

ANALYSIS OF GENDER-RELATED INEQUALITIES AND DISCRIMINATION IN THE HEALTH SECTOR IN SENEGAL: TOWARD EFFECTIVE HUMAN RESOURCES MANAGEMENT

December 2021

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CONTEXT

Discrimination and violence against women, and cultural factors promoting inequalities, in the health education and employment sectors and in the wider society, constrain the ability of governments, nongovernmental organizations, and health facilities to recruit and retain health workers to provide accessible services. Gender-neutral laws and policies, even if not overtly discriminatory, preclude protection of female workers' employment rights in overtly or covertly gendered work cultures that favor masculinist leadership and management stereotypes, male bias, and a male ideal worker norm, allowing the uncontested and unimpeded operation of gender bias and discrimination, to women's disadvantage. Ultimately, a gender-neutral stance in gendered organizations permits the operation of processes and systems that offer de facto forms of affirmative action for the dominant and privileged group (Newman et al., 2017).

Health workforce gender research has identified several forms of co-occurring bias and discrimination. Foremost among these is occupational segregation, which is recognized as an indicator of discrimination limiting equal opportunities, as defined by ILO Convention No. 111, 1958. Occupational segregation is one of the most intractable aspects of inequality between men and women in the labor market (Anker et

al., 2003) as it is generally accompanied by lower wages and poorer working conditions in female-dominated professions. Previous gender and workforce research also demonstrate that it occurs in a constellation of a gender "wage gap," sexual harassment, and discrimination based on pregnancy, family responsibilities, and stereotyping.

Prior to the research described in this brief, Senegal had no analyses of gender discrimination and inequality in the health sector. Most of its gender-related research had focused on aspects of gender-based violence in the community, overlooking the discrimination and violence that exists in the world of professional work in general and specifically in the health sector. The 2015 Ministry of Health and Social Action (MOHSA) gender audit report had identified areas where human resources management (HRM) practices were insensitive or blind to gender in the health workforce. Following the gender audit, the MOHSA developed an institutional gender institutionalization plan that highlighted several gender-related problems in HRM and the establishment of decent working conditions and gender mainstreaming, including:

- Working women who must constantly reconcile family, social, and professional responsibilities.
- Workers posted far from their spouses and marital homes, a greater issue for women who face more familial conflict in such situations.



- Absenteeism, an issue deemed greater among women than men, and its impact on the continuity and quality of health services.
- Sexual violence.

The MOHSA gender institutionalization plan also outlines a set of underlying issues related to traditional expectations and practices, especially the inequitable division of labor, which are thought to contribute to gender inequality, such as gender stereotypes and beliefs that constrain women's leadership.

MOHSA promotes decent work at all levels of the health pyramid, and aims to create work environments that promote equity between women and men and decent work for health workers. Decent work is productive and offers a fair income; provides safety in the workplace; ensures social protection for families and better prospects for personal development and social integration; guarantees freedom for people to express their concerns, organize and participate in decisions that affect their lives and work; and ensures equal opportunities and treatment for all women and men.¹ In response to the gender audit findings, MOHSA, in collaboration with the USAID-funded Neema project led by IntraHealth International, designed and conducted a gender discrimination and inequality analysis related to HRM and decent work, including violence and discrimination in the health sector.

METHODOLOGY

The Gender Discrimination and Inequality Analysis took place from April-May 2021 in the Saint Louis, Matam, Tambacounda, Kédougou, Kolda, Sédhiou, and Diourbel regions of Senegal. The data were collected through an online questionnaire, individual (key informant) interviews, focus group discussions (FGDs), an employee-count data collection sheet, and a policy review framework. Three regions, and sites in those regions, were

chosen in a purposive manner for individual interviews and FGDs. The online questionnaire, in KoBoToolbox, was responded to by 456 health care providers. There were 13 individual interviews and 12 FGDs: four per region including nine homogenously female and three homogenously male. Quantitative data were analyzed using SPSS and Excel. Qualitative data were transcribed in Microsoft Word and imported to Dedoose for analysis.

RESULTS

POLICY REVIEW

Gender equality has been integrated into national policies, initiatives, and strategies over the past several decades and the government of Senegal has taken legislative and regulatory measures to promote the rights of vulnerable people, especially women and children, in key policies and documents.² In addition, Senegal has signed on to and ratified multiple international and regional protocols;³ however, these documents and an understanding of their contents are not well known and disseminated, nor are they systematically applied in organizational HRM policy and practice in Senegal's public health sector.

ATTITUDES, BELIEFS, AND STEREOTYPES

In Senegal, it is believed that a woman should be behind a man, and that she should not lead a man. When the chief is a woman, the community itself does not give her legitimacy and in some health posts where a woman is in charge, men who come for treatment belittle her. Facility managers who are women are often very strict, which is why men call them tough. Also, men are not used to taking orders from women, which is why some men do not cooperate when a woman is their manager. Table 1 shows the pervasiveness of gender stereotypes according to survey respondents.

¹<https://www.ilo.org/global/topics/decent-work/lang--en/index.htm>

²*Stratégie d'Équité et d'Égalité de Genre (SNEEG 2), 2016-2026; La Convention sur l'élimination de toutes les formes de discrimination à l'égard des femmes a été adoptée le 18 décembre 1979; Constitution du Sénégal de 2001; Le code du travail sénégalais promulgué en 1997; Code de Famille de 1972; le Plan National de Développement Sanitaire et Social (PNDSS) 2019-2028 et le Plan National de Développement des Ressources Humaines (PNDRHS 1) 2011-2018 du MSAS de 2010.*

³Sustainable Development Goals: SDG 5: Achieve gender equality and empower all women and girls; *Protocole à la Charte Africaine des droits de l'homme et des peuples sur les droits des femmes en Afrique* (2004); Beijing Declaration and Platform for Action (1995); ILO conventions (n 111, 100, 156, 183, et 190) and Recommendation R206 and the modified penal code (1999).

Table 1: Percent of survey respondents that said the stated type of gender stereotype occurred sometimes or often

Description	Women % (N, den.)	Men % (N, den.)
Implying that the person cannot manage both work and family responsibilities	76% (274)	65% (118)
The fact that a woman is expected to do tasks that are not part of her job description (e.g., women must arrange meals during labor and cleaning)	74% (269)	59% (125)
The fact that a man is expected to do tasks that are not part of his job description (e.g., men are expected to move heavy boxes; safety-related elements)	73% (266)	72% (123)
Referring to particular jobs as “men’s work” or “women’s work”	66% (265)	64% (123)
Asking someone to care for children of another person while they are at work (e.g., when you are on call)	73% (264)	66% (117)
Blaming a woman in a position of responsibility for being too authoritarian or not assertive enough	56% (268)	54% (122)
Blaming a woman for being too emotional	62% (266)	56% (120)
Being criticized for not behaving “like a woman should”	49% (261)	36% (115)
A man wanting to explain to a woman things that she already has skills or knowledge about	60% (257)	48% (118)
Being required to prove one’s competence several times before being promoted (compared to a male colleague)	41% (261)	26% (117)
Assuming that a person does not want an opportunity for a decision-making role because of their female sex or because of assumed family concerns	40% (252)	27% (116)
Excluding a person from important tasks or decision-making because of their female sex	37% (255)	17% (117)
Someone who assumes that you are not in a senior management position or that you are in a subordinate role compared to a male colleague	33% (254)	15% (114)

WORK CONDITIONS AND PROFESSIONAL DEVELOPMENT

Work conditions: Work travel is often not safe as women often travel by motorbike. While travel does not lead to health workers advancing in their career, it contributes to reaching program indicators and can contribute to the manager’s ratings. In terms of housing, there is great variability in the conditions wherein doctors and hospital directors have nice apartments, while nurses and midwives have small quarters that cannot accommodate all of their family members. Safe housing allocated to nurses and midwives in villages is often difficult to find. Within health facilities, toilets are often not separate between men and women (women have specific toilets only in maternity) leading to infection and menstrual hygiene management challenges.

Professional development: Women face constraints in their professional career, while men are less subject to such constraints. This is explained by a socio-cultural configuration where family and domestic work are mainly done by women, which leaves more time for men to study and enjoy the possibility of increased professional mobility. Building professional careers is described as an easier path for men. “It’s easier for a man because a married woman doesn’t have enough time to properly build her career.”

GENDER-BASED VIOLENCE AND SEXUAL HARASSMENT

Three broad categories of sex-based harassment (Fitzgerald et al., 1995) exist within the health sector in Senegal: gender harassment, unwanted sexual attention, and sexual coercion. Sexual harassment is a reality in all the study sites, but the subject is taboo and difficult to address. Furthermore, 38% of female health workers and 40% of male health workers say there are no clear policies and procedures for reporting gender-based harassment, and 53% of females and 62% of males say the target of sexual harassment has no say in what happens to the abuser (see Table 2).

“Gender-based violence is often verbal or physical violence. But it must be recognized that health workers, especially women, are victims of this violence. Indeed, women health workers are often verbally harassed by those accompanying patients during childbirth and consultations, especially on holidays. There is violence that exists.”

—Female focus group participant.

Table 3 summarizes findings related to gender-based violence.

The majority of these instances go unreported for fear of different repercussions, including being

Table 2: Organizational climate: % of survey respondents who felt the statement was sometimes or often true

Question	Women % (N, den.)	Men % (N, den.)
Do you believe that you will have opportunities for career advancement in this institution?	76% (273)	78% (109)
Does the institution offer training opportunities to everyone regardless of gender?	76% (245)	81% (111)
Does the organization's environment facilitate respectful and inclusive relationships between employees?	90% (250)	88% (112)
Are there situations where you feel in addition to discrimination based on sex, discrimination related to your level of responsibility?	43% (243)	29% (110)
Would you recommend that a friend or family member work at this institution?	56% (242)	58% (108)
Do all employees participate in decisions related to their own work?	72% (250)	83% (114)
Are there equal opportunities for men and women in this institution?	84% (245)	91% (112)
Do workplaces organize training on how to recognize and prevent gender-based bullying and harassment?	34% (241)	40% (110)
Are there clear policies and procedures for reporting and stopping gender-based harassment?	38% (233)	40% (108)
Does a target of sexual harassment have a say about what happens to the abuser (including restorative justice)?	53% (229)	62% (104)
To what extent do those responsible in this workplace seem to tolerate harassment (gender-based or moral) of employees?	34% (221)	33% (107)
To what extent are those responsible for this workplace harassing (sexual or moral) employees?	34% (221)	30% (106)
To what extent are victims of gender-based harassment encouraged to remain silent about it?	39% (229)	24% (106)
To what extent do workplace officials encourage reporting of bullying or gender-based harassment?	45% (229)	51% (106)

Table 3: Types of violence, perpetrators, and victims

Type	Perpetrator(s)	Victim(s)
Verbal, psychological, or physical violence	Health workers Patient families	Health worker (M&F) Women in labor (F) Patients with HIV or tuberculosis
Sexual harassment: sexual coercion	Organizational superior Local administrative authorities Colleagues	Female health workers
Sexual harassment: linked to career progression	Facility managers	Female interns Female contractual workers
Sexual harassment: unwanted sexual attention	Organizational superior Patient families Colleagues	Health workers (M&F)

sidelined during training, not being considered for promotions (following refusal), beatings, intimidation, injuries, threats of being transferred to the interior of the country, psychological effects, fear of reprisals, stigma, and blame. Ultimately, this leads to many victims resigning from their jobs.

CONCLUSION

The Gender Discrimination and Inequality Analysis revealed several obstacles and consequences within the health care professional environment in Senegal including the fact that gender bias and discrimination is often based on pregnancy/maternity factors that exclude women and value the

work of men more. In addition, while the legal and policy framework is based on human rights, they are not implemented, which allows socio-cultural models to influence the workplace. For example, women are harassed with impunity in the workplace, often because they are interns or contractors and do not want to lose their jobs or may face retaliation. The perpetrator of sexual coercion is often their hierarchical superior although other perpetrators of harassment include colleagues, families of patients, and patients.

RECOMMENDATIONS

In order to improve the recruitment, retention, and promotion of women in the health sector in Senegal and improve gender equality, the following actions are needed:

- Ensure wide dissemination of the results of the MOHSA/Neema political/legal analysis and advocate for its recommendations
- Develop or improve systems to report, monitor, and evaluate progress made in favor of gender equality and decent work
- Integrate indicators and targeted objectives to monitor progress
- Ratify ILO Convention 190 (Violence and harassment) and C 156 (Workers with family responsibilities)
- Desegregate professions to facilitate access to all worker profiles and to remedy staff shortages through behavior change communication interventions
- Integrate national labor policy protections in the next National Plan for Human Resources Management to make HRM more responsive to gender issues
- Develop a Code of Conduct for the health sector
- Put in place a sexual harassment prevention and response system
- Establish a strategy for the education of girls and boys on gender equality aimed at changing the expectations that contribute to the inequitable division of labor, professional segregation, and the undervaluation of women's work
- Conduct a behavior change communication and social dialogue campaign to fight against sexist stereotypes in the professions, using the appropriate channels
- Support behavioral changes in favor of gender equality and the fight against stereotypes regarding each issue and the underlying inequalities.

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