even more fearful and violated. The evening continued and somehow, I ended up speaking with the perpetrator again, in the same location. He AGAIN firmly placed his hand on my buttock.

At some point he also touched my breast. I can recall the feeling too vividly. Again, disgusted and fearful, I did not remove his hand. He was surrounded by his colleagues and I feared that if I said or did anything, this would cause an unwanted scene, or worse, more violations or vulnerabilities.”

STEP NINE: Increased audacity with time.

Silence and tolerating SEAH may well lead to an increased audacity by the perpetrator as experienced by a midwife from Ethiopia:

“He even started to scare my friend and everyone around me. I couldn’t work and I couldn’t even live properly .. he is everywhere demanding I speak to him, blocking roads, holding my hand, refusing to let go...”

In another story from Kenya, a health policy maker faced humiliation in the long run. She said:

“I told them and he completely denied it. And everyone laughed it off and pretended nothing happened and continued their conversation.”

STEP TEN: Repeated harassment.

Finally, the cycle completes and the perpetrator continues the act of SEAH with the same victim or other victims. Narratives of repeated harassment emerged from almost every story.

A Namibian pharmacist recalled:

“I told a workmate some days later, and that I wanted to report the incident. She responded by saying she went through the same thing with the same driver.”

A nurse from Ghana said:

“I realized that I was not the only lady he was doing that with.”

Similarly, a doctor from Portugal noted:

“And it is not like I was the only one.. He acted like this to other female residents who needed him to get enough surgery time to get their rotations signed-off and acknowledged.”

And a researcher from Spain:

“...It is widely known in the institution that the co-director looks at women’s breasts.”

A doctor from the UK reported:

“A senior doctor constantly made inappropriate sexual jokes with me and a number of other women.”

Many more women told a similar story. This suggests that some men are repeat offenders.

This is a pattern of abuse that they have perpetrated on a series of women, often emboldened or enabled by others in senior positions who are aware and ‘turn a blind eye’ or have heard rumours and choose not to investigate. All the stories reported suggest that unequal power dynamics are a major enabler of SEAH.



“I’m one of the architects of the “bystander approach” [which emphasizes the roles witnesses can play in challenging behaviour]. This can be something as simple as intervening when someone tells a rape joke to stopping a rape in progress in front of you. It’s not about being a superhero or rescuing the damsel in distress. It’s about as a man, making it clear you don’t tolerate sexism or misogyny...”

- JACKSON KATZ, ‘The time for men to step up is right now!’: what all men can do to help end violence against women²⁴

2.2 NATURE OF WORK-RELATED SEAH

The stories that were received from women working in health all over the world reveal the range of SEAH incidents affecting women in the health sector. The types of SEAH reported in the #HealthToo stories included the following:

Sexist remarks and 'jokes'.

Sexist remarks can be made about an individual or can be pejorative remarks made about a person's gender that are intended to reflect negatively on the individual.²⁵ Narratives received from the #HealthToo platform reveal a pattern of sexist remarks followed by an act of sexual harassment. Sexual remarks can be hard to separate from wider harassment as shared by a woman community health worker from the USA:

"He would loudly tell people in the office, 'I don't understand why we hired her,' and claimed that another manager hired me because I was there as a "pretty face" for the office."

In another instance, a nurse from Nepal faced a similar situation where her knowledge of reproductive health became an excuse for sexist remarks:

"As I am working in the sector of sexual reproductive health and rights and I am vocal about the SRHR issues, some of the co-workers said 'I think you have all the experience for your future husband'."

Sexist remarks can also come from patients and co-workers with equal status. In the words of a Nigerian nurse:

"He stayed a couple of weeks in a hospital. During that time, he always refers to me in a degrading manner as if I am not his nurse, rather his girlfriend, like 'sweety' 'pretty face' 'nice back'."

An Ethiopian midwife faced a different issue. She narrates:

"One of the doctors there, a local person in the area, claimed he was in love with me a few weeks after I moved there. I told him I am not interested and I have a boyfriend back in my hometown. He never accepted my opinion and kept begging me, harassing me at work and started following me to my home."

Abuse of interns/juniors.

Women of every age can be targets for SEAH but #HealthToo stories reflect women being abused most often during their internships or studentships when they are low down in the professional hierarchy. Many junior doctors shared experiences of abuse. A doctor from the USA wrote:

"Once there was an attendant who was rubbing my back after I presented a patient to him. I felt so uncomfortable and embarrassed, but worse because I didn't even know what to do as a resident."

An Ethiopian doctor faced a similar situation in her early career:

"I'm an intern in one of the most prominent medical schools in my country and this is a very short story of how the nurse (male) working with me kissed me against my will while I was trying to do my work."

Threats, retaliation and abuse of power.

A doctor from Ethiopia relayed how her senior doctor used his position to exploit her:

"I shouted for help and the ward nurses ran towards me to his surprise. He immediately ran away through another door telling me that if I tell anyone I'm losing my grades and will be dismissed"

In another story, a Kenyan health administrator experienced sexual exploitation. She shares:

"...He told me that I need to show him a good night-life in Nairobi. When I said no, he said, 'How can we work together with this attitude of yours? It means you don't want your promotion that much which I can give you in 5 minutes.' I still said no."

Then after a couple of days, he informed me that I didn't qualify for the role and that I had performed poorly over the past couple of months."

In one particularly violent case, another health administrator from Kenya reported:

“During that period, he attempted to sleep with me and I refused him, he insisted on raping me, he failed because I became very angry and he was afraid that the others might listen to us because we were in the same hotel. He was really upset and humiliated. From then on, I became his pure enemy, and he started fights against me and even threats, until everyone saw that it was not going well between us. Then he ended up creating a nuisance for me with the management committee as well as with the religious congress which managed this institution.”

A midwife from Chile felt so helpless when the head of the service abused her:

“I sent for the doctor on duty who was the Head of Service, who instead of evaluating the clinical situation of the patient, pushed me and cornered me against a stretcher groping me and exposing his body against mine.”

Abusers outside the health system.

In most of the cases, the abuser holds a powerful position in the workplace or has a higher social status so that they feel superior to the victim. #HealthToo stories revealed a range of abusers inside and outside the health sector: from male senior colleagues to male hospital drivers, male police, male health officers, male international health representatives, male teachers, male interns, male nurses, male patients.

A narrative reveals how an international health representative harassed an English intern:

“On at least two occasions, the perpetrator asked me for my room number, insinuating that he wanted to meet privately in my room that night...”

Women can also abuse their power.

Although women typically reported being harassed and abused by male perpetrators, one doctor reported sexual harassment from a senior female colleague:

Responses to and the range of impacts of SEAH in the health sector on women survivors varies with the type

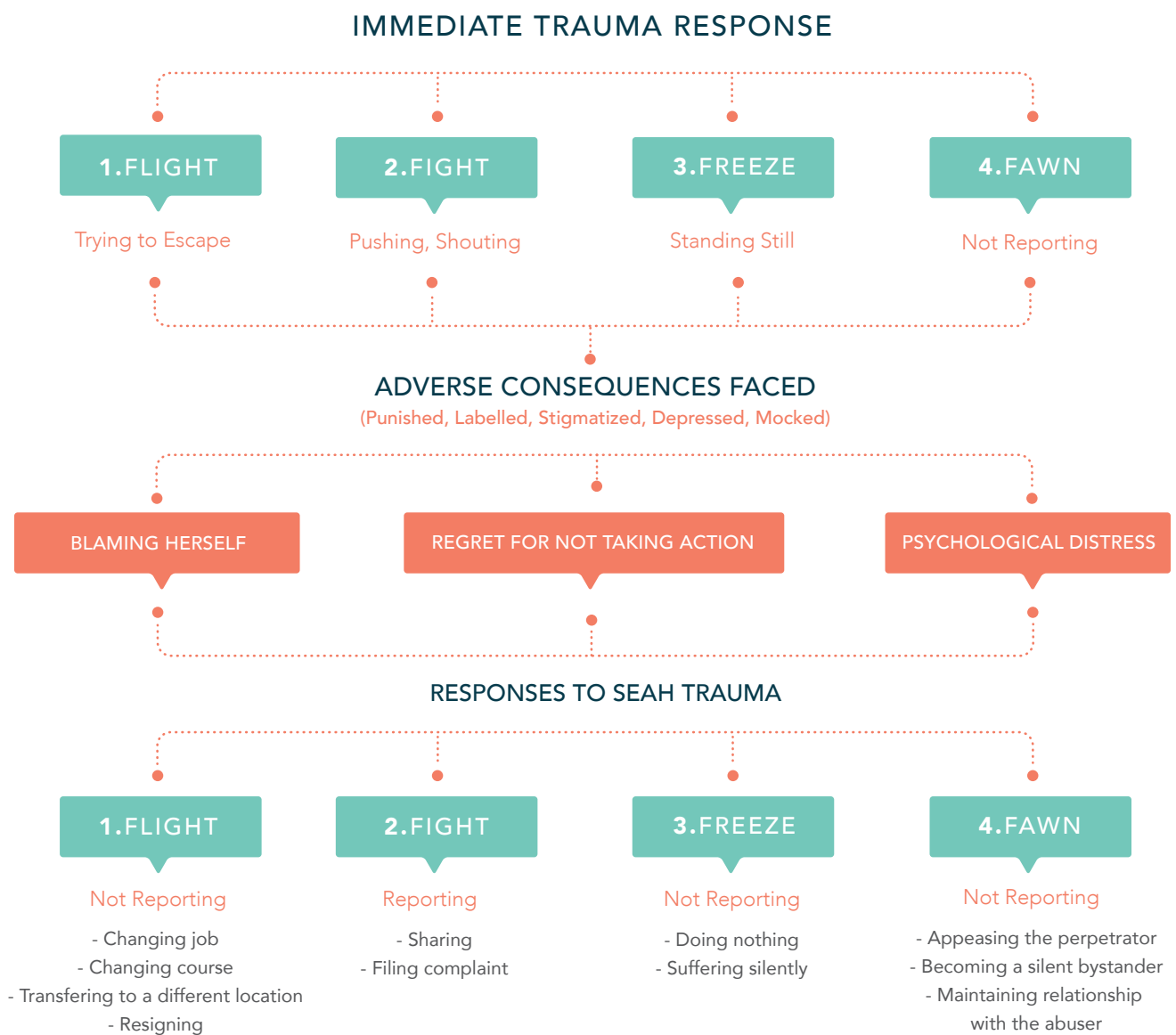


2.3 RESPONSES TO AND IMPACT OF WORK-RELATED SEAH

of abuse and the woman's personal circumstances. Many storytellers described incidents as "vivid traumatic memories". If we consider these experiences through the lens of trauma response, they show two types: the immediate trauma response to the situation and secondly, the long run trauma response if the trauma does not get resolved. Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical responses.²⁶ Survivors' concern that someone will hurt them triggers automatic responses: often described as flight, fight, freeze or fawn.²⁷

Longer term impacts include unpredictable emotions, flashbacks, strained relationships, and physical symptoms such as headaches or nausea. The stories told by women to #HealthToo include incidences of rape and other physical violence which is likely to result in short and longer term physical and mental harm, including unwanted pregnancy, sexually transmitted diseases and lasting damage. People have different coping mechanisms for dealing with traumatic situations, not all trauma responses are unhealthy or dysfunctional.

Figure 2 below shows the range of impacts of SEAH in the health sector on women survivors which varies with the type of abuse and the woman's personal circumstances.



It is critical to note that no judgment or blame should ever be attributed to the victim for any course of action they take. Responsibility for SEAH always rests with the perpetrator. The victim will respond in different ways depending on the nature of the abuse and their personal circumstances. None of these courses of action is 'better' than another. A highly trained health worker may have more job options and may be financially better able to leave a job despite not wanting to do so. A low paid health worker with no alternative ways of making a living may have little choice but to stay in a job with an abusive colleague, however much she would want to get away.

Women health workers in many contexts have no mechanism whereby they can report abuse by a senior male colleague and not attract retaliation. Women victims of sexual violence in some contexts may fear stigma, shame, divorce and even prosecution, if they do report the case.



The **'flight'** response is used to describe fleeing and avoiding a potentially harmful situation. Many survivors displayed the flight response when they felt threatened. In the words of a Mexican doctor:

"I walked towards the door while trying to tell him that it seemed to me that he was making a mistake with me that I was not like that. When I saw the opportunity, I ran away."

The **'fight'** response can kick in when a victim feels instinctively they must fight back to avoid harm.

This was the experience of a midwife from Chile who shared:

"The patient pushed me and cornered me against a stretcher, groping me and exposing his body against mine.. I pushed him and yelled."

An Ethiopian doctor recalled:

"He told me to grab a seat and after a few minutes started to crawl over me. I was shocked and bit his arm and ran away."

The third coping mechanism is to **'freeze'**; the victim may feel like they are paralyzed and cannot move or talk. A Mexican doctor displayed a freeze response when she faced a traumatic situation:

"Once I had to go to the surgery floor and I put on a mask so he wouldn't greet me. He saw me and came up to me and I told him not to come near me because I was sick. He then came up to me and spread his tongue in my ear and then he was gone. I was paralyzed and I couldn't say anything to him."

The final response is the **'fawn'** response. Fawning is fundamentally about appeasing other people and acting to try to pacify the abuser to avoid harm. A doctor from Ethiopia shared her experience,

"..I shouted for help and the ward nurses ran towards me to his surprise and he immediately ran away through another door telling me if I tell anyone I'm losing my grades and will be dismissed. I was so scared so I told them I saw a rat and was scared. The nurses laughed."

Whichever response women take after SEAH they may still face retaliation and injustice. Often women get punished even if they don't report the abuse. An administrative worker from Kenya reported:

"Then after a couple of days, he informed me that I don't qualify for the role and told me I performed poorly the past couple of months."

A woman physician from USA faced retaliation and reputational damage:

"I believe that after this encounter, this cardiologist went and spread vicious rumours about me."

In a few cases, the victim was stigmatized:

"You have gone crazy while working with crazy people!" (Community Mental Health Worker, India) or mocked by colleagues, which was the experience of a doctor from England:

"I explained to my clinical supervisor what had happened. He laughed, called in some of the other consultants to the theatre to joke about it and asked me if I needed counselling then told me to toughen up as it happens to a lot of the girls."

Instead of getting justice, they may start to blame themselves. They continue to relive the incident again and again, and put themselves in that situation and imagine what could have been done differently.

"It was summer and I was wearing a top. I tried to end the conversation as quickly as I could. I have never worn the same top to work ever again, feeling that maybe I was badly dressed."
(Researcher, Spain).

Women may blame themselves for fighting back, for reporting, or for not reporting. A doctor from the USA said:

"I felt too embarrassed and frankly very annoyed with myself for not stopping it."

A doctor from England felt regret for not taking action:

"I didn't feel strong enough to drag it all up again, which filled me with guilt."

This cycle continues and women may find it challenging to manage their jobs and daily life.

"I was very traumatized and didn't know who to talk to about it. I kept it to myself, as if it was my fault that it had happened to me. In what way did I act? I asked myself, I doubted myself."

The pain of an Ethiopian doctor is reflected in her words.

Responses to SEAH have a huge impact on the emotional well-being of the survivor. Stressful events like SEAH lead to a generalized vulnerability to stress, and stressors have more of an adverse influence on a person's mental health than if they were encountered earlier in life.²⁸

For example, if a person has a string of bad job experiences during their career, the cumulative impact of these stressors may be more detrimental to their mental health than a single, isolated episode.²⁹ An Indian doctor expresses her feelings:

"I feel uncontrollable anger sometimes."

Due to trauma, survivors of sexual abuse may be at risk for mental health issues.³⁰

"I didn't say anything even though I was traumatized." (Pharmacist, Namibia).

Sexual abuse victims may experience burnout, depression, anxiety, PTSD, personality disruption, attachment issues, addiction and other complicated mental health issues. The same Indian doctor also said:

"Unsurprisingly, I was flung so deep into depression that I even tried to hang myself once".

Other narratives shared by doctors from Ethiopia and Malawi echoed the same sentiments:

"That day, even if I was so happy, I got to deliver my first baby, I also felt like a loser and worthless how I was treated by him the whole day." And "This affected my self-esteem and when I would open up to my fellow women, they would say something like, "Ah! Let it go." But honestly, I couldn't let it go."

Some narratives depict symptoms of long-term trauma, where adverse feelings of helplessness have persisted. In the words of a community health worker from the USA:

“It was a horrible, gas-lighting, self-esteem blowing mess. It took me at least a year to get over it and even then, I still have moments where I think about how horrible that experience was.”

The impact on survivors’ mental health is greater when they must maintain a relationship after SEAH. An Ethiopian doctor shared her frustration:

“ I was afraid nobody would believe me since he is well loved by his colleagues and appreciated for his hard work by his supervisors. So I kept quiet. Even if I report, it will lead to a drama with no concrete outcome so why bother? I kept silent for 3 months and waited it out. It was the most frustrating experience of my life.”

A doctor from the USA described how it affected her job:

“I was just too exhausted by the whole system and stress in my job.”

Often dismissed as ‘banter’ or just a joke, there is no doubt from the #HealthToo stories, that SEAH has a profound impact on women affected by it in the health sector.

Employers might be more likely to take action to end SEAH if they fully understood the damage done to critical workers.

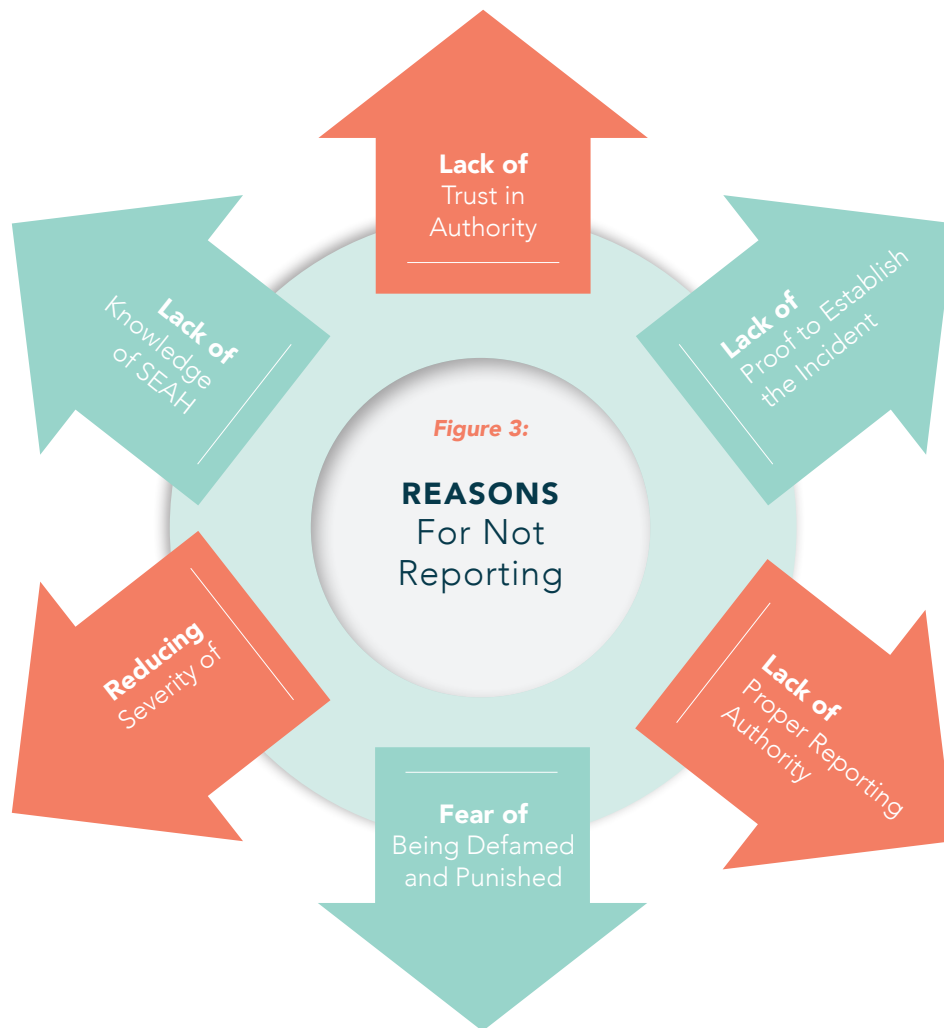


2.4 REASONS FOR NOT REPORTING

Research and data from multiple countries and sectors shows widespread under-reporting of SEAH and sexual violence both work-related and outside work. A 2022 global study from ILO³¹ found women victims of sexual violence and harassment (all sectors, multiple answers possible) did not report for the following reasons:

- 62% 'waste of time'.
- 54% 'fear for their reputation'.
- 51% 'worried people at work would find out'.
- 43% 'unclear what to do'.

Analysis of the #HealthToo stories finds women survivors of SEAH in the health sector had similar reasons for not reporting (Figure 3):



The following reasons for not reporting emerged from the #HealthToo stories.

Lack of knowledge about SEAH

Some survivors did not have awareness about the existence of SEAH, nor knowledge of laws related to it. Despite being a doctor, an Indian survivor did not have any knowledge of sexual harassment when she experienced it.

“By that time, I had been dis-empowered and isolated to such an extent that I could either not recognize it was sexual harassment, or had no hope of being heard by anyone, given the extremely masochistic and sexist environment around me.”

Fear of retaliation and blame

Many survivors described fear as the main reason for not reporting the incident. The stories show that there are two types of fears.

Firstly, the fear of being defamed. It is challenging for survivors of sexual harassment to communicate their experiences because of myths and misconceptions regarding sexual violence and the stigma associated with it .

“Besides, I didn’t want to be judged. Sometimes we the victims are rather blamed and labelled.”
(Nurse, Ghana)

Secondly, the fear of being punished. Victims fear they will not be believed or understood, and they will get punished instead of the perpetrator due to the unequal power dynamics.

“It is a small country, I knew nobody would take it seriously and there could be repercussions to my medical career,” (Doctor, Portugal)

“I didn’t want to get fired.” (Health Technician, Kenya)

Reducing severity of abuse

According to studies, different women respond to sexual harassment in different ways. This includes downplaying, negating, or even dismissing the incident as serious.

“What he did was come up to me and put his tongue in my ear and then he was gone. I was paralyzed and I couldn’t say anything to him... I thought that what he did was not serious enough to complain.” (Doctor, Mexico)

This can also be considered a defensive action or flight response.

Absence of reporting authority

After overcoming the stigma and fear, many times, when they finally decide to report, the lack of a reporting authority makes it more difficult for women.

“The hospital did not have a reporting structure for sexual abuse.”(Pharmacist, Namibia)

Lack of trust in authority

Sometimes, even if there is a reporting authority, survivors who report do not get justice. This is a deterrent for victims, and as a result they refrain from reporting.

“This male colleague has been reported to HR in the past and nothing was done about it.”
(Health Worker, Nigeria)

Lack of proof

If they do report, women may face the practical issue of having to prove the incident with evidence. The onus should be on the institution and not the victim to investigate incidents, prove the action of perpetrators and determine the facts. In the absence of reporting mechanisms, that responsibility is levelled on already traumatized victims.

Whereas, it should be the authority who is responsible to investigate instead of the victim. However, circumstances push the victims to be responsible to prove the perpetrators’ action.

“...But at the Ministry of Health, I was asked to accuse him in court and I did not do so, because I had no proof and I gave up.”
(Health Technician, Rwanda)

PART 3: RECOMMENDATIONS

The stories collected through #HealthToo have come from women in 40 countries, and WGH dialogues have received reports from many more. Although SEAH of women health workers appears to be universal, legal frameworks, cultures and socio-economic contexts vary widely. Action needed to end SEAH in the health workforce must follow broad principles and approaches but be closely tailored to the country context. The recommendations below outline approaches and critical points that have emerged from #HealthToo that should be addressed in all contexts.

Five Core Approaches to Driving Change

- ACT AT ALL LEVELS:** The ecological model³² in health below (Figure 4)³³ situates individuals in their social and public policy context and identifies factors at different levels that impact upon individual action, in this case, the drivers and enablers of SEAH against women health workers. The model highlights how action is needed at all levels to end SEAH in the health sector, including action to end the gender inequities in the health workforce and in wider society that create the power imbalances that increase risks for women. Enacting laws and putting reporting mechanisms in place in organizations will not, on their own, encourage women to report SEAH if they fear stigma and retaliation.
- SURVIVOR CENTRED APPROACH:** An effective approach must centre the voices of survivors - seeking, listening to and learning from their stories. Too often, it is the survivor and not the perpetrator who suffers the consequences of SEAH: losing their job, facing retaliation, social stigma and personal harm. Policies and actions should be centred around survivors, acknowledging them as rights' holders.
- INTERSECTIONALITY:** Interventions to prevent and respond to work-related SEAH must address socio-economic and personal characteristics that intersect with gender, including age, race, disability, economic status, ethnicity, migration status, and multiply vulnerability. Some groups of women health workers are at greater risk because of deeply unequal power dynamics.
- MULTI-STAKEHOLDER APPROACH:** Collective action should engage everyone involved to end work-related SEAH, including trade unions, professional and staff associations and women's organizations. It is important to engage and enable men, as well as women.
- GENDER-TRANSFORMATIVE LEADERSHIP:** The majority of perpetrators of SEAH against women health workers are men. Health sector leaders of all gender identities (not just women leaders) must adopt a gender transformative leadership approach and intentionally address all forms of gender inequity in the health workforce that enable work-related SEAH.

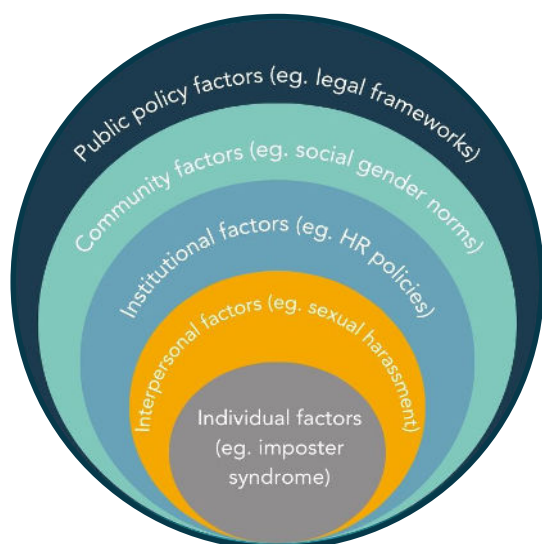


FIG 4:

THE ECOLOGICAL MODEL:

WORKPLACE VIOLENCE AGAINST WOMEN IN HEALTH AND SOCIAL CARE



Source: Women in Global Health, 2022

UN Women: Addressing Sexual Harassment - some pointers (summary extract)

- Start by naming the problem.
- Know the knowers and learn from them.
- There may be policies and procedures in place but are they fit for purpose?
- Build a culture of respect, practice equality and ensure diversity in senior positions.
- Develop and demonstrate unequivocal leadership.
- Learn from evidence and research.
- Ensure prompt, appropriate responses to reports and provide transparency in processes and outcomes.
- Ensure that the rights of survivors are clear, documented and known.

Source: UN Women, *Towards an end to sexual harassment: the urgency and nature of change in the era of #MeToo*, 2018.³⁴

Recommendations arising from the #HealthToo stories

The following six points emerged from analysis of the stories submitted by women to #HealthToo on ways to prevent and respond to SEAH against women health workers.

Breaking the cycle

The pattern of abuse described in Section 2.1 of this report must be broken to ensure that incidents are not repeated, enabling perpetrators to go on and abuse more victims. Increased understanding of the pattern and nature of SEAH, including why perpetrators abuse women, is needed to help break the cycle. Governments and employers must be held accountable, bystanders who do not act must also be held accountable and above all, perpetrators must be held accountable and sanctioned. As this mental health activist from India noted:

"If I could have told someone, or if my colleagues had not kept quiet and given me the courage to protest, it would not have progressed this far."

Combating denial and fear

Women do not report SEAH if they fear stigma and retaliation. Perpetrators and bystanders can deny that they were abusive or witnessed abuse if SEAH is not clearly defined as unacceptable behavior that will be sanctioned. A social worker from Kenya suggested:

"Sensitization should take place on what is professional behaviour".

Support for survivors to deal with trauma

Professional help should be provided to SEAH survivors to mitigate the longer term impact of untreated trauma. A health policy worker from Zambia reported:

"There were no safe options for me, especially after reporting such a case. Also, reporting is one thing, being believed, trusted and respected afterwards is another.. Keeping it to myself was a better option, for fear of more violence afterwards."

Work facilities safe for women

Perpetrators take advantage of facilities, such as changing and overnight duty rooms, that may meet men's needs but are not safe for women.

Women health workers are at greater risk of SEAH if hospitals and clinics have poor night security, inadequate lighting, isolated buildings etc. Work facilities and policies must explicitly address the safety of women.

"Every hospital should have rules and regulations to ensure the safety of females and it should be a part of the training of every newly appointed staff in every level (males and females)." (Nurse, India)

"CCTV cameras should be placed in places wherever there is potential threat for women." (Nursing student, India)

Serving justice

Action on SEAH complaints must be dealt with in a timely manner when reported. Survivors can be exhausted and re-traumatized by very lengthy disciplinary processes and they may drop charges. Justice is then not done and perpetrators may continue abusing women.

Survivors may lose trust in their employers, feeling they are not interested in their safety or welfare. It is critical that employers keep and publish sex-disaggregated data on prevalence of SEAH, and outcomes of cases so there is a baseline to monitor progress and change and a signal to all staff that SEAH is serious and unacceptable.

“If only I could report to that office immediately without fear. And work on that report would have started immediately, then he would not have had the courage to carry on.” (Community mental health worker, India)

Trust in authorities to take speedy and decisive action, regardless of the seniority of the accused, encourages survivors to report, and it deters perpetrators. As this health worker from England suggested:

“Every complaint should be followed up regardless of the position of the culprit.”

Counting the cost, including the cost of inaction

The stories relayed by women under #HealthToo demonstrate the serious physical, mental, personal and economic costs for women health workers of SEAH. Less obvious are the significant costs for health systems of health workers who are traumatized, distracted, depressed and lacking motivation as a direct result of SEAH.

Organization leaders in the health sector must count the cost of inaction. The cost of taking action to prevent SEAH will be lower than the cost to individual women and health systems of letting abuse continue.



“...When we deny our stories, they define us. When we own our stories, we get to write a brave new ending.”

Brene Brown, Author³⁵



PART 4: FINAL WORD

In 2017 the hashtag #MeToo took off on social media as women reported that they too had experienced sexual assault and harassment, especially in the course of their work. The phrase “Me Too” was originally used in 2006 by sexual assault survivor and activist Tarana Burke³⁶ to draw attention to the prevalence of such abuse, build solidarity and catalyze action.

WGH have used #HealthToo for the same purpose, to make visible and real a serious human rights violation and abuse of power that is blighting the lives, careers and well-being of women health workers. The main enabler is systemic gender inequality in the health workforce that clusters women into less powerful roles and encourages men to feel they can abuse women with impunity.

Shame and blame may fall upon female survivors if the story does surface but as seen from #HealthToo, very often the story does not surface so perpetrators and employers can deny SEAH is a problem. Women in Global Health, with our global network of chapters and partners, will continue to raise SEAH of women health workers until all women in the health sector have safe and decent work.



ANNEX: METHODOLOGY FOR #HEALTHTOO STORIES

Data collection process: Work-related SEAH stories were collected from women anonymously via the online #HealthToo platform and from WGH Chapter members. Stories were also gathered through organizations that work on the topic, including Surviving in Scrubs, Survivor Stories, and Mandela Ethiopia Doctors. In addition, case stories published in journals, the media, and gray literature were also included; for example, from NursingTimes, ABC News and Public Services International (PSI).

Table: Sources of stories

Source	#HealthToo Platform	Stories collected from other organizations	Stories from articles	Excluded stories	Total stories for analysis
Number of Stories Collected	111	142	12	30	235

Table: Summary of #HealthToo platform respondents' locations, languages, & roles

Countries (40 total)	Congo, USA, Mexico, Spain, Kenya, Egypt, Peru, India, Croatia, Rwanda, Algeria, Syria, Namibia, Guinea, Nigeria, Chile, Portugal, Ghana, Sweden, Ethiopia, UK, Pakistan, Nepal, Senegal, Uganda, Switzerland, Brazil, Malawi, Zambia, Libya, Germany, Ecuador, Finland, Zimbabwe, Canada, Niger, Italy and Luxembourg, South Africa, Cameroon
Languages (10 total)	English, French, Spanish, Swahili, Arabic, Portuguese, Bengali, Hindi, German, Amharic
Type of roles (16 total)	Executive Director, Community Health Worker, Doctor/Physician, Nurse, Health Policy, Health Technician, Health Administrator, Midwife, Dentist, Pharmacist, Case Assistant, Health Manager, Health Researcher, Community Mental Health Worker, Mental Health Activist, Peer Counsellor, Social Worker, Nursing Student
Type of organizations (8 total)	NGO, Hospital, Care Home, Health Policy Organization, Government Office, Clinic, United Nations or other International Organization

Inclusion and exclusion criteria

Stories of work-related SEAH in the health sector submitted by women over 18 years, in any language were included for analysis. Stories of domestic violence, professional rivalry, and stories about general issues in the health sector were excluded.

Ethical considerations

To ensure the survivor's security and anonymity, all identifying data was removed from the stories **before any analysis was undertaken, including name, organization, specific location, name of perpetrator, and any description that could identify the storyteller, perpetrator or their organization.**

Before submitting the stories, all survivors were required to read our #HealthToo Story Submission Privacy Notice and Rules and consented by accepting the terms.

WGH recognizes that the process of reporting or reading SEAH stories can result in re-traumatizing survivors. However, we also believe that sharing traumatic experiences can be part of the healing process for individuals. We are grateful to all the women who bravely shared their stories for this report.

WGH is committed to using their stories to help shed light on the problem at the highest levels and mobilize action to end SEAH.

Data management

Only three people (Research Analyst, Project Associate and Policy Associate) had access to the raw data submitted through #HealthToo platform. Stories were directly uploaded to NVivo, which requires a password to access known only by the Research Analyst.

Data analysis

This was a qualitative, exploratory study that used an interpretive approach to understand the respondents' experiences through their own words and meanings.

The interpretive approach does not impose a particular perspective or truth on data but accepts the experiences and perceptions of respondents as a reality.

Data was coded using NVivo software, and thematic analysis conducted to identify patterns and trends.

Limitations

The online nature of the platform allowed us to potentially reach a large sample, but not those (for example, the millions of community health workers on the front line of global health) lacking Internet access or literacy skills.

Furthermore, #HealthToo only asked women to submit stories if they have experienced or witnessed SEAH; the study did not collect data from women with no experience of SEAH and cannot, therefore, tell us about prevalence among women health workers; nor can it tell us about how SEAH affects women compared to other genders.





ABOUT WOMEN IN GLOBAL HEALTH

Women in Global Health (WGH) is the fast-growing women-led movement demanding gender equity in global health. While women represent 70% of the workforce and about 90% of front-line health workers, they hold just a quarter of leadership positions. Now with supporters in more than 90 countries and 44 official chapters predominantly in low-income countries, WGH campaigns for equal representation for women in health leadership; equitable pay and ending unpaid work for women health workers; protection and safe and decent work; and the prevention of sexual exploitation, abuse and harassment. These are the essential foundations for strong health systems, Universal Health Coverage and global health security.

For more information: www.womeningh.org

Follow us: [@WomeninGH](https://twitter.com/WomeninGH)

Contact us: info@womeningh.org



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