

Commentary

Women Doctors and Health Services in Sudan

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In their account of the issue of women doctors' impact on health services in Sudan, Ahmed and Mohammed have touched upon important concerns. The underestimation of women in the world of work mentioned by the authors is not only a historical fact, more importantly it has often led to negative implications and gender biases against women. Although health sector workforce is one of the most "female" in composition, women are less likely to be found in senior professional, managerial and policy-making roles⁽¹⁾.

Concerning the issue of women in medical schools, the authors pointed to the increasing trend of female students witnessed in Sudan. In a recent study, Gismella found that female medical students accounted for 59.4 percent in our medical schools in the year 2001. If the same pattern continues, female ratios will reach 75 percent by the year 2011⁽²⁾. A strong perception, supported by the current status of medical practice, points to the negative implications of increasing numbers of female doctors on the equity and coverage of health services in the country. The alarming issue, in my opinion, is not the decision to restrict or not the numbers of females in medical schools; it is rather the fact that this matter is not up till now seriously discussed despite its urgency. This typifies the lack of integration between education policy and human resource planning in our country. Innovative means to deal with the situation could be found if the dialogue was initiated around the issue.

With regards to problems facing women doctors, the authors mentioned family responsibilities as distracting factor from work. This factor has led to discrimination against women widely known in the literature⁽³⁾. The general assumption is that women

did not want or were not able to advance their careers because of family responsibilities. This pressure of family duties has often led to a common stereotyping of women doctors as "inefficient" and lacking motivation because they are more likely to work part-time or take career breaks⁽⁴⁾. However, the problem, I think, is again up the system. Due to the under representation of females and gender issues, a male pattern of work has shaped the working environment. As Standing noted, the male-employee based norms see women as "the problem" because these norms focused on full-time, uninterrupted service and certain career structures⁽³⁾. To reassure employers, especially in the private sector, two points need to be highlighted in my opinion. The first one is that the modern concepts of management, which are largely applicable now, focus on results as indicator of good performance. These concepts can be more accommodative for gender dimension with their celebration of principles such as tasks, regulation of working hours, part-time jobs and contractual basis. This in turn can provide room for efficiency. The second point is that, equal opportunity recruitment policies have been shown to be highly cost-effective. There is an added value of having diversity in the workforce. For example, women experience in managing multiple tasks simultaneously (work/home) can be an excellent asset for managing in workplace⁽³⁾.

Regarding medical marriage, the authors pointed to the advantages gained through better chances for economical security and understanding between husband and wife. In fact, for health services, medical marriage can provide room for equity and deployment of staff to rural areas. The transfer of a

doctor whose wife or husband is also a doctor can result in double benefit for the receiving area. As the main worries of female doctors in states and rural areas in Sudan are housing and security⁽⁴⁾, medical marriage can be an effective mean in solving these problems. However, it should also be noted for service planners that the transfer back of doctors from rural areas can mean double loss for health facilities in those areas in case of medial marriage. I still remember that densely populated area in Sudan which lost four specialists in the same day due to transfer of two surgeons whose wives were a pediatrician and a gynecologist.

In the aspect of gender and medical specialization, the authors were concerned about the low interest of females in surgical disciplines. They went to suggest means like part-time training and role models to encourage females to choose these specialties. I want to add in this regards that, health planners and policy makers should also consider other means such as providing incentives for male doctors to get enough numbers in disciplines like orthopedics, urology and neurosurgery that are hardly preferred by women doctors.

Finally, I think this article has brought an important topic to the domain, which is gender issue in health services. The authors were successful to focus on the supply side of gender in health care (service

providers) rather than the demand side (service users) on which most is written in the literature. The main lesson, in my opinion, is that our health and human resource planning should be more aware of gender dimension in health. In our increasingly feminized health sector, gender effects on occupational choices, career patterns and working practices are becoming more prominent. The way forward is that, gender should be incorporated as a key contextual factor in human resource policy and planning frameworks.

References

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