PACE Think Tank

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Policy Brief

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Policy Brief

Gender, intersectionality and infectious risks in Senegalese healthcare facilities.

Key Messages

- Strengthening WASH, healthcare waste management, and electricity services in healthcare facilities is essential for improving quality of care, reducing healthcare-associated infections, and protecting both patients and healthcare workers.
- Evidence from Senegal indicates that gaps in WASH and IPC disproportionately affect women healthcare workers, persons with disabilities, older adults, and other vulnerable populations, highlighting the need for gender-responsive and intersectional approaches.
- Existing national health and gender policies provide a strong foundation, but stronger implementation, routine monitoring, and integration of gender-responsive WASH and IPC indicators are needed to translate policy commitments into equitable health outcomes.

Healthcare Facility Conditions and Unequal Infection Risks

Healthcare facilities in Senegal continue to face important gaps in water, sanitation, hygiene, waste management, and infection prevention and control, creating avoidable risks for patients, staff, and caregivers. National assessments show that progress has been uneven: in 2010, only 39% of primary health care facilities had basic infrastructure, and access was much lower in rural areas than in urban areas. In the 2012 Service Provision Assessment, 61% of facilities had basic water services, 24% had limited water access, and 74% still had limited waste management and disposal. Even though water and sanitation indicators improved by 2017, critical gaps remained in electricity and service reliability, which continue to affect routine IPC practice.

These facility-level weaknesses translate into real occupational exposure risks for healthcare workers, especially where hand hygiene, sharps safety, waste handling, and protective equipment are inconsistent. In a study of private healthcare facilities in Dakar, 40.6% of healthcare workers reported accidental exposure to blood or body fluids, showing that occupational infection risk is a routine workplace issue rather than a rare event. Nurses, midwives, cleaners, and other support staff are particularly vulnerable because they are more likely to have direct contact with patients, contaminated materials, and waste streams, often under conditions of limited protection and uneven IPC enforcement.

Children and persons with disabilities are also more affected when WASH and IPC systems are weak because they are more likely to require repeated, assisted, or prolonged care. Senegal's current sector policy also identifies vulnerable populations as a priority and notes that disability coverage remains limited, with only 24.8% of persons with disabilities holding a disability-equality card in 2023. This makes safe and inclusive facility environments essential for reducing avoidable infection risk.

Senegal already has relevant policy actors and implementation tools. The Ministry of Health and Public Hygiene leads IPC and patient safety efforts, the Ministry of Hydraulics and Sanitation is central to facility water access, and the Ministry of Family, Solidarity and Social Action provides the gender and social protection mandate. Senegal also uses WASH FIT and related quality-improvement approaches to assess and strengthen facility conditions. However, the key gap is weak coordination between WASH, IPC, occupational protection, and gender-responsive monitoring in day-to-day implementation.

The Research Project

This project aimed to generate actionable evidence on WASH, infection prevention and control, and gendered exposure risks in healthcare facilities in Senegal, with a focus on improving safety for patients, workers, visitors and other vulnerable users. Its specific objectives were to produce a baseline dataset on WASH conditions in targeted facilities, identify barriers faced by vulnerable and marginalized groups, support the development of a progressive improvement plan, and create a monitoring and alert mechanism for facility WASH conditions in Diamaguene Sicap Mbao. The project was designed to inform policy options for the Ministry of Health and Public Hygiene, the Ministry of Hydraulics and Sanitation, and the Ministry of Family, Solidarity and Social Action.

The approach was participatory and co-produced, using an intersectional and GEDSI-informed lens. It was led by a mixed team including public health, sanitation, and engineering students, district health actors, facility staff, municipal committees, and representatives of women, youth, older persons, and persons with disabilities. The project also used consultations with sectoral ministries and local authorities to align the work with institutional priorities, clarify responsibilities, and strengthen coordination across sectors.

The data combined three sources: facility-level WASH FIT assessments, spatial and environmental observations, and focus group discussions with vulnerable groups and frontline actors. The fieldwork covered three healthcare facilities in Diamaguene Sicap Mbao: PS Taif, PS Fass Mbao, and CS Khadim Rassoul. Qualitative evidence came from focus groups with persons with disabilities, women and Badiènu Gox, older persons, and female health workers, while WASH FIT data captured service conditions such as water, sanitation, hygiene, waste management, and environmental cleaning.

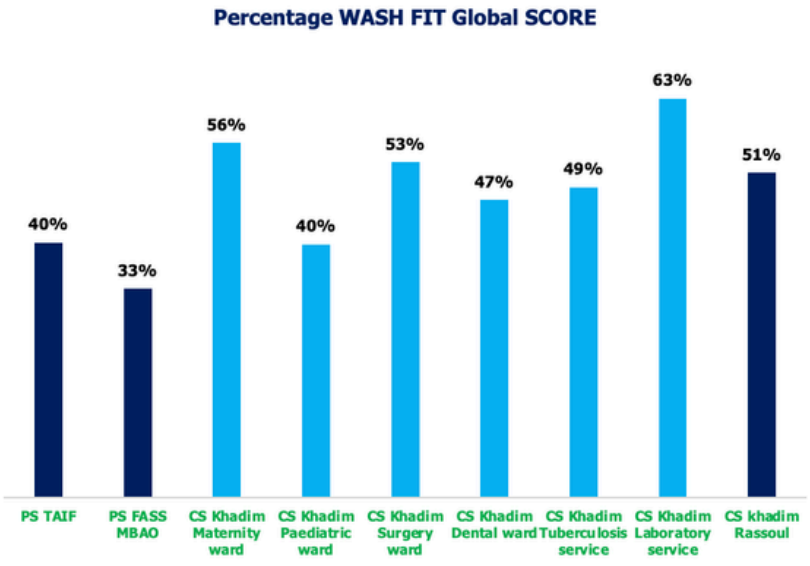
Methodologically, the project used a cross-sectional phased design combining structured WASH FIT tools, participatory workshops, revised indicators implemented in KoboToolbox, drone-based spatial documentation, and GEDSI-informed focus groups. The evidence produced by this mixed-methods process showed both measurable facility deficits and lived experiences of exclusion, such as inaccessible toilets, flooding, weak waste management, poor privacy, inconsistent water access, and uneven treatment of vulnerable users. Together, these findings provide a strong empirical basis for evaluating policy options that link WASH, IPC, gender, disability inclusion, and local governance in Senegalese health facilities.

Key Findings

The evidence shows that WASH and IPC failures in Senegalese health facilities create unequal infectious risk across users and workers on top of general service inefficiency. In the three facilities assessed in Diamaguene Sicap Mbao, the best overall WASH FIT score was 51%, still below the 67% threshold used in the project materials, which indicates that conditions remain critical despite variation across sites. Because the findings come from a mixed-methods design combining WASH FIT assessment, spatial observation, and focus groups, they are credible enough to support policy discussion as well as descriptive commentary.

A first key finding is that **persons with disabilities** face structural exclusion in everyday access to care. Participants described inaccessible toilets, lack of grab bars, Turkish-style toilets, flooding during the rainy season, slippery floors, and unsafe movement paths between entry points and service areas. One participant captured the core issue in a way that is especially useful for policy: **"En réalité, ce n'est pas la personne qui est handicapée, mais c'est l'environnement de la personne qui est handicapée,"** meaning that it is not the person who is disabled, but the environment that makes access disabling. This supports a policy argument that accessibility, drainage, and safe circulation should be treated as core IPC and facility-quality standards.

The evidence also shows that **older adults** also face mobility and access barriers that weaken safe care. They reported difficult access during flooding, long waiting times, poor internal mobility, and toilets that were unusable for people with limited movement. Some also described administrative and financial barriers linked to free-care arrangements and delayed service use. This means that safe WASH conditions and streamlined access procedures are necessary for older people, not optional add-ons.

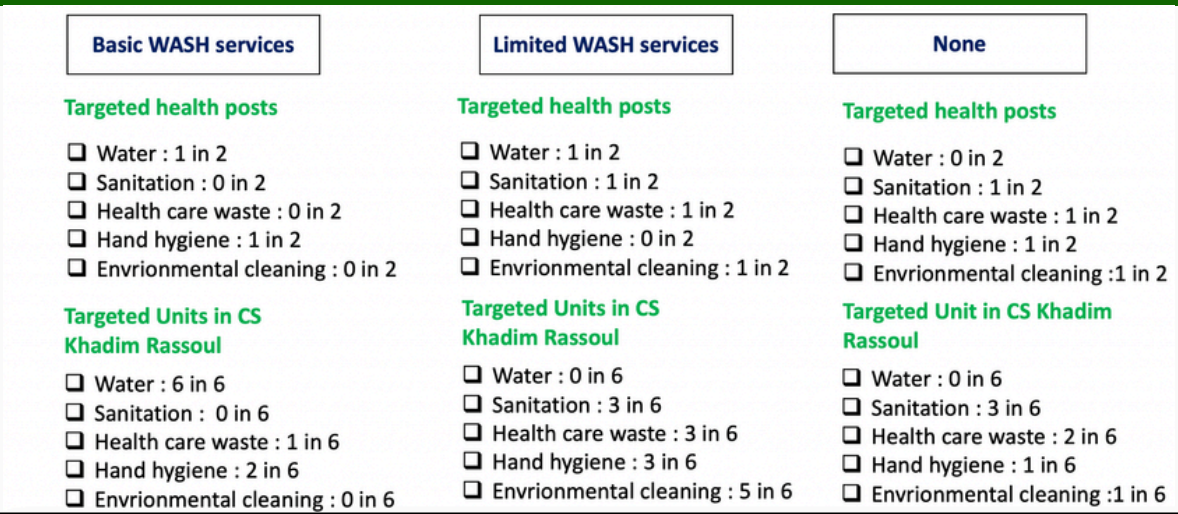


Women, especially those using maternity services, face gender-specific sanitation and privacy problems. Women and Badiènu Gox participants described shared toilets for men and women, lack of privacy, insufficient menstrual hygiene facilities, poor cleanliness, and water shortages in maternity spaces. One participant explained the impact clearly: **"En période d'hygiène menstruelle, il nous est difficile de nous gérer quand cela nous arrive dans les structures de santé notamment en l'absence d'eau courante,"** indicating that it is difficult to manage hygiene menstruation in health facilities when there is no running water. These conditions increase infection risk, reduce dignity, and may discourage timely use of services, especially during pregnancy and childbirth. The evidence therefore supports gender-responsive WASH standards in maternity, consultation, and sanitation areas.

Key Findings (continued)

Frontline female health workers are also exposed to unsafe working conditions. They reported flooding during the rainy season, weak toilet conditions, intermittent water supply, missing handwashing devices, poor night security, and weak enforcement of personal protection and hygiene rules. As one participant put it, **"Il nous faut des canalisations pour évacuer les eaux pluviales au niveau du poste et ses environs,"** meaning that drainage channels are needed to remove rainwater from the health post and its surroundings. These risks matter because staff safety and patient safety are linked: the same weak systems that expose users also expose workers, especially those handling cleaning, deliveries, and waste.

Finally, the project shows more of an implementation gap than a lack of policy language. Laws and commitments on disability inclusion, hygiene, and social protection exist, but they are not consistently applied in facility design, supervision, or follow-up. This is reflected in the WASH FIT breakdown, where basic services are uneven and some key services are limited or absent across facilities and units. It also appears in problems such as inaccessible toilets, weak drainage, poor water points, and poor monitoring of hygiene standards. Together, these findings show that vulnerable users and staff continue to face avoidable risks in everyday care. The policy debate should therefore focus on practical enforcement, budgeted upgrades, and routine monitoring across health, water/sanitation, and social protection systems.



Option	Meaning	Scenario
1. Targeted infrastructure fixes	Upgrade the most urgent gaps in toilets, water access, drainage, and handwashing points.	Quick reduction in immediate WASH-related risks, but limited long-term change.
2. Integrated WASH-IPC enforcement	Clearer standards, staff training, and regular supervision to make sure facilities comply to hygiene and infection prevention rules.	Stronger WASH service quality and safer care, but needs consistent oversight.
3. Multisector inclusion and monitoring mechanism	Create coordinated system where health, water and sanitation, social protection, and local authorities jointly track whether facilities meet the needs of women, persons with disabilities, older adults, and health workers.	Stronger follow-up and accountability, with clearer responsibility for fixing repeated implementation gaps

Conclusions and Policy Messages

The data shows that weak WASH conditions in Senegalese health facilities are creating avoidable infection risks and unequal access to care. These risks fall most heavily on women, persons with disabilities, older adults, and frontline health workers, showing that facility WASH is both a patient-safety issue and an equity issue. Technical improvements alone will not be enough unless they are matched with stronger enforcement, routine supervision, and inclusion-focused monitoring.

The evidence points clearly toward **Option 2 and Option 3**: strengthening WASH-IPC enforcement while creating a multisector inclusion and monitoring mechanism. The following actions are recommended for the Ministry of Health and Public Hygiene, district health services, municipal authorities, and relevant sector partners:

1) Require immediate WASH and accessibility fixes in priority facilities.

- The Ministry of Health and Public Hygiene should instruct district teams and facility managers to correct urgent gaps in toilets, drainage, water points, handwashing stations, waste management, and privacy, with priority for maternity, consultation, and high-traffic areas.

2) Institutionalize routine WASH-IPC supervision.

- District health services should use WASH FIT indicators to monitor compliance regularly, with clear reporting lines to the Ministry and corrective action for persistent failures.

3) Formalize a multisector inclusion and monitoring mechanism.

- The Ministry of Health and Public Hygiene, the Ministry of Water and Sanitation, the Ministry of Family, Solidarity and Social Action, and municipal councils should jointly track whether facilities are meeting the needs of women, persons with disabilities, older adults, and health workers.

4) Integrate user feedback into facility oversight.

- Health districts and facility managers should systematically include women, disabled persons, and older adults in quality checks so that recurring problems are identified early and fixed quickly.

5) Link WASH upgrades to gender and disability policy priorities.

- Senegal's current commitments to gender institutionalization and equitable health services create a strong policy window for aligning facility-level WASH reforms with ongoing national priorities.

Roadmap

To move from evidence to implementation, the Ministry of Health and Public Hygiene and its partners should take a phased approach:

1. **Short term:** prioritize repairs in the most affected facilities, especially toilets, drainage, water access, and handwashing points.

2. **Medium term:** introduce routine WASH-IPC monitoring using WASH FIT, and assign clear responsibilities to district health teams and municipal actors.

3. **Long term:** establish a permanent multisector mechanism for inclusion and accountability so that WASH, gender, disability, age, and worker safety are monitored together.

Key enabling conditions include modest rehabilitation budgets, maintenance supplies, and staff training. Likely partners include district health services, municipal councils, the Ministry of Water and Sanitation, the Ministry of Family, Solidarity and Social Action, health development committees, and representatives of women, persons with disabilities, and older adults.

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"Clean water, decent toilets, and good hygiene are not just basic human rights; they are the foundation for a healthy and prosperous life."

-WaterAid