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Rise of Women in Leadership in Senegal's Health and Social Action Sector

Contents

List of Figures

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Cover photos feature health workers in Senegal. Courtesy of HRH2030 and Photoshare.

Abbreviations

HRH2030	Human Resources for Health in 2030
MOHSA	Senegal Ministry of Health and Social Action
OECD	Organization for Economic Co-operation and Development
SNEEG	National Strategy for Equity and Gender Equality
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Between 2000 and 2019, Senegal showed dramatic increases in the proportion of women in leadership positions within the Ministry of Health and Social Action, from almost zero in the decade prior to 52 percent in 2016 following enactment of national gender policy and a female minister of health.

Women comprise seven out of ten health and social care workers globally and contribute US$3 trillion annually to global health, half in the form of unpaid care work.[1] However, they are woefully underrepresented in executive and management positions in these sectors due to considerable systemic and cultural barriers. Career prospects for women in the health sector can be depicted by a pyramid, with more opportunities for women in the lower categories working as service providers; fewer as managers of facilities; and even fewer roles in the highest management positions.

The World Health Organization (WHO)'s Health Employment and Economic Growth report[2] spotlights how gender dynamics in the health workforce are underexplored, leading to poor retention, ineffective distribution, and missed opportunities in leadership and governance. Building the evidence-base on women in the health workforce is imperative. Likewise, as 2020 is the Year of the Nurse and Midwife, it is critical to examine these two cadres which are dominated by female contributions, yet often overlooked for leadership potential.

As the United States Agency for International Development's (USAID) flagship program for human resources for health, the Human Resources for Health in 2030 (HRH2030) conducted multi-method explanatory research to better understand: the landscape of female leadership in the health sector; the impact of greater female leadership; and remaining gaps in parity in leadership in the health sector. After a global literature review to identify specific policies, strategies, or initiatives to increase female participation in health and social sector leadership, HRH2030 identified Senegal as a country context in which to collect quantitative and qualitative data through surveys and key informant interviews. This case study describes the Senegal results.

Data in Figure 1 shows substantial increases in female representation between 2000 and 2019, with particularly striking progression between 2010 to 2019. In 2016, female representation in leadership positions at cabinet, directorate, and division levels was at its highest with 57 percent an increase from 40 percent in 2014. The position of Minister of Health and Social Action (MOHSA) was held by women 45 percent of the time between 2000 and 2019, and the proportion of female leaderships seems to have spiked during these times. A gender equity strategy (SNEEG) and total gender equity law preceded the upsurges in 2010 and 2015.

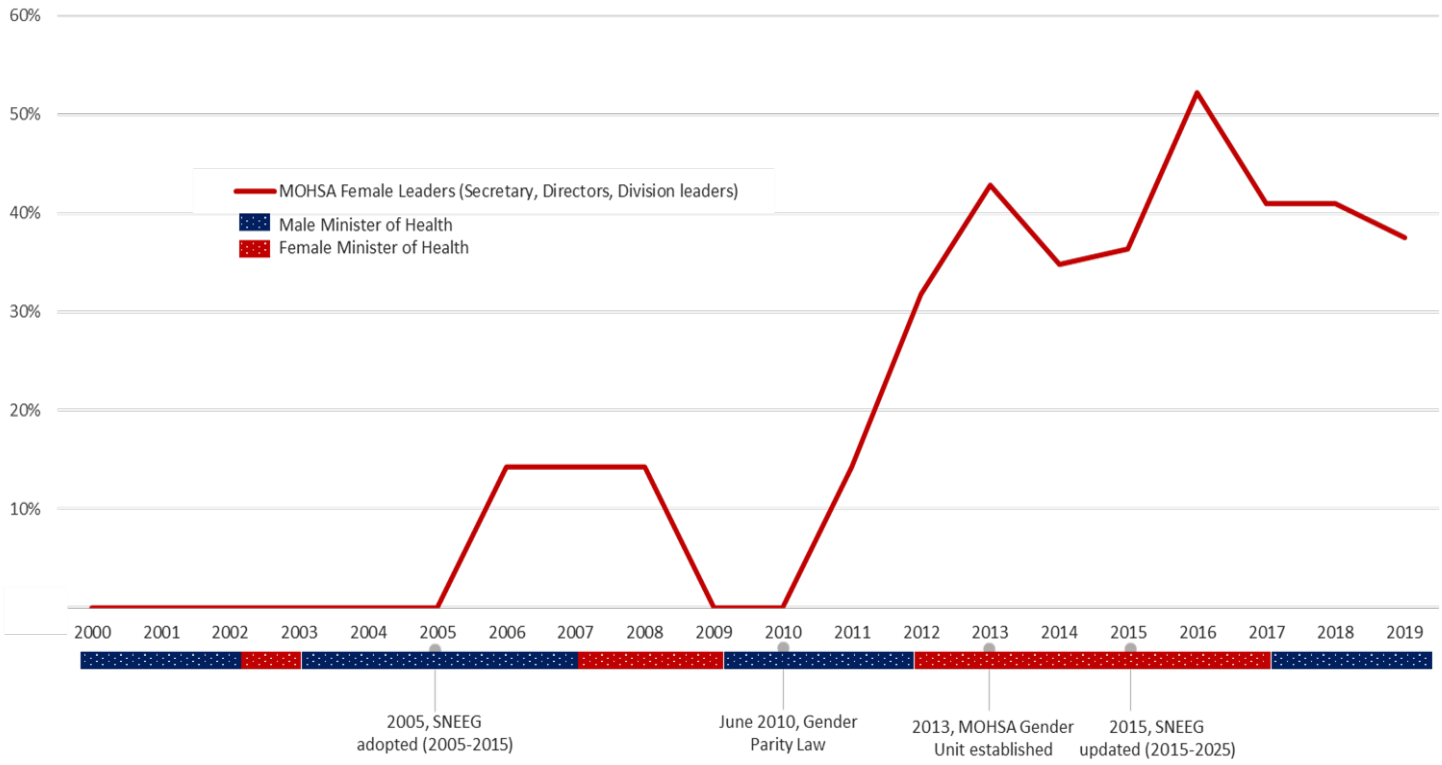
However, within the Ministry of Health and Social Action relatively more women serve in lower-level positions. For example, at the division level 53 percent of the positions were filled by women between 2000 and 2019. The highest proportion of 86 percent was reached in 2016 and remained at 83 percent in 2019. Many strategic, highest-level positions have been occupied by men from 2000 to 2019, such as the secretary general (100 percent male) and the 16 ministerial directorates (78 percent male) despite substantial increases in positions filled by women over time reaching a height of 44 percent in 2016 but dropping to 22 percent in 2019.

Global research points to occupational segregation in the health sector where women are systematically encouraged to select lower-level positions typically more associated with caring such as nurses rather than doctors[3] and data from Senegal points to similar patterns with women more represented in non-physician health worker roles.[4] Despite much progress for women to ascend into leadership positions in Senegal's health and social sectors, data show stereotyping of certain positions towards women in directorates and divisions, for example in the Ministry of Health and Social Action Gender Unit or with the Maternal Health and Child Survival Directorate.

While discrete initiatives to fast-track access to leadership positions, such as a particular training program or policy, did not emerge in the Senegal case study, there were several patterns in the qualitative data. Patterns of key initiatives for

[1] Boniol et al., 2019
[2] Buchan, 2017
[3] WHO, 2019
[4] Honda, 2019

FIGURE 1: CHANGE IN FEMALE REPRESENTATION IN THE HEALTH SECTOR IN TERMS OF THE MAJOR INITIATIVES, 2010-2019



increasing the number of women in leadership positions included:

- Policies and legislation
- School, scholarships, and training
- Intentional recruiting of female candidates
- Organizational practices and movements
- Representation and female role models
- Standalone leadership programs and activities

In analyzing the impact of increased female participation on the health and social sectors, qualitative data noted decisions by female leaders benefitting women and children. One participant suggested a cyclical effect, adding when programs for women and girls receive more priority and investment, they are in turn more likely to have female leadership.

It is impossible to research enablers to women's ascension to leadership roles without recognizing the barriers that exist. Respondents noted challenges that echo global research on barriers, most notably dual responsibilities of home and work and occupational segregation.

An average increase in the proportion of women in leadership positions at almost 3 percent per year over the last 20 years is a major accomplishment for Senegal's health and social sectors. However, such an achievement is fragile as a declining rate across all levels of MOHSA leadership over the last two years has shown. In addition, women in certain public institutions such as referral hospitals and universities continue to occupy less leadership positions. Institutionalizing gender equity in the sector's leadership requires continued attention, advocacy, action, and reform.

To further increase the evidence-base on promising initiatives that lead to an increase in women's leadership in the health sector, HRH2030 is applying this methodology to Madagascar as next steps.

Introduction

Globally, barriers that prevent women from accessing top-level positions in the government or private sector are in general well known, including at the individual, interpersonal, institutional, community, and policy levels.[5] There are many of the same workforce challenges across sectors, such as gender bias, discrimination, sexual harassment, disproportionate burdens of family responsibilities, pay gaps, and lack of supportive networks. There are also more specific health workforce challenges such as occupational segregation, where traditionally female roles such as nursing or midwifery are excluded from leadership positions, or proper remuneration in the case of community health workers.

But there is less research on the effective interventions that work to increase the number of women in leadership positions. While there are research and case studies describing the overall results of major corporate initiatives in developed contexts, little has been published about similar efforts in developing countries or regarding the health workforce specifically. Globally, action taken to support women in leadership positions ranges from broad draft laws, such as establishing gender quotas; major projects that foster gender equality, mainly through sponsorships, professional monitoring, and coaching; involving men as drivers of change; skills development; accountability systems; to simply establishing common and clearly defined goals and evaluating progress made using key performance indicators.[6]

It is meaningful to explore effective interventions in developing countries and in the health sector in particular as there is indication that women in leadership positions in health expand the agenda, giving greater priority to health and gender issues, such as reproductive health, and contribute to the scale up of the health and social workforce needed to achieve the Sustainable Development Goals.[7]

Increasingly there are calls to expand the evidence base on impacts from women in health leadership.[8] Existing research on gender parity in leadership across sectors demonstrates the financial loss of not facilitating conditions for women to be equals in economic participation. For example, McKinsey, a leading consulting group, estimates that achieving gender parity would be worth around US$28 trillion to the global economy, an increase of 26 percent from levels projected given conditions of continued gender inequity.[9] Additionally, randomized trials in India based on the 1993 quota law (states required to reserve a certain proportion of all council chief-seats in villages for women reserved female leadership) demonstrated that women in leadership positions in local governance structures promoted policies that are more supportive of women and children and favorable for achieving universal health coverage compared to men occupying the same positions.[10] Female elected officials were more likely to support health facilities, antenatal care, and immunizations. The research found that for every one standard deviation increase in the number of female-held seats in the district council, neonatal mortality dropped by 1.5 percent.

HRH2030 conducted a strategic literature review as a preliminary phase of this study in which interventions or initiatives (type and country) aimed at increasing women's participation in leadership positions were identified and described for 13 countries (Annex A). Observations showed a sustained increase in the number of female leaders in the Senegalese Parliament, up to 42 percent in 2017,[11] which made this country a promising candidate for a case study.

Methodology

To improve understanding of how to increase the number of women in leadership positions in the health and social sectors and the impact of doing so on health and social policies, strategies, and programs benefitting women, girls and children, HRH2030 proposed the following set of research questions:

Research Questions

1. Did the number of women in leadership positions in the health and social services sectors increase after public or private sector institutions took specific measures or initiatives? Specifically, has there been an increase in the number of women in leadership positions in the health and social services sectors and have specific measures or initiatives of public or private institutions contributed to increasing the number of women in leadership positions?

[5] World Health Organization, 2019
[6] Cao et al. 2018
[7] World Health Organization, 2019
[8] Dhatt, 2017
[9] Woetzel et al., 2015
[10] Downs, 2014
[11] OECD, 2019

2. What is the anecdotal evidence that an increase of women in leadership positions in the health and social sectors had an impact on organizations' and/or the country's health and social policies, strategies, and programs benefitting women, girls, and children?
3. What is the remaining gender gap concerning women's leadership in public or private sector institutions engaged in health and social services; and what are the perceived prevailing barriers and biases contributing to the remaining leadership gender gap?

Study Design

After conducting a strategic literature review to identify countries with promising increases of women in leadership positions, HRH2030 selected Senegal for further research. This study uses a multi-method explanatory sequential model with two phases: a quantitative phase followed by a qualitative phase.

First, HRH2030 researched relevant public records and online sources to identify and inventory male and female individuals in health sector leadership positions (per criteria outlined in Figure 2) and analyzed the gap that separates men from women in leadership. Due to the availability of national records, public sector leadership profiles for the past two decades were documented, and trends examined.

Subsequently, HRH2030 conducted key informant interviews from a purposive sample of the women leaders from those identified in the inventory and referrals about: specific measures or initiatives to increase the number of women in leadership positions; the effect of an increase of women in leadership positions on policies, strategies, and programs for women (women and girls); and the perceived barriers and biases that contribute to the remaining disparities in leadership positions between men and women.

The rationale for this approach is that the quantitative data provides a foundational situational understanding of the leadership gender gap in Senegal and related trends, while the qualitative data provides an in-depth explanatory understanding of the leadership gender gap, specific initiatives, impact, and remaining challenges.

Data Collection and Analysis

Quantitative and qualitative data were collected in Senegal from May to August 2019.

Sex-disaggregated leadership inventory

An inventory of female participation in leadership positions in the health and social services sectors was disaggregated and analyzed by sex. Initially, the inventory list of positions in the public, private, and academic sectors and in NGOs was drawn up and validated by stakeholders (Figure 2).

FIGURE 2: TYPES OF LEADERSHIP POSITIONS CONSIDERED

Public, all sectors	Minister
Public, health and social sectors	Cabinet members, Secretary General, Deputy Minister, Directors/Department Heads (e.g. Preventive Medicine, etc.), Division Heads (e.g., HIV/AIDS), Regional/Provincial Directors, Hospital CEO, Hospital Administrator, COO, CFO, Department Heads (e.g., Surgery, Internal Medicine)
Private Sector	Hospital CEO, Hospital Administrator, COO, CFO, Directors/Department Heads, Head of health and social research institutes, Senior leadership positions in research institutes
NGO*& Donor Programs	President, CEO, COO, CFO, Directors/ Department Heads, Project Directors or Chief of Party, Country Director
Academia**	Dean, Academic Department Heads, (Epidemiology, Policy, Management, etc.), Clinical Department Heads (Anesthesia, Otology, Laryngology, Dermatology, etc.)

* Only NGOs with at least 25 employees were included
** Academia includes schools of medicine, public health, social development, women's development, nursing, allied health professions, etc. Both public and private academic and research institutions were included.

For data at the minister level, all ministries were included. For other public sector positions, the review was limited to Ministry of Health and Social Action. The hospitals that were included were located in Dakar. In total, 77 leadership positions were identified according to the eligibility criteria in Figure 1, however due to data availability before 2018 many positions beyond the public sector at the national level were not included (Annex B, Table 1). Next, the sex of individuals that held these positions from 2000 to 2019 was catalogued by organizing them according to key leadership positions. Information on NGOs and universities was catalogued for the current year only and for the highest positions based on public information available online.

The data were compiled based on publications in the Official Gazette of the Government of Senegal; the official sites of the Ministry of Health and Social Action; and searches based on keywords, such as the position searched for and the period for retrieving articles on programs carried out by the department in which the names of individuals in those departments or institutions were listed. The local press and

information and national news platforms such as Senweb published several articles online pertaining to leadership positions. Additional information was collected directly from resource persons in the divisions and departments of the Ministry of Health and Social Action and academic institutions. This information was collected by position based on earlier service memoranda, archives, files and personal databases, and institutional memory of staff. There was no complete database of staff members in the Health and Social Information System Division, in the IT unit, human resources, or in the IT section of the Ministry of Health and Social Action.

Sex-specific data collected on individuals who in the past served or are currently serving in the various positions since 2000 were compiled in an Excel file. This was done to analyze the change over time in leadership positions within the Ministry of Health and Social Action including hospital, division, directorate, and cabinet levels. Trend data for leadership in other public (regional offices) and private institutions and NGOs were not available; instead, 2019 data were used for as many of these as feasible.

Trends were analyzed by sector of activity (public, private); level of responsibility of the position (minister, secretary general, directorate head, division chief or program manager); and level within the hierarchy of the organization (directorate or division). The data are analyzed using a sex-disaggregated approach. This primarily entails measuring the occupancy rate of positions according to sex by year from 2000 to 2019, measured as the proportion of women occupying a position per year. Overall averages weighted by the proportion of positions available in each year were calculated.

Key informant interviews

Key informant interviews served to examine the effect of specific measures or initiatives taken to increase the number of women in management positions; anecdotal evidence that links the increase in the number of women with its impact on women, girls, and children; and the perception of barriers which inhibit women's ascendance to leadership positions. In total, 12 semi-structured interviews were conducted using an interview guide (Annex C) with key informants in the Ministry of Health and Social Action and public institutions. They were based on purposive sampling, with priority for the highest leadership positions.

Each informant that signed a consent agreement was interviewed for 30 minutes to one hour. The audio recordings of the interviews were transcribed and transferred to the Dedoose software for thematic coding and analysis. The coded data were arranged by themes before they were analyzed. To preserve the confidentiality of the participants, the names were removed from the transcripts before the data were analyzed.

Ethics Committee review and approvals

The protocol and research tools were submitted to the National Ethics Committee for Health Research in Senegal, which reviewed and approved them. A research permit was also obtained from the MOHSA Secretariat General.

Limitations

Research on barriers and enablers to women's leadership is methodologically challenging. The MOHSA has undergone substantial structural changes over the last 20 years, mostly adding new divisions and directorates to reflect changing health and social sector strategies and policies. In addition, some positions were not filled every year or data were not available. This affected the completeness of quantitative data for the earlier period from 2000 to 2010.

With regard to qualitative information, the results presented here represent individual perceptions, there are interconnected and intersectional factors influencing leadership. It is difficult to distinguish individual actions and wider system-level determinants. Moreover, using individual recollection masks isolated variables. An individual may not attribute a specific program to her success, instead seeing her current position as the result of individual actions rather than system-level experiences or isolated interventions.

It must be noted, women are a heterogeneous group and that the privileges and disadvantages that hinder and enable women's career progression cannot be reduced to a shared universal experience, explained only by sex and gender.[12] Further, analyzing health workforce challenges related to sex and leadership is only one dimension of the complex sociocultural forces involved. This study is limited in analysis of other intersectionality considerations such as class, race, and ethnicity, which have impact on attainment of leadership positions.

The respondents to interviews in this study represent senior leadership perspectives, in Dakar. The majority of women in management positions are in mid-level positions such as facility-in-charge and spread across the country.

[12] Zeinali, 2019

Results

Over the last 20 years, female leaders in Senegal have increased in proportion and in the level of leadership positions attained, particularly in the health and social sectors. The following analysis shows the current status of female representativeness in decision-making circles in the government and various health subsectors such as the health system, training, and development assistance. It also documents several initiatives which leaders perceived as having had an impact on their current status as senior leaders.

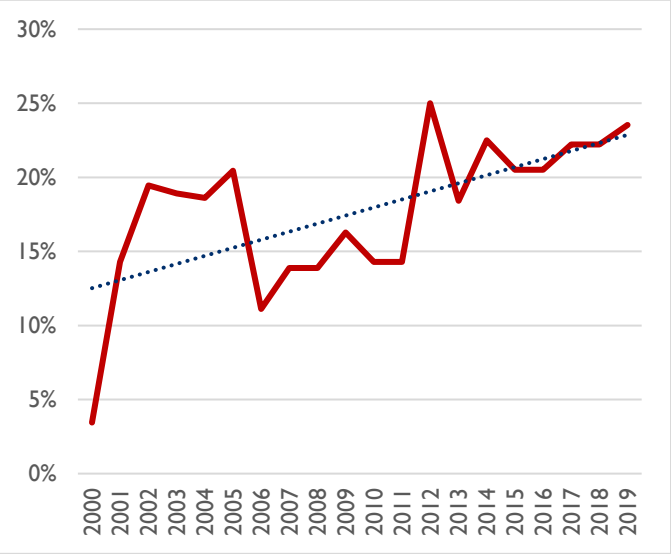
HRH2030 developed a sex-disaggregated leadership inventory to determine if female participation in leadership positions in the health and social services sectors increased after public or private sector institutions took specific measures or initiatives. First, HRH2030 analyzed high-level leadership across sectors to determine national trends, then specifically analyzed data related to the health and social sectors.

Limited Female Ministerial Representation Across Sectors

To determine if the representation of women in leadership in the health and social sectors was reflective of larger national trends or unique to the sector, HRH2030 first conducted an analysis of all sectors. As shown in Figure 3, the ratio of women to men who head the various government ministries is limited for the period from 2000 to 2019, ranging from a low of 3 percent in 2000 to a high of 25 percent in 2012 and 24 percent in 2019 with an average across the time period of 18 percent. This breakdown is based on information available from 29 to 45 of the 64 ministries between 2000 and 2019; data are available in Annex B, Table 2.

From 2000 to 2019 there have been two female prime ministers, both of whom were ministers of justice before holding the post of prime minister. Female representation in Senegal since independence demonstrates occupational segregation with a higher representation of women in sectors that are perceived to be more related to the role of women including microcredit, education, and social development, as well as lower or non-physician health cadres.[13]

FIGURE 3: PERCENTAGE AND NUMBER OF FEMALE MINISTERS IN SENEGAL ACROSS ALL SECTORS, 2000-2019



"In the Ministry of Health and Social Action, the promotion of female leadership is a reality at every level"

The leadership of the Ministry of Health and Social Action includes the following positions: minister, secretariat general, ministry directorates, and units and programs and divisions.

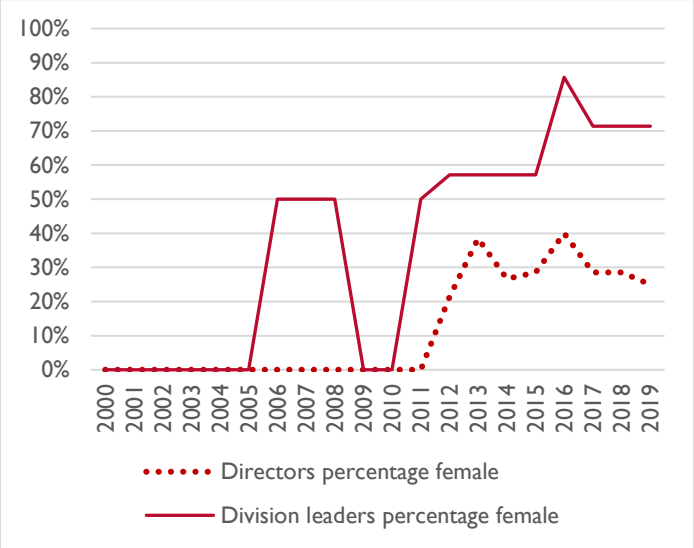
In 1986, Marie Sarr Mbodj became the first female health minister. Thèrèse King replaced her from 1988 to 1990. Men served in this position from 1990 to 2001. Eva Marie Coll Seck held this position from 2002 to 2003. Two other women headed the ministry from 2007 to 2009, with the return of Eva Marie Coll Seck in 2012 until 2017.

Within the Ministry of Health and Social Action there are overall positive trends in female representation between 2000 and 2019 with particularly striking progression between 2010 to 2019, although men continue to occupy most of the higher-level, strategic positions at directorate and cabinet levels. For example, all secretary generals have been male from 2000 to 2019 (Annex B, Table 3).

Analyzing the directorate and divisional leadership levels separately, as shown in Figure 4, relatively more women are represented at the lower division level reaching a high of 86 percent in 2016.

[13] Honda, 2019

FIGURE 4: PERCENTAGE OF FEMALE MOHSA LEADERS OF DIVISIONS AND DIRECTORATES, 2010-2019



The key informant interviews confirm a noticeable increase in the number of women in the ministry. Nearly all respondents noticed more women in positions of responsibility over the years. For example,

> *"The director general is a woman and there are three directorates, two of which are occupied by women. The minister himself appointed them. The minister's staff consists only of women: technical advising, communication and cooperation, and these women are all very competent. In the Ministry of Health and Social Action, the promotion of female leadership is a reality at every level."*

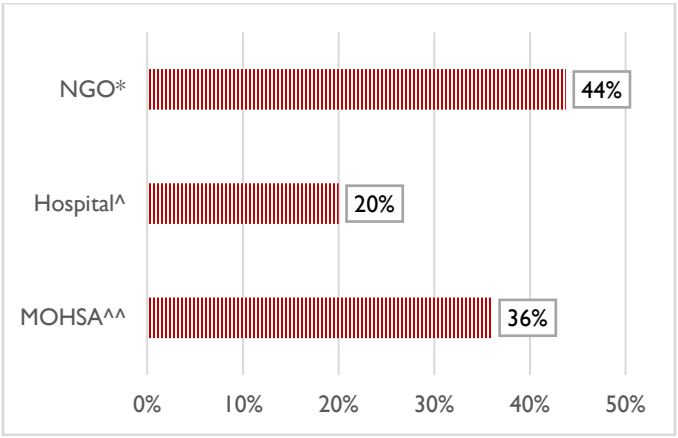
While data was not available for analysis beyond the division and directorate level, one key informant noted that a growing number of women are taking on leadership responsibilities in health districts.[14] Of the 14 medical regions in Senegal, in 2019 six are led by women, whereas a decade ago, only men served in these positions. However, the 2015 gender audit by the Ministry of Health and Social Action concluded positions of responsibility are still mainly occupied by men at the central, intermediate, and peripheral levels.

Health and Social Sectors Beyond the Government

Looking beyond government structures, an analysis of leadership positions across the health sector from 2010 to 2019 revealed modest gains in the representation of women.

Of available data, NGOs have greater female representation in leadership positions, as shown in Figure 5.

FIGURE 5: PERCENTAGE OF FEMALE LEADERS ACROSS PUBLIC AND PRIVATE HEALTH AND SOCIAL ACTION INSTITUTIONS, 2019



** NGO data includes all information available from the positions listed in Figure 2.*
^Hospital data includes the director level only.
^^MOHSA data includes the minister, secretary general, directors, and division leaders.

Data on hospital leadership was less available but generally aligns with other sector trends. For example, at the University of Saint-Louis, one of Senegal's largest universities, of the 30 teaching and research staff members, only seven are women. There are three levels of teaching staff: professors, lecturers, and assistants. Of the 12 staff members who have the rank of professor, 10 are men and two are women. Data for available positions across public and private health and social action institutions is available in Annex B, Table 1.

Room for Improvement in Parity

Consistent with global statistics which indicate that women make up the majority of the world's health workforce, according to a gender audit by the Ministry of Health and Social Action in 2015, women make up 56 percent of the overall health workforce in Senegal.[15]

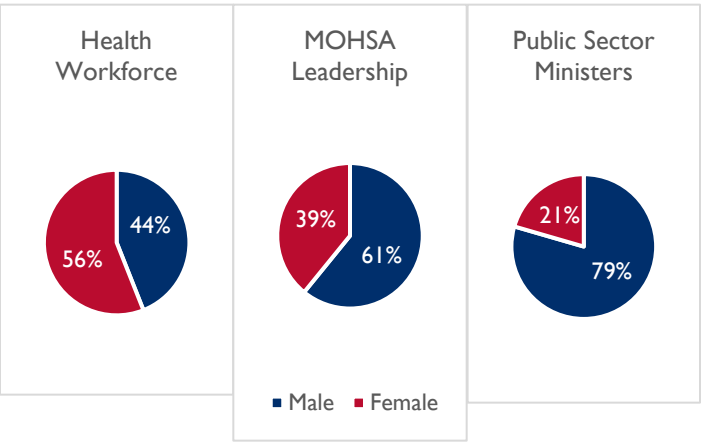
As Figure 6 shows, the overall leadership in the MOHSA is more representative of the health workforce than leadership across sectors but continues to have opportunities for growth to reach parity between sexes. Moreover, a declining rate in female representation across all levels of MOHSA leadership over the last two years is concerning and needs to

[14] Ministry of Health and Social Action, 2015a

[15] Ministry of Health and Social Action, 2015b

be closely monitored. Data was selected from 2015, as it was available for the overall health workforce.

FIGURE 6: PERCENTAGE OF WOMEN REPRESENTED IN HEALTH WORKFORCE, MOHSA LEADERSHIP, AND PUBLIC SECTOR MINISTERS, 2015



Impact of Initiatives to Increase Women in Leadership Positions

An average annual increase of almost 3 percent in the number of women in leadership positions over the last 20 years is a major accomplishment for Senegal's health and social sectors. There are many promising initiatives contributing to the advancement of women in leadership roles in Senegal. This study sought to identify the key enablers of this progress through key informant interviews. Interviews were coded according to the following types of initiatives that emerged during analysis:

- Policies and legislation
- School, scholarships, and training
- Intentional recruiting of female candidates
- Organizational practices and movements
- Representation and female role models
- Standalone leadership programs and activities

Policies and legislation

The government of Senegal's 2005-2015 and 2015-2025 National Strategy for Equity and Gender Equality (SNEEG), overseen by the Minister of Women, Family and Children, offers a guide for executive branch efforts to enhance women's participation. Following the launch of the SNEEG, ministries were asked to incorporate gender considerations into their projects and programs. The SNEEG was developed for all stakeholders in society, the national gender unit, sectoral ministries, civil society, members of Parliament, and the technical and financial partners. Its purpose is to help bring gender equality and equity to fruition in Senegal. One respondent noted of the SNEEG:

> *"Finally, there is a policy that proves that the state really does care about the well-being of women to the degree of a national intervention. Also, regarding laws, alongside the policy for parity, awareness raising is always necessary."*

In addition to the SNEEG, under the leadership of the female Minister of Health and Social Affairs Awa Marie Coll- Seck, the Ministry of Health and Social Action took further action to improve gender equality in ministry interventions by signing a memorandum of understanding and cooperation with the Ministry of Women, Families and Children. This led to the establishment of the Ministry of Health and Social Action Gender Unit in March 2013 through Primatorial Circular No. 009159 (there was an additional decree in 2015 about the structure and functions[16]), which carried out a gender technical audit of the MOHSA to assess the level of integration of gender within health programming, and to create management procedures and practices to enhance gender equality. It also called for the formulation of a plan to institutionalize gender considerations in the health sector over the period of 2016 to 2020 based on the audit.[17]

Further, there are several institutions in charge of monitoring gender equality in Senegal. For one, the National Observatory of Women's Rights was established in 2008 to monitor violations of women's rights. Second, the National Parity Observatory, established 2011 monitors, evaluates, and develops proposals to promote parity between men and women in public policy. Also, the Organization for Economic Co-operation and Development (OECD) issues a Social Institutions and Gender Index score. It rates Senegal as 'medium' (on a scale ranging from very low to very high) on its gender discrimination scale, because of the nation's discriminatory family laws regarding ownership of assets, inheritance, and other legal rights.[18]

Regarding legislation, men are permitted to have multiple spouses, women are not. The constitution prohibits all employment, wage, or tax discrimination between men and women but does not specifically cover job advertisements, selection criteria, recruitment, hiring, terms and conditions, promotions, training, assignments, or termination. The law

[16] MOHSA, 2015c
[17] Ministry of Health and Social Action, 2015a
[18] OECD, 2019

mandates equal remuneration for work of equal value and paid maternity leave of 14 weeks for women and 1 day for men.[19]

Senegal successfully instituted a gender quota law in 2010 under President Abdoulaye Wade.[20] Senegal has a unicameral parliament and this law mandates an equal number/ percentage of men and women (50/50) on all candidate lists for the general elections for the single/lower house and at the sub-national level. Candidates listed must alternate between male and female candidates. Although this particular initiative is beyond the health and social sectors, several leaders cited this law as influencing the overall perceptions of women and career opportunities available for them:

> *"Today, there is national political will; there is a policy to better involve women in leadership responsibility. Even the law for equality, even if it's for elected officials and not really at our level, I think it is a very important step. Today, when you go to local communities, there are as many women as men [out and about], when before, that was unthinkable. Same for the rural areas where women were considered inferior. Today, these women have reclaimed their position. Because the law is there."*

> *"It materializes first by law but also in the actions that authorities take. This consideration for equality is the reason why female leadership is a reality. It is not due to the will of one person; it is a process that has been ongoing since independence."*

School, scholarships, and training

Many respondents noted school opportunities as contributing to their leadership positions today, both early school opportunities and specific trainings. One female leader shared,

> *"I think that the participation of women in leadership positions is the result of educating girls and maintaining their education."*

Beyond addressing very root causes in leadership inequity beginning in access to school, leaders also identified specific training opportunities as adults, which had contributed to their leadership position. For example,

> *"We need to support our personnel, especially women because they face many more constraints. We need to support them by providing funding to enable them to undergo training. For me, this is what I have done. Every time I hear about a training, I look for funding to help them move forward."*

This respondent went on to explain it is not as simple as having trainings available, but also a proactive strategy to ensure female participation:

> *"When they have scholarships, they should always ask for women [to apply] and even note they wish for female candidates. So, [it is clear] yes, they really want women. When, for example, they offer summer scholarships or school scholarships, they should specify that female candidates are encouraged. And this is how I did my training."*

Intentional recruiting of female candidates

As alluded to in the previous quote, many respondents also recalled the impact of intentional recruiting of female candidates for leadership positions, whether by specifying so in an application, or political will to deliberately target female candidates for leadership roles.

One respondent noted,

> *"Even in recruitment policies, we sometimes ask if there is a female [candidate] preferred for this or that position. Of course, gender is not just about women. It really pertains to both sexes. Same in recruitment, it's the quality of people that counts. This is all to encourage the establishment of women to leadership positions."*

Often the intention to promote women into leadership and management positions is less formal and driven by individuals prioritizing women's leadership. Several respondents noted this effect:

> *"There is also clear political will demonstrated by the authorities, at least by the two successive ministers, Eva and the current minister. I think these positions were created to promote women."*

> *"You see a genuine desire to promote women among our decision-makers. That's a very good thing for the Ministry of Health."*

The risk of this intervention is that, applied in the wrong way, females can be siloed into stereotypical categories rather than being encouraged to apply for a range of roles.

Organizational practices and movements

A commonly cited barrier in research about challenges for women to attain leadership positions is the difficulty of balancing work and home responsibilities. Several international businesses have promoted childcare as a method to attract and retain qualified women, increase productivity, and reduce absenteeism.[21] In Senegal, several respondents mentioned childcare at the workplace as a potentially enabling factor, but one that was yet to be offered.

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[19] OECD, 2019
[20] Tøraasen, 2017
[21] International Finance Corporation, 2017

Thus, it was not something that had previously helped propel their careers.

External pressures often influence gender equity in the health workforce. One respondent pinpointed activities which address barriers to women in leadership, sharing:

> *"For example, the president of the womens' associations knows our plans to develop a roadmap to move towards [the creation of] a law against the discrimination of women in the workplace…To be successful, you have to have good working conditions."*

> *"It is already entrenched in the Ministry of Health. Not only do I think that is the reason why this approach is there, there are also partners who remind us of it every time. Whenever we plan, USAID reminds us to keep in mind gender considerations and so on."*

Respondents also credited the gender unit to maintain gender considerations on the agenda:

> *"The coordinator of the gender unit, who is very dynamic, must tell us not to forget the gender approach, otherwise we even forget during planning."*

However, it is unclear from the responses whether individuals were recalling instances of the gender unit and partners influencing women's participation in leadership, or recalling general instances of external influence on gender, such as gender-responsive budgeting or prioritization of maternal health services.

Other known initiatives to support women in a leadership trajectory were not mentioned specifically in Senegal but include clear promotion criteria and access to mentors.

Representation and female role models

Several respondents credited changes in the opportunities for female leaders to specific champions. For example:

> *"I think that is the minister's leadership. At one point she [Minister of Health Awa Marie Coll-Seck] was minister and every time she made [leadership] appointments, I remarked that she was paying attention [to parity]."*

> *"But with [Minister Seck], I felt it—the promotion of women in this ministry. She even appointed the director who appointed me here, and she was a woman."*

Respondents also cited a role model effect, where seeing women in positions of leadership inspired career aspirations and confidence in assuming leadership positions themselves:

> *"It is impactful seeing a woman in a leadership position. As director, I saw Mimi Toure as my [role] model. She said we need to step up the pace into fast track mode and it was motivating. She's a role model for people who know her. It's motivating – we say it's possible since this woman succeeded. We no longer say it's a man's job, or that we're not going to succeed."*

> *"Dakar, the capital, is a difficult place and she succeeded. Maybe it pushed people to say, 'OK, this is why we offered her the job as director general of health'… Certainly, she had to do a good job so that we can trust women. Before there were no women at the directorate level. Now all three [Ministry of Health branches] are managed by women! That means that she has done a good job. There is more and more trust in women for leadership positions and management. She had to do a good job because, before, that never existed."*

Respondents also explained that beyond breaking barriers and providing inspiration, other female leaders may be more cognizant of giving other women opportunities for formal and informal leadership roles. One explained:

> *"My director appointed me as organizer of our coordination meetings– I remind my colleagues every Monday that we have a meeting. She (my director) tries to bring me forward. I 've noticed that women help each other; they do everything so that the female gender is propelled."*

Standalone leadership programs and activities

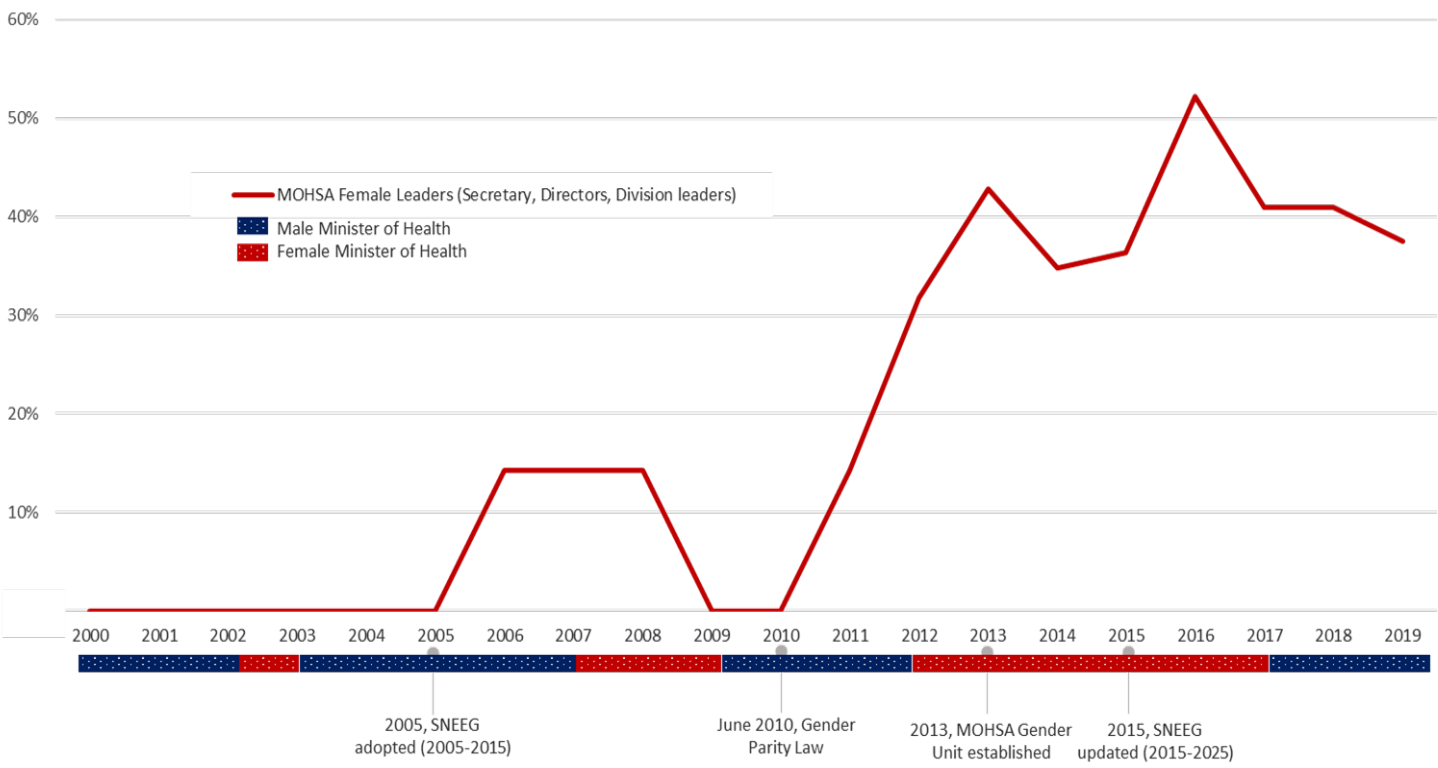
Literature reviews and in-person interviews revealed very few programs focused on increasing the number of women in leadership positions and brought forth no specific programs aimed at supporting women's trajectory within the health sector, which has majority female workforce participation.

Several international organizations and aid agencies like USAID, have invested in women's leadership programs. Many cater to women already in management or leadership positions and focus on enhancing their leadership skills. Many standalone leadership programs in Senegal are outside the health sector, including the Rural Women's Leadership Africa Pilot Project for Rural Women's Leadership, *Forum Africain des Femmes Leaders,* aimed at building presence and capacity of women's leadership in the business sector; AFROSAI-GIZ Women Leadership Academy, a yearlong leadership training program for female leaders in accounting in West Africa; and Empowering Women's Leadership in Civic Leadership and Journalism, to increase acceptance of women as public leaders in these domains. These programs were all funded by international donors.

Mapping Key Initiatives and Events with Changes in Female Leadership

Using the sex-disaggregated leadership inventory and responses from key informant interviews, it is possible to compare the results to determine key initiatives that have led to measurable changes. Various key dates mark the progress that has been achieved in the institutional and legislative framework to promote gender equality in Senegal, as shown in Figure 7.

FIGURE 7: CHANGE IN FEMALE REPRESENTATION IN THE HEALTH SECTOR IN TERMS OF THE MAJOR INITIATIVES, 2010-2019



In 2005, the government of Senegal's SNEEG was enacted to describe the vision of achieving gender equality and enhance commitment among various key stakeholders. In the subsequent year, there was a small increase in the female leadership at the MOHSA.

In 2010, the parity law was published in the Official Gazette. This law was a turning point in parity legislation in Senegal. The March 2013 circular (Primatorial Circular No. 009159) sparked the creation of the Gender Unit that same year.

Based on key informant interviews, various communication and awareness activities may also have contributed to increasing female representation in leadership roles between 2014 and 2016.

In 2016, female representation in leadership positions at directorate and division levels of MOHSA was 52 percent, its highest and a 16 percent increase from the previous year when the SNEEG was updated and re-released. The first female division leaders were hired in 2006, the year after the first SNEEG and there was another large increase in 2011, the year after the parity law was adopted in 2010.

The highest representation of women in leadership positions occurred in the years following female Minister of Health and Social Action Awa Marie Coll Seck's term in office (2012), the creation of the ministry's Gender Unit (2013), and following the 2015 renewal of the SNEEG to span the next decade. After reaching a high of 52 percent in 2016, the number of women in leadership positions decreased to 36 percent between 2016 and 2019. Respondents to the key informant interviews frequently referenced both the SNEEG and the Gender Unit as important initiatives influencing the presence of women in leadership roles. However, respondents did not seem to be aware of the recent decline of women in leadership positions at the highest levels of the MOHSA.

Continued Barriers for Women to Leadership Positions

While barriers to women's ascent to leadership roles across the globe are more documented than enabling factors, it is still important to understand the challenges that persist and inhibit equitable workforce participation and leadership opportunities for women.

Typically, women in Senegal who work outside of the home have a dual responsibility with household and workplace demands. During the key informant interviews, family

responsibilities were mentioned most frequently among the challenges that limit women's movement into positions of leadership. Often, women in Senegal must choose between their workplace or their household. Among the women interviewed, one referenced her dedication to her professional duties as choosing a "polygamous relationship." Several women stated that they have only one child to enable working outside of the home, while one woman said that she is able to serve in a position of high responsibility only because her children are grown up.

> *"We [women] don't get the same chances. Men don't get pregnant; they don't feel the family burden [the same way we do]. When we are in a household, we carry the weight of our immediate family and our extended family. Men aren't the problem; there are also our in-laws."*

> *"For example, a man can stay here until 9 p.m. He has nothing to worry about. He goes home, he is given his meal, it is served to him, and he watches TV. You can't be a modern woman and finish your meeting at 9 p.m. because when you return home, you have other obligations."*

> *"I can stay at my office until 9 p.m. and go home worry-free, but my wife who works as a teacher must be home around 5 p.m. either to make dinner or take care of her children. I don't do any of that. I deal with my work and I go home worry-free."*

Impact from Participation of Female Leaders in the Health and Social Sectors

During the interviews, several leaders mentioned the qualitative effects of women in leadership positions, in particular that decisions made benefitted women and girls directly. For example:

> *"I think that women consider the needs of girls and women more than men do."*

> *"The presence of women can be positive because sometimes, when women are there, men take women into account. Therefore, their presence can encourage policies."*

One respondent even suggested a cyclical effect; when programs for women and girls receive more priority and investment, they are in turn more likely to have female leadership:

> *"For some time now, USAID has been working in maternal and child health, in planning for the empowerment of women. Indirectly, perhaps these programs push people to put women in certain positions of responsibility. [But I believe] some programs must be lived to manage them. When you are a woman, when you are a wife, and when you are a mother and you are also a doctor, you touch a little of everything and so perhaps this leaves you better placed to manage certain programs."*

However, it was also noted that a female leader's influence is not always visible in how policies, strategies, or programs that aim to increase women in leadership are implemented. Most respondents did not identify a link between the presence of women in leadership roles and the impact on such programs. It was noted that civil servants simply translate current government policies and the general government policy for parity takes precedence over other initiatives and efforts.

Discussion

Senegal's health and social sectors experienced dramatic increases in the proportion of women in leadership positions over the past 10 years from almost zero in 2010 to equality or 52 percent in 2016 at the divisional and directorate leadership levels. While this study was not designed to establish causality, there is strong circumstantial evidence from the quantitative and qualitative data that point to likely reasons for these changes.

What is Working?

Policies and laws. One large factor in Senegal is the parity or quota law. To remedy historic inequalities between men and women, Senegal developed a quota system. This does appear to have influenced the percentage of females in positions of leadership, including within the health sector. Many respondents cited the parity law and political will for initiatives, noting specific political agendas for gender equity. However, quotas do not transformatively (i.e. change root causes) address the inequities that serve as barriers to women's attainment of leadership roles in the first place, such as access to education, networking, or home and family care responsibilities.

Champions. The diversification and expansion of some strategic positions for women occurred at the same time that a woman returned as minister and the gender unit was created. Between 2012 and 2016, under a female minister of health the representation of women in the leadership positions at MOHSA averaged 40 percent, while under the current minister who is male, the rate fell to 36 percent. Likewise, the key informant interviews affirmed that female leadership may advance female representation at every level.

A commonly cited enabler to women's leadership is seeing other women in positions of power. This "role model effect" is reflected in the research. For example, in India a 1993 law reserved leadership positions for women in randomly selected village councils. A subsequent study found that in villages with female political leaders, girls were 25 percent

more likely to expect to achieve the same level of educational achievement as their male peers.[22]

As Figure 7 shows, the highest sustained growth of women in leadership positions in the MOHSA came when both policy (SNEEG in 2015), the gender unit, and a female minister of health (Awa Marie Coll Seck) aligned. As one respondent described, "[gender equality] materializes first by law but also in the actions that authorities take."

Promising Practices

There seems to be a clear temporal relationship between the initiatives described above and substantial increases in women leadership in the MOHSA. In addition, Senegal has implemented many other gender policies, strategies, and initiatives inside and outside the health and social sectors that were referenced in key informant interviews as having impact on leadership opportunities. However, their timing and impact could not be specifically linked to quantitative increases of women in leadership roles in the MOHSA.

Proactive measures to encourage female applicants. Several respondents perceived specific calls to action to apply for leadership positions, either informally through word of mouth and prioritization or through written instructions in applications. For example, at the time of this analysis, the United Nations Career website advertised a position in Dakar where "applications from qualified female candidates are especially encouraged".[23] Gendered wording in job descriptions can perpetuate gender inequality.[24] But proactive instructions for women to apply for leadership and management roles can overcome traditional scenarios with men having access to information and networks for faster promotion.

Create equitable opportunities for training and professional development. Many respondents noted their access to professional development and training opportunities as a key factor in their current leadership roles. Associating these individual level events with trends in female occupancy of leadership positions is not possible, however global research reflects the need for equitable opportunities to training and professional development.[25] Yet research also shows there are often fewer opportunities for professional development at work for female candidates.[26] For example, trainings held outside of working hours or announced informally by primarily male managers. Strategies to mitigate this include scholarships and blended learning approaches such as online training or "elearning," which is accessible to a broader audience.

Continue to invest in gender-specific resources. Many respondents noted the parity laws, as well as specific strategies and policies for heightening awareness around gender inequality. For example, in 2013 the Ministry of Health and Social Action established a gender unit to better address equity. The gender unit is attached to the Directorate for Planning, Research and Statistics[27] and is not listed in the ministry's organizational chart (many other units are shown), which may or may not be an indication of the level of importance assigned to it.[28] According to interviewees, the existence of the gender unit has raised awareness, and subsequently has influenced decision-making as reflected at every level–from candidate selection to the implementation of activities. The creation of the gender unit has led to gender-focused activities, including gender training and awareness activities, the development of the Ministry of Health and Social Action's gender audit report and the Plan for Gender Institutionalization and Increased Capacity for Gender Integration, both published in September 2015.

While a single gender equity strategy such as the SNEEG is an important initiative to create a conducive environment, its effect needs to be seen in the broader context of gender policies and strategies that together lead to the large-scale increases in women leadership in Senegal's health and social sectors. Moreover, trainings and implementation of gender policies and strategies need continued resources and investment. As one key informant interview explained, women sometimes become the gender experts just because they are women, without proper training on gender. To continue progress on parity in leadership, there must be continued trainings on gender and inclusivity.

Continued Opportunities

Despite great progress in the representation of women in leadership, there is room for growth in Senegal. Based on the sex-disaggregated leadership inventory and key informant interviews, there are several key remaining areas to address for sustained, equitable leadership opportunity at multiple levels.

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[22] Beaman, 2012
[23] UN Career, 2019
[24] Gaucher, 2011
[25] WHO, 2019
[26] HRH2030, 2019
[27] MOHSA, 2015c
[28] MOHSA, 2020

Reduce dependence on a female champion. One event associated with an increase in women in leadership was having a female minister and under the current male minister there was a decline in female leadership in MOHSA. While the increases are positive, gender equity must be institutionalized and sustained beyond a particular leader.

Moreover, many positions are filled from political assignments. There is a risk of having women in token positions without responsibilities and accountability. A sequential danger is the perception that that very few women in leadership positions are empowered to bring about change.

Breaking into historically male positions. Strategic positions such as secretary general have only been occupied by men in Senegal. While lower-level leadership positions such as the division level have sometimes over 80 percent female representation, moving to the directorate level changes to less than a quarter female representation and higher positions are even less likely to be occupied by women. Likewise, there is little movement in hospital and university leadership positions.

Consider all health workers as having leadership potential. There is a common perception that doctors are more qualified for leadership positions. Given that many females are more represented in other health cadres, this further limits leadership opportunities. To minimize the ramifications of occupational segregation, all types of health workers should be considered for leadership roles. For example, nurses and midwives, which tend to have higher female representation bring critical leadership qualities.

Implement evidence-based initiatives to promote equitable leadership opportunities. The barriers shared by key informant interviews included primarily the dual responsibilities of work and home. These examples align with common barriers cited around the world. However, it is important to consider these responses as nuanced elements of a larger set of barriers. For example, in previous HRH2030 research on women in leadership roles in Jordan, women reported their top barrier to attaining leadership positions as a "lack of women in general/line management" followed closely by "discrimination against women by supervisors/line managers at point of promotion." Juxtaposing this, the main barrier perceived by male respondents was "women having family and domestic responsibilities," which was only the fifth most mentioned barrier by women.[29] Similarly, in Senegal, a male respondent shared:

> *"I think women sometimes fear having to bear a certain burden in terms of responsibility, wearing two hats, that of mother and that of manager. To use them wisely, you must be really headstrong. I think here in Senegal, many women are afraid of taking on certain responsibilities, if only to avoid encroaching on their family life."*

The key takeaway here is that while disproportionate home and childcare responsibilities may be a factor for some women inhibiting their ability to access leadership positions, each situation is unique and under no circumstances should others assume a woman is not interested in leadership responsibilities because of her family and other care responsibilities. Research and analysis in each situation is critical to inform effective policies and investments.

Conclusions

The number of women serving in leadership positions in the health and social sectors in Senegal rose to impressive heights over the last decade. Concerted efforts to implement parity policies and gender strategies that encourage female leadership and gender equity can be credited for this success story. There remains room for further improvement to achieve gender balance at all levels of the sector's leadership. This requires accurately monitoring trends in female representation in leadership positions and catching negative trends as early as possible to take appropriate and corrective action.

While this research sought to comprehensively document both quantitative and qualitative trends in female leadership, there are gaps in data availability, particularly at the lower-level leadership and management levels. Some data is available on regional and district female leadership representation, but further research covering all leadership and management levels could reveal important differences in trends across all levels of leadership and gaps in the pipeline of female leadership.

Further, the various intersectional identities of women may contribute to initiatives serving as enablers or barriers to leadership and management roles.

Prerequisite to conversations about women's leadership are ensuring decent work, fair and equitable pay, and safe workplaces. Although sexual harassment was not mentioned

[29] HRH2030, 2018

in the qualitative findings, addressing it head-on is critical for equity and productivity.

An average 3 percent annual increase in the number of women in leadership roles over the last 20 years is a major accomplishment for Senegal's health and social sectors. However, such an achievement is fragile as a declining rate across all levels of MOHSA leadership over the last two years has shown. In addition, women in certain public institutions such as referral hospitals and universities are still underrepresented in leadership positions. Institutionalizing gender equity in the sector's leadership requires continuing attention, advocacy, action, and reform.

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Annex A. Literature Review: Summary of Women in Leadership, by country

A strategic literature review was completed as the first phase of this project in which interventions or initiatives (type and country) aimed at increasing women's participation in leadership positions were identified and described for 13 countries. A summary of results from Phase 1 are included below.

The literature review for rigorous studies identifying the impacts of women's leadership on policy and program outcomes included 4 multi-country studies; 22 studies in India; 3 in sub-Saharan Africa (Tanzania, Rwanda); 1 in Afghanistan; and 4 in Latin America countries (Argentina, Brazil, Colombia). Overall, women in leadership positions are more likely to prioritize poverty reduction strategies, health care, education, and women's rights. They are more likely to take on causes that directly benefit women, particularly health and including infrastructure improvements and water. Notably, a few studies mentioned that while increasing the number of women in leadership positions can result in improved attention to women's issues (on the agenda-setting/process end), it does not always result in changed outcomes. In addition, the expected changes in outcomes may be associated with the level and type of leadership position women have. For example, while studies have shown associations between increased numbers of women in local district level leadership positions and education in India, a study in Latin America showed that increasing women mayors have no effect on education spending or policies to improve education. It is important to note that of the 34 studies HRH2030 explored, only a small number can be considered rigorous evaluations based on methodology of the impact of women leaders specifically on the health and social sectors. Nonetheless, results provide us with critical insights into the challenges of measuring impact and in which contexts we can expect potential impact.

In this document we present a summary of findings from a strategic literature review that succinctly identifies and describes the interventions or initiatives (type and country) aimed at increasing women's participation in leadership positions. It is important to note that some of the interventions described might have been carried out after a law or mandate to increase number of women leaders has been enacted and implemented (i.e. quotas and reservations). Thus, the intervention might have been directed at increasing the effectiveness of women already in leadership positions. In addition, neither the literature review which focused on the policy and programmatic impacts of women's leadership, nor the review which identified initiatives aimed at increasing the numbers of women leaders, found interventions that were exclusively directed at increasing the numbers of women in leadership positions in the health sector - the overarching aim of this study. However, we assume that many of these interventions did include women in the health sector even though not designed specifically for health leaders.

IDENTIFYING COUNTRIES

To identify appropriate countries where we could productively conduct a case study of interventions expanding women's leadership presence and strengthening women's leadership contributions, we started with the 25 USAID which had made a pledge with USAID to end preventable child and maternal deaths (EPCMD). Out of the 25, based on whether the country had experienced an increase in women's leadership at the parliamentary or at the ministerial levels, we identified thirteen countries(Angola, Bangladesh, Ethiopia, Indonesia, Kenya, Madagascar, Mali, Mozambique, Nepal, Rwanda, Senegal, Tanzania, Uganda) on which to focus.

REVIEW OF DONOR INTERVENTIONS RELATED TO WOMEN'S LEADERSHIP

The US, the Netherlands (with its 10-year initiative on "Funding Leadership Opportunities for Women", 2011-2015; 2016-2020), and Australia (with its decade-long $320 million goal to 'empower women and to promote gender equality in the Pacific' in 2012) are the donor nations most explicitly focused on women's leadership. The Netherlands funding has been to NGOs that regrant across multiple countries to smaller NGOs. USAID and Norway's aid agency Norad, and to a lesser extent Sweden's Sida, have also focused resources on increasing the capacity and numbers of women leaders in legislatures, particularly in post-conflict situations (e.g., Afghanistan, Mali, Nepal, among others). USAID, UKaid, and the UNDP (with Nordic country and other support), have all devoted resources to the study of what works to increase numbers of women in political leadership, and to a lesser extent, in public administration; of factors that enable women and girls' leadership capabilities; and on whether/how women and girls are able to use leadership positions to achieve more equitable outcomes. Other donors (Canada, Norway, Sweden) have devoted considerable support to enhancing gender equity more broadly

throughout their aid portfolios. Finally, there are some smaller, country-level efforts to foster women's leadership through one-off conferences or seminars, supported by bilateral donors, companies, or the national government.

SUMMARY OF COUNTRY-SPECIFIC RESULTS

Angola. Angola (Republic of Angola) has a unicameral parliament with legislated quotas for the single/lower house. 59 of 220 (27%) seats in the National Assembly are held by women. More than 38 percent of women have parliamentary seats, a 22.7 percentage point increase since 2000; and 22 percent of ministries are occupied by women, a 16.7 percentage point increase since 2005. Angola ranks 19th globally in the proportion of parliamentary seats held by women. The increase in women's political representation is in large part due to party-assigned seats being allocated to women by the ruling party, a former/current socialist party. There are no specific studies on women's leadership and the health and social sectors in Angola. Despite the important numbers of women leaders, Angola's socio-demographic indicators show very slow or no progress in major areas of health and education.

Bangladesh. A 2004 constitutional amendment reintroduced quotas for women: 13 percent of seats are reserved for women and are divided among the political parties based on the proportion of seats they have won in the election. Bangladesh has observed a slight decrease (-2%) in women in cabinet ministries since 2005; but an increase of 11 percentage points of women in the parliament since 2000; and has 20 percent of women in managerial positions in the public sector. The country has made significant improvements in maternal and child mortality in the last two decades. However, no studies looking at the role of women leaders and its impact on health has been found during our target review.

Ethiopia. Ethiopia has a bicameral parliament with the use of voluntary party quotas. 212 of 547 (39%) seats in the Yehizb Tewokayoch Mekir Bete / House of Peoples' Representatives are held by women. Women representation in leadership positions has been even higher in the past. Ethiopia ranks 17th globally in the proportion of parliamentary seats held by women. Between 2000 and 2017, a decrease by 2.2 percentage points was observed for female cabinet ministers as was a decrease of 3.1 percentage points for parliamentarians since 2000. As is the case with other former/ current socialist parties, Ethiopia's ruling party (the Ethiopian Peoples' Revolutionary Democratic Front or EPRDF) has made increasing women's political, economic, and social profile a priority. The women's leadership interventions found involved the imparting of technical and sector specific skills (especially with support from USAID and Norad); this is likely in response to national government direction. The government has not countenanced political activity outside the ruling party framework and is often not transparent.

Indonesia. Indonesia (Republic of Indonesia) has a unicameral parliament with legislated quotas for the single/lower house and at the sub-national level. 94 of 560 (17%) seats in the Dewan Perwakilan Rakyat / House of Representatives are held by women. Currently Indonesia has 22.5 percent of cabinet minister positions occupied by women, an increase of 7.1 percentage points since 2005, and 38.8 percent of parliament seats are occupied by women, an increase of 31.1 percentage points since 2000. Indonesia has made significant progress in the health sector, but no studies were found linking this progress to women in leadership positions.

Kenya. Kenya has both reserved seats and voluntary party quotas. Its constitution, adopted in 2010, mandated that no more than two-thirds of the legislature be held by one gender. Yet the government has delayed enforcing that ruling. The 2009 Political Parties Act (Article 30, 4) created a Support Fund for Political Parties only available to parties in which women comprise at least a third of the total membership. Kenya has seen an increase by 12.4 percentage points in its women cabinet Ministers, now at 22.5 percent; and an increase in parliamentarian women by 18.2 percentage points, now at 21.8 percent. It is not clear whether there are women's leadership initiatives taking place beyond the reserved seats and voluntary party quotas. Kenya has made some improvements in the health sector, especially with regard to maternal and under-five mortality.

Madagascar. In Madagascar, 17.9 percent of cabinet ministers are women, an increase of 12 percentage points since 2005; 19% of seats in parliament are also occupied by women, an increase of 11 percentage points since 2000. Institutions influential in promoting women's political leadership in Madagascar include the Electoral Institute for Sustainable Democracy in Africa, Norad, and the Southern African Development Community. There are several initiatives on women's leadership such as the Young Women Leadership Program, an initiative of Youth First to strengthen young women's management, leadership, and technical skills to enhance and bring to scale programs that advance young women's empowerment (2014-2018) [UNFPA, Germans].

Mali. Mali (Republic of Mali) has a unicameral parliament with the use of voluntary party quotas: 14 of 147 (10%) seats in the Assemblée Nationale / National Assembly are held by women. In addition, after the 2012-2015 period of conflict perpetrated by self-proclaimed jihadi armed groups, a November 2015 law was passed requiring 30 percent of elected or appointed officials to be women at the national and sub-national levels. Civil society groups joined forces with the Ministry of the Promotion of Women, Children and the Family, and women legislators of the Network of Parliamentary Women (Réseau des Femmes Parlementaires - REFEP) to enact this law and to advance women's symbolic and substantive representation generally. Mali has seen a significant infusion of funding from external donors for women's political leadership over the past 10 years, and the 2015 reform has very promising implications for women's leadership in both the legislature and the executive branch. However, these reforms are at very early stages, and it is likely still premature to see any repercussions of this progress at the policy level.

Mozambique. As in Angola and Ethiopia, since coming to power, the ruling party has firmly retained leadership with large majorities. Mozambique has a weak but centralized government that is firmly tied to the ruling party, corruption, a limited civil society, and weak media. Nonetheless, the ruling party's originally Marxist orientation has motivated substantive attention to improving women's economic, political, and social status. Mozambique has a unicameral parliament and has instituted (40%) voluntary party quotas within a proportional representation electoral system. In 1994, the dominant political party, Mozambique Liberation Front or FRELIMO, adopted a policy of ensuring that 30 percent of candidates for the National Assembly and local government were women, raised the quota level to 35 percent and then to 40 percent for the 2004 election. 99 of 250 (40%) seats in the Assembleia da Republica / Assembly of the Republic are held by women. Mozambique ranks 13th globally in the proportion of parliamentary seats held by women. There do not appear to have been significant donor initiatives to support women's leadership; those that exist are either very short-term, or reach few leaders, or both.

Nepal. Nepal (Federal Democratic Republic of Nepal) has a bicameral parliament with legislated quotas for candidates at the single/lower house (33%) and at the sub-national level (40%). The proportion of women elected fell only slightly after the 2013 elections (holding 176 of 597 (29%) seats in the Sambidhan Sabha/Sansad/Constituent Assembly/Legislature/Parliament); an elected women's presence was key for maintaining gains during the 2014 redrafting of the constitution. Further, public sector policy reserves 45 percent of civil service positions for underrepresented groups, 33 percent of which are for women (this pertains to the civil service as well as other public agencies - Nepal Police, Nepal Armed Forces, Teachers Service Commission, etc.). European donors and the US have channeled significant support to women's political leadership development in Nepal in the wake of re-establishment of greater political security in the country.

Rwanda. Rwanda is the first country in which women have moved into more than half of all political leadership roles. Factors behind Rwanda's improvements in gender equity in political leadership include a women's ministry with a broad mandate; "women's councils elected at the grassroots and represented at the national level; a women-only ballot; a gender-progressive constitution shaped by women leaders in government and civil society; and, perhaps most important, a required quota of 30 percent women in all government decision-making bodies." Rwanda has a bicameral parliament with legislated quotas for the single/lower house and upper house and at the sub-national level. 51 of 80 (64%) seats in the Chambre des Députés / Chamber of Deputies are held by women. Rwanda also ranks 7th in the world for women in ministerial positions, with women occupying 9 of the 19 ministerial positions in the country. However, Rwanda lacks an organized political opposition, and its exceptional improvements hinge on a President widely acknowledged as being the driving and determinant force behind measures to improve women's leadership.

Senegal. Senegal (Republic of Senegal) successfully instituted a gender quota law in 2010, during a time of political stability and of relatively low levels of perceived corruption. Senegal has a unicameral parliament and national law mandates parity (50%) in all candidate lists for the general elections for the single/lower house and at the sub-national level. Candidate lists must be composed of alternating male and female candidates. In 2017, 69 of 165 (42%) seats in the Assemblée nationale/National Assembly were held by women, ranking Senegal 11th globally for the proportion of parliamentary seats held by women. Further, the government's 2005-2015 and 2015-2025 National Strategy for Equity and Gender Equality (SNEEG), overseen by the Minister of Women, Family and Children, offers a guide for executive branch efforts to enhance women's participation. In addition, the Université Cheikh Anta Diop (Ucad) now contains a Gender Lab (Laboratoire Genre), where promising women's leadership initiatives are being evaluated.

Tanzania. Tanzania has a unicameral parliament with constitutionally legislated quotas for the single/lower house (30%) and at the sub-national level (33%). Constitutionally mandated quota seats for women have been in place in Tanzania for more

than three decades (since 1985) but came into play with the 1995 multi-party elections. After the 2015 elections, 136 of 372 seats (37%) in Parliament are now held by women, a 14-percentage point increase over 2000, and notably higher than the global average of 23 percent. Women can both run for openly contested seats, and also be awarded an additional 30 percent of seats on a proportional representation basis according to the strength of each party. Women's representation in the Tanzanian cabinet is 34 percent. The Ministry of Community Development, Gender and Children (MCDGC) is responsible for mainstreaming gender in Tanzania's government, and produced a National Strategy for Gender Development in 2005 which includes women's leadership.

Uganda. Uganda (Republic of Uganda) has a unicameral parliament with legislated quotas for the single/lower house and at the sub-national level (one woman per district). The country has seen a notable increase in the proportion of parliamentarians and government ministers who are women. Currently, 153 of 465 (33%) seats in the Parliament are held by women, up 17 percentage points over the past 15 years. In addition, Uganda ranks 19th in the world for proportion of ministerial seats held by women (37%, up 13 percentage points over the past 10 years). Uganda has been ruled by the same party (The National Resistance Movement or NRM) since it came to power in 1996. UNDP produced a 2012 case study of Uganda's track record in advancing gender equity in public administration. While Uganda has been stable and does have notable levels of women's leadership in government (in parliament and at the ministerial level), there is little evidence of other targeted efforts to increase or strengthen women's leadership.

Annex B. Senegal Sex-Disaggregated Leadership Inventory

TABLE 1: LEADERSHIP POSITIONS IN THE HEALTH AND SOCIAL SERVICES SECTORS IN SENEGAL, 2019

Entity/Organization	Sex	Entity	Position	Sector
Minister of Health and Social Action	Male	Government	Minister	Public
Secretary General Minister of Health	Male	Ministry of Health	Secretariat general	Public
Directorate General of Health	Female	Ministry of Health	Directorates	Public
Direction of Health Establishments	Male	Ministry of Health	Directorates	Public
Directorate General of Social Action	Female	Ministry of Health	Directorates	Public
Prevention Directorate	Male	Ministry of Health	Directorates	Public
Medical-Social Action Directorate	Male	Ministry of Health	Directorates	Public
Human Resources Directorate	Male	Ministry of Health	Directorates	Public
Laboratory Directorate	Male	Ministry of Health	Directorates	Public
Directorate for the Promotion and Protection of Disabled Persons	Male	Ministry of Health	Directorates	Public
Directorate of Infrastructure, Equipment and Maintenance	Male	Ministry of Health	Directorates	Public
General Administration and Equipment Directorate	Male	Ministry of Health	Directorates	Public
Planning, Research and Statistics Directorate	Male	Ministry of Health	Directorates	Public
Pharmacy and Medication Directorate	Male	Ministry of Health	Directorates	Public
Directorate for the Promotion and Protection of Vulnerable Groups	Female	Ministry of Health	Directorates	Public
Disease Control Directorate	Male	Ministry of Health	Directorates	Public
Maternal Health and Child Survival Directorate (DSMSE)	Male	Ministry of Health	Directorates	Public
Gender Unit in the Ministry of Health	Female	Ministry of Health	Directorates	Public
National Malaria Control Program PNLP	Male	Ministry of Health	Director/Chef division	Public
National Tuberculosis Control Program (PNT)	Female	Ministry of Health	Director/Chef division	Public
Dakar Polyclinic	Female	Hospital	Director	Public
Main Hospital	Male	Hospital	Director	Public
Keur Massar Health Post	Not answered	Hospital	Not answered	Public
Pikine National Hospital Center	Male	Hospital	Director	Public
Golf sud, Dalal Jaam Hospital	Male	Hospital	Director	Public
Roi Baudouin Hospital	Female	Hospital	Director	Public
Elisabeth Diouf Hospital	No answer	Hospital	Director	Public
Youssou Mbargane	Male	Hospital	Director	Public
St Jean de Dieu Thiès Private Catholic Hospital	Male	Hospital	Director	Private
Pasteur Institute of Dakar (IPD) - Director	Male	Hospital	Director	Public
Institute for Population, Development and Reproductive Health (IPDSR) in the UCAD - Director	Male	Hospital	Director	Public

Entity/Organization	Sex	Entity	Position	Sector
CEFOREP (Training and Research Center for Reproductive Health) - Director	Male	Hospital	Director	Public
President	Male	NGO	Africare	CSO
Chief of Operations	No answer	NGO	Africare	CSO
Financial Director	Female	NGO	Africare	CSO
Project/Program Directors of Chief of Party/COP	Male	NGO	Africare	CSO
Country Director	Male	NGO	Africare	CSO
President	Male	NGO	ASBEF	CSO
Chief of Operations	Female	NGO	ASBEF	CSO
Financial Director	Male	NGO	ASBEF	CSO
Project/Program Directors of Chief of Party/COP	Female	NGO	ASBEF	CSO
Country Director	Female	NGO	ASBEF	CSO
President	Male	NGO	Red Cross	CSO
Chief of Operations	Male	NGO	Red Cross	CSO
Financial Director	Female	NGO	Red Cross	CSO
Project/Program Directors of Chief of Party/COP	No answer	NGO	Red Cross	CSO
Country Director	Male	NGO	Red Cross	CSO
President	Male	NGO	CRS	CSO
Chief of Operations	Female	NGO	CRS	CSO
Financial Director	Male	NGO	CRS	CSO
Project/Program Directors of Chief of Party/COP	Female	NGO	CRS	CSO
Country Director	No answer	NGO	CRS	CSO
President	Male	NGO	DKT International	CSO
Chief of Operations	No answer	NGO	DKT International	CSO
Financial Director	Female	NGO	DKT International	CSO
Project/Program Directors of Chief of Party/COP	Female	NGO	DKT International	CSO
Country Director	Male	NGO	DKT International	CSO
President	Male	NGO	Intrahealth International	CSO
Chief of Operations	No answer	NGO	Intrahealth International	CSO
Financial Director	Male	NGO	Intrahealth International	CSO
Project/Program Directors of Chief of Party/COP	Female	NGO	Intrahealth International	CSO
Country Director	Male	NGO	Intrahealth International	CSO
President	Female	NGO	Oxfam	CSO
Chief of Operations	No answer	NGO	Oxfam	CSO

Entity/Organization	Sex	Entity	Position	Sector
Financial Director	No answer	NGO	Oxfam	CSO
Project/Program Directors of Chief of Party/COP	No answer	NGO	Oxfam	CSO
Country Director	Male	NGO	Oxfam	CSO
President	Female	NGO	Plan International	CSO
Chief of Operations	Female	NGO	Plan International	CSO
Financial Director	Female	NGO	Plan International	CSO
Project/Program Directors of Chief of Party/COP	Male	NGO	Plan International	CSO
Country Director	Male	NGO	Plan International	CSO
ISED (Health and Development Institute) - Dean	Male	University	UCAD	Public
Gaston Berger - Saint Louis – Director of the Health Sciences Research Training Unit	Male	University	UGB	Public
ENDSS – National School of Health and Social Development - UCAD - Dean	Male	University	UCAD	Public
Institute for Population, Development and Reproductive Health (UCAD) – Director of Cooperation	Male	University	UCAD	Public
School of Medicine, Pharmacy and Odontostomatology (FMPOS) in UCAD - Dean	Male	University	UCAD	Public

TABLE 2: MINISTERS IN SENEGAL BY SEX, 2000-2019

M= Male F= Female	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019
Ministries	*3-Apr*	*4-Mar*	*4-Nov*	*22-Aug*	*21-Apr*		*23-Nov*	*19-Jun*		*1-Mar*	*3-Dec*			*4-Apr*	*29-Oct*	*2-Sep*	*6-Jul*	*22-Jun*		*4-Sep*		*7-Apr*
Prime Minister	M	F	M	M	M	M	M	M	M	M	M	M	M	M	M	F	M	M	M	M	M	M
Ministre des Forces armées	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de l'intérieur	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre des finances et du budget	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre des affaires étrangères et des sénégalais de l'e-térieur	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de la justice, Garde des sceau-	F	M	M	M	M	M	M			M	M	M	M	F	F	M	M	M	M	M	M	M
Ministre du développement communataire, de l'Equité sociale et territoriale	-	-	F	-	F	F	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	M
Ministre du pétrole et des Energies	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	M	M	M	M	M
Ministre de la Fonction publique et du renouveau du secteur public	M	M	M	M	-	-	M	F	F	-	M	M	M	M	M	M	F	F	F	F	F	F
Ministre des infrastructures terrestres et du Désenclavement	M	M	M	M	M	M	M	M	M	-	-	-		M	M	M	M	M	M	M	M	M
Ministre de l'Eco ie, et de la coopération	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de la santé et de l'Action Sociale	M	M	F	M	M	M	M	F	F	F	M	M	M	F	F	F	F	F	F	M	M	M
Ministre de l'agriculture et de l'équipement rural	M	M	M	M	M	M	M	M	M	F	F	F	F	M	M	M	M	M	M	M	M	M
Ministre de l'eau et de l'assainissement	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de la F, de la famille, du genre et de la protection du genre et de la protection de l'enfant	-	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Ministre du tourisme et des transports aériens	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	F	F	M
Ministre des pêches et de l'éco ie maritime	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F

M= Male F= Female	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019
Ministre de l'éducation nationale	M	M	M	M	M	M	M	-	-	-	-	-	-	M	M	M	M	M	M	M	M	M
Ministre des collectivités territoriales et de l'aménagement du territoire		-	M	M	M	M	M	M	M	M	M	M	M	M	F	M	M	M	M	M	M	M
Ministre de l'enseignement supérieur de la recherche et de l'innovation	M	M	-	-	-	-	-	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre du développement industriel et des petites et moyennes industries	-	M	M	M		F	M	M	M	M	M	M	M	-	M	M	M	M	M	M	M	M
Ministre de l'environnement et du développement durable	M	M	M	M	M	M	M	M	M	M	M	M	M	-	-	M	M	M	M	M	M	M
Ministre des mines et de la géologie	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	F
Ministre des sports	M	M	M	M	M	M	M	M	M	-	-	-	-	M	M	M	M	M	M	M	M	M
Ministre de l'élevage et des productions animales	M	M	M	M	F	F	F	F	F	-	F	F	F	F	F	F	F	F	F	F	F	M
Ministre du travail, du dialogue social, des organisations professionnelles et des relations avec les institutions	-	M	-	-	-	-	M			M	M	M	M	M	-	-	M	M	M	M	M	M
Ministre de l'urbanisme, du logement et de l'hygiène publique	M	M	-	M	M	M	-	-	-	M	M	M	M	F	-	F	-	-	-	-	-	M
Ministre du commerce et des petites et moyennes entreprises	M	M	F	F	M	M	M	M	M	M	M	M	M	F	M	M	M	M	M	M	M	F
Ministre de la culture et de la communication	M	F	M	F	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de la jeunesse	M	M	M	M	M	M	M	M	M	M	M	M	M	M		M	M	M	M	M	M	F
Ministre de la microfinance et de l'éco ie sociale solidaire	-	-	F	F	F	F	M	-	-	-				-	-	-	M	M	M	F	F	F
ministre de l'emploi, de la formation professionnelle et de l'artisanat	M	-	-	-	M	M	-	-	-	-	M	M	M	M	M	M	M	M	M	M	M	M

M= Male F= Female	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019
Ministre de l'éco ie numérique et des télécommunications	-	-	-	-	-	-	-	-	-	M	-	-	-	-	M	-	M	M	M	M	M	F
Ministre du renouveau urbain, de l'habitat et du cadre de vie	-	M	M	-	M	M	M	M	M	-	-	-	-	-	-	-	M	M	M	M	M	
Ministre de l'intégration africaine, du NEPAD et de la francophonie	-	M	M	-	M	M	M	M	M	M	-	-	-	-	-	-	M	M	M	M	M	-
Ministre de la promotion des investissements, des partenariats et du développement des téléservices de l'Etat	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	M	F	F	F	F	F	-
Ministre des transports aériens et du développement des infrastructures aéroportuaires	-	-	-	-	-	-	-	-	-	M	M	M	M	-	-	-	-	-	-	F	F	-
Ministre de la formation professionnelle de l'apprentissage et de l'artisanat	M	-	M	M	M	M	M	M	M	M	M	M	M	-	-	-	-	-	-	M	M	-
Ministre du plan	M	M	-	M	M	M	M	-	-	-	-	-	-	-	-	M	-	-	-	-	-	M
Ministre délégué chargé du budget	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	-	-	-
Ministre des communications et technologies de l'information	-	M	-	-	M	M	M	-	-	-	-	-	-	-	M	M	-	-	-	-	-	-
Ministre de la petite enfance	-	F		F	-	-	-	-	-	F	F	F	F	F	F	F	F	F	F	-	-	-
Ministre chargé des relations avec les institutions	-	F	M	M	F	F	-	M	M	-	M	M	M	M	M	M	M	-	-	-	-	-
Ministre de la coopération décentralisée et de la planification régionale	-	-	F	F	M	M	-	-	-	M	M	M	M	-	-	-	-	-	-	-	-	-
Ministre de la recherche scientifique et de la technologie	-	-	M	M	F	F	F	-	-	M	-	-	-	-	-	-	-	-	-	-	-	-
Ministre de l'Education pré-scolaire et case des tout petits	-	-	F	-	-	-	-	M	M	M	-	-	-	-	-	-	-	-	-	-	-	-

M= Male F= Female	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019
Ministre de l'entreprenariat féminin	-	-	-	F	-	-	-	-	-	F	F	F	F	F	F	-	-	-		-	-	-
Ministre des Sénégalais de l'e-térieur	-	-	-	M	M	M	M	F	F	M	M	M	M	M	M	M	M	M	M	-	-	-
Ministre du cadre de vie et des loisirs	-	-	-	-	F	F	F	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ministre délégué auprès du ministre de l'éducation, chargé des questions pédagogiques	-	-	-	-	M	M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ministre délégué auprès du ministre de l'éducation chargé de l'alphabétisation des langues nationales, francophonie	-	-	-	-	M	M	M	-	-	M	-	-	-	F	-	-	-	-	-	-	-	-
Ministre délégué auprès du premier ministre	-	-	-	-	F	F	F	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ministre de l'information (communication)	-	-	-	-	M	M	M	M	M	M	M	M	M	M	-	-	-	-	-	-	-	-
Ministre de la prévention de l'hygiène publique et de l'assainissement	-	-	-	-			M	M	M	M	M	M	M	-	-	-	-	-	-	-	-	-
Ministre des energies renouvelables	-	-	-	-	-	-	M	M	M	-	-	-	-	-	-	-	F	M	M	-	-	-
Ministre du réseau hydrographique national: cours d'eau, bassins de rétention, lacs et canals latérau-	-	-	-	-	-	-	M	M	M	M	M	M	M	-	-	-	-	-	-	-	-	-
Ministre délégué auprès du premier ministre	-	-	-	-	-	-	M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ministre de la décentralisation et des collectivités locales	-	-	-	-	-	-	M	-	-	M	M	M	M	-	-	-	-	-	-	-	-	-
Ministre de la transformation alimentaire des produits agricoles	-	-	-	-	-	-	-	-	-	F	M	M	M	-	-	-	-	-	-	-	-	-
Ministre délégué auprès du ministre de l'agriculture, chargé des relations avec les organisations paysannes	-	-	-	-	-	-	-	-	-	M	M	M	M	-	-	-	-	-	-	-	-	-
Ministre des Biocarburants	-	-	-	-	-	-	-	-	-	F	F	F	F	-	-	-	-	-	-	-	-	-

M= Male F= Female	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019
Ministre de l'écologie et de la protection de la nature	-	-	-	-	-	-	-	-	-	-	-	-		M	M	-	-	-	-	-	-	-
Ministre de la bonne gouvernance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	M	M	-	-	-	-	-	-
Ministre de la restructuration et de l'aménagement des zones d'inondations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	M	M	F	F	F	-	-	-

TABLE 3: MOHSA LEADERSHIP IN SENEGAL BY SEX, 2000-2019

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019	Average Occupancy	
	3-Apr	*4-Mar*	*4-Nov*	*22-Aug*	*21-Apr*		*23-Nov*	*19-Jun*		*1-Mar*	*3-Dec*			*4-Apr*	*29-Oct*	*2-Sep*	*6-Jul*	*22-Jun*		*4-Sep*		*7-Apr*	Male	Female
Minister of Health n=7	M	M	F	M	M	M	M	F	F	F	M	M	M	F	F	F	F	F	F	M	M	M	54.5%	45.5%
Secretary General n=3			M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	100.0%	0.0%
Director General of Health n=5	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	F	86.4%	13.6%
Health Facilities Director n=7	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	M	M	M	M	M	M	90.9%	9.1%
Director General of Social Action n=3														M	M	M	M	M	F	F	F	F	55.6%	44.4%
Prevention Director n=1														M	M	M	M	M	M	M	M	M	100.0%	0.0%
Medical-Social Action Director n=2														M	M	M	M	M	M	M	M	M	100.0%	0.0%
Human Resources Director n=4				M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	100.0%	0.0%

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019	Average Occupancy	
Laboratory Director n=2														M								M	100.0%	0.0%
Director for the Promotion and Protection of Disabled Persons n=1														M	M	M	M	M	M	M	M	M	100.0%	0.0%
Director of Infrastructure. Equipment and Maintenance n=2														F	F	F	F	F	F	M	M	M	33.3%	66.7%
General Administration and Equipment Director n=8	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	F	F	F	F	M	M	M	72.7%	27.3%
Planning, Research and Statistics Director n=2																	M	M	M	M	M	M	100.0%	0.0%
Pharmacy and Medication Director n=3														M			M		M			M	100.0%	0.0%
Director for the Promotion and Protection of Vulnerable Groups n=1														F	F	F	F	F	F	F	F	F	0.0%	100.0%
Disease Control Director n=3														M	M	M	M	M	F	M	M	M	88.9%	11.1%
Maternal and Child Survival Health Directorate (DSMSE) n=2														M	M	M	M	M	M	M	M	M	100.0%	0.0%
Gender Unit at the MOHSA n=1																F	F	F	F	F	F	F	0.0%	100.0%

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		2010	2011	2012		2013	2014	2015	2016	2017	2018	2019	Average Occupancy	
National Malaria Control Program n=6	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	100.0%	0.0%
Maternal and Newborn Health Division DSMSE n=3														M	M	M	M	M	F	M	M	M	88.9%	11.1%
Child Survival Division DSMSE n=1														F	F	F	F	F	F	F	F	F	0.0%	100.0%
Adolescent Health Division DSMSE n=1														F	F	F	F	F	F	F	F	F	0.0%	100.0%
Food and Nutrition Division DSMSE n=1														F	F	F	F	F	F	F	F	F	0.0%	100.0%
Family Planning Division n=2														M	M	M	M	M	F	F	F	F	55.6%	44.4%
National Tuberculosis Control Program n=6	M	M	M	M	M	M	F	F	F	M	M	M	F	F	F	F	F	F	F	F	F	F	40.9%	59.1%

Annex C: Key Informant Interview Guide

Research Questions (for interviewer reference only)

1. Have any specific measures or initiatives undertaken by public and private sector institutions contributed to increasing the number of women in leadership positions?
    a. Direct contribution
    b. Indirect (either measurable or perceived) contribution
2. What is the anecdotal evidence that an increase of women in leadership positions in the health and social sectors had an impact on organizations' and/or the country's health and social policies, strategies, and programs benefitting women, girls, and children?
    a. Direct impact – e.g. support passing a pro-women/children/family policy
    b. Indirect impact – e.g. influence in parliament to support a pro-women/children/family policy
3. What are the perceived prevailing barriers and biases contributing to the remaining leadership gender gap?

Introduction (2-3 minutes)

- Introduce yourself
- Review the purpose of the study: to understand how women's participation in leadership positions has changed over time, what initiatives may have contributed to increasing the number of women in leadership roles, and whether there is any anecdotal evidence that greater participation in leadership roles resulted in policy, strategy, and program changes that are pro-women/children/families in the social and health sectors
- Explain to the informant what to expect of the interview
    - Duration 45-60 minutes
    - Covering three sections: initiatives to increase the number of women in leadership positions; impact of women in leadership positions on health and social policies, strategies, and programs benefitting women, girls, and children; and prevailing biases and barriers contributing to the remaining gender gap in leadership representation in the health and social sectors
- Explain to the informant that we are trying to learn and understand this topic
    - We especially want to learn about what you think about this topic
    - There is NO 'right' or 'wrong' answer
    - Your answers will be put together with the answers of other people to help get a wide understanding of what people think about this topic

Part 1: Background Information

Collect background demographic information from each informant using the following form:

<table>
<tr><td colspan="5">Information about informant</td></tr>
<tr><td rowspan="5">Age range (check applicable range)</td><td colspan="2"><20y</td><td colspan="2"></td></tr>
<tr><td colspan="2">20-30y</td><td colspan="2"></td></tr>
<tr><td colspan="2">30-40y</td><td colspan="2"></td></tr>
<tr><td colspan="2">40-50y</td><td colspan="2"></td></tr>
<tr><td colspan="2">>50y</td><td colspan="2"></td></tr>
<tr><td>Sex (check applicable box)</td><td>Female</td><td></td><td>Male</td><td></td></tr>
<tr><td>In what type of institution do you work? (private sector, public sector, academic, NGO)</td><td colspan="4"></td></tr>
</table>

What is your current role?	
How long have you been in this role? (in years)	

Part 2: Measures or initiatives to increase the number of women in leadership positions

We would like to discuss measures or initiatives that were designed to increase the number of women in leadership positions and are particularly interested in examples from the health and social sectors.

1. Are you familiar with any such initiatives implemented in Senegal?
    a. Probe if needed with example: For an example not in the health sector, there was a program called the Women Leadership Academy which aimed to equip women in middle management to become leaders in Supreme Audit Institutions in West Africa[30]
    b. Probe: can be national, sub-national, institutional levels
2. What can you tell us about what this initiative was supposed to do?
3. Did it accomplish what it was supposed to do?
    a. Why/why not?
    b. Did it *directly* contribute to increasing women in leadership positions?
        i. e.g. quotas for gender parity
    c. Did it *indirectly* contribute to increasing women in leadership positions?
        i. e.g. training program in leadership skills
4. Repeat questions for each initiative that is discussed.
5. If example was not specific to the health and social sectors, probe for additional examples that are. Probe if needed: mentorship programs, grants to conduct research, opportunities for networking, training programs.

Part 3: Impact of women in leadership positions on health and social policies, strategies, and programs benefitting women, girls, and children?

6. Thinking of particular women in leadership position whom you know personally or know about, can you tell me about health and social policies, strategies, or programs they have directly or indirectly influenced since being in a leadership position? (interviewer instruction: when possible, build on examples given in Parts 2 and 3)
    a. What was the policy, strategy, program?
    b. How did they influence it?
        i. E.g. being directly responsible for leading the team to develop a strategy; being vocal in policy discussions to influence the direction, etc
    c. Was their influence particularly focused on benefitting women, girls, or children?
        i. Probe: describe why or why not.
    d. Was it more focused on the benefit of women and girls than previous policies, strategies, or programs?
        i. Probe: describe why or why not.
    e. Probe: repeat questions with other examples (probe for as many examples as can be provided)

Part 4: Prevailing barriers and biases contributing to the remaining leadership gender gap

There have been many socio-, economic-, cultural barriers identified related to women ascending to leadership positions (examples include: discrimination in promotion, double burdens of work and home responsibilities, less access to educational opportunities, no female mentors or representation in leadership, sexual harassment, amongst others), most of which continue to act as barriers in many countries. **Specifically in the health and social sectors** in Senegal though, we would like to explore what existing biases and barriers that are contributing to the persistent gender gap could be overcome with initiatives such as those we just discussed. (interviewer instruction: when possible, build on examples given in Part 2)

[30] More information here: https://genderstrategy.giz.de/?wpfb_dl=1017

7. Recognizing the barriers that women have to overcome to get into any management or pre-leadership position (e.g. differential access to education) and thinking beyond those, once women in the health and social sectors are in those pre-leadership positions what barriers have you observed that women have to overcome to rise up into leadership positions?
8. For women currently in management positions, is there a path to follow in terms of advancement or continued professional growth?
9. What kind of initiative/approach could be adopted/implemented to eliminate these barriers to women occupying leadership positions or to support more women to overcome the barriers/biases? Please describe.

A health worker in Senegal speaks with a client. Credit: Photoshare.

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About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.

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