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Trends of Women in Leadership in Madagascar's Health and Social Service Sectors

Contents

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Cover photos (*in clockwise order*): 1) A community health volunteer in rural Tulear, Madagascar, gives instructions to a client on the use of pregnancy tests. Image by Samy Rakotoniaina, Management Sciences for Health (MSH) for *Global Health Now*. 2) Women from a youth community theatre group in Madagascar work on changing attitudes towards gender equality. Image posted to *GenderLinks*. 3) A health worker provides family planning options for a woman in rural Malagasy, Madagascar. Image by Fanja Saholiarisoa, *MSH*. 4) Supervision field visit of community health workers in Morondava village, Morondava City, Madagascar. Image by Ravelomaharavo Andre Leonard, MD for *GFMER*. 5) Participants at a session of the Young Women's Leadership Program (YWLP) identify issues in their communities, then devise practical, effective solutions. © Youth First for *UNFPA*.

Acronyms

CEO	Chief Executive Officer
COVID	Coronavirus disease
CSB	*Centre de Santé de Base*
CSO	Civil Society Organizations
FES	Friedrich-Ebert-Stiftung
GOM	Government of Madagascar
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRH2030	Human Resources for Health in 2030
HRIS	Human Resource Information System
INSPC	*Institut National de la Santé Publique et Communautaire* (National Institute for Public Health and Community Health)
IVLP	International Visitor Leadership Program
LMIC	Low- and middle-income countries
MoPH	Ministry of Public Health
NDP	National Development Plan (*Plan National de Développement*)
NGO	Non-Governmental Organization
PANAGED	*Plan d'Action National sur le Genre et le Développement* (National Action Plan on Gender and Development)
PARGED	*Plan d'Action Régional sur le Genre et le Développement* (Regional Action Plan on Gender and Development)
PMO	Programme de Mise en Œuvre (Implementation Plan for the National Development Plan)
PNPF	Politique Nationale de Promotion de la Femme (National Policy for the Advancement of Women)
PUP	Programme d'Urgences Présidentielles (Presidential Emergency Program)
SADC	Southern African Development Community
SG	Secretary General
SNLVBG	Stratégie Nationale de Lutte contre les Violences Basées sur le Genre (National Strategy against Gender-based Violence)
USAID	United States Agency for International Development
WHO	World Health Organization
YALI	Young African Leaders Initiative

Executive Summary

In Madagascar, the number of female leaders in the public sector has increased in the past two decades. More recently, a greater proportion of women have attained leadership positions in the health and social service sectors.

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.

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) program conducted mixed-method explanatory research to better understand the landscape and impact of female leadership in the health and social service sectors as well as the remaining gaps in leadership parity. Based on a global literature review to identify countries with specific policies, strategies, or initiatives to increase female participation in health and social service sector leadership, HRH2030 collected quantitative and qualitative data in Senegal and Madagascar through surveys and key informant interviews. This report summarizes the results from the Madagascar study.[2]

Overarching Trends

Growth in the proportion of female leaders in government coincides with legislative initiatives

Over the last 17 years, female leaders in Madagascar's public sector have gradually increased in proportion and in the level of leadership positions. The proportion of women who head various government ministries more than quadrupled from 2004 to 2020. The sharp increase of women in leadership positions in government ministries from 2007 and 2011 coincided with several legislative actions to promote gender equality and advance women's participation in public service. For instance, the 2004-2008 National Action Plan on Gender and Development (Plan d'Action National sur le Genre et le Développement or PANAGED) focused on mainstreaming a gender dimension into all development interventions. From 2009 and onward, there were several more actions to reduce cultural barriers to achieving gender equality. Madagascar's 2010 Constitution guaranteed equal rights and fundamental freedoms regardless of gender, creed or belief, financial status, origin, or religion, as well as equal access to employment and freedoms in the political, economic, and social spheres. In 2011, new national, legal, and policy declarations promoted political leadership among women.

A community health worker explains various methods of family planning to an interested woman. Image by USAID.

The number of women in leadership positions in the health sector is growing but challenges persist

Women in the health sector did not seem to benefit equally from initiatives between 2004 and 2018. The analysis across all administrative services of the Ministry of Public Health (MoPH)– cabinet and central level directorates, services, and regional directorates – shows that the percent of women in leadership positions has only varied moderately around 30 percent, the median, since 2004. However, there has been a marked improvement since 2018 – almost closing the gender gap – reaching 46 percent in 2020. Much of this recent

[1] Boniol et al., 2019

[2] The Senegal report can be found at https://hrh2030program.org/rise-of-women-in-leadership-in-senegals-health-and-social-action-sector/

increase is due to the inclusion of services-level units (with positions such as Head of Child Health Services and Head of Epidemiological Surveillance Services) in 2019 and 2020 data. Such that in 2020 women made up 40 percent of the MoPH leadership positions at the cabinet and directorate levels, but 54 percent of the leadership positions at the services level, up from 47 percent in 2019. However, the policy measures coincided with a higher impact for women leaders at the regional level. Across the 22 regional health directorates, the proportion of female directors more than doubled from nine percent in 2007 to 23 percent in 2020 with a high of 32 percent in 2017.

Women occupy most leadership roles at NGOs, donor programs, and international organizations

There is a greater representation of women in leadership roles in NGOs, donor programs, and international organizations supporting the health sector in Madagascar than those represented in the MoPH administration. Women occupy 53 percent of leadership positions across all these organizations compared to 46 percent across MoPH administration.

Dr. Bako Harisoa Ravaomanalina (center) believes women are becoming scientific leaders in Madagascar. Image by A.G. Klei for USAID.

Gender stereotypes continue to plague women's leadership in the health sector

Despite the progress in the representation of women in leadership in the MoPH over the last three years, one can question whether the narrowing of the gender gap can be achieved and sustained at all levels of the organization. The highest representation of women still occurs at the lowest level of the ministry – program services units (e.g., child health services). Moreover, a pattern of directorates and services, where women are employed in greater numbers and/or hold more leadership positions than men may suggest persistent gender stereotyping.

Women-friendly policies, laws, and leadership may positively impact women's interest and access to leadership roles

Key informants highlighted the importance of women-friendly policies, laws, and leadership in their personal decision and ability to assume leadership positions in the health sector. In addition, female leaders frequently specifically cited gender policies as helping to improve women's access to leadership positions in the MoPH.

Recommendations for Closing the Gender Gap

Suggested actions to help the MoPH reduce the gender gap in Madagascar's health sector include:

- *Develop a human resource information system (HRIS)* to provide much-needed evidence about the status and progress of gender equality in the health sector. An efficient and accurate HRIS can evaluate existing health staff and facilitate decision-making regarding the appointment of staff for leadership positions.
- *Recreate a gender directorate* to elevate the importance of women-specific policies and actions. Such a dedicated team could help the MoPH better understand and dismantle the root causes of gender disparity and provide the structure, guidelines, and processes for making gender equality in leadership a reality throughout all its organizational levels.

In Madagascar, women may walk for hours to meet female health workers at health facilities. © Image by Carolyn Sein, STOP Volunteer for CDC Global Health.

Introduction

Globally, barriers that prevent women from accessing top-level positions in the government or private sector are well-documented, including at the individual, interpersonal, institutional, community, and policy levels.[3] Many of the same workforce challenges cut across sectors, such as gender bias, discrimination, sexual harassment, a disproportionate burden of family responsibilities, wage inequity, and the 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 a lack of pay in the case of community health workers.

But there is less research on the interventions that can increase the number of women in leadership positions. While there are research and case studies describing the overall results of major corporate leadership initiatives in high-income country contexts, little has been published about similar efforts in low- and middle-income countries (LMIC) or initiatives targeting the health and social service sectors. Globally, the actions to support women in leadership positions ranged from broad draft laws or policies, such as establishing gender quotas; major projects that foster gender equality (mainly through sponsorships, professional mentoring, and coaching); involving men as drivers of gender-transformative change; skills development; accountability systems; establishing common and clearly defined goals; and evaluating progress made using key performance indicators.[4]

Exploring effective interventions in LMICs and particularly in the health sector is meaningful given that having women in health leadership positions expands the development agenda, giving greater priority to health and gender issues, such as reproductive health, and contributes to the scale-up of the health and social service workforce needed to achieve the Sustainable Development Goals.[5]

Increasingly, there are calls to expand the evidence base on impacts from women in health leadership.[6] 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 estimates that achieving gender parity would be worth around US$28 trillion to the global economy, an increase of 26 percent from levels projected under conditions of continued gender inequity.[7] Randomized trials in India based

[3] World Health Organization, 2019
[4] Cao et al. 2018
[5] World Health Organization, 2019
[6] Dhatt, 2017
[7] Woetzel et al., 2015

on the 1993 quota law, whereby all states were required to reserve a certain proportion of all council chief seats in villages for female leaders, demonstrated that women in leadership positions in local governance structures promoted policies that were more supportive of women and children and favorable for achieving universal health coverage, compared to men occupying the same positions.[8] Female elected officials were more likely to support health facilities, antenatal care, and immunizations. The research found that for each standard deviation point increase in the number of female-held seats in the district council, neonatal mortality dropped by 1.5 percent.

HRH2030 conducted a literature review between December 2018 and May 2019 to identify and describe the interventions and initiatives that countries have used to increase the participation of women in leadership roles (Annex A). The desk review indicated that Madagascar was a promising candidate for a case study given the positive trends in women's leadership.

Madagascar is a traditionally patriarchal society.[9] Persisting gender stereotypes categorize men as the dominant breadwinners, decision-makers, and heads of the household. Women are perceived as caregivers responsible for household tasks like cooking and tending to children.[10] Girls can be married as young as age 14, and about a third of Malagasy women under age 19 have already had at least one child.[11] Under the weight of these stereotypes and socio-cultural norms, gaining the required education or skills necessary to work outside the home can be very challenging for women. Overall, women in Madagascar often face economic and political exclusion and are disproportionately affected by poverty, discrimination, and exploitation.[12]

Methodology

Study Purpose

HRH2030 sought to assess the effectiveness of measures for increasing women's participation in leadership positions in the health and social sectors. The study's purpose was to document how women's participation in leadership positions changed over time and whether greater participation in leadership roles resulted in positive policy, strategy, and program changes in the social and health sectors. The research questions included:

1. Did the number of women in leadership positions in the health and social service sectors increase after public or private sector institutions took specific measures or initiatives?
2. What is the anecdotal evidence that an increase of women in leadership positions in the health and social service 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 are the remaining leadership gender gaps and the prevailing barriers and biases concerning women's leadership in public or private sector institutions engaged in health and social services?

Study Design

The study employs a multi-method explanatory sequential model with two phases: quantitative followed by qualitative. The quantitative data provides a foundational situational understanding of the gender leadership gap and related trends. The qualitative data gives an in-depth explanatory understanding of the leadership gap, specific initiatives, impact, and remaining challenges. Data were collected in Madagascar from March 2020 to January 2021.

Data Collection and Analysis

Quantitative Data

First, HRH2030 researched relevant public records and online sources to identify and inventory the number of health and social service sector leadership positions from 2004 to 2020. Identifying the number leadership positions within Madagascar's public sector was complicated by government structure changes with each election cycle and sometimes even within a cycle. It is not uncommon that a change in government appointments occurs during a given year and can even happen multiple times for the same position. Ministries changed their title and scope combining responsibilities in some years and splitting them into separate ministries in other years. For instance, in the public sector, 16 to 34 minister-level positions were assessed over the 17-year period. The highest number of minister-level positions identified was 34 between 2011-2013 while in 2020 there were 25.

The inventory identified a total of 252 leadership positions (Figure 1 and Annex B). Of these, 48 top positions were in government ministries (health and other sectors); 175 positions within the MoPH administration; 8 positions in public hospitals (located in Antananarivo); 6 positions in research and academic institutions; and 15 positions in

[8] Downs, 2014
[9] OECD, 2010
[10] Jarosz, 1997
[11] Sharp & Kruse, 2011
[12] Gaye, 2020

NGOs, donor programs, and international organizations supporting the health sector in Madagascar. The 175 MoPH positions were grouped by level in the organizational structure: ministry cabinet and directorates, MoPH services, and regional health directorates. Public hospitals were analyzed separately because of their greater autonomy in making leadership appointments. MoPH services are units within directorates, such as child health services and epidemiological surveillance services.

FIGURE 1: MINIMUM AND MAXIMUM NUMBER AND TYPES OF LEADERSHIP POSITIONS (2004-2020) ASSESSED

Organization	Position	Number[1]	
		Min	Max
Government ministry	Minister	16	34
Ministry of Public Health	Secretary-General, director, department head (e.g., preventive medicine)	22	45
	Service head (e.g., HIV/AIDS)	93	95
	Regional or provincial director	22	22
	Hospital chief executive officer (CEO), administrator	6	8
Research institute	Director, head, senior leader	2	3
Academia[2]	Dean, director	2	3
NGO, donor, international organization[3]	President, CEO, Chief of Party, Country Director	3	15

[1] Represents the minimum and the maximum number of positions for which information was available between 2004 and 2020; the positions established and/or with data varied from year to year. [2]Includes schools of medicine, public health, and nursing in the public sector. [3]Only NGOs working in the health sector with at least 25 employees were included.

The MoPH also underwent internal structural changes during the study period. For example, directorates were added, combined, or eliminated over time. The MoPH had the highest number of directorates (45) in 2018 while in 2020, there were 35. As another example, the national programs for the control of HIV/AIDS, tuberculosis, and malaria were designated as the 'services' level in 2019, while they were at the directorate level in earlier years. The MoPH services level saw new services added or eliminated over the study period. Because of the frequent changes and large fluctuations in the number of services units (106 in 2019 and 2020 compared to 74 in 2016), our study includes only 2019 and 2020 data about each service unit head. No information was available for 13 and 11 unfilled head of service unit positions in 2019 and 2020, respectively. The regional or provincial public health structure did not change over the study period with complete information available for all 22 positions each year. Information about the leadership positions in hospitals, research and academic institutes, and NGOs, varied slightly from year to year.

Next, we identified the gender of the individuals occupying each leadership role. If a position changed hands in any given year, the gender of the person occupying the position the larger portion of the year was included in the assessment. Public records were the data source for government ministries. Information for the health and social service sectors came from the MoPH's Department of Legislation and was complemented by personal communications with MoPH officials. Data about the international organizations, research and academic institutions, and NGOs were collected through an online survey of the highest-level positions.

The sex-specific data were compiled in an Excel file to analyze trends in leadership positions. The total number and the proportion of positions occupied by women in each year were calculated using the number of positions with information available. The analysis was done in three groups: (1) government ministries for health and other sectors; (2) MoPH administrative units (cabinet and directorates, MoPH services, regional public health directorates); and (3) public hospitals, research and academic institutions, and NGOs. Organizations in the third group were analyzed separately as their decision-making processes regarding leadership positions can vary greatly by type of organization. Within the MoPH administration, the data were also analyzed in three groups by organizational hierarchy: (1) cabinet-level and directorates; (2) MoPH services units; and (3) regional public health directorates.

Qualitative Data

Subsequently, HRH2030 conducted key informant interviews based on a purposive sampling of the women leaders identified in the inventory, with priority for the highest leadership positions of each group. Due to COVID-19 travel restrictions and lockdowns in Antananarivo, interview participants were mostly contacted by e-mail and engaged in phone interviews of no more than one hour in duration. In-person interviews were conducted in November and December, following protective protocol. Interview notes were then analyzed and coded by themes.

The study team conducted a total of 16 semi-structured interviews with 14 female and two male informants using an interview guide (Annex C). Interviewees included six leaders from the MoPH (including two former health ministers), four from research and academic institutions, and three each from NGOs and donor programs. The quotes from the key informants in this report are not attributed by name to protect the identities of the individual respondents.

Ethics Review and Approval

Non-biomedical research does not require review by the Research Ethics Committee in Madagascar. Instead, HRH2030 obtained ethical approval through a signed letter of approval from the MoPH's secretary-general.

Limitations

Research on barriers and enablers to women's leadership is methodologically challenging even in normal times. The spread of COVID-19 and the mobilization of ministry staff away from their offices during the pandemic made it difficult to obtain quantitative and qualitative data from the MoPH and the other organizations in a timely manner.

It is important to note that a complete assessment of leadership in a country is much more complex with a host of interconnected and intersectional factors influencing leadership. Based on the interviews alone, which represented individual perceptions, it is difficult to distinguish individual actions and wider system-level determinants. Moreover, using individual recollections may mask the importance of systemic changes. An individual may not attribute a specific program to her own success, instead of seeing her current position as the result of individual actions rather than system-level experiences or specific interventions initiated by the government, international organizations, donors, or NGOs.

Women are a heterogeneous group and that the privileges or disadvantages that enable or hinder women's career progression cannot be reduced to a shared universal experience, explained only by gender.[13] Further, analyzing health workforce challenges related to sex and leadership is only one dimension of the complex socio-cultural forces involved. This study is limited in the analysis of other intersectionality considerations such as class, race, and ethnicity, which have an impact on the attainment of leadership positions.

Also, due to the poor quality of information recorded in the national health information system—specifically, the lack of data and digitalization of paper records in the MoPH—quantitative data before 2004 are mostly lacking, and information for 2004 and 2005 is incomplete.

Community health workers in Madagascar review patient data. Image by Samy Rakotoniaina, MSH.

[13] Zeinali, 2019

Results

Over the last 17 years, female leaders in Madagascar's public sector have gradually increased in proportion and in the level of leadership positions attained. Below we provide the trends of female representativeness in decision-making circles in the government and various health subsectors such as the health system, training institutes, and development assistance.

Trends in Women's Leadership by Institution

Government Ministries

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 across all sectors. As shown in Figure 2, the proportion of women who headed government ministries more than quadrupled from 2004 to 2020. The increase occurred rapidly between 2007 and 2011 and then slowed considerably. The percentage of women in the role of government minister was as low as 6 percent in the years between 2004 to 2007, and as high as 32 percent (or eight out of 25 minister-level positions) in 2020.

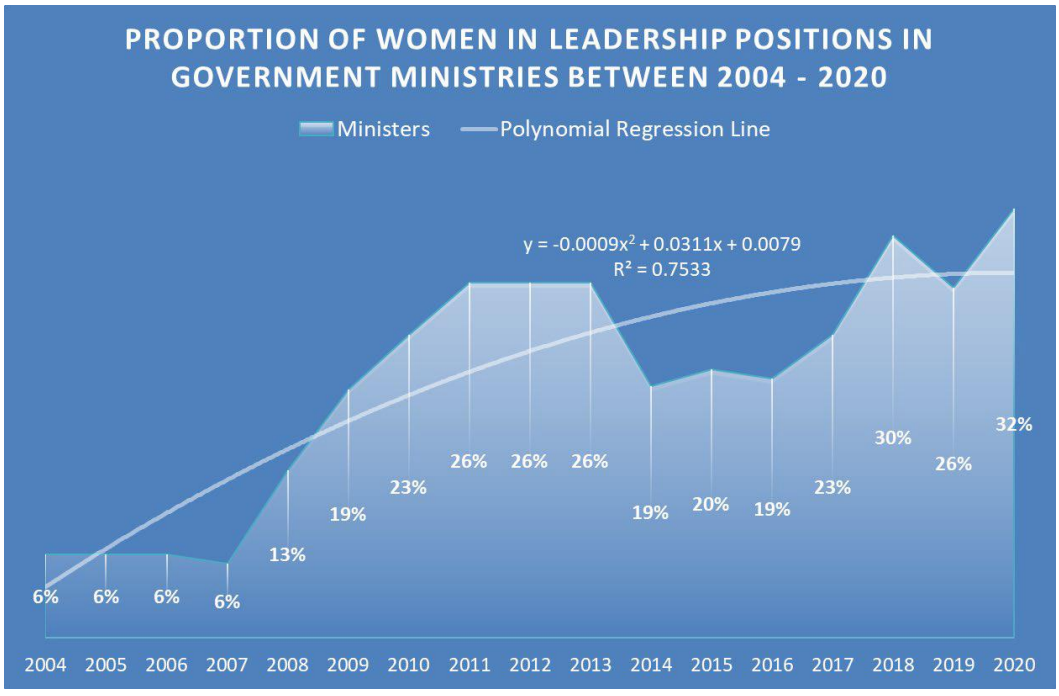
Overall, government ministries are predominately led by men. In 1977, however, Gisele Rabesahala made history by becoming the first female minister in government; she led the Ministry of Culture until 1991.[14] Thereafter, the role of the minister in both the Ministry of Justice and the Ministry of Population has been largely held by women. Also, women often occupy leadership positions within the Ministry of Communication, Ministry of Culture, and Ministry of Foreign Affairs. This may reflect the gender stereotypes and norms of the country which assigns women to the role of mediator and care. While the MoPH oversees health "care" it is considered part of biomedical sciences, which might explain why the top-level leadership in the ministry (minister and cabinet) is still dominated by men. This might be attributable to the presence of a strong gender stereotype perceiving men as natural leaders in this field. This was mentioned in the key informant interviews as one barrier to women accessing leadership positions in the country.

Of note, while Madagascar has never had a long-term female president, prime minister, nor female governor, some male presidents were influential in supporting women in leadership roles. as will be described later in the report.

Ministry of Public Health (MoPH)

The analysis of women's participation in leadership positions across all sections of the MoPH combined shows that the percent of women leaders varied moderately around 30 percent, the median, from 2004 to 2020 (Figure 3). There was marked improvement over recent years ($p<0.02$) – almost closing the gender gap – reaching 46 percent in 2020

FIGURE 2: PERCENTAGE AND TREND OF FEMALE MINISTERS ACROSS ALL GOVERNMENT SECTORS, 2004-2020



[14] Altius & Raveloharimisy. 2016

(70 women out of 152 total positions). Much of this recent increase is due to the inclusion of MoPH services in 2019 and 2020 data, as the services units had a large share of women leaders. A significantly low level of women's participation in leadership roles ($p<0.01$) occurred between 2005 and 2011 with the lowest proportion at 22 percent in 2008. Between 2011 and 2012, there was an increase to 30 percent under a female minister. The high percentage in 2004 is an artifact of incomplete data.

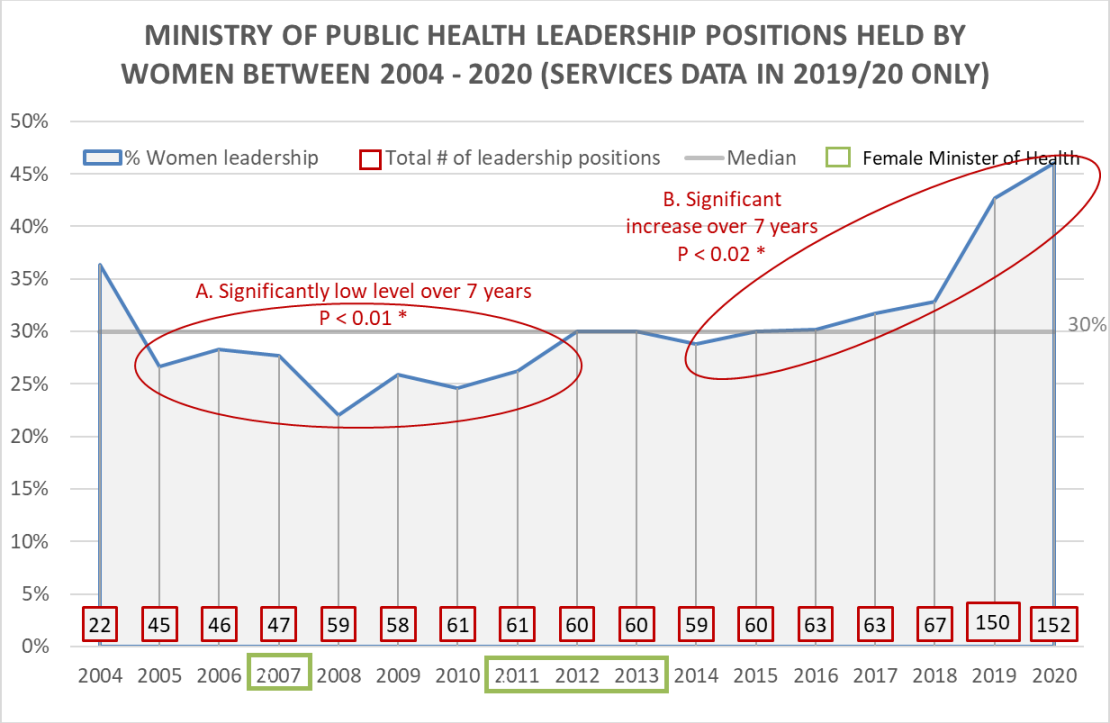
Three women have held the position of Minister of Health in Madagascar since 2000. Professor Razafimahefa Rahantalalao Henriette was the first woman health minister of Madagascar from1997 to 2001. After her, it was only in 2007 that another woman, Rahantanirina Marie Perline, held the minister position for less than a year. In 2011, Ndahimananjara Johanita was the third and last female health minister of Madagascar from 2011 to 2013. A woman was appointed as secretary-general of the MoPH for the first time in late 2020[15].

Figure 4 presents a separate analysis of MoPH leadership disaggregated by organizational level – cabinet and central level directorates, MoPH services, and regional health directorates.

Cabinet and central level directorates. The trend in women's leadership at the directorate level has largely been flat with a median of 36 percent from 2004 to 2020. The spike in 2007 should be viewed with caution because of incomplete data for early years. There are some directorates within the ministry that are almost exclusively led by women such as the family health directorate, the paramedic institutes directorate, and the health promotion directorate. The following quote highlights the issue of gender stereotyping at this level:

> *"There are directorates within the ministry that are always occupied by women due to stereotypes. For example, the directorates involving logistics are always occupied by men. Directorates that involve women and children's health are headed by women: such as the Family Health Directorate, the Maternal and Child Health Directorate, and the Directorate for the Expanded Immunization Program. Directorates which do not receive much funding are also headed by women."*

FIGURE 3: TREND OF FEMALE LEADERSHIP ACROSS ALL MOPH ADMINISTRATIVE LEVELS COMBINED



** p-values are based on the statistical properties of control charts representing the probability of observing (A) 7 values in a row that fall below the median and (B) 6 values increasing consecutively (only counting 1 value for 2015 and 2016).*

[15] However, a male occupant is listed for this position in Annex B because this appointment occurred late in the year.

MoPH services. At the lower MoPH services level, women occupied 54 percent of the leadership positions in 2020, up from 47 percent in 2019. This increase in female leadership at this administrative level overlaps with an expansion of services offices to 101 compared to 74 in 2016.

Regional health directorates. As seen in Figure 4, across the 22 regional health directorates, women directors more than doubled from nine percent in 2007 to 23 percent in 2020 with a high of 32 percent (or 7 out of 22 positions) in 2017. While women have clearly progressed at the regional level, primary reasons why their level of participation is still low compared to other administrative units of the MoPH may include security concerns at regional posts (some regions are insecure because of high rates of violent crimes, often associated with cattle theft); limited social and educational opportunities (in particular for school-age children for whom women bear the responsibility); and/or physical challenges (due to a need to travel to very remote rural areas to supervise community-based services, which are often only accessible bymotorbikes or several days of walking).

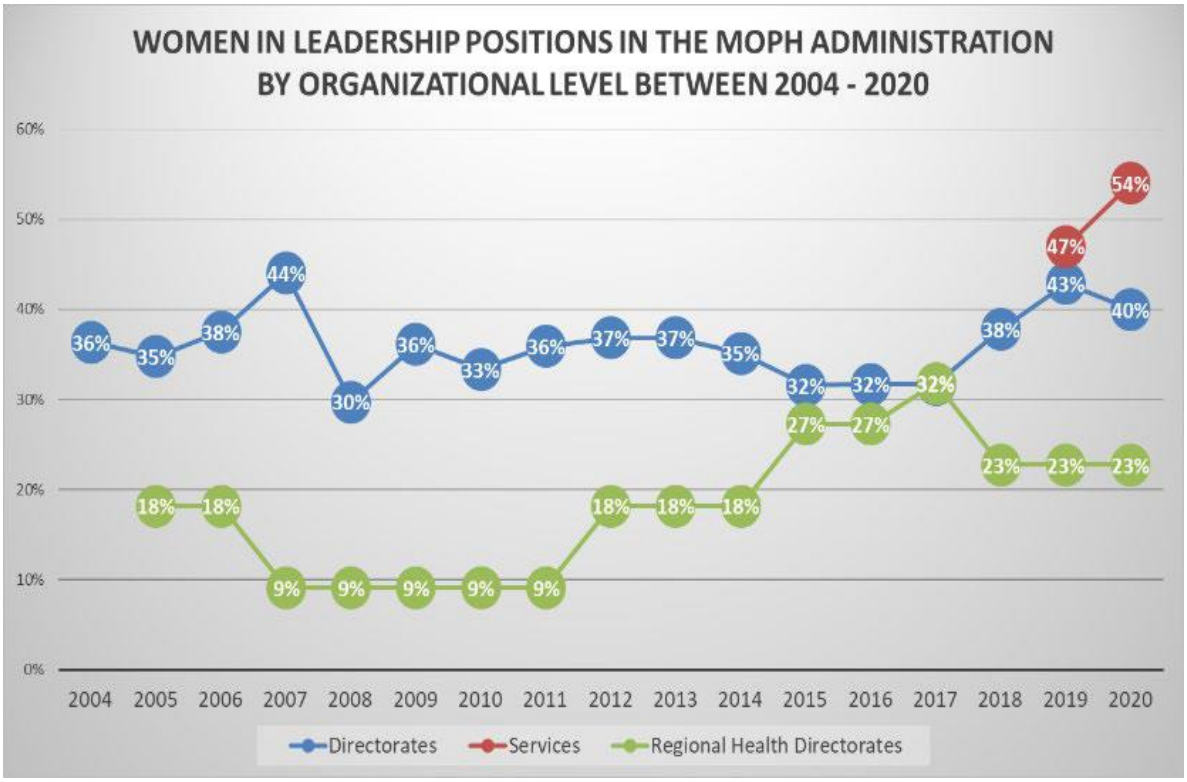
So, while regional appointments often offer excellent opportunities to gain a wide range of experiences, which in turn can lead to rapid promotion to higher leadership at the national level, the challenges can be especially difficult for women to navigate. Men can take on remote regional positions because they can do so early in their careers when family considerations do not weigh as heavily. Regional Director positions seem to be an option only later in women's careers when home, child-rearing, and other family responsibilities tend to lessen. But attaining a leadership position later in life often limits further ascension simply because of age. The following quote highlights the issue for women at the regional level.

"For women to be chosen to be [regional] directors, they must first begin their careers. Even at the start of her career, she encounters challenges. For example, men are more likely to enter the system early because most of the available regions are those that are remote, and women are reluctant to be posted in these areas. So already at this level, women quickly fall behind because they must wait for a [suitable] place to become available. As the man has access to a post earlier, he can hope for promotion and faster ascent [in the MoPH hierarchy]."

Public Hospitals and Research and Academic Institutions

Regarding public hospitals and research and academic institutions, the gender gap seems to widen or at least fluctuate greatly over time (Figure 5). This may indicate that

FIGURE 4: TRENDS IN FEMALE LEADERSHIP IN MOPH DIRECTORATES, SERVICES, AND REGIONAL OFFICES



there are few if any, policies in place that specifically address the gender balance in the leadership of these types of institutions.

The proportion of women in leadership roles in eight large public hospitals in the capital Antananarivo decreased from 50 percent in 2004 to 25 percent in 2020. The representation of women was lowest at 13 percent in 2015 and 2016. Looking at the six positions in research and academic institutions included in the assessment, the number of women in leadership increased over time, reaching a high of 50 percent in 2016 and 40 percent in 2020. However, the sample is very small; and these percentages varied widely from year to year.

NGOs, Donors, and International Organizations

According to Figure 5, the greatest representation of women in leadership roles in the health and social services sector is found in NGOs, donor programs, and international organizations. In 2020, women occupied 53 percent (or 8 out of 15 leadership positions) across the 11 organizations sampled (compared to 46 percent in the MoPH). It was recurrent during the interviews that, unlike in the public sector, these organizations have specific gender policies (such as non-discrimination policies) and take affirmative action that increase the opportunities for women in leadership roles.

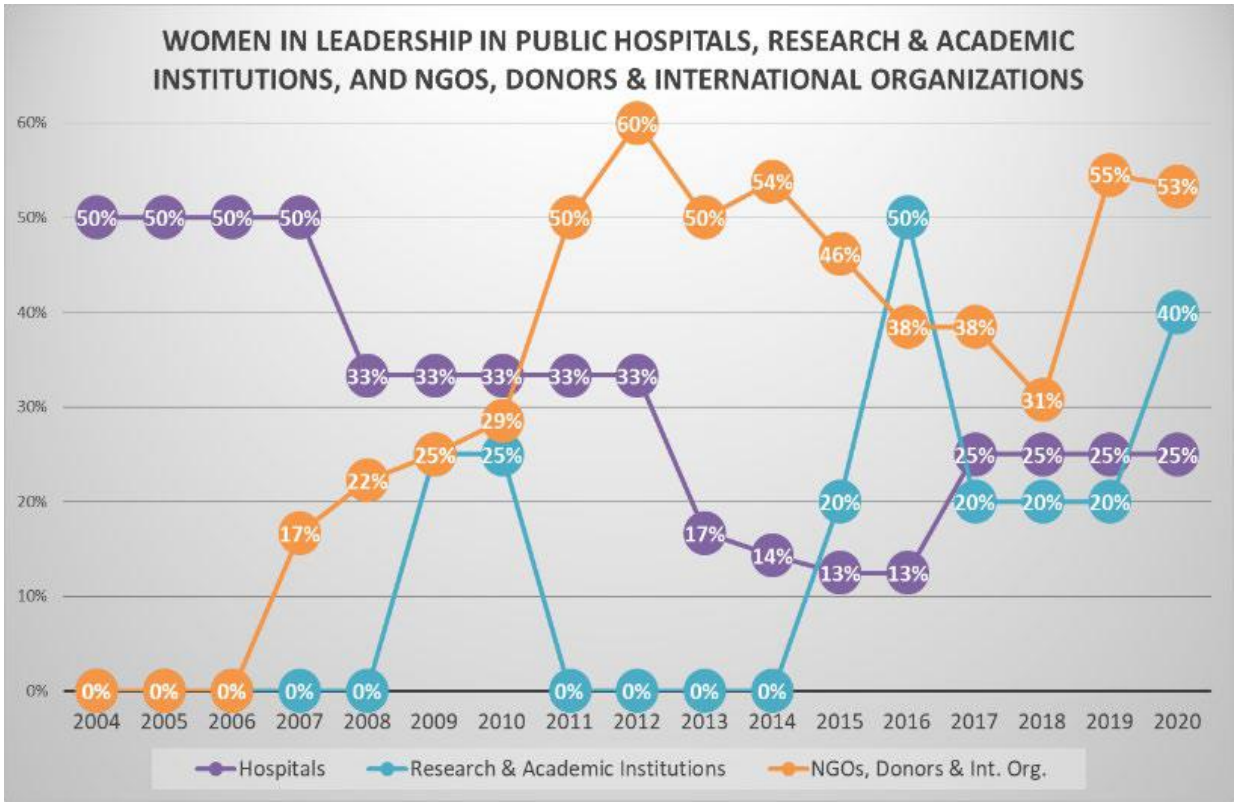
"There is no specific policy that obliges leaders to recruit women for leadership positions in the MoPH. It is not like in the NGOs or donor organizations. That is also the reason why women who have abilities prefer to work for NGOs instead of staying here (at the MoPH). It is sad, but sometimes it is only after a woman accesses a leadership position in the private sector that the government sees her potential."

Factors Influencing the Proportion of Women in Leadership Positions

There were several promising initiatives that took place over the past 17 years that may have contributed to the advancement of women in leadership roles in Madagascar (Figure 6). Key informant interviews, structured around the following themes, helped to identify the potential enablers of progress:

- Policies and legislation
- Organizational practices and initiatives
- Representation and female role models
- Intentional recruiting of female candidates
- Standalone leadership programs and activities

FIGURE 5: TRENDS IN FEMALE LEADERSHIP IN PUBLIC HOSPITALS, RESEARCH, AND ACADEMIC INSTITUTIONS, AND NGOS, DONOR PROGRAMS, AND INTERNATIONAL ORGANIZATIONS BETWEEN 2004 AND 2020



National Policies and Legislation

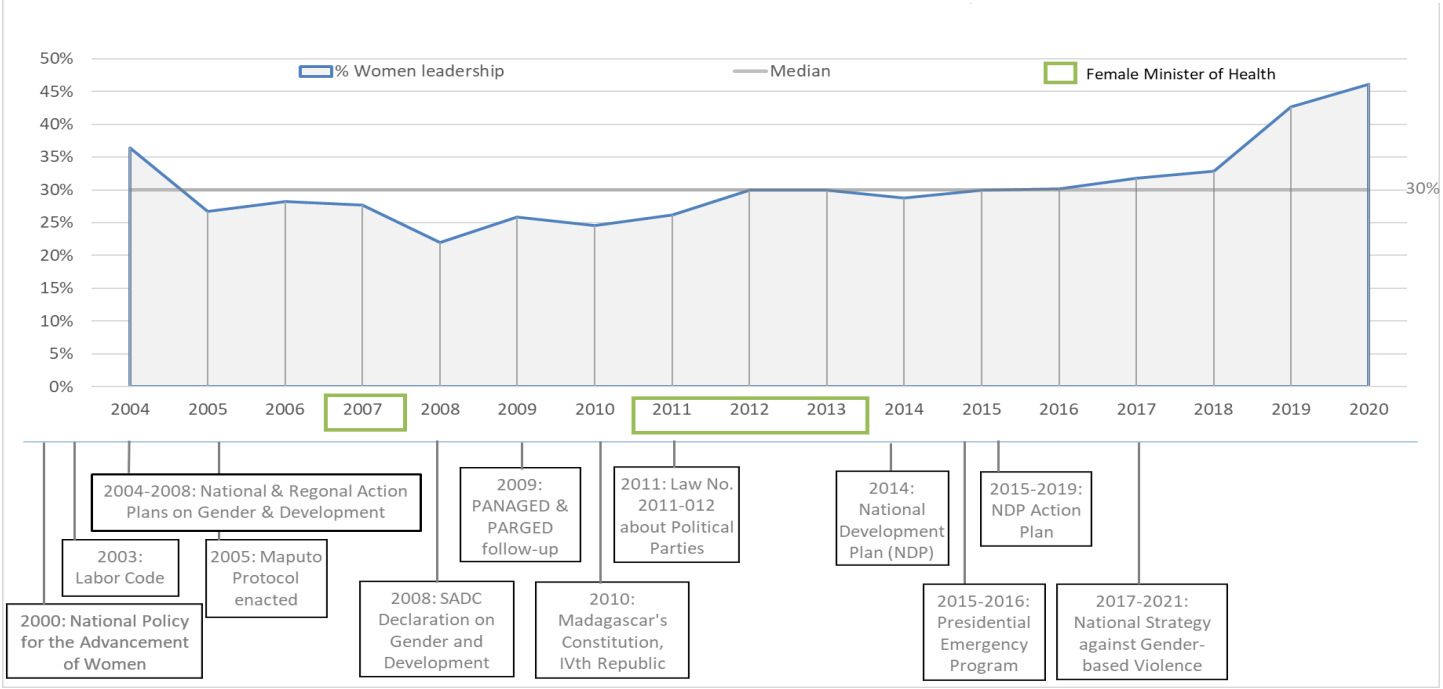
In 2000, the Government of Madagascar (GOM) enacted the National Policy for the Advancement of Women (*Politique Nationale de Promotion de la Femme* or PNPF) to provide a comprehensive strategic framework for the advancement of women and for greater equality between men and women from the perspective of sustainable development.[16] This policy was meant to guide future actions to promote gender equality in a coordinated and effective manner. It marked the political will of the GOM to advance women's leadership in Madagascar. As seen from the gender gaps across government ministries (Figure 2) and in the MoPH (Figure 3), this early policy did not seem to have an immediate effect.

Women's participation in the workplace is addressed in the 2003 Labor Code (*Code du Travail: Loi 2003-044*).[17] The labor law stipulates that all women have the right to work and equal pay. It prohibits sexual harassment and discrimination in employment based on gender. The labor code provides that a woman does not have to inform that she is pregnant, she may not be terminated for being pregnant, and she must receive 14 consecutive weeks of paid maternity leave (men receive a minimum of ten days of paid paternity leave). Women are also given one hour per day for breastfeeding in the workplace. However, notably, the labor code did not seem to have a positive effect on women in leadership positions over the years immediately following its release (see Figures 2-3).

The National Action Plan on Gender and Development (PANAGED) and its equivalent at the regional level (PARGED) were implemented from 2004 to 2008 to advance women's participation in public service. These legislative actions aimed to improve the representation of women in decision-making bodies and reduce cultural barriers to achieving gender equality.[18] Post-PANAGED, Madagascar witnessed a sharp rise in the number of women leading government ministries (Figure 1) and a smaller increase within the MoPH (Figure 6). Earlier and later legislative actions were not associated with such dramatic changes for women.

In 2005, Madagascar became a signatory of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol. Established by the African Union, it is an international human rights instrument that guarantees comprehensive rights to women including the right to take part in the political process, social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation.[19]

FIGURE 6: MAPPING OF LAWS AND POLICIES AND AGAINST TRENDS IN WOMEN IN LEADERSHIP POSITIONS IN THE MOPH



[16] Ministry of Population and Social Affairs. 2000. Politique national de la promotion de la Femme.

[17] http://www.droit-afrique.com/upload/doc/madagascar/Madagascar-Code-2003-du-travail.pdf

[18] Gouvernement de Madagascar, 2003. Plan d'Action National sur le Genre et le Développement 2004-2008.

[19] Wikipedia. https://en.wikipedia.org/wiki/Maputo_Protocol. Accessed 05/27/2021.

"During the transition (between 2009 and 2014) there was an increase in the number of women in government. This is due to the requirements mentioned in the Maputo roadmap [Maputo Protocol, African Union 2003, enacted in 2005] for ending the crisis in Madagascar which called for gender equality in decision-making positions."

In 2009, follow-up action plans to PANAGED and PARGED were designed to increase women's participation and representation in the conduct of public affairs in Madagascar. The plan had its foundation in the Southern African Development Community (SADC) Declaration on Gender and Development from 2008, which commits member states to "ensuring the equal representation of women and men in the decision-making of member states and SADC structures at all levels" and, in particular, called for an increase in women's participation in political processes going from an interim 30 percent to 50 percent by 2015.[20] Unfortunately, despite the country's signature to implement this policy, the plan was not adopted by the council of ministers and therefore, never became national policy. That said, the declaration still had some residual positive impact.

"There was a quota to be respected. Thirty percent of leadership positions should be held by women. The high-level commitment ensured that it was respected by all. This influenced the adoption of the disaggregation of data by gender in the Health Sector Development Plan in 2009. This initiative had influences at all levels and not just in the health sector."

Madagascar's 2010 Constitution guaranteed equal rights and fundamental freedoms regardless of gender, creed or belief, financial status, origin, or religion, as well as equal access to employment and freedoms in the political, economic, and social spheres. Several laws address the rights of women and children within the family context. The three-year period immediately following the adoption of the Constitution, which also coincided with the tenure of a female head of the MoPH, showed a slight increase in the number of women leaders in the ministry (Figure 6).

Madagascar's parliament has taken up the promotion of gender equality in its offices by establishing caucuses and "gender committees." Their challenge is the adoption of laws aimed at making gender equality a reality in the country. The ombudsman of the Republic, the independent National Commission for Human Rights, and the Ministry of Justice are implementing institutional mechanisms for promoting gender equality. In 2011, new national, legal, and policy declarations promoted political leadership among women. Law No. 2011-012 about Political Parties required all parties to adopt a "gender approach" in their objectives and activities and to include provisions to implement a quota system requiring that at least 30 percent of elected and nominated positions be filled by women.[21] Alas, of the 151 members of the National Assembly elected in 2019 only 26 members, or 17 percent, were women (EISA Madagascar 2019).

The new National Development Plan in 2014 committed the government to address structural gender inequities and promote the participation of women in development activities and politics. Though it acknowledged "the insufficiency of policies oriented towards the promotion of gender equality," the document also suffered from a lack of analysis of these "deficits" and remained too general to meet specific challenges of gender equality.[22] The 2015-2019 NDP implementation plan (Programme de Mise en Œuvre or PMO) included among its ten priorities a strategy for inclusive growth to "create an environment conducive to the participation of women in development." Meanwhile, the 2015-2016 Presidential Emergency Program (Programme d'Urgences Présidentielles or PUP) included a professional integration and capacity-building program for women.

The most recent gender-specific policy is the 2017-2021 National Strategy against Gender-based Violence (SNLVBG) which also includes an action plan. This policy may have had the most noticeable impact as during the last three years the gender gap narrowed considerably in the MoPH (Figure 6), and in research and academic institutes and NGOs (Figure 5).

Organizational Practices and Movements

Some organizations like CSOs, comprising international and national associations and NGOs, have taken on an increasingly important role in advancing gender equality, particularly since the 2009 National Plan of Action. The CSOs intervene on several fronts such as through political dialogue, advocacy, awareness-raising, implementation, reporting to treaty bodies, and monitoring the application of recommendations. CSOs have made remarkable progress in networking with sub-regional, regional, and global movements, suggesting positive effects of gender equality in Madagascar. In this regard, the country's progress, particularly in terms of governance, matrimonial rights, nationality,

[20] Rakotondrasata, 2013

[21] Gouvernement de Madagascar. 2011. Loi No. 2011-012 Relative aux Partis Politiques.

[22] This and the following paragraphs are cited from: Groupe de la Banque Africaine de Développement. 2016. Profil genre pays République de Madagascar.

entrepreneurship, and the fight against gender-based violence, are attributable to the intensive and increased action of CSOs engaged in the defense of women's rights. Donor, technical, and financial partners play a key role in supporting CSOs in several of these initiatives, although government institutions remain their main partners.

The recent increases in women's leadership roles may be partly attributable to increased advocacy for gender equality from CSOs and donor partners:

"The Ministry of Health is mostly donor-driven so the changes in terms of gender strategies depend more often on the donor and not necessarily on female leadership."

At the individual level, a commonly cited barrier in research about challenges for women to attain leadership positions is the difficulty of balancing work and home responsibilities. Several organizations have promoted childcare as a method to attract and retain qualified women, increase productivity, and reduce absenteeism.[23] Interviews with key women leaders in the health system in Madagascar show that this practice has been effective in advancing women's careers since the early 2000s.

"At the time of [Minister of Health] Professor Henriette, women could work and pursue their studies at the same time, even if pregnant or breastfeeding. If they had any discomfort, they could ask the teachers to make them a remedial course which was free. They could get out of classes without sanctions to breastfeed. Breastfeeding women could also take care of their children at the office, and there were even specific places for this in all the departments of the ministry. Because of those initiatives, women like me could aspire for leadership roles."

The interviews also highlighted that access to higher leadership positions were mainly due to the practice of tying promotions to seniority in the Ministry of Health. Women who have worked in the ministry for more than 20 years may be rewarded with a position of director before their retirement.

"I personally got my position thanks to my seniority. They asked if there was a professor who had worked for a long time but had never held a senior position. That's how I got my position. If it wasn't for my seniority, I don't think I could have held this position."

"In my case, it was recognized that I had 30 years of service, that my retirement was approaching, and that I deserved the leadership position now."

Besides seniority, nepotism and corruption stand in the way of applying existing policies. Some women leaders affirmed that sometimes appointments of directors and leaders in the MoPH are based on personal relationships with decision-makers such as university, family, or region of origin.

"In my time, people are paying attention to the place where you study and they judge you based on that. That is why, I needed to work harder to prove that even though I was from the west, I was capable of being a leader."

"Some directors/ leaders are occupying their position because they come from the same region as the minister for instance."

Representation and Female Role Models

Women in leadership serve as role models for other women who aspire to have careers in the health system. The data show a modest gain of six percent of women in leadership positions, while a female minister was in office from 2011 to 2013 (Figure 6). Several respondents credited changes in opportunities for female leaders as their reasons to stay in the field. Interview participants often cited former female ministers as significant influences for aspiring to leadership positions in the health sector.

"At the beginning, there were not many women who applied for entrance examinations or positions that led them to become head of department or director. But the leadership of Professor Henriette pushed many women to make efforts and gave them some motivation to participate because they knew that it was possible for a woman to become a leader."

[23] International Finance Corporation, 2017

Having an embedded unit specifically tasked with increasing the gender balance can also make a difference. The Ministry of Population, Social Protection, and Promotion of Women has had a dedicated Gender Mainstreaming Unit since 2015. This unit is responsible for the coordination of specific actions at the Directorate General level for the advancement of women. One of its recent achievements, with the support from civil society organizations (CSO), donors, and financing partners, was the ratification of the SNLVBG. The Ministry of Population, Social Protection, and Promotion of Women is also active in developing regional instruments on gender equality, such as the post-2015 SADC gender protocol and the protocol in the African Charter on Human and People's Rights, relating to the rights of women in Africa. Gender focal points exist within the various ministry departments. However, their operational effectiveness and ability to influence internal policies are limited, in part because of frequent personnel changes. For example, the MoPH only had a gender director in 2007 and 2008.

Intentional Recruiting of Female Candidates

Several respondents 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 or exclude them from leadership roles.

"The goal at the time was to put more women in administration and leadership in the health sector. Regarding the National Institute for Public Health and Community Health (Institute National de la Santé Publique et Communautaire or INSPC), there was a competition for hospital administration. We were 400 to take part in the competition, 18 were selected for the orals and 3 of them were women. It was the minister himself who gave the order to stop failing these women, and I think it was happening in all sectors."

"Women enter leadership positions when the leader of the country is truly committed. For example, I was chosen by President Ratsiraka himself."

Standalone Leadership Programs and Activities

During interviews, several female leaders recognized the importance of leadership programs and training to develop women's leadership skills but also to legitimize their abilities.

"Women must constantly participate in training to legitimize their skills and show that they are capable."

Government initiatives such as the National Leadership Institute of Madagascar or the Diplomatic and Strategic Study Center (Centre d'Etude Diplomatique et Stratégique or CEDS) have contributed to the participation of women at higher positions in the public sector. National leadership was mentioned in interviews as an important factor for addressing the gender gap, for example during President Ravalomanana's tenure from 2002 to 2009, which saw an increase in minister-level positions for women, but a slight decline of female directors in the MoPH.

"In [former President] Ravalomanana's time, many civil servants without gender distinction received leadership training. Nevertheless, many women benefited from this initiative."

Several international organizations and aid agencies have invested in training programs to enhance leadership skills. For instance, USAID funded the Young African Leaders Initiative (YALI) and the International Visitor Leadership Program (IVLP). The German foundation Friedrich-Ebert-Stiftung (FES) supports the Youth Leadership Training Program. Most of these programs are outside the health sector and few target women specifically. One that does is called the Young Women Leadership Program (YWLP) and is initiated by a youth group called Youth First.

"Almost all donors have an Academy or training program. Some women leaders were able to participate in programs such as FP2020, Women Deliver, or AIDS and Rights Alliance for Southern Africa (ARASA)."

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

Key informant interviews affirmed the perception that there exists a correlation between the presence of women in leadership positions in the MoPH and a greater number of policies and actions advancing women and girls' health in Madagascar. According to respondents, contributions from women leaders have led to the promotion of safe motherhood and community health approaches, the creation

of the basic health centers (Centre de Santé de Base or CSB), a decentralized health system, and the ratification of major health policies that benefit women and girls.

"Despite the changes of positions in the ministry, the directorate in charge of maternal health has been occupied by the same person (a woman) for several years. This has contributed to the facilitation of the implementation of the family planning law. Thanks to this, community officers can now provide family planning injections, because the director has contributed to lobbying. This is also the same for the use of misoprostol in case of bleeding during delivery, the director was lead for those activities."

"[Former Minister of Health] Prof. Henriette has been a pioneer in implementing the decentralized health system and the promotion of maternal health within the MoPH."

"When women lead the Directorate for the Expanded Program on Immunization, immunization coverage increases."

In addition, women leaders within NGOs have contributed to a legal environment that benefits women and girls. Several interview participants noted that the implementation of the family planning policy that exempts contraceptives from sales taxes, hence making them more affordable, was possible because of the contributions of the female NGO heads.

"The example I will use here would be the exemption from taxes for contraceptive products. Several entities have worked and collaborated to achieve this end. The finance law on this subject was passed several years ago with application this year 2020. At the head of these entities (Management Systems International, Management Science for Health, John Snow Inc.), they were all women. This is to say that the women leaders of the various NGOs have contributed in one way or another."

Continued Barriers for Women to Attain Leadership Positions

While the barriers to women's ascent to leadership roles across the globe are much more frequently documented than the enabling factors, it is still important to understand the challenges that persist and inhibit equitable workforce participation and leadership opportunities for women in a country. Responses from interviews with the selected women leaders show that several recurring issues surfaced regarding women's opportunities to progress to leadership positions in the health system.

Sociocultural Barriers and Gender Stereotypes

Gender stereotypes are still a major barrier to women's leadership. Traditional norms and beliefs regarding masculinity and femininity in Madagascar expect men to be the stronger sex and women to be the weaker ones, the latter often is referred to as *fanaka malemy* (fragile furniture).[24] Leadership behaviors are associated with stereotypically masculine traits such as assertiveness, independence, and self-reliance. This association creates a conflict for women when they attain leadership positions because they are expected to act like a leader ("male" traits) and like a woman ("female" traits).

"Iron Lady ("dame de fer"), that's what they call me here because I'm a woman."

"Because she was a woman with authority, people thought she was rigid and inhuman."

Gender norms and stereotypes support the notion of men as breadwinners, heads of households, and leaders. In all instances, including within the health system, women who do not obey those stereotypes are shamed and continuously criticized by the community.

"For example, my husband was a respectable man with a good career, yet it was hard for him to accept that I am a woman leader not the wife of a leader. Sometimes he doesn't want to come with me to formal and public events. He said he was ashamed because he is the boss' husband. He feels diminished."

"It is not easy to be heard in a man's world. It is cultural that the man is the spokesperson, not the woman."

Certain gender norms and stereotypes that consider men as more capable of leading have effectively excluded women from all forms of decision-making mechanisms. These same prejudices create in women a feeling of being illegitimate when it comes to taking part in public life.

[24] Kellum et al, 2020.

"Men have been president of midwife associations while it is an essentially female department. This is due to the norms and lack of leadership of women. Women (midwives) are the ones who vote for the male president without him even having to impose himself."

Responses from interviews also highlighted the strong gender stereotypes that come forth when a woman succeeds in a world dominated by men. It is oftentimes incorrectly assumed that she must have used her femininity and sexuality to get the position.

"Women face discrimination or rumors. When a female leader is appointed, people automatically think that she is someone's sexual partner."

"And even though I work hard, people always say that it's because I slept with the minister and the Secretary-General that I get things successfully done."

Work-Family Balance

Key informants cited social expectations around motherhood as one of the main obstacles affecting women's advancement. Several women stated that it is nearly impossible for women with young children to ascend to leadership positions and that women are only able to serve in positions of high responsibility once their children are adults, which legally is at the age of 21.

Moreover, because of women's perceived absenteeism after childbirth when they take family leave that is guaranteed by law, women are oftentimes excluded from decision-making positions.[25]

"The leadership positions here in Madagascar were not designed for women who have just had a baby because there is too much work."

"My strength is that I have already reached a stage where I no longer have a child to look after. It would be very complicated for a woman with a young child to occupy this position because management positions demand all of your time."

When offered leadership positions, it is commonplace for women to seek approval from their husbands and families first. Women who have progressed to leadership levels have emphasized having strong family/parental and spousal support in their careers. Typically, women in Madagascar who work outside of the home have a dual responsibility with household and workplace demands, with it still being less acceptable to spend too much time away from the home. This has contributed to the leadership gender gap in the health system.

"One day I asked a woman to become head of the department, and she told me that it was too much work. She had to refuse because she would no longer have time to take care of her home. In addition, her husband did not agree with her professional rise."

"When you become a director, the workload increases. Sometimes you must work even on Saturdays and Sundays. Meetings almost always end late at night, sometimes at midnight. This is not suitable for all women because they are afraid of being judged."

Lack of Political Participation

Interviews with women leaders in health show that the lack of political participation of women is also a major barrier to access leadership positions. Overwhelming responsibilities at work and at home have been stated by women leaders as critical impediments to being a part of a political party. Due to these time constraints, women's network of influence remains limited.

"Leadership positions in the ministry are also political positions, and women are not very active in politics. For those who are, they are there by accident, or they are the wives of politicians."

"A condition for women's participation in leadership positions is also political party affiliation. It is difficult for women to access high-level positions without a party."

Several women leaders stated that access to leadership positions is most of the time (but not always) based on a political decision or a donor institution's agenda and does not specifically consider gender. In the MoPH the appointment of

[25] Rakotoarison & Hajavonjiniaina. 2005

a directorate, a secretary-general (SG), or a minister is based on their political affiliation.

"There are no real gender-related policies because the appointment of people is made by political affinity and does not depend on sex or any other policy."

Sometimes even the minister of health does not have the final word when appointing a director as a staff member.

"In 2015, the SG contacted me to be the national director, and I agreed. I waited for my appointment and when the day came, they appointed another person for the position of director. The SG called me right after to tell me that he was under political pressure and that he had no choice but to appoint the person his superior had chosen."

Despite Law No. 2011-012 which requires a quota system within political parties, most political parties have not adopted it in practice. The law urging all parties to "implement the gender approach" is too vague and generally fails to outline specific measures to accelerate women's representation and leadership.[26] The absence of specific implementation guidelines and an action plan for enacting this law hinders women to access leadership positions overall, not only in the health sector.

"I think we need a strict system of quota in Madagascar. Without that, leaders will still appoint men and sometimes without any abilities, just because of the political preference."

However, participants in the interview also noted that a quota system has its risks, as the basis for the appointment of a woman could be perceived as a mandate to respect the quota, rather than on her abilities and competencies. Many women selected in a quota system may be incorrectly labeled as underqualified merely because of the quota system itself. This could further discriminate against women, who would be challenged to prove themselves above and beyond current prejudices.

[26] Madagascar Coalition of Civil Society Organizations. 2015.

Discussion and Recommendations

The proportion of women in leadership positions in the health sector markedly increased in Madagascar since 2018. The trend was mostly flat in earlier years with the proportion varying slightly between 25 and 30 percent. This study was not designed to establish causality, and there is only circumstantial evidence that broad policies and laws aiming at promoting gender equality had a direct impact within the MoPH. This contrasts with the sharper increase of women in leadership roles in government ministries from six to 26 percent between 2007 and 2011, which was preceded or accompanied by major legislative initiatives explicitly promoting gender equality. Quantitative results notwithstanding, key informants highlighted the importance of women-friendly policies, laws, and leadership in their personal decision and ability to assume health leadership positions. The importance of gender policies, which are strongly driven by donors such as USAID and the European Union, was cited repeatedly as improving the access to leadership positions by women in the MoPH.

As the same women's leadership study in Senegal found, the most common enabler of women's leadership in Madagascar is seeing other women in positions of power. Many of the key informants mentioned this "role model effect" as having an enormous influence on other women's choices of careers and ambitions. Moreover, they felt that more practices that enable women to flourish in their careers are implemented during a female minister's term.

Of the female leaders interviewed, the majority reinforced the need for continuous training to enhance their skills and capacity, and especially to legitimize their leadership role. Unfortunately, Madagascar does not have the training and mentoring programs specifically designed for women in the health sector. Most often, leadership training opportunities are used by men. The health sector should look to create programs like Youth First's Young Women Leadership Program for women in health to help mitigate this.

Several respondents mentioned that they obtained their leadership position because of a particular measure taken to support their application. Such measures can depend greatly on the political will of those in power to intentionally appoint women or to encourage the application by women for certain leadership opportunities.

Several women leaders pointed out the importance of a supportive work environment and policies that change gender

norms and help women to pursue a leadership career. Evidence from Madagascar suggests the effectiveness of enabling policies and practices such as family leave before and after birth that includes the father, breastfeeding policies, safe and sound childcare services, and flexible work schedules.

Also needed, but more difficult to provide, are measures to ensure the physical security of women in remote regional directorates. While the data show progress over the last 16 years, these regional leadership positions are still easier for men to fill, not only because of security concerns but also because of the constraints they impose on family life including access to quality education.

Despite the progress in the representation of women in MoPH leadership over the last three years, there should be a concern about whether the narrowing of the gender gap can be achieved and sustained at all levels of the organization. This study shows that the largest representation of women still happens at the lowest level--the service level of the ministry. Moreover, there is a pattern of which directorates and services are assigned to women that suggest persistent gender stereotyping. The following recommendations offer specific actions for closing the gender gap in Madagascar's health sector.

Based on the challenges of collecting complete data for this study, a well-functioning human resource information system (HRIS) could provide much-needed evidence about the status and progress of gender equality in the health sector. An efficient, accurate HRIS can assess existing health staff and facilitate decision-making for more gender-equitable appointment of staff for leadership positions, as the following quote underlines:

> *"The operationalization of a human resource information system will inform the leaders which person has held such position and for how long. Was she/he performing? Is she/he a good candidate for a leadership position?"*

To promote women in leadership positions in the MoPH, the ministry might want to elevate the importance of women-specific policies and actions by recreating a gender directorate similar in structure and mandate to that in the Ministry for Population, Social Protection, and Promotion of Women. Such a dedicated team with the aim of gender mainstreaming could help to understand and dismantle barriers to gender disparity in leadership positions and advance the commitment of the health sector to gender equality and social inclusion. A dedicated directorate would show the political will to institutionalize quotas and parity across the organization.

Madagascar has broad policies and laws in place that promote gender equality; the MoPH needs the structure, guidelines, action plans, and processes for making them a reality at all its organizational levels.[27] Donors, NGOs, and international organizations have had an important influence and can be expected to continue providing necessary and critical support in advancing gender quality in the health sector.

An elder Malagasy woman poses for the camera and smiles. Image courtesy of Wikimedia Commons.

[27]Madagascar Coalition of Civil Society Organizations. 2015.

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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 is 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 American 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 the methodology of the impact of women leaders specifically on the health and social service 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 the 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 literaturereview 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 increasingthe 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 can use leadership positions to achieve more equitable outcomes. Other donors (Canada, Norway, Sweden) have devoted considerable support to enhancing gender equality 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 (27percent) 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 service 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 where 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 (-2percent) 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 (39percent) 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 (17percent) 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 percent 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. The Young Women Leadership Program, an initiative of Youth First, has been one of few initiatives in Madagascar working 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 (10percent) 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 (40percent) 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 (40percent) 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 (33percent) and at the sub-national level (40percent). The proportion of women elected fell only slightly after the 2013 elections (holding 176 of 597 (29percent) 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 the 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 equality 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 (64percent) 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 (50percent) 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 (42percent) 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 (30percent) and at the sub-national level (33percent). 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 (37percent) 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 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 (33percent) 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 the proportion of ministerial seats held by women (37percent, 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 equality in public administration. While Uganda has been stable and does have notable levelsof 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. Madagascar Sex-Disaggregated Leadership Inventory

TABLE 1: GENDER OF LEADERSHIP POSITIONS IN GOVERNMENT MINISTRIES

Organization/Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Government ministries: 48																	
Ministere de la santé	M	M	M	F	M	M	M	F	F	F	M	M	M	M	M	M	M
Primature	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministere de la defense nationale	M	M	M	M	F	M	M	M	M	M	M	M	M	M	M	M	M
Ministere des affaires etrangeres	M	M	M	M		M	F	M	M	M	F	F	F	F	M	M	M
Ministere de la Justice	F	F	F	M	F	F	F	F	F	F	F	F	M	M	F	M	M
Ministere des finances et du budget	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F		
Ministere de l'Economie et des Finances	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de l'Intérieur							M										
Ministere de l'Intérieur et de la Décentralisation	M	M	M	M	M	F	M	M	M	M	M	M	M	M	M	M	M
Ministere de la Décentralisation							M										
Ministere de la Sécurité Publique.	M	M	M			M		M	M	M	M	M	M	M	M	M	M
Ministere de l'Aménagement du Territoire, de l'Habitat et des Travaux Publics	M	M	M		M			M	M	M	M	M	M	M	F	M	M
Ministre des Travaux Publics et des Infrastructures	M	M	M			M	M				M	M	M	M	M		
Ministere de l'Education Nationale et de l'Enseignement Technique et Professionnel	M	M	M			F	M	M	M	M	M	M	F	F	F	F	F
Ministere de l'Agriculture, de l'Elevage et de la Pêche	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministere de l'elevage						M	M	F	F	F	M	M					
Ministre des Ressources Halieutiques et de la Pêche						M	M	M	M	M	M	M	M	M	M		
Secrétaire d'Etat auprès du Ministre des Ressources Halieutiques et de la Pêche chargé de la Mer													F	F			
Ministere de l'Energie et des Hydrocarbures	M	M	M	M	M	M	M	F	F	F	M	M	M	M	M	M	M
Ministre des Mines				M				F	F	F		M	M	M	F	M	M
Ministere de l'Energie, de l'Eau et des Hydrocarbures				M		M	M	M	M	M							
Ministere de l'Eau, de l'Assainissement et de l'Hygiène					M	M	M	M	M	M	F	F	M	M	M		F
Ministere des Transports, du Tourisme et de la Météorologie	M	M	M	M			M	M	M	M	M	M	M	M	M	M	M
Ministere des Transports.					M			M	M	M							
Ministre des Transports et de la Météorologie	M	M	M	M	M			M	M	M	M		M	M	M		
Ministere du Travail, de l'Emploi, de la Fonction Publique et des Lois Sociales	M	M	M			M	M									F	F
Ministre de la Fonction Publique, de la Réforme de l'Administration, du Travail, de l'Emploi et des Lois Sociales	M	M	M	M				M	M	M	M	M	M	M	M		
Ministre de la Recherche Scientifique pour le Développement	M	M	M														
Ministere de l'Enseignement Supérieur et de la Recherche Scientifique.	M	M	M				M	M	M	M	F	F	F	F	F	F	F
Ministere de l'Industrie, du Commerce et de l'Artisanat	M	M	M													F	F
Ministre de l'Industrie et du Développement du Secteur Privé	M	M	M								M	M	M	M	M		
Ministre du commerce exterieur	M	M	M														
Ministre du Commerce et de la Consommation	M	M	M			M	F	F	F	F	M	M	M	M	F		
Ministere de l'Environnement et du Développement Durable	M	M	M		M											M	F
Ministre de l'Environnement, de l'Ecologie et des Forêts	M	M	M	M		M	M	M	M	M	M	M	F	F	M		
Ministere des Postes, des Télécommunications et du Développement Numérique	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministere de la Population, de la Protection Sociale et de la Promotion de la Femme	M	M	M			F	F	F	F	F	F	F	F	F	F	F	F
Ministre de la Jeunesse et des Loisirs						M	F	M	M	M							
Ministere de la Jeunesse et des Sports	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Ministre de la Culture, de la Promotion de l'Artisanat et de la Sauvegarde du Patrimoine	F	F	F			M	F	F	F	F	F	F	M	M	F		
Ministre des Relations avec les Institutions								M	M	M							
Ministre de la Promotion de l'artisanat								F	F	F							
Ministere de la Communication et de la Culture	M	M	M				F									F	F
Ministre de la Communication et des Relations avec les Institutions	M	M	M			F	M	M	M	M	M	M	M	M	M		
Ministere en charge des villes nouvelles et de l'habitat																	M
Ministre d'Etat chargé des Projets Présidentiels, de l'Aménagement du Territoire et de l'Equipement											M						
Ministre auprès de la Présidence chargé des Ressources Stratégiques											M						
Ministère de la Défense Nationale chargé de la Gendarmerie						M	M	M	M	M	M	M	M	M	M	M	M
Total positions assessed	***32***	***32***	***32***	***18***	***16***	***27***	***31***	***34***	***34***	***34***	***32***	***30***	***31***	***31***	***30***	***23***	***25***
Women leadership	***2***	***2***	***2***	***1***	***2***	***5***	***7***	***9***	***9***	***9***	***6***	***6***	***6***	***7***	***9***	***6***	***8***
Percent with women as leaders	***6%***	***6%***	***6%***	***6%***	***13%***	***19%***	***23%***	***26%***	***26%***	***26%***	***19%***	***20%***	***19%***	***23%***	***30%***	***26%***	***32%***

TABLE 2: GENDER OF LEADERSHIP POSITIONS IN MOPH CENTRAL DIRECTORATES

Organization/Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
MoPH Central Directorates: 58																	
Ministere de la santé	M	M	M	F	M	M	M	F	F	F	M	M	M	M	M	M	M
Vice ministre charge des affaires sociales et de la sante des meres et enfants					F												
Secrétaire Général Ministere de la santé	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Direction générale de la medecine preventive																M	M
Directeur de cabinet					M	M	M	M	M	M	M	M	M	M	M	M	M
DGS					M		M	M	F	F	F	F	F	F	F		
Direction Générale de la Protection Sociale				F	F												
Directeur de la Protection Sociale					M												
Direction de la veille sanitaire, de la surveillance epidemiologique et riposte (DVSSER)						M	M	M	M	M	M	M	M	M	M	M	M
Direction de la lutte contre les maladies transmissibles (DLMT)					M	M	M	M	M	M	M	M	M	M	M	M	M
Programme national de lutte contre le Paludisme PNLP					F	M	M	M	M	M	M	M	M	M	F		
Programme national de lutte contre le SIDA et les IST						M	M	M	M	M	M	M	F	F	F		
Programme national de lutte contre la tuberculose (PNT)						M	M	F	F	F	F	F	M	M	M		
Coordonnateur Général du Bureau Central de Coordination du Ministère de la Santé Publique												M	M	M	M		
Directeur Général des Etablissements Hospitaliers Universitaires	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M		
Institut National de Santé Publique et Communautaire	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Agence de Contrôle de la Sécurité Sanitaire et de la Qualité des Denrées Alimentaires		M	M	M	M	M	M	M	M	M	M		M	M	M	M	M
Unité de Coordination des Projets							M					M	M	M	F	F	M
Direction de la sante familiale (DSFa)	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Direction de la Santé de l'Enfant (DSE)					M	F	F	F	F	F	F	F	M	M	M	F	F
Directeur de la Santé de la Mère et de l'Enfant					M	F	F	F	F	F	F	F	F	F	F	F	F
Direction du programme elargie de vaccination (DPEV)													M	M	F	F	F
Direction generale de la fourniture de soins (DGFS)																M	M
Direction du Système Hospitalier (DSH) :					M	M	M	M	M	M	M	M	M	M			
Direction des hopitaux des regions et des districts (DHRD)	F	F	F									F	F	F	F	F	F
Direction de la pharmacie et des laboratoires et de la medecine traditionnelle (DPLMT)	F	F	F	F	F	M	M	M	M	M	M	M	F	F	F	F	F
Direction des Districts Sanitaires (DDS) :	M	M	M	M	M	F	F	F	F	F	F	F	M	M	M		
Direction des soins de sante de base (DSSB)					M											M	M
Direction de la transfusion sanguine (DTS)	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F	F
Direction des instituts de formation paramedicaux (DIFP)	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Direction generale des ressources (DGR)															M	M	M
Direction des affaires administratives et financieres (DAAF)	M	M	M	M	F	M	M	M	M	M	M	M	F	F	F	F	F
direction des ressources humaines (DRH)	M	M	M	M	M	F	F	F	F	F	F	F	M	M	M	M	M
Direction des Etudes et de la Planification (DEP)	M	M	M	M	M	M	M	F	F	F	F	F	F	F	M		
Direction du Système d'Information (DSI)	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M		
Direction des etudes, de la planification et du Systeme d'Information (DEPSI)															M	F	F
Personnes Responsables des Marchés Publics (PRMP)							M	M	M	M	M	M	F	F	F	F	F
Agence de contrôle de la sécurité sanitaire et de la qualité des denrées alimentaire (ACSQDA)	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Directeur des Urgences et de la Lutte contre les Maladies	F	F	F	F	M	F	F	M	M	M	M	M	M	M	M		
Direction des Centres d'aides médicales d'Urgence de Madagascar								F								M	M
Cellule d'Appui à la Couverture Santé Universelle								M	M	M			F	F	F	F	F
Direction de la Promotion de la Santé	F	F	F	F	F	F	F	F	F	F	F	F	F	F	M	M	M
Directeur de l'Unité d'approvisionnement en Solutés Massifs	F	F	F	F	F	M	M	M	M	M	M	M	M	M	M	M	M
Directeur du Partenariat					F	F	F	F	F	F	F	M	M	M	M		
Directeur de l'office national de lutte anti-tabac	F	F	F	F	F	M	M	M	M	M	M	M	M	M	M	M	M
Directeur de l' Agence National Hospitalier						M	M	M	M	M	M	M	M	M	M		
Directeur de Developpement de Districts Sanitaires	M	M	M	M	M	F	F	F	F	F	F	M	M	M	M		
Directeur de la Mobilisation Sociale, des Relations Publiques et Juridiques de la Caisse Nationale de Solidarité pour la Santé															F		
Directeur du Genre				F	M												
Directeur du Bureau de l'Audit					M	M	M	M	M	M							
Directeur de la Cellule de Suivi Budgétaire						F	F										
Directeur du Suivi-évaluation et de l'audit			F	F	M	M	M										
Direction du Contrôle et de l'audit de la direction nationake de solidarité pour la santé															M	M	M
Direction de la caisse nationale de Solidarité															M	M	M
Direction de lutte contre les maladies non transmissibles								M	M	M	M	M	M	M	F	M	M
Directeur des Urgences et de Lutte contre les Maladies Négligées	M	M	M	M	M	F	F	M	M	M	M						
Observatoire de la Mise aux Normes des Soins											M	M	M	M	M	F	F
Direction Agence du Médicament de Madagascar	M	M	M	M	M	F	F	F	F	F	F	F	F	F	F	F	F
Total positions assessed	***22***	***23***	***24***	***25***	***37***	***36***	***39***	***39***	***38***	***38***	***37***	***38***	***41***	***41***	***45***	***35***	***35***
Women leadership	***8***	***8***	***9***	***11***	***11***	***13***	***13***	***14***	***14***	***14***	***13***	***12***	***13***	***13***	***17***	***15***	***14***
Percent with women as leaders	***36%***	***35%***	***38%***	***44%***	***30%***	***36%***	***33%***	***36%***	***37%***	***37%***	***35%***	***32%***	***32%***	***32%***	***38%***	***43%***	***40%***

TABLE 3: GENDER OF LEADERSHIP POSITIONS IN MOPH SERVICE UNITS AND REGIONAL DIRECTORATES; MOPH SUB-TOTAL

Organization/Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
MoPH Services: 95																	
Total positions assessed																*93*	*95*
Women leadership																*44*	*51*
Percent with women as leaders																*47%*	*54%*
MoPH Regional Directorates: 22																	
DRS Analamanga		F	F	F	F	F	M	M	M	M	M	F	F	F	M	M	M
DRS Atsinanana		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Analanjirofo		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Amoron'i Mania		M	M	M	M	M	M	M	F	F	F	F	F	F	F	F	F
DRS Haute Mahatsiatra		F	F	F	F	F	F	F	F	F	F	M	M	M	M	M	M
DRS Vatovavy fitovinany		M	M	M	M	M	F	F	F	F	F	M	M	M	M	M	M
DRS Atsimo Atsinanana		M	M	M	M	M	M	M	M	M	M	M	M	F	F	M	M
DRS Ihorombe		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Menabe		M	M	M	M	M	M	M	M	M	M	F	F	F	F	M	M
DRS Atsimo Andrefana		M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F
DRS Androy		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Anosy		F	F	M	M	M	M	M	M	M	M	M	M	M	M	F	F
DRS Diana		M	M	M	M	M	M	M	F	F	F	M	M	M	F	F	F
DRS Sava		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Itasy		M	M	M	M	M	M	M	M	M	M	M	M	M	M	F	F
DRS Vakinakaratra		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Bongolava		F	F	M	M	M	M	M	M	M	M	F	F	F	F	M	M
DRS Sofia		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Boeny		M	M	M	M	M	M	M	M	M	M	F	F	F	M	M	M
DRS Betsiboka		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
DRS Melaky		M	M	M	M	M	M	M	M	M	M	F	F	F	M	M	M
DRS Alaotra Mangoro		M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Total positions assessed		*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*	*22*
Women leadership		*4*	*4*	*2*	*2*	*2*	*2*	*2*	*4*	*4*	*4*	*6*	*6*	*7*	*5*	*5*	*5*
Percent with women as leaders		*18%*	*18%*	*9%*	*9%*	*9%*	*9%*	*9%*	*18%*	*18%*	*18%*	*27%*	*27%*	*32%*	*23%*	*23%*	*23%*

Organization/Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
MoPH Subtotal: 175 Units																	
Total positions assessed	*22*	*45*	*46*	*47*	*59*	*58*	*61*	*61*	*60*	*60*	*59*	*60*	*63*	*63*	*67*	*150*	*152*
Women leadership	*8*	*12*	*13*	*13*	*13*	*15*	*15*	*16*	*18*	*18*	*17*	*18*	*19*	*20*	*22*	*64*	*70*
Percent with women as leaders	*36%*	*27%*	*28%*	*28%*	*22%*	*26%*	*25%*	*26%*	*30%*	*30%*	*29%*	*30%*	*30%*	*32%*	*33%*	*43%*	*46%*

TABLE 4: GENDER OF LEADERSHIP POSITIONS IN PUBLIC HOSPITALS; RESEARCH AND ACADEMIC INSTITUTIONS; NGOS, DONORS AND INTERNATIONAL ORGANIZATIONS

Organization/Unit	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hospitals: 8																	
Centre Hospitalier Universitaire gynecologie et obstetrique Befelatanana	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Centre Hospitalier Universitaire Joseph Ravoangy Andrianavalona	M	F	F	F	M	M	M	M	M	M	M	M	M	F	F	F	F
Centre Hospitalier de Soavinandriana	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Centre Hospitalier Universitaire Joseph Raseta Befelatanana	F	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Centre hospitalier Mere enfant Ambohimiandra	F	F	F	F	F	F	F	F	F	M	M	M	M	M	M	M	M
Centre Hospitalier mere enfant Tsaralalana	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Centre Hospitalier Universitaire Anosiala												M	M	M	M	M	M
Centre Hospitalier Universitaire Andohatapenaka											M	M	M	M	M	M	M
Total positions assessed	***6***	***6***	***6***	***6***	***6***	***6***	***6***	***6***	***6***	***6***	***7***	***8***	***8***	***8***	***8***	***8***	***8***
Women leadership	***3***	***3***	***3***	***3***	***2***	***2***	***2***	***2***	***2***	***1***	***1***	***1***	***1***	***2***	***2***	***2***	***2***
Percent with women as leaders	***50%***	***50%***	***50%***	***50%***	***33%***	***33%***	***33%***	***33%***	***33%***	***17%***	***14%***	***13%***	***13%***	***25%***	***25%***	***25%***	***25%***
Research Institutions: 2 (3 positions)																	
Institut National de la sante publique et Communautaire (INSPC)	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Institut Pasteur de Madagascar , Directeur General	M	M	M	M	M	F	F	M	M	M	M	M	F	M	M	M	M
Institut Pasteur de Madagascar , Directeur scientifique												F	F	F	F	F	F
Academic Institutions: 3																	
Universite d'Antananarivo, Faculte de medecine	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	F
Institut National de la sante publique et Communautaire (INSPC)	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Institut de formation des paramedicaux													F				
Total positions assessed	***4***	***4***	***4***	***4***	***4***	***4***	***4***	***4***	***4***	***4***	***4***	***5***	***6***	***5***	***5***	***5***	***5***
Women leadership	***0***	***0***	***0***	***0***	***0***	***1***	***1***	***0***	***0***	***0***	***0***	***1***	***3***	***1***	***1***	***1***	***2***
Percent with women as leaders	***0%***	***0%***	***0%***	***0%***	***0%***	***25%***	***25%***	***0%***	***0%***	***0%***	***0%***	***20%***	***50%***	***20%***	***20%***	***20%***	***40%***
NGOs, International Organizations, Donors: 11 (15 positions)																	
Population services International Madagascar , COP	M	M	M	M	M												M
Population services International Madagascar , DCOP	M	M	M	M	M	M											M
Marie stoppes Madagascar, COP			M	M	M	M	M	M	M	M	F	F	F	F	F	F	F
Croix rouge Malagasy, Président National			M	M	M	M	M	M	M	M	M	M	M	M	M	F	F
Croix rouge Malagasy, Secrétaire Général			M	M	M	M	M	M	M	M	M	M	M	M	M	F	F
CRS, COP											M	M	M	M	M	M	F
Management Science of Health (MSH) , COP										M	M	M	M	M	M		M
Management Science of Health (MSH) , DCOP										M	M	M	M	M	M		F
John Snow Inc (JSI) Research & Training Institute Inc./Community-Based Integrated Health Program (2011-2016) and Community Capacity for Health Program 92016 – 2021), COP								F	F	F	F	F	F	F	F	F	F
John Snow Inc (JSI) Research & Training Institute Inc./Community-Based Integrated Health Program (2011-2016) and Community Capacity for Health Program 92016 – 2021), DCOP								F	F	F	F	F	F	F	M	M	M
Care International , COP					M	M	M	M	M	M	M	F	M	M	M	M	M
FISA/IPPF, Directeur Executif	M	M	M	F	F	F	F	F	F	F	F	F	F	F	F	F	F
WHO, Représentant					F	F	F	F	F	F	F	F	F	F	F	F	F
UNAIDS, Représentant								F	F	F	F	M	M	M	M	M	M
UNFPA, Représentant					M	M	M	M	F	F	F	M	M	M	M	M	M
Total positions assessed	***3***	***3***	***6***	***6***	***9***	***8***	***7***	***10***	***10***	***12***	***13***	***13***	***13***	***13***	***13***	***11***	***15***
Women leadership	***0***	***0***	***0***	***1***	***2***	***2***	***2***	***5***	***6***	***6***	***7***	***6***	***5***	***5***	***4***	***6***	***8***
Percent with women as leaders	***0%***	***0%***	***0%***	***17%***	***22%***	***25%***	***29%***	***50%***	***60%***	***50%***	***54%***	***46%***	***38%***	***38%***	***31%***	***55%***	***53%***

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 service 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 service 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:

Age (check applicable range)		Sex (check applicable box)		In what type of institution do you work? (private sector, public sector, academia, NGO)	What is your current role?	How long have you been in this role? (in years)
<20y						
20-30y		Female				
30-40y		Male				
40-50y						
>50y						

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 service sectors.

1. Are you familiar with any such initiatives implemented in Madagascar?

   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[28]
   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 service 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 positions 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 service sectors** in Madagascar 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)

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 service 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.

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

Yrogerette, a community health worker, with father-to-be Ratolojanahary at a health center in Miandrivazo, Madagascar. Image by Karen Kasmauski, MCSP.

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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 curricula relevant to students' future patients. This objective also addresses the 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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