

ANALYSIS OF INEQUALITIES AND DISCRIMINATION IN THE RECRUITMENT, RETENTION, AND PROMOTION OF WOMEN IN PRESERVICE EDUCATION AND HEALTH CARE FACILITIES IN MALI

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BACKGROUND

Discrimination and gender inequalities are among the many external factors that directly impede the ability of governments, nongovernmental organizations, and health training institutions to develop human resources for health (HRH).

In Mali, the promotion of gender equality has been at the heart of all development policies, initiatives, and agendas for several decades. The Malian government has taken legislative and regulatory measures to promote the rights of vulnerable people, especially women and children, including ratifying the Convention on the Elimination of all Forms of Discrimination against Women in September 1985, and adopting Conventions C100 (equal pay) and 111 (equal opportunity) of the International Labour Organization (ILO). Despite the efforts of the Malian authorities to develop women's socio-professional lives, socio-cultural

burdens remain an obstacle in applying the measures taken by the government.

Discrimination against women and cultural factors that promote inequalities in preservice education institutions, the employment sector, and society in general are a direct impediment to the ability of government and key health actors to train and retain available workers to provide equitable and accessible health services. The gender gap in education, health, economics, public life management, and law remains an issue in Mali.¹

In response to these findings, Mali's Human Resources Directorate for Health (HRD), with the support of IntraHealth International through the USAID/Mali HRH Strengthening Activity, carried out a gender analysis in preservice education institutions and health facilities to highlight institutional and cultural barriers to women's access to and retention in preservice education and employment systems in the health sector.

¹ *Etude sur la situation de la femme au Mali*, RECOFEM (2007).



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METHODOLOGY

The study took place from November 2018 to February 2019 in preservice training institutions and a cross-section of health facilities at different levels of the health system in the Kayes, Koulikoro, Sikasso, Gao, and Bamako regions. The data were collected through individual interviews and focus groups, including interviews with 347 students, 133 health care providers, and 36 teachers. The sites were chosen within the USAID/HRH project's intervention regions. Data collection and entry of quantitative data were done through KoBoCollect and analysis using SPSS software. Qualitative data entry was carried out in Microsoft Word and exported to Dedoose software for analysis.

RESULTS

1. Participants' profiles

More than half of the respondents were male (51%, or 263/516), including 54% (186/347) of students and 86% of teachers (31/36). However, 65% of health care providers who participated (87/133) were women (Figure 1). Among female participants, the majority of students and health workers were married (Figure 2); however, there were very few married women in the teaching sector (12% of respondents).

2. Findings on the preservice education system

An analysis carried out on the basis of mixed cohorts (both men and women, but not including midwives) showed the admission rate was clearly higher for men than for women: 57.5% versus 42.5%. This difference can be explained by the multiple social responsibilities imposed on women in addition to their school obligations:

Figure 1: Distribution (by %) of respondents by gender (N=516)

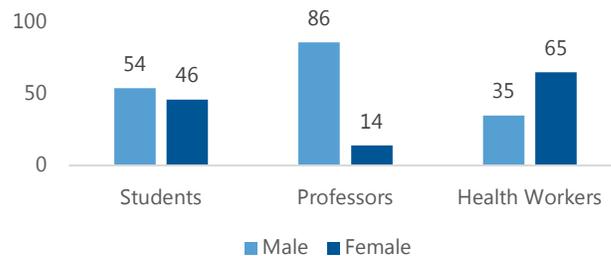
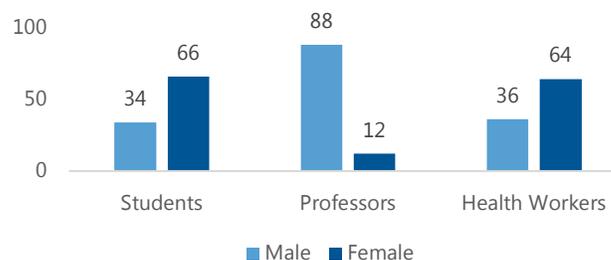


Figure 2: Distribution (by %) of married respondents by profession (N=214)



"The woman will be forced to make a choice between marriage and her studies, so to have a good reputation in society one is obliged to continue with the marriage. The husband is going to get tired and will say that the wife does not stay at home to take care of the children and will seek to marry another woman, and that's what we women hate, so we'll try to stay with the husband. It's a reality of life, especially in Africa."—Focus group participant.

This statement alludes to indirect discrimination based on household responsibilities and pregnancy.

There is low representation of women among staff in management positions. Men are in higher hierarchical roles in private, public, and medical school institutions, where very few women hold positions of responsibility (Figure 3).

"It's hard for them to be the person in charge... See the person who is regularly on time, is never absent, equipped to participate in many activities outside of

Figure 3: Proportion of health workers in managerial positions at different preservice training institutions that are each gender (N=48)

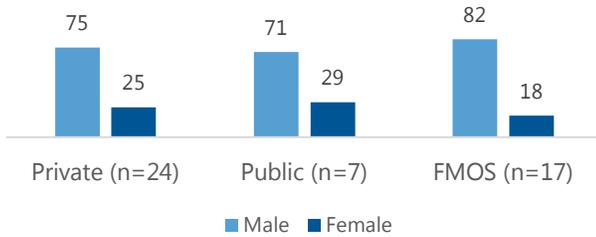


Figure 4: Number of students admitted to the doctoral program in 2011 and those who graduated in the cohort by gender

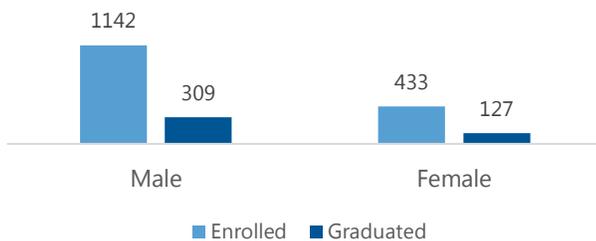


Figure 5: Proportion of employees at each level of responsibility that are male or female (N=133)

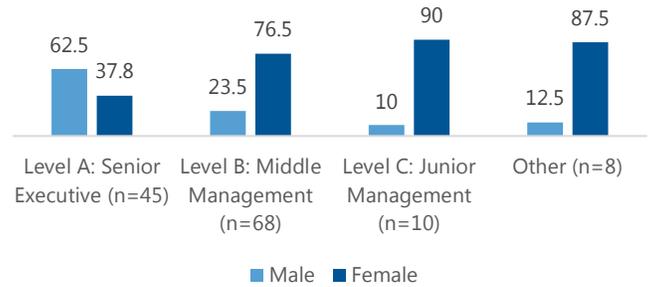
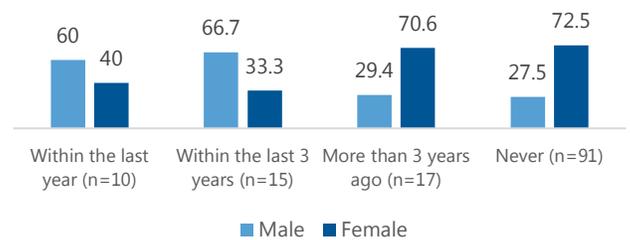


Figure 6: Proportion (in %) of employees with their most recent promotion in the given timeframe by gender (N=133)



Mali, and who can participate in internal activities at any time... for a young mom, it's hard! For men there are no difficulties!" –Focus group participant, teacher.

The cohort analysis shows that there are more male enrollees and graduates than women for the doctoral cycle of the Faculty of Medicine and Odontostomatology (FMOS) for the period 2011-2018 (Figure 4).

3. Findings on the employment system

Despite the high number of women in health facilities, men are more likely to hold higher-level positions, and most women are concentrated in the lowest paid positions (Figure 5).

"If they think a woman is their leader, it can be a great challenge for some men. But do you know who replaced their leader, a woman. So much so that they couldn't accept it, that they marched in protest until their shoes broke because they couldn't accept

that a woman could become their leader. So, it's psychological for some people who think women should stay behind. There are men who don't change. They have been thinking the same way since colonial times."—Focus group participant, provider.

Men also enjoy much more career advancement than women (Figure 6).

The study shows some of the socio-cultural burdens that remain a barrier in the application of measures to promote equal opportunities in the recruitment, retention, and promotion of women. For example, most household chores are performed by women.

4. Findings on sexual harassment

Sexual harassment is a reality in all the study sites, but the subject is taboo and difficult to address: 17% of providers, 19% of students, and 28% of teachers say that sexual harassment behaviors exist (Figure 7). Students, teachers, and providers say

Figure 7: Rate of those who affirmed existence of sexual harassment in health training establishments and in the employment system (N=516)

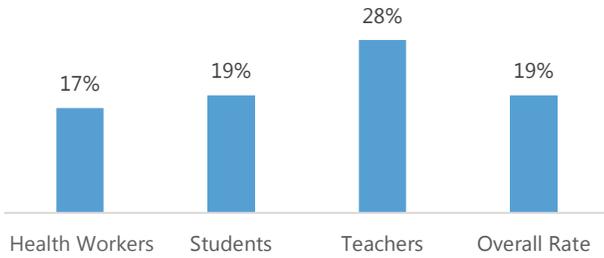
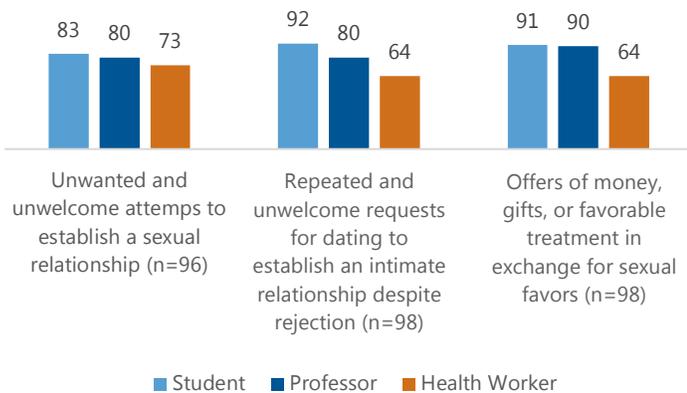


Figure 8: Types of harassment (by %) cited by profession (N=516)



that unwelcome advances, repeated and unwelcome requests for dates, and offers of money are the most common types of harassment in their facilities (Figure 8).

Victims of harassment have difficulty finding the appropriate way to report their abuser. Harassment reporting is done informally among friends with the following common outcomes:

- More often than not, the problem goes unnoticed
- No sanctions are taken to avoid legal trouble for the perpetrators
- The perpetrators are covered up by their colleagues
- There is no recourse for victims, so they are silent.

"It exists, it's a student who told me about it, she was a victim... the person told me that they were being harassed at all times by a teacher who promised

them good grades. She came to tell me to talk to the union, but I didn't want to report it to her because he's a colleague of mine, as far as the teacher was concerned, he was here and harassing us, and fortunately, he left."

5. Institutional responses to gender differences and inequalities

In training institutions, men have better knowledge about specific policies or provisions to help balance work with family responsibility, contrary to what is seen in the employment system among health workers (Figure 9). Men at training institutions also claim to have knowledge of policies to promote affirmative action and non-discrimination in hiring more than women. We observe the opposite trend in the employment system (Figure 10).

Figure 9: Proportion of respondents that have knowledge of implementation of specific policies or services to help employees balance their work and family responsibilities by gender by profession

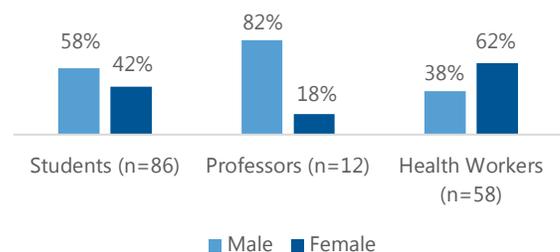
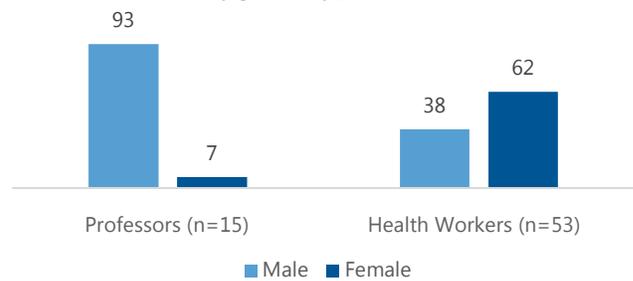


Figure 10: Proportion of respondents with knowledge of establishment of policies to promote affirmative action and non-discrimination in hiring or promotions by gender by profession



CONCLUSION

The study highlighted the fact that Mali has ratified several conventions that support equal rights and gender promotion; however, awareness of this, as well as the conventions' provisions, is not well known to beneficiaries. The study revealed a lack of dissemination and application of gender policies. There is also occupational segregation that starts during health workers' preservice education and extends to retention and hierarchical progression in the education and employment systems. Sexual harassment is a reality in health facilities as well as in training institutions. It is common among women for their direct manager to abuse their power, but victims have difficulty finding the appropriate way to report such harassment, either out of modesty or through fear of societal repercussions.

RECOMMENDATIONS

To improve the recruitment, retention, and promotion of women in training and health care facilities in Mali, the following actions are needed:

- Incorporate a component of the National HR Development Strategy to empower women in the education and employment systems to improve their decision-making status and capacity, especially in relation to governance and leadership in the health sector:
 - Implement a strategy to communicate and raise awareness of employees, students, and HR managers on gender bias, stereotyping, rights, equal opportunities, and new measures and initiatives.
 - Strengthen governance mechanisms and complaint procedures to address allegations of bias/discrimination/harassment and create disincentives to future discrimination.

- Introduce special measures to neutralize or dismantle gender discrimination in the health sector.
- Establish institutional provisions that promote a balance between family and work life, or otherwise allow women to access opportunities for gender equality in the health sector.

NEXT STEPS

The findings and recommendations of the study led to several next steps at different levels of the health system in Mali that are making an impact. At national level, it initiated the identification of "gender focal points" in all technical services (Ministry of Health, national hospital evaluation agency, national hospitals), which now meet on a quarterly basis. A new gender technical working group was also formed, and a Gender Roadmap developed to incorporate gender-sensitive planning in all technical areas of the Ministry of Health. The preservice training institutions developed gender action plans and made accommodations for students who are mothers (baby spaces, lactation rooms) to improve retention among these students. Additionally, some regional health directorates (e.g., Gao, Koulikoro) have named gender focal points to promote greater gender equity in the workforce moving forward.

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