ALiGN

Advancing Learning and Innovation on Gender Norms

BRIEFING NOTE

Cameroon: Norms and gender-based violence in hospitals

By Community Centre for Integrated Development

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Contents

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About Community Centre For Integrated Development

Community centre For Integrated Development (CCID) is a youth-led organisation created to advocate and advance the rights of women and girls, particularly in the area of Human Rights, Sexual and Reproductive Rights and Health. We also aim to build resilient communities through research and training.

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Key findings

- This brief finds that female health workers in Cameroon's Buea Health District experience three main forms of gender-based violence (GBV): physical, emotional and sexual.

- The most frequent perpetrators of violence against women within hospitals are reported to be managers, male workers and male patients.

- The social norms identified as underpinning GBV in hospitals include expectations that women will submit to such violence and the belief that they are objects to be possessed by men.

- Health workers also report a lack of effective reporting channels, a lack of knowledge and empathy among administrators, inadequate responses from law enforcement and the silence of survivors who may fear that they will lose their jobs if they report GBV.

- Health workers also reported difficulties in talking about GBV and in gathering evidence, as well as encountering 'victim-blaming' and disbelief.

- Respondents believe that an effective GBV policy would help to eradicate such violence in the workplace and also suggested the following specific measures:
    - raise awareness about GBV in particular and violence in general
    - train colleagues on GBV policy requirements
    - encourage staff – including female nurses – to report GBV
    - raise awareness of the need to respect human rights
    - create reporting channels where they do not exist.

Background

Violence in the workplace in general and gender-based violence (GBV) in particular, is a critical problem affecting women employees globally each year. Workplace violence is found in every country and region, and is experienced by employees across all occupations and locations. While GBV also affects men and boys, women are more often targets (Sida, 2015a; 2015b), reflecting unequal power relations between men and women in their personal relationships and in wider society, including the workplace (Sida, 2015a; Bott et al., 2005).

While workplace violence is commonplace, some evidence confirms that the health sector is among the sectors with the highest rates of GBV (Newman et. al, 2011; Van Den Bossche et. al., 2012). The diverse forms of GBV in the health sector include physical, emotional and sexual violence that disrupts the rights of workers with severe consequences, including depression, anxiety, absenteeism and low performance and productivity in the workplace. Despite research showing the prevalence of GBV, the majority of women do not report or disclose experiences and occurrences (Sida, 2015b), limiting the visibility of the severity of the phenomenon.

According to a study carried out by the Norwegian Refugee Council, 56% of women in Cameroon, suffered emotional and/or physical violence in 2020 (Brun, 2020). According to a UN Women Cameroon database on violence in the period 2006-2008, 3,680 women reported physical violence, and 2,500 reported cases of verbal abuse.[1] However, there are few data on the prevalence of violence in the health sector. Research on this area is of utmost importance because health personnel are usually some of the first to respond to violence, and it is difficult to carry out this duty if they themselves are also experiencing GBV.

Research objectives/rationale

- To establish the prevalence of GBV in health facilities in the Buea Health District
- To identify the forms of GBV in health facilities in the Buea Health District
- To identify and understand gender norms that underpin GBV in the health sector
- To examine the effects of GBV on female staff
- To examine policies addressing GBV in the Buea Health District.

[1] https://evaw-global-database.unwomen.org/fr/countries/africa/cameroon/2006/reported-cases-of-violence-against-women

Methodology

The research is descriptive and exploratory as it describes female workers' experiences on the prevalence, forms and root causes of GBV in health facilities in the Buea Health District. The study combined qualitative and quantitative approaches to determine the prevalence of workplace violence and its forms and perpetrators. It also sought to describe victims' reactions and the consequences for their physical and psychological wellbeing and their performance. It also identifies any existing policy and programmes on GBV in the health sector at the district level that could be reinforced or extended to address the issue. The study involved a health workers survey and key informant interviews.

Sampling

The health workers' survey was carried out in purposively selected health areas in the Buea Health District. Within the district, 17 different health facilities were then selected at random with 53% made of government facilities and 47% made up of private facilities. The facility sample included hospitals, health centres, clinics, and public health units or health posts, each of which was managed either by the government (public) or by non-governmental organisations authorised by the government (accredited facilities) or, in some cases, by the private sector.

The health worker sample consisted of those who were in the randomly selected facilities on the day data collectors arrived at the targeted sites. A total of 150 workers in the different health institutions were then selected for the study, with responses received from 128. Most of the 122 nurses who were interviewed (109) were female, and 20% were student nurses. Midwives and lab technicians accounted for 7% of those interviewed, and cleaners for 4%. Only one of those interviewed was a doctor.

To complement data and information collected through the health workers' survey, key informant interviews with managers of five institutions (three females and two males) were conducted (see Annex 1). Annex 2 summarizes respondent demographic information. As seen from the data, there is a high level of education among interviewees, particularly health staff, which could be one of the reasons for such high levels of awareness of GBV.

Limitations

Given the stigmatisation associated with GBV, the majority of respondents were unwilling to speak out and talk about their experiences of GBV although they were briefed on the objectives and assured of confidentiality. This greatly affected the duration of data collection, and the target number of respondents (150) for the study was not attained. Other issues and challenges including administrative procedures and bottlenecks, as well as COVID-related restrictions which limited access to the health institutions in general and health workers in particular.

Findings

Forms of gender-based violence

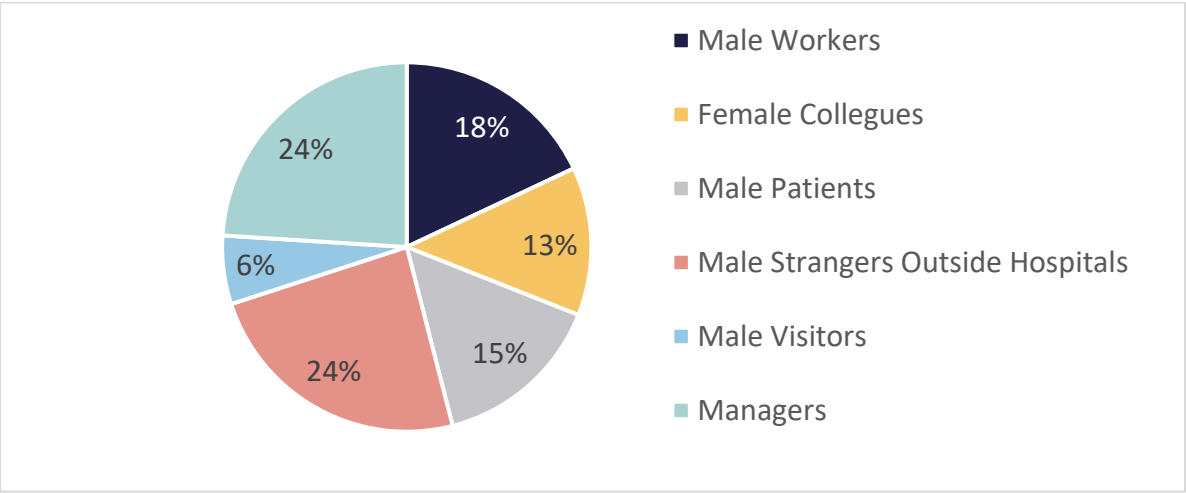
Respondents identified three major types of violence; physical, emotional and sexual. While 43% of female staff agreed that they had experienced physical violence, 42% indicated that they had experienced emotional violence, while 21% reported having been victims of sexual violence, in most cases sexual harassment.

Considering violence as any act that is likely to cause physical, sexual and emotional harm, female staff were asked to explain their understanding of violence. Most (72%) of the respondents observed that GBV is a violation of one's human rights, while 73% agreed that GBV should not be tolerated in any health facility. Discussing responses to GBV, 59% of the respondents said GBV must be reported, while 42% agreed that victims and survivors of GBV must be supported.

Perpetrators of gender-based violence on female staff in health facilities

In all, the responses of the health workers suggest that 87% of those perpetrating GBV are men. Most respondents reported that incidents of violence occur at the workplace. The main perpetrators of GBV within health facilities are managers (24%), male workers (18%) and male patients (15%). Three of the hospital administrators said most of the complaints received were against male staff and patients, but there was not sufficient evidence to substantiate the claim. Respondents reported that female colleagues (13%) and male visitors (6%) are also perpetrators. Much of the violence (24%) experienced by health workers had been perpetrated by male strangers outside the hospital. While this is not related to their work, 20% said it affected their work performance. Three of the hospital administrators said most of the complaints received were against male staff and patients, but there was not sufficient evidence to substantiate the claim. None of the interviewees reported violence by family members, perhaps as this was not explicitly asked.

Figure 1: Perpetrators of violence



Gender norms and gender-based violence in health facilities

Extensive evidence from the interviews (see also Mashiri, 2013), confirms that power imbalances and unequal power relations are harmful gender norms that place women at a disadvantage and that contribute to the violence they experience. Unhealthy gender norms, which perceive women as humble, submissive and docile, are very likely to hamper the ability of women to report cases and undermine the impact of reporting. In addition, most men see their unwanted sexual gestures as a form of flattery, and there is a widely held view in society that women are 'objects' to be possessed by men.

There is also a prevailing norm that women should endure violence – a norm that strengthens current perceptions around GBV. Such norms have an influence on GBV in health facilities, as in any other workplace, and contribute to the silence of victims or their preference to talk about GBV only with their friends or family.

Respondents to the survey said that they had encountered different challenges when trying to deal with GBV in the health facilities. Many of those surveyed (40%) identified difficulties in gathering evidence to show that GBV had occurred, while 39% said that it is difficult to talk about GBV. Meanwhile 34% of the respondents reported that people rarely believe victims and 32% indicated that victims are blamed for the violence. Some facility managers downplay GBV, while one senior manager 'victim-blamed' by arguing that '*…. a military violated the nurse because the nurse spoke rudely to him. That is why an outsider can violate a nurse because they too, at times, do not have a good manner of approach.*'

Impact of gender-based violence and coping strategies

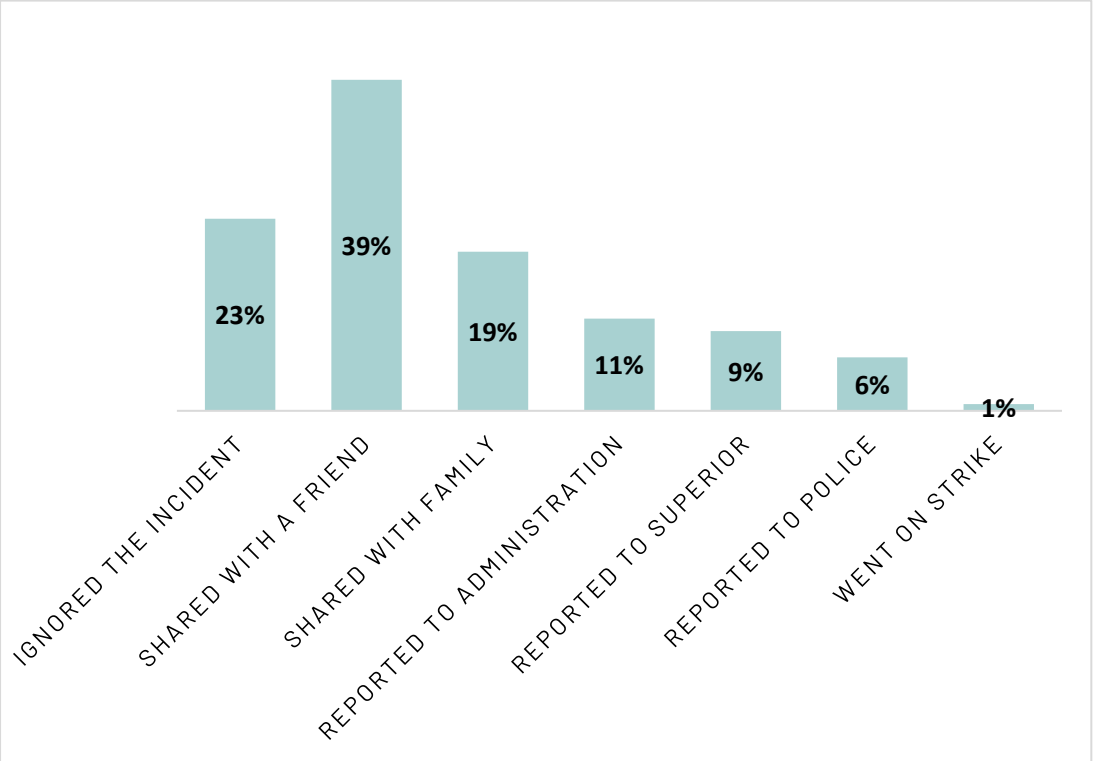
The impact of GBV can be severe. In all, 31% of the respondents reported suffering from fear and anxiety as a result of the violence they had experienced in their health facilities. Other consequences included shame (27%), not wanting to be with other people (16%), loss of sleep (11%) and guilt (7%).

At least 40% of female staff tried to protect themselves against violence by working in pairs and by wearing trousers instead of their nursing gowns. Counselling was adopted by some as a form of healing (23%), while others opted for silence (18%) and others sought support from social networks (12%).

Channels for reporting of gender-based violence in health facilities

According to respondents who had faced violence, a greater share of respondents (39%) preferred sharing their stories of such abuse with a friend, 23% ignored the incident while 19% told their families. Meanwhile, only 27% of respondents reported cases of violations to either the hospital administration (11%), their direct managers (9%) or to the police (6%) (Figure 2).

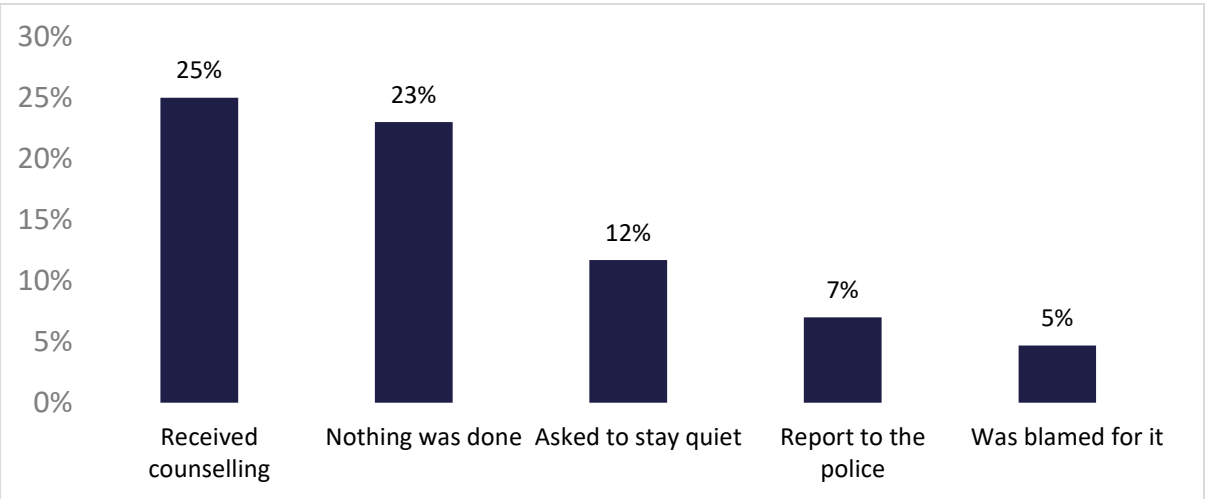
Figure 2: Who the interviewee reported the incident to



Reactions and responses to reports of gender-based violence against female staff

As shown in Figure 3, a quarter (25%) of respondents said they received counselling after reporting cases of violations, while for 23% there was no reaction from the authorities. A smaller proportion (12%) was either asked to stay quiet by family members and friends, (7%) was asked to report to the police, (5%) was blamed for being violated (Figure 3). As noted, the gender norm that women should endure violence strengthens perceptions on issues of GBV, and also the reluctance of some institutions to incorporate sanctions on violations as by laws.

Figure 3: Response to report of violent incidents



Policies and mechanisms for the management of gender-based violence

Findings from the field revealed that one cause of inadequate intervention by administrations in GBV cases in hospitals is because most (92%) of the female staff in hospitals are not aware of the existence of any internal policy or mechanism to address GBV. Some of the staff (6%) are of the opinion that in such situations, self protection is the solution. The Chief of Molyko Health centre said that she always advises survivors to seek legal help or counselling. However, this is in contrast with most health centres, since administrators themselves are ignorant about most of the forms of GBV leading to a lack of or inadequate response mechanisms or policies.

Only 10% of the respondents indicated that they would follow up with the mechanism for reporting cases of GBV (if this exists) because reporting 'makes perpetrators to be watchful' and 'brings safety risks' to nurses at work. On the other hand, a greater majority (92%) of workers in the health institutions studied explained that reporting cases is not considered realistic because '*I don't know of any mechanism*'; and '*no laws or procedures exist to punish defaulters*'; and '*no procedure is put at our disposal*'.

This suggests that the existence of a policy on GBV or a mechanism that seeks to protect victims of GBV would be helpful in curbing the rate of GBV in health institutions. The General Supervisor of Mount Mary hospital, however, was of the view that such a policy can only reduce GBV in health centres but not eliminate it. She insisted that the most reliable way was to seek justice through law enforcement agencies.

It is important to note that 57% of respondents observed that the presence of a policy to tackle GBV would make them feel safer in their workplace. Respondents associate the existence of a policy and laws against GBV with safety at work, arguing that a policy will raise awareness and restrict perpetrators, who will be afraid of the consequences. On the other hand, 47% of respondents were unconcerned about the presence of a policy, arguing that it would make no difference given the prevalence of corruption and lack of respect for rules and regulations. However, it is our opinion that broader policy and specific legislation on GBV would reduce the prevalence of GBV in hospitals.

Preventive measures to limit gender-based violence in hospitals

It is important to note that respondents identified some measures that could be put in place to curb the prevalence of GBV in health facilities. Respondents observed that raising awareness on the harm of GBV and training of colleagues on GBV policy requirements will assist in reducing the prevalence of such violence, since most men see unwanted sexual gestures as flattery and society views women as objects to be possessed. On the other hand, to encourage staff to report incidences of abuse, reporting channels should be created and made public while all staff should raise their voices against GBV.

The perspectives of health facility managers

During the key informant interviews with facility managers and general supervisors, a male administrative staff member for the Buea Health District indicated that, *'…I do not know what gender based violence is all about. Violence in general is not good, thus gender-based violence is not good either.'* The general view was that GBV, like any other violence, was certainly bad. However, those interviewed confirmed the absence of mechanisms or policies to manage cases of GBV specifically. One interviewee reported that *'we do not have any regulation or mechanism for the management of GBV cases but I know the Ministry of social Affairs is there for that. But with regards to public health, we don't have any national policy relating specifically to GBV….It is not a priority public health concern for now…'*. This low prioritisation reflects the gender norms that trivialise GBV as a woman's issue, and that mean reports of GBV are ignored and that little effort is made to assist victims.

Outlining the effects of GBV on female nurses and workers, an officer in the Buea Health District was of the opinion that, *'…generally the victims are traumatised and the patient sometimes is affected and also affects the quality of care given by the care*giver'. The related consequence is that it affects the working relationship between the nurse and the patient and the performance of the health worker and the general quality of the care rendered.

Regarding sanctions taken by the administration on perpetrators of violence, the head of one health centre, observed that, *'…apparently, we report perpetrators to the Divisional Officer*'. On the other hand, the general supervisor at a private hospital mentioned sanctions such as dismissal, saying *'…If a female staff complains about being harassed by a male or female staff, the case is investigated and if found guilty, he is sacked from work. Free treatment is given to them and the hospital helps them take the problem to the law enforcement for proper prosecution of the case. We have had cases of female patients who have been violated. They are also given treatment…'*

In some cases, survivors are referred to non-governmental organisations for counselling or law enforcement agencies, particularly in cases of sexual violence.

These perspectives are drawn from key informant interviews with five senior staff who headed up health facilities, three of them female and two male. While the response to GBV from female-headed facilities appeared to be more positive and more protective of women than in male-headed facilities, this is a suggestive finding that needs further scrutiny to determine whether facilities headed by females are truly more responsive.

Conclusion/recommendations

Gender-based violence in health facilities is underpinned by the gender norms that tolerate and trivialise such violence and that result in a lack of the responses and reporting mechanisms that could curb such abuse. As observed in the study, 85% of respondents were female and most health workers (59%) have a university education. This could mean that most of them have been exposed to some form of education about GBV, which may be why they understand the concept and believe that it is a bad practice and it should not be tolerated because it is a violation of their human rights.

Despite this perception, the practice still persist because most people at the high level of decision-making in the hospitals trivialise GBV and there are no reporting channels in hospitals with regards to GBV, nor are there specific laws or regulations that target GBV in hospitals. These administrative and legal challenges, coupled with discriminatory gender norms, help to increase the prevalence of GBV in health facilities. The study found that 43% of health workers the Buea Health District had experienced physical violence, while 42% had experienced emotional violence and 21% had experienced sexual violence in their health facilities.

Despite the prevalence of GBV in health facilities in the health district, there is a dearth of policies or mechanisms to address and manage issues or incidences of GBV. Respondents to the study believe that the presence of a policy would decrease some of the risks of being violated. They recommended training and awareness raising on negative gender norms, and on the consequences and implications of GBV as key mechanisms that can help reduce the prevalence of such violence.

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Annex 1. Key informant interviews

Hospital	Position	Sex
Molyko Health Centre	Chief of Centre	Female
Mount Mary Hospital	General Supervisor	Female
Biaka Hospital	Supervisor	Female
Buea Health District	PBF(Performance-based financing) officer	Male
Buea General Hospital	Administrative staff	Male

Annex 2. Demographic characteristics

Age	
21-30	49.2%
31-40	28.1%
41-50	13.3%
51-60	0.8%
Marital status	
Single	63.3%
Married	35.2%
Divorced or widowed	0.8%
Education	
At least secondary school degree	85.2%
University degree	58.6%
Licensed nurses	71.1%
Student nurses	19.5%
Midwives	7.8%
Lab technicians	3.9%
Doctor	0.8%