WomenLift Health

Stakeholder Analysis Report: Nigeria

Advancing Women's Leadership in Health

Nextier

Nigeria Stakeholder Analysis Project Report

WomenLift Health | BIXAL | Nextier

Contents

Acronyms

CEO	Chief Executive Officer
DEI	Diversity, Equity, and Inclusion
FCDO	Foreign, Commonwealth and Development Office
FMOH	Federal Ministry of Health
FMWSD	Federal Ministry of Women and Social Development
GESI	Gender Equality and Social Inclusion
GEESI	Gender Equality, Empowerment of Women and Social Inclusion
INGO	International Non-Governmental Association
LNGO	Local Non-Governmental Association
MWAN	Medical Women's Association of Nigeria
NGOs	Non-Governmental Associations
SDGs	Sustainable Development Goals
UN	United Nations
USA	United States of America
USAID	United States Agency for International Development

Executive Summary

Introduction

In Nigeria, women are underrepresented in senior leadership roles despite dominating the health workforce.[1] Men occupy most decision-making positions in a system that has kept women on the sidelines of leadership for decades.[1] This gender disparity in leadership is not limited to the health sector. Women are also underrepresented in political leadership and other areas.[1] The barriers to women's leadership in Nigeria's public health organizations abound and arise from individual, societal, cultural, religious, and organizational factors. Gender disparity in health sector leadership impacts health outcomes.[2] Therefore, stakeholders must identify critical barriers to gender parity in leadership and explore opportunities to increase the proportion of women in senior leadership roles in the health sector.

WomenLift Health Nigeria Stakeholder Analysis

Since its inception, WomenLift Health has spearheaded efforts to reduce gender disparity in health sector leadership in different countries and regions through advocacy, stakeholder engagement, capacity development and the implementation of contextually appropriate interventions. With the recent expansion of its programs beyond the USA to India and East Africa, WomenLift Health commissioned Nextier to conduct a stakeholder analysis of Nigeria's health sector. The project's main objectives were to identify key health sector stakeholders and organizations, determine barriers to gender parity in health sector leadership, and explore opportunities for WomenLift Health to design tailored interventions for Nigeria. These objectives aim to increase the collaborative implementation of programs to reduce the gender disparity in health sector leadership.

Methodology

The Nextier project team identified key stakeholders and organizations, reviewed existing grey and peer-reviewed literature, conducted fifty-six (56) interviews, and hosted a focus group discussion with 12 participants. The team purposively sampled interview and focus group discussion participants across seven sectors: government, international non-governmental organizations (INGOs), local non-governmental organizations (LNGOs), multilateral organizations, philanthropies, private sector organizations and academia. The interview and focus group discussion recordings were transcribed and thematically analyzed. The project team triangulated data from the different engagement methods to provide answers to the key research questions.

Barriers to Women's Leadership

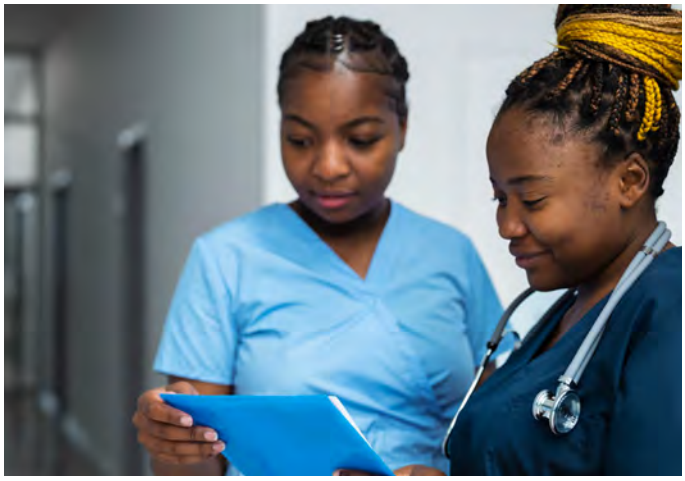
The stakeholder analysis identified several barriers to women's leadership in Nigeria's health sector. These barriers include limited opportunities for girl-child education and advancement, societal norms and gender stereotypes, inadequate enabling resources, poor implementation of enabling policies, and considerations of family obligations or responsibilities. Other barriers identified include male dominance of health sector systems, unfavorable workplace practices, gender bias, limited mentorship or professional support, female workplace rivalry and personal barriers linked to women's backgrounds, upbringing, and personalities.

Opportunities to Advance Women's Leadership

Several opportunities (policies and programs) exist to advance women's leadership in Nigeria's health sector. These opportunities include the availability of senior-level women leaders interested in mentoring others, ongoing advocacy by women's professional groups, notable male champions of women's leadership, gender-centered policies, and continuous efforts of multiple stakeholders to address societal stereotypes and harmful gender norms. Another indicator of a positive milieu is women's enthusiasm to collaborate with WomenLift Health to advance gender parity. Furthermore, several organizations have women's mentorship programs and flexible work arrangements to ensure work-life balance. Some of these organizations also provide workplace amenities that support women's aspiration for senior leadership roles in Nigeria's public health organizations.

Recommendations for WomenLift Health Programming in Nigeria

The study participants made several recommendations for WomenLift Health programming in Nigeria. These recommendations and possible collaboration points include broad stakeholder engagement to improve policies, design diversity, equity and inclusion (DEI) evaluation metrics, and address negative stereotypes and norms. Other suggestions are that WomenLift Health leverages existing professional groups to advance advocacy efforts, design and implement a leadership training program, and organize periodic engagements for women, including a conference with fellowship and mentorship opportunities. The engagement should feature prominent health sector personalities who are leading 'champions of women's leadership' as an advocacy initiative. Furthermore, there is a need for a program that targets high school and female university students for early development of their leadership qualities. The program should also advocate for girl-child education. Given the relative lack of data on women's leadership in the health sector, further research is necessary to help advocacy efforts and to track progress.



Conclusion

The WomenLift Health Stakeholder Analysis project outlines the key issues and opportunities which can change the status quo and advance gender parity in Nigeria's health sector leadership. The study participants were excited about WomenLift Health's interest in Nigeria. They expressed their interest in collaborating with WomenLift Health to address existing barriers and leverage the opportunities to increase the critical mass of women occupying senior leadership positions in Nigeria's public health organizations. While the recommendations of this report are not exhaustive, they provide valuable insights and a preliminary roadmap for WomenLift Health programs and interventions in Nigeria.

Introduction

Established in 2019, WomenLift Health is committed to expanding the power and influence of talented women in global health and catalyzing systemic change to achieve gender equality in health leadership. With Hubs in East Africa, North America, South Asia, Southern Africa, and with plans for further expansion into other regions, WomenLift Health envisions a world where diverse, accomplished leaders collectively transform health outcomes..

WomenLift Health implements a portfolio of interventions that reinforce transformative change and that ripple out to reach an increasing number of women and men. One core intervention is the Leadership Journey, designed to give talented women leaders the tools – confidence, networks, and understanding of barriers – along with peers, mentors, and coaching to use their voice, expertise, and leadership skills for health impact.

WomenLift Health's programs and interventions focus on stimulating organizational and societal level changes and addressing barriers for women to attain senior and executive leadership positions in global health at organizational and country levels. WomenLift Health's strategies to drive the desired change are the engagement and convening of thousands of women and men to address contemporary issues limiting women's ascent to senior leadership positions. WomenLift Health disseminates the key discussion points and recommendations from these stakeholder engagements and convenings through its Speaker Series and Women Leaders in Global Health Conference.

To inform the expansion of the Leadership Journey, WomenLift Health has partnered with Nextier to undertake a Stakeholder Analysis within Nigeria to ensure the inclusion of local voices into its program design. Nextier is a public sector advisory firm committed to solving Africa's development challenges. The firm has competencies in policy research, analysis and advocacy, project and stakeholder management, monitoring and evaluation, program implementation and impact assessment. Leveraging its technical experts and extensive network, Nextier convenes senior leaders in government, academia, and the private and development sectors to co-create and implement solutions for health, governance, investment promotion, public finance, energy, security, and development.

WomenLift will use the findings and recommendations outlined below to build a network of partners, identify best practices and inform key priorities for the upcoming and future cohorts of the Leadership Journey.

Background

Globally, the movement for increased representation of women in leadership has been on the rise, with civil society organizations and young feminists championing gender parity in leadership.[3] The gender disparity in leadership transcends sectors, including the global health space – where it impacts health outcomes.[2] The drive to increase women's representation in leadership is connected to Target 5.5 of the Sustainable Development Goals (SDG), which seeks equal opportunities for the full and effective participation of women in leadership at all levels of decision-making.[4] The goal of gender equality and equal opportunities for leadership in the health sector remains elusive globally, as women account for barely 25 percent of senior and 5 percent of top management positions in global health organizations, despite comprising about 70 percent of the health workforce.[5] The barriers to women's ascent to senior leadership in public health are linked to individual, organizational and societal factors, whose manifestation varies across cultural contexts.[6] These barriers are compounded by gender-related biases, such as higher work standards for women, perception of women as aggressive, and gender pay disparities.[6]

Female leadership has led to tangible improvement in policy implementation and health programs, particularly bettering outcomes for women and children.[2] Recently, countries with female political leaders managed the COVID-19 pandemic better, recording six times fewer COVID-19-related deaths than countries with male political leaders. Furthermore, female political leaders acted quickly and more decisively than their male counterparts in the COVID-19 pandemic response.[7] These findings correspond with the results of a McKinsey study which demonstrated that the presence of women in company top management strongly correlated with better financial and operating outcomes.[8]

With evidence showing that women's leadership positively impacts health outcomes, there are likely to be significant improvements in health indices if more women are at the helm of affairs in the health sector.

Women's Leadership in the Nigerian Context

Women's Leadership in the Nigerian Context

In Nigeria's health sector, women are under-represented in leadership positions and have a slower ascent into senior leadership roles than their male counterparts.[1] This is ironic since women constitute about 50 per cent (108 million) of the 2022 estimated population of over 216 million.[9] Nigerian society is patriarchal, with some cultural and religious practices entrenching male domination and women's marginalization.[10,11] The existing patriarchal leaning was not prominent in the pre-colonial era, as prominent female leaders in different parts of Nigeria, such as Queen Amina of Zaria and Madam Efunroye Tinubu of Lagos, successfully led men and women alike.[11] With the colonial incursion in 1884, patriarchy gradually grew with changes to traditions and practices influenced by the colonialists.[11] This patriarchy has remained the norm, with women consequently denied leadership positions or having herculean hurdles before occupying top-management positions.[11] Although the preceding points suggest the likely existence of a pre-patriarchal utopia, some scholars opine that most pre-modern societies were patriarchal, with men dominating and controlling political, economic and religious power.[12]

In Nigeria, the gender equity gap is longstanding and affected by cultural and societal norms and gender stereotypes. From birth, males are the preferred gender, leading to their prioritization for access to several socioeconomic necessities, including education, inheritance and employment.[13,14] Socialized to play second fiddle to men, many women accept the societal norm that leadership is the exclusive reserve of men.[1] This norm limits the leadership aspirations of many women, making them take their place as 'the led'. As a result, there is low participation of women in political leadership. For example, Nigeria has never had an elected female governor, with only a handful of women emerging as deputy governors and legislators.

The trend of low female representation in leadership persists to date. Women constituted barely 6 per cent in the Nigerian Senate and House of Representatives with male to female ratio of 102:7 and 338:22, respectively, as of 2021.[15] Some of the barriers to women's participation in political leadership include the relatively low proportion of women with leadership aspirations, electoral violence, unfavorable schedules for political meetings, and male dominance in political parties.[16,17] Furthermore, evaluating women's leadership capacity using the same metrics as men pose a barrier to women's leadership.[16] These undifferentiated evaluation metrics (such as availability for impromptu travels and late-night meetings) put women at a disadvantage, not considering their peculiar responsibilities, gender roles and biological difference.[1]

The patriarchal positioning of Nigerian society has continued to limit opportunities for women's leadership.[1] Although the 2021 National Gender Policy recommends gender equality in public service, elective offices and political appointments[18], it lacks the structures and processes for its effective implementation.[19] In 2022, the National assembly rejected five proposed bills that sought to increase women's participation in politics and leadership.[20] This situation indicates that attaining gender parity in leadership within the political space and other sectors, such as health, remains arduous.

Women's Leadership in Health

Women's Leadership in Health

Only a handful of literature was found specific to women's leadership in health. However, the findings from the albeit limited literature indicate that gender disparity in leadership is also a challenge in Nigeria's health sector. Gender disparity exists across government ministries, medical training institutions, multilateral organizations, and non-governmental organizations. For example, only a handful of women have been appointed as provosts or chief executive officers (CEOs) of medical training institutions and tertiary health organizations.[1] Gender disparity is also evident in the National Council of Health – the highest decision-making body in the Nigeria's health sector – which in 2022 had only 11 per cent of members as women.[1] Women's representation in Nigeria's health sector leadership positions is incongruent with their representation in the sector. For example, the 2018 Nigeria Health Workforce Profile indicates that women constitute 35 per cent of medical doctors, 44 per cent of dentists, 87 per cent of nurses/midwives, 52 per cent of Optometrists and 70 per cent of Dental Surgery Technicians.[21]

Findings from a recently conducted USAID Gender Equality and Social Inclusion (GESI) Analysis indicated that men occupied most of the leadership positions in the health sector, with women underrepresented in decision-making positions, although the latter dominate the workforce.[20] The USAID GESI study reported that as of 2020, only 5 of the 36 commissioners of health in Nigeria were female. The report also showed that some organizations reserved certain leadership positions for women in line with societal norms and perceptions about jobs suited for women, resulting in women often occupying positions such as Director of Maternal and Child Health and Director of Family Planning in government ministries.[22]

Although the gender disparity in health sector leadership persists, there has been some improvement in recent years. For example, a 2017 study found that over the prior decade, there was a significant increase in the proportion of women holding executive positions in academic dentistry, despite the higher proportion of male residents and lecturers.[23]

Barriers in Women's Leadership in Health

Barriers In Women's Leadership in Health

Some barriers to women's leadership in the health sector stem from the patriarchal nature of Nigerian society and the inherent sociocultural norms. Women face gender bias, discrimination, and sexual harassment in the workplace and lose opportunities on the presumption that they are 'weaker' than their male contemporaries.[1,24] Pregnancy, childbirth, and family responsibilities linked to home building often stunt women's ascent to leadership positions. Other barriers to women's leadership and managerial aspiration include low self-esteem, imposter syndrome, and gender stereotypes.[25] The absence or inadequacy of support networks and professional mentorship for women also makes it difficult for them to climb the leadership ladder in the health sector.[1] Also, some women are held back by internal factors such as a lack of self-confidence and low personal motivation.[24]

Across Nigeria, but particularly in northern parts, many girls are out-of-school, with a high tendency to become 'child brides'. Nigeria accounts for the highest number of child brides in Africa.[26] Figure 1 below shows the disparity in education between women in northern and southern parts of Nigeria. While Lagos in southern Nigeria has the highest proportion of women with at least a secondary education (65 per cent), Sokoto State in northern Nigeria has only 5 per cent of women educated to at least a secondary level.[27] Furthermore, data from the World Bank showed that more adult men (71 per cent) were literate.[28] In contrast, the female adult literacy rate was 53 per cent in 2018.[29] This disparity in access to education and opportunities for women puts them at a disadvantage, giving their male counterparts an edge for leadership positions

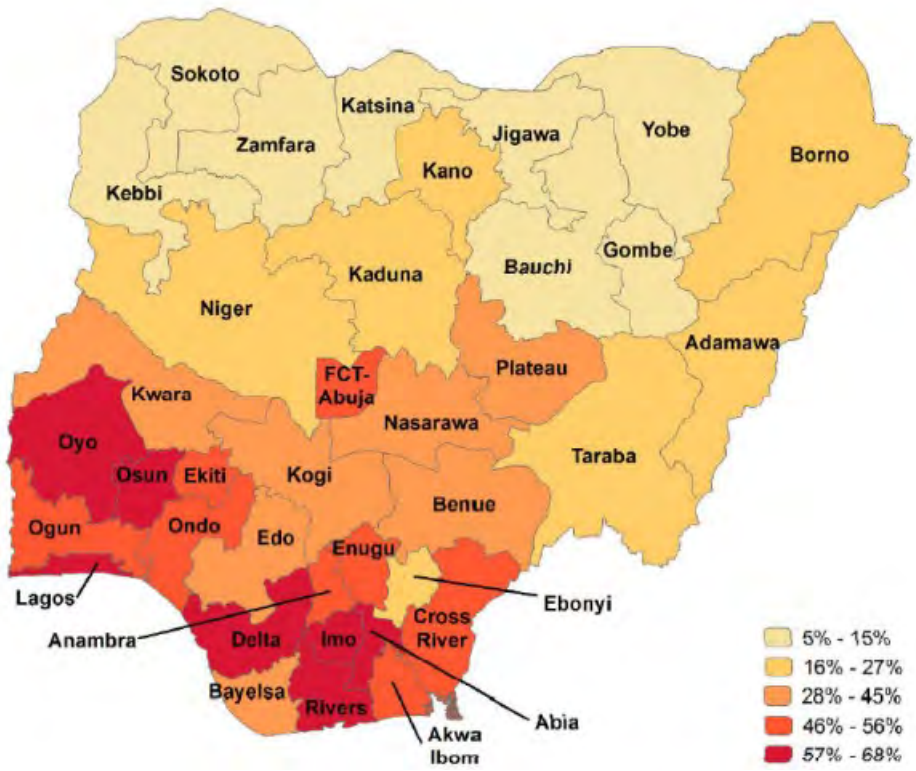


Figure 1. Percentage of women aged 15-49 with secondary education or higher[27]

Facilitating Women's Leadership in Health

Facilitating Women's Leadership in Health

Despite existing barriers to women's leadership in the health sector, recent developments could facilitate women's leadership in the health sector. A federal high court recently mandated the Federal Government of Nigeria to implement the provision of the 2021 National Gender Policy, which stipulates that women should receive 35 per cent of all political appointments in Nigeria.[30] States, such as Ekiti, Kaduna, Lagos, and Oyo, have reviewed their public services guidelines to give women six months of paid maternity leave.[31] At the same time, the federal government recently approved four months of paid maternity leave.[32]

The emergence of advocacy groups and professional coalitions that provide peer support and mentorship for women may be the game-changer that accelerates women's representation in health sector leadership. The Medical Women Association of Nigeria (MWAN) and the Women in Global Health are prominent among such organizations. The Women in Global Health established a Nigerian chapter in 2020 and has advocated for reduced gender inequities in the health sector. MWAN has a nationwide spread and provides mentorship and support for women health leaders, including opportunities for publishing through its peer-reviewed journal. With help from UN Women, the Federal Ministry of Women and Social Development championed the HeForShe movement. This global solidarity campaign engages boys and men to support advancing gender equity. In 2017, the Vice President of Nigeria launched the HeForShe advocacy campaign, established in at least 11 states across Nigeria, with the movement helping to raise male allies for gender equality in Nigeria.[33]

Advancing Women's Leadership in Health

Advancing Women's Leadership in Health

The government of Nigeria and its partners must make concerted efforts to advance women's leadership in the health sector. These efforts should address identified barriers and support facilitators of women's leadership at individual, organizational, and societal levels.[6] Targeted advocacy is needed to challenge the patriarchal status quo in Nigerian society, encourage men to support the movement for gender parity, and showcase the positive impact of increased participation of women in decision-making within the health sector. Nigeria must formulate and implement policies that address discrimination against women in the workplace and provide opportunities for girls to be educated and mentored to become women leaders.

It is also crucial for women to continue to support and mentor each other through platforms like Women in Global Health and MWAN.[1] Nigeria needs more women empowerment programs and should institutionalize the policies that provide quotas for women's representation in leadership positions.[10] Furthermore, strategies like training women, reviewing organizational processes, gender mainstreaming and contextualizing gendered solutions to the traditional, cultural, and religious context[6] have the potential to fast-track the attainment of gender equality in Nigeria. Not-for-profit organizations like WomenLift Health can collaborate with local organizations to drive advocacy efforts, engage stakeholders, and support policy formulation and program implementation.

Study Design

In Nigeria, gender disparity in health sector leadership remains a contemporary challenge influenced by varying organizational and sociocultural factors. Although the barriers to advancing women's leadership in the health sector may appear insurmountable, some facilitators have the potential to fast-track the attainment of gender parity in health sector leadership.

Developing strategies to advance women's leadership in health sector organizations requires a clear understanding of its critical determinants. To this end, WomenLift Health engaged Nextier to conduct a Stakeholder Analysis to gain insights into the determinants that influence women's leadership in Nigeria.

WomenLift Health envisioned that the Nigeria Stakeholder Analysis team would:

1. Conduct a desk review and analysis of existing data on women's representation in the public health sector.

2. Identify and engage critical stakeholders in influential public health organizations to establish relationships and gain insights into the current realities concerning women's leadership in the public health space.

3. Draw upon the collective experiences of stakeholders and organizations to identify barriers and opportunities around women's leadership in public health.

4. Understand current efforts to foster women's leadership, diversity, and inclusion within organizations.

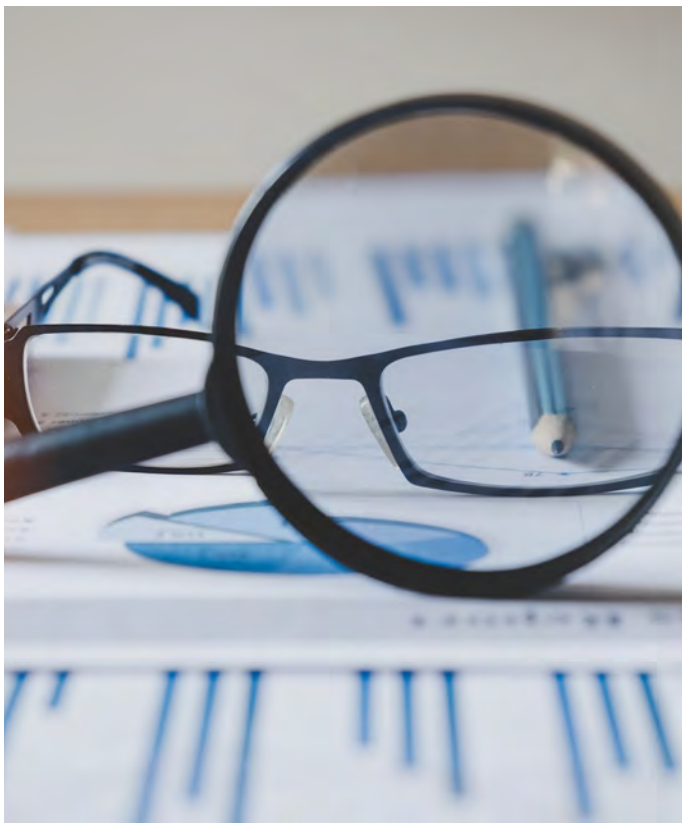
5. Curate recommendations on strategies to increase the proportion of women in senior health sector leadership positions and outline opportunities for collaboration between WomenLift Health and stakeholders/organizations to inform program design.

The Nigeria Stakeholder Analysis project addressed three research questions:

i. What barriers and opportunities exist around women's leadership in public health to address in the program design?

ii. What current efforts foster women's leadership, diversity, and inclusion within organizations?

iii. What are the various ways that organizations and the WomenLift Health program may work together?



The WomenLift Health, Bixal, and Nextier team jointly designed a methodological approach to meet the research objectives and robustly answer the research questions.

Methodology

The conduct of the Stakeholder Analysis involved mixed qualitative methods, a desk review, interviews, and a focus group discussion. Before the commencement of the project, Nextier sought and obtained ethical approval from the National Health Research Ethics Committee with research ethics approval number - NHREC/01/01/2007-10/10/2022.

At the start of the project, the research team mapped and developed a long list of influential organizations, which the team subsequently pruned to a shortlist of organizations. The team selected participants for the interview and focus group discussions from the shortlist. The list of organizations cuts across seven sectors: government, academia, local NGOs, international NGOs, philanthropy, multilateral organizations, and the private sector. The team purposively sampled 2-3 influential stakeholders at mid-career and senior management levels in each shortlisted organization. The researchers ensured an even geographical spread of sampled organizations and stakeholders. The sample covered all geopolitical zones to enable the identification of any differences across regions. The team contacted sampled stakeholders via physical letters,

emails, and phone calls. In addition, the team gave sampled participants all the project details for their voluntary participation. Following confirmation of participation, the team scheduled interviews at the participant's convenience. At the end of the interviews, the project team conducted a focus group discussion to augment the interviews and seek new insights or possible consensus and validation of the interview findings.

The target number of participants for the interviews and the focus group discussion were 70 and 12, respectively. The team contacted 100 potential participants for the interviews but conducted 56 interviews. Twelve potential participants responded but could not make it for the interviews, while 32 persons did not respond. The overall response rate for interviews was 78 per cent. Furthermore, the team contacted 20 participants for the focus group discussion and 12 persons subsequently participated. The response rate for the focus group discussion was 60 per cent.

A summary of the different methods used for the project is detailed below:

a. **Desk Review:** The research team screened multiple databases and the websites of relevant organizations for peer-reviewed and grey literature using keywords combined via Boolean operators. Furthermore, the principal researcher screened the titles and abstracts of the retrieved articles, reviewed the relevant ones and snowballed the reference list of retrieved articles to identify further relevant articles. Then, the project team curated the findings from the literature review to provide answers to the research question.

b. **Interviews:** Using a semi-structured interview guide, the research team conducted 56 virtual interviews with participants from different sectors. Fifty-three of the interview participants were women, while the other three participants were men. Each interview lasted about 60 minutes. The interviews were recorded and then transcribed for analysis. Although the team did not conduct the target 70 interviews, the data obtained had reached saturation; hence, there was no need for further interviews.

c. **Focus Group Discussion:** The research team hosted a virtual focus group discussion with 12 participants. The engagement lasted for 120 minutes. The focus group discussion was recorded and then transcribed for analysis.

Table 1 below outlines the sectoral distribution of the interview and focus group discussion participants.

	SECTOR	INTERVIEWS	FOCUS GROUP DISCUSSION
1	Government	12	3
2	Universities/Academia	6	1
3	Local NGOs	15	3
4	International NGOs	10	2
5	Multilateral Organizations	4	2
6	Philanthropy	2	-
7	Private Sector	7	1
	TOTAL	**56**	**12**

Table 1. Sectoral Distribution of interview and focus group discussion participants

Data Analysis

The research analysts reviewed interview transcripts for accuracy, conducted a preliminary thematic analysis, and shared the transcripts and the initial codes with the project management team. The principal investigator developed a codebook for thematic analysis, and two project team members analysed each transcript. The transcript texts were managed and coded on NVivo 12. Subsequently, the principal investigator created themes based on the identified codes. The principal investigator also thematically analyzed the focus group discussion transcript. Finally, the research team triangulated the findings from the desk review, interviews and focus group discussion and utilized them to answer the research questions.

All research analysts involved in the project were given refresher training on interviewing and thematic analysis before the project commenced. The activity aimed to increase the rigour and quality of the data collection and analysis. Additionally, the codebook was developed based on preliminary coding by four research team members. Subsequently, two senior members of the project team coded each transcript.

Challenges Encountered

Despite efforts to ensure the rigor of the project methodology, the research team encountered a few limitations highlighted below.

a. The team encountered challenges in obtaining timely feedback from potential participants. To mitigate this challenge, the research team sent out more invitations to increase the likelihood of getting a sizable number of participants. This intervention enabled the team to achieve a 78 per cent response rate.

b. The sample of participants was less varied than planned because few participants from specific sectors responded to the invitation to participate. Specifically, philanthropy and multilateral organizations had the least number of participants.

c. Similarly, only some participants from northern Nigeria were represented in the sample. This is because there were fewer women from northern Nigeria who were occupying leadership positions in public health organizations. The research team mitigated this by including organizations with women from northern Nigeria even, though such organizations may not have been included in the original sample.

d. The project focused on mid-career and senior executive-level women. However, the classification of participants' seniority or career level was dissimilar as the organizations explored had varying approaches to placing staff in career and leadership positions.

The project management team mitigated the challenges encountered using strategies outlined in **Table 2** below.

S. No	CHALLENGES	MITIGATION STRATEGY
1.	Initial low participant response rate	• The team increased the number of participants sampled and contacted to increase the potential number of responses.
2.	Getting stakeholders from some sectors and regions to participate in the interviews was difficult.	• The study team made more efforts to get participants from under-represented sectors and regions
3.	Difficulty scheduling interviews	• Constant follow-up via emails and calls • Scheduling interviews at the convenience of participants.
4.	Varying approaches to seniority and career-level placement across organizations	• The determination of career level for participants was handled differently for each organization and not strictly based on years of experience in the public health space.

Table 2. Challenges encountered and mitigation strategies employed.

Findings

Findings

The findings from the stakeholder analysis study are based on the triangulated data from the desk review, focus group discussion and interviews. The answers to each of the project questions are detailed below.

Barriers and Opportunities Around Women's Leadership

The project identified the barriers that impede women's ascent to senior-level leadership and the opportunities that can be leveraged to increase the proportion of women in top management positions in Nigeria's public health organizations. Although many of these barriers are linked to women's leadership in the health sector, they also apply more broadly to women's leadership in politics and other sectors.

A. Barriers

A1. National/Societal Barriers

A1a. Limited Opportunities for Girl-child Education and Advancement

There is a considerable gender gap in access to education and advancement opportunities from childhood, with male children prioritized over their female counterparts. This gap is not unconnected to the patriarchal nature of Nigerian society. Furthermore, girl-child marriage is another barrier that reduces girls' likelihood of evolving into women leaders in the health sector. Most child brides are not likely to receive tertiary education, which is a crucial factor determining suitability for health sector leadership. Although a nationwide barrier, this limited access to education and other opportunities is more predominant in northern Nigeria. Overall, this barrier limits the potential for girls to become educated women with the required skills to assume leadership positions.

> *....in a population where about 75 per cent of persons live on less than $1 a day, most families when they have to prioritize people for education, they want to prioritize the male child.*
>
> **– Mid-level participant working with a LNGO**

Some families believe funds should be put towards male education rather than women's education. And so, you find out that some men are much more educated. If you look at the indices, you may even find out that the field activities are mostly carried out by women, women with lower educational levels, and who have more ability to penetrate households to carry out projects as there are limitations to men. And over time, people just tend to believe that's the job for the woman, while the higher roles are the job for the men.

- Senior-level participant working with an INGO

So, I think a lot of work has to do with working on the girl child. Right? Making sure the girl child understands that irrespective of her gender, she can take up any position.

– Senior-level participant working with a LNGO

To me, I think probably if we start from the basics to say, when you look at different parts of Nigeria, for instance, what proportion of the girl child goes to school, first of all? Because you need to get the education. And you see that of course it differs in different geopolitical zones, but you know, obviously it is worse in the northern geopolitical zone. So, a female child that is born is already disenfranchised for being female. She most likely may not have opportunities to go to school to even build the capacity for us to say: 'okay, let us provide, let us give her opportunities for leadership

– Senior-level Male participant working in a LNGO

A1b. Societal Norms and Gender Stereotypes

Society norms and gender stereotypes significantly hinder women's leadership in public health organizations. The study findings suggest a societal acceptance that women are not supposed to be leaders but followers whose primary responsibility should be caring for and nurturing their families. The societal norm that women should not be outspoken, visible, loud, or noticeable has conditioned many women and girls to accept that they can't be leaders.

Gender stereotyping also influences people's perception of the ideal leader'. These stereotypes put women at a disadvantage as they primarily generate societal bias against women's capacity and suitability for leadership. This barrier is strongly linked to religious and cultural beliefs and the patriarchal nature of Nigerian society. The study revealed that some women have had to shelve their leadership ambitions due to spousal objections linked to expected family responsibilities or the mindset that wives should not be more successful than their husbands.

One of the reasons why I haven't done a PhD is because when I had thought of doing it a couple of years back, my dad and my husband called and sat me down and said come. I mean, you have a first degree in medicine, we spent so many years doing that, then you have two master's degrees, and you're working full time. Don't you think you should rest? For a woman you have tried. Do you really need that PhD? Meanwhile, your husband doesn't have a PhD yet. You're not competing. So, I am like, okay, so I have to soft pedal.

– Senior-level participant working in Government

Nigeria is a patriarchal society, and so generally, within the society, women tend to believe their role is in being subservient to the men. And I think that generally, that sort of affects the woman's courage, ambition and drive to go for higher roles or higher responsibilities. It affects not only the women but also men. Certain genders are expected to perform higher responsibilities: men are expected to take on higher responsibilities. The women are expected to serve. And that also generally affects the culture at work where you have a man and a woman due for promotion. I've been in conversations, and I've heard people say: This young lady is going to be taken care of by a man eventually. So, since they're both fit and both qualified, why don't we push the man forward? He has a stronger voice, a stronger tone. He'll be a better leader than putting a woman there. She would have to struggle.

– Mid-level participant working in an INGO

In the nursing and midwifery cadres, we have more women than men. In fact, we can say 85 per cent of professionals are women. In Nigeria and equally in Africa, women shouldn't be seen or heard. The women should be in the background. So, despite a large number of women, they hardly allow women to come into leadership positions.

– Mid-level participant working with a LNGO

At the individual level, in Nigeria, for example, we are raised as women to aspire to be nothing, but to be somebody's wife and to be a good mother and to end up being a grandmother like that's our achievement in life. So, it's already built into your brain growing up as a young girl that if you have not achieved that, you have not attained success. Even if you acquire all the degrees in this world and you're not married, or you are a single mother, or you choose not to be married. And so in and of itself, I've seen that as a barrier for many women where either they don't pursue more advanced opportunities because they want to retain a relationship and make sure it leads to marriage. And so, you see a lot of women naturally self-selecting. We don't go for more advanced educational opportunities.

– Mid-level participant working in an INGO

Women are raised not to speak unless they're called upon to speak. Women are raised to wait their turn. A woman who is very vocal is often considered disrespectful or misconstrued as thinking she knows it all, but a man who speaks his mind and even sometimes shuts people down is considered strong and commanding respect. I've seen this play out all the time. A lot of times you go to meetings, and people are just dismissive of women who want to speak or don't even create that room for women to voice their opinion

-Mid-level participant working with an INGO

Africa is a chauvinistic society dominated by men, and this affects women stepping into leadership roles.

- Senior-level Male participant working with an INGO

Culture also tells women not to argue with men, and this sometimes shows up in the workplace as women not advocating for themselves in the workplace.

- Senior-level Male participant working with an INGO

A1c. Inadequacy of Enabling Resources

The study findings show that the non-availability or inadequacy of enabling resources for leadership is another barrier that puts women at a disadvantage in the quest for health sector leadership. These enabling resources which are inadequate or unavailable include peer-to-peer mentorship, professional networks, and finances to pay for further academic or professional development programs. Furthermore, some women are unaware of the critical qualities and technical competencies required for leadership. This unawareness makes it less likely for such women to increase their potential for leadership. The absence or inadequacy of enabling resources reduces the proportion of women with the academic, professional, and social skills needed for senior executive leadership positions, thus cascading into the existing gender disparity in health sector leadership.

> *So one of the key things I think I lacked at the early part of my career was actually being able to identify a suitable mentor, especially a female mentor within the space. I think that's very important. ...and as I did mention to you, there are already limitations with women assessing funds, so women-focus scholarships and immersion programs are actually very critical. Those are some of the opportunities that I wish were readily available for me while I was growing within my career.*
>
> **-Senior-level participant working in a private-sector organization**

> *I've lost a lot of opportunities because I had very little networking skills. I've met people that, ideally, if I had those skills and have cultivated this sort of relationship that, would have helped over time. Also, with very good networking skills, you're able to hear about opportunities you're able to learn and grow faster.*
>
> **- Senior-level participant working in a multilateral organization**

A1d. Absence/Poor implementation of Enabling Policies

The study findings also link the gender disparity in health sector leadership to the absence of enabling policies supporting women to advance into leadership positions. Where such policies exist, the political will to follow through with the implementation of these policies is lacking. This lack of political will may be connected to the patriarchal nature of society and the male dominance of leadership positions in politics and the health sector. For example, although a National Gender Policy has been in place since 2006, with the aspiration to reduce gender disparities and to increase the proportion of women holding political office,[34] not much progress has been made as the proportion of women in leadership positions in Nigeria has remained low.

When people talk about policies for women, they only think about body policies like maternal leave, childcare etc. While these are very important, we need to have policies that protect women, such as safety and sexual harassment policies. For some public health service delivery like immunization, women are often needed to deliver last-mile health delivery. These women go into very remote areas too, and yet there's often no protection for their safety, making them less likely to go to the field.

- Mid-level participant working in a LNGO

There is no single policy that supports women to ascend into leadership positions in the public health space. The system is hypocritical. Men often cite that women deliver services. However, there is a difference between delivering and controlling. They say women are visible. Yes, but as nurses and community health workers. How many community health workers can even imagine being a local government chairman or a health minister one day?"

- Senior-level participant working in a LNGO

…. like I said earlier, there are no policies in place. However, both men and women are given equal opportunity to grow in the academic space

- Senior-level participant working in academia

A1e. Considerations of Family Obligations and Responsibilities

Some women choose to decline or not aspire for senior leadership positions in the health sector because of considerations that they would be unable to combine workplace responsibilities with family responsibilities effectively. Since gender norms commonly suggest that women are carers and men are breadwinners, some women shelve their workplace advancement and leadership aspirations to face family responsibilities.

Women need to be encouraged to apply for international positions. Women have to grapple with several considerations like children, husband etc, and so a lot of women don't apply. However, men find it easier to move because they leave their wives back with the children or they move with the wives.

- Senior-level participant working in a multilateral organization

Obviously, in a society like Nigeria, a woman bears more of the responsibility when it comes to giving birth, raising children and all that. Just being able to balance that family life with work priorities and responsibilities and even the societal definition of what roles a woman has and just putting those limits on how far you can progress. Sometimes even women in our society in Nigeria are not our own best advocates. We have older women, making younger women feel like: "why are you pushing this career when you've not gotten married? You don't even have kids" telling them to focus on those things above career, which at the end of the day should be a personal choice.

- Mid-level participant working in a local LNGO

Women subconsciously force themselves to choose, and we think we have to choose. And I don't think we have to choose, honestly. I think we have to balance, but a lot of women think that because of societal conditioning. For example, they think: "I have three children, and I'm running for a senior management position in my organization. But you know, the senior management position means that I'll be travelling 40 per cent of the time. My husband and I? He's not going to be able to stay home and take care of the children..." without even exploring having those conversations with the partner. They decline putting themselves forward

- Senior-level participant working in a multilateral organization

A2. Organisational Barriers

A2a. Male dominance and the 'Men's Club Effect.'

The study findings identified male dominance in the leadership space in the health sector as a barrier to the entry of women. This dominance likens the top echelon of most public health organizations to a 'Men Club' that determines the conditions for ascendancy, the yardstick for accessing leadership suitability, and the metrics for measuring leadership capacity and performance.

This male dominance in boardrooms and executive positions poses a barrier to women as these men are more likely to prefer to be succeeded by or work with men. Our findings indicate that although some women successfully break the glass ceiling and become independent female leaders, a handful of women leaders are 'patriarchal princesses' who hold leadership positions as stooges for the 'men's club'. Such women may not be fully independent leaders as they tend to always receive some directives from the men who put them in leadership positions. Additionally, some patriarchal princesses may not want the status quo of gender disparity in leadership to be changed since they are beneficiaries of the tokenistic offer of leadership that creates a semblance of women's inclusion in leadership.

> *I don't know to what extent people understand the social biases that limit women. So you find out that even when you do things like say women will be given preference or women will be preferred or we are encouraging female candidates to apply. You find out that the interview process, everything's designed for men. They make it very difficult for a woman to bypass.*
>
> **- Mid-level participant working in a LNGO**

> *Men are a big part of the problem. Negative peer pressure prevents many men from advocating for women*
>
> **– Senior-level Male participant working in a LNGO**

> *Weekend or old boys meeting where men discuss office work is one of the ways of keeping women out. Men have a lot of informal meetings at the golf club while women are at home.*
>
> **- Mid-level participant working in a LNGO**

> *You know, so there's always that boys club in most organizations, to be honest, you know. And I remember, like, back when I started my public health career, somebody making a joke out of staying power. Oh, do women have the same power? So, I was like, what do you mean? So, I was in a workshop outside the country, and this comment was made, " Oh, women don't, you know, the staying power, " and I said, " What do you mean by the staying power? This person says oh, staying up late to do some work, staying behind to do some meetings, or team building, or maybe to drink with the boys after work. And at that time, I was, well, maybe I was too young to process what it meant, do you get? But now I do understand because it's practically impossible, sometimes for at least I can speak on a personal level as a woman, for me to stay back with the boys to have drinks. So, if that's what it takes to belong, I'm sorry, I'll have to be left out*
>
> **- Senior-level participant working in a LNGO**

A2b. Unfavorable workplace practices and arrangements

We found out that most organizations had unfavorable workplace practices and arrangements that discouraged women from aspiring for leadership positions that would require responsibility. These adverse work practices included impromptu travels, late-night meetings, working extended hours, the absence of paid maternity leave, workplace toxicity, and gender pay gaps. Some of these workplace practices affect the work-life balance, making it difficult for women to perform optimally at work and meet their personal and family commitments/responsibilities concurrently.

I said, this lady had CS, caesarean section, and she was only given two weeks maternity leave because she is a short-term staff. I didn't say one month, two weeks. .... It's just circumstances that she came in as a contract staff.

-Senior-level participant working in a LNGO

We can also get into issues like the pay gap, right? The gender pay gap. For example, I have a colleague who has an advanced degree, I also have an advanced degree, but he's hired ..... pounds more than I am. And we're both very good, but the organization feels: "well, she didn't ask for anything; give her the lower end. He asked for ..... and if we give him anything less, he would turn down the job, and we want both of them". They give one what he asks, and then they give me the lower end. Right. You see that play out.

-Senior-level participant working in an INGO

I was in a place where even because I had to go and give birth, I had my employment terminated for that period

- Mid-level participant working in a LNGO

...if you have a situation where women are consistently being put down, the way that you speak to them, the way you relate, the culture of the organization. Then even when the opportunities come up, women may not want to apply.

- Mid-level participant working in a LNGO

A2c. Absence or Poor implementation of existing Policies

We found out that while a handful of organizations did not have any DEI policies to support women's ascent into senior management leadership positions, many organisations with such policies made minimal effort to implement them effectively. This absence or poor implementation of DEI policies was linked to existing gender workforce disparity regarding pay, promotion, and leadership opportunities. We also found that some of the existing DEI policies were not robust enough to guarantee equal leadership opportunities for men and women. We deduced that the incidence of sexual harassment and 'sex-for-roles' incidents are likely to be reduced if organizations developed and implemented DEI policies intentionally designed to ensure workplace gender equity.

> *So, I don't know of specific policies for women in public health, but I know that there are these mechanisms or platforms, so to speak, that try to help women take up those leadership roles*
>
> **- Mid-level participant in an INGO**

A2d. Gender Bias in Recruitment, Organizational Culture and Leadership Opportunities

We also identified gender bias in recruitment and leadership opportunities as another barrier to women's ascent to senior leadership in public health organizations. We found that this bias was more against married women as most organizations preferred single women. Some organizations considered that such gender bias in recruitment would limit the potential 'productivity losses' associated with maternity leave and the lactation period. Some study participants noted that some women remain single (despite wishing otherwise) to make them more 'suitable' for promotions and leadership opportunities. In addition, they had to work twice as hard as their male counterparts to prove their mettle and affirm their capacity and suitability for senior leadership positions.

> *There is also the creep of religion and societal/ cultural norms into these biases. ... Sometimes religion is brought in as the reason to validate that bias or culture is brought in. ...We should be cognizant of some of the shields that we promote as the reasons why we are not supporting other women.*
>
> **- Mid-level participant working in government**

There are many women that, like people were saying about, like, for example, tone of voice—the way pattern of dressing, those things. There are still places that require women to wear jackets, trousers and jackets, like seriously, that is traditionally a man's outfit. If we choose to wear it, that's fine. But there are other beautiful frocks that we can wear. And I will say no, oh, no, it is not professional, you know, that kind of even like Ankara, when did Ankara become a normal thing in the workplace? So those are the kind of things, I think, subtle biases that we need to pay attention to because they do make the workplace very, you know, harsh for women. And I've seen a lot of women exit. They just exit quietly without saying anything.

-Senior-level participant working in a LNGO

You would see where CEOs or country directors or leaders in the organization kind of select, just based on some bias that "She won't be able to do it. She's pregnant," or "She won't be able to take on this role because we need somebody who can speak and stand in front of these government officials". So naturally, they just want to pass that on to the guy on the team. And this is, again, based on our societal conditioning and our social norms."

- Senior-level participant working with a LNGO

A2e. Limited Mentorship and Professional Support

The absence or paucity of mentorship and professional support in some organizations made it more difficult for women to occupy senior leadership positions. This limited mentorship and professional support make it unlikely for women in such organizations to have the appropriate skill set, mentorship and support to take on senior leadership positions confidently. Additionally, the absence of mentorship and professional help makes it less likely that women will be aware of professional and leadership advancement opportunities such as conferences, scholarships and fellowships. In cases where some women are aware of such opportunities, a significant proportion of these women encounter difficulties putting up competitive applications without mentorship and organizational support.

Identifying a talent for a role is one part of the coin, while supporting the person in the role is another. I really didn't have leaders to look up to

- Senior-level participant working in the private sector

I started out wanting to be a pediatrician but having to combine that with a young family just was not compatible. It was clear again that with support, people do it. A lot of women do it now. They manage to train as pediatricians and also manage their own families on the side as well. For me, if I had the support, I could have done that.

- Senior-level participant working in the private sector

A2f. Female Rivalry in the Workplace

We discovered that female workplace rivalry was a barrier to women's leadership in some organizations. Some participants opined that a handful of women perceived their female peers or subordinates as contenders or threats to their ascent to senior leadership positions. Such women assume that supporting or mentoring others will empower the competition. In extreme cases of female workplace rivalry, some women intentionally place hindrances that limit the likelihood of other women climbing up the leadership ladder. Some women have also been noted not to have confidence in their female counterparts and assume that the 'failure' of a female leader would limit prospects for other women.

....At some of the highest levels where women are going for positions of leadership, I have seen petitions against certain women and believe me, 80-90 per cent are from fellow women.

- Senior-level participant working in a LNGO

Because, you know, we keep hearing in some spaces that women are their own worst enemies. Sometimes it's true, and sometimes it's not... I was in conversation with someone who retired as the HR lead of one of the biggest government entities or agencies. And we're trying to form a committee within an estate, and someone said, let's expand women on this committee or members of the board. And she said, 'No, their wahala is too much'. This is a woman who was head of HR.

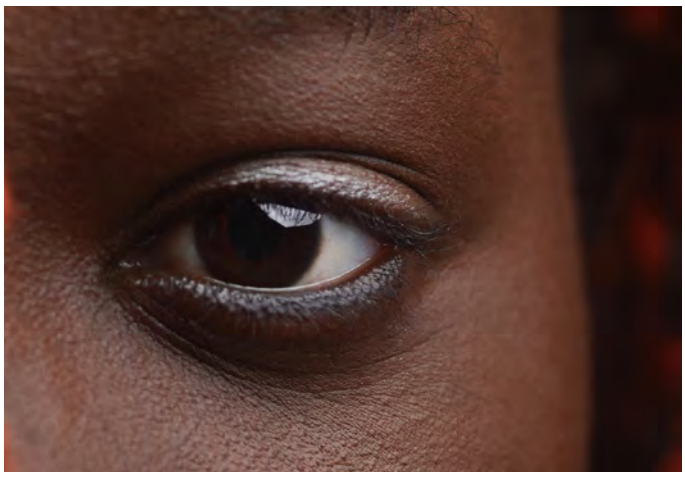
- Senior-level participant working in a LNGO

....Where there is an opportunity, and you have a panel of people, experts, and leaders, who are in a position to propel or project a particular woman, oftentimes, the one voice or several voices who would be seen as barriers or impediments towards that woman s advancement would be other women, and when probed, they say that there is a fear that if that woman fails and it will reflect poorly or badly on women folk.

- Mid-level participant working in government

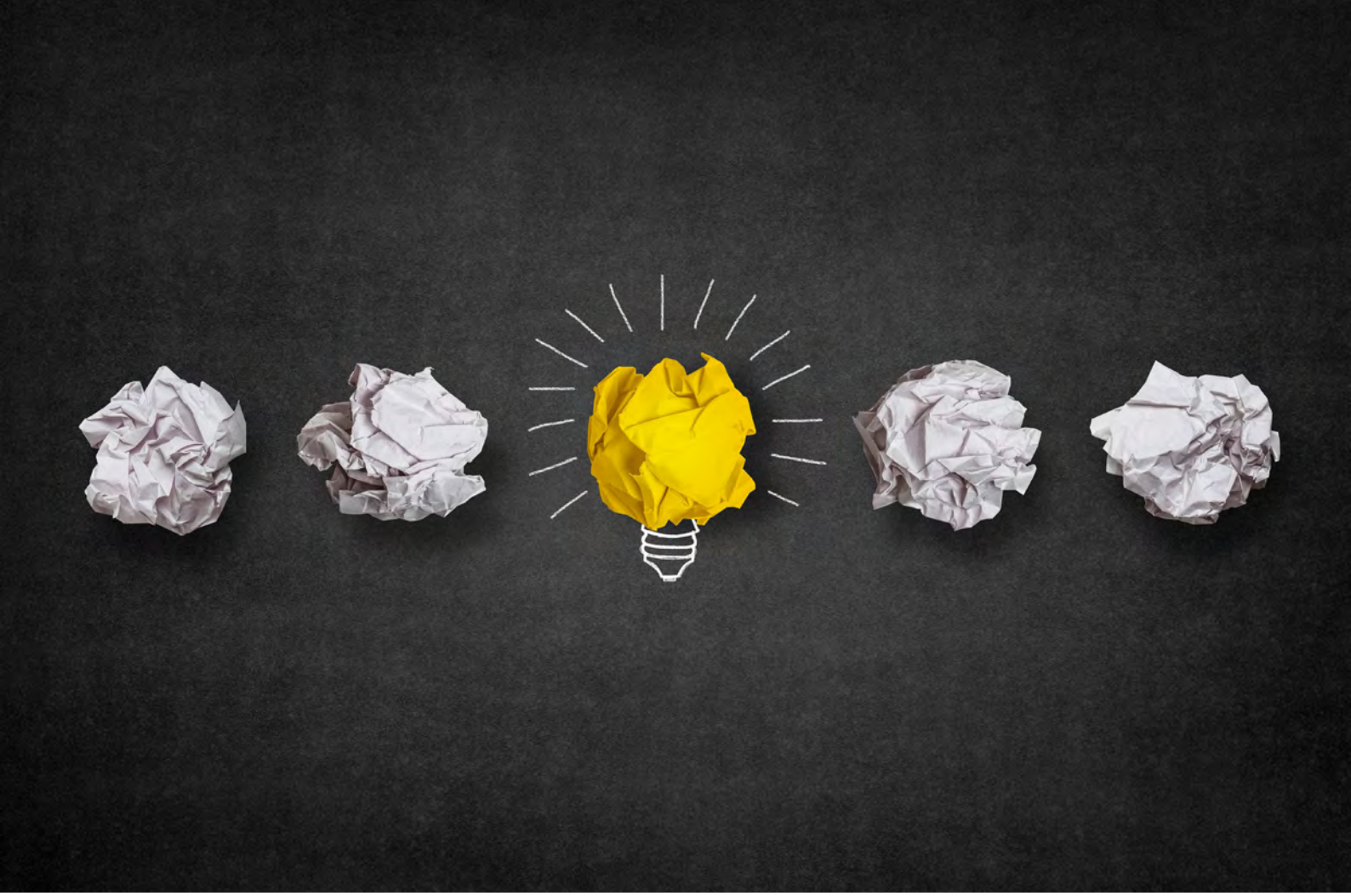
A2g. Personal Barriers

Some barriers are linked to women's personalities and their perception of themselves vis-a-vis their work environment. These personal barriers include low self-esteem, low drive/aspiration, self-doubt, timidity, and poorly managed imposter syndrome. These barriers vary across women and appear to be influenced by factors such as childhood upbringing, socialization, societal norms/stereotypes, and workplace practices.



> *Another thing I will say is that some women are not very assertive in the workplace. If they know they're due for a promotion, they feel that if they're the ones to speak up, they'll be seen as rude, disrespectful, and subordinate. They'll rather not want to upset the norm. You see a woman just sitting and waiting, hoping that the system works, and she just gets promoted without having to fight for it or have to prove herself.*
>
> **– Senior-level participant working in a LNGO**

> *I don't think they're confident enough. They don't have the confidence to take on the position. Very few women have confidence. That is why I give you the example of the nurses, a discipline that is 90 per cent women, but leadership is 90 per cent men.*
>
> **– Senior-level participant working in government**



B. OPPORTUNITIES

B1. National/Societal Opportunities

B1a. Available Epitomes of Women's Leadership

Although there is a significant gender disparity in health sector leadership, some women can be recognized as 'epitomes' of women's leadership in the health sector. This recognition can be based on their position, capabilities, performance and accomplishments. Such women leaders often provide women with inspiration and affirmation that their dreams of occupying top leadership positions are valid. These epitomes of women's leadership who have managed to break the glass ceiling and have become corporate CEOs, heads of departments, and university vice-chancellor, can support other women as role models and mentors. Recognizing these women and having them serve as role models presents an opportunity for advancing women's leadership in the health sector, as early and mid-career women are likely to be motivated to follow in the footsteps of prominent women leaders in public health organizations. Exemplary women leaders in the health sector will make other women realize that they can challenge and overcome societal norms, gender stereotypes and other barriers just like the few successful women leaders ahead of them had done. Additionally, the recent slight increase in women's political participation has encouraged more women to see themselves as leaders in health and other sectors.

> *Some of them are also provided with the opportunity to join fellowships that target women where they can learn from the journey of senior women leaders, that way, they're able to overcome imposter syndrome and self-doubt and forge their own paths*
>
> **– Senior-level participant working in an INGO**

> *But most importantly, the more those women become an inspiration to other women, you know, to say: 'okay, if this woman can get these opportunities, then I can.' It means a lot.*
>
> **– Senior-level male participant working in an INGO**

B1b. Increased Advocacy for Women's Leadership in the Health Sector.

Recently, there has been increased advocacy and consciousness about the need to accelerate the representation of women in leadership positions in the health sector. Organizations like MWAN and Women in Global Health have been at the forefront of such advocacy efforts. They have supported several women to ascend to senior executive positions in different health organizations. Stakeholders can leverage the increase in advocacy efforts to encourage more women to overcome existing barriers and aspire to leadership in different public health organizations.

> *I'm aware of some that are also creating opportunities and building women's capacity to advocate for themselves and for other women, even within the organization out there and within public health programs that they support.*
>
> **– Senior-level participant working in an INGO**

> *I think advocacy, in the first place, is key. ...You usually get that pushback that: "well, you know this is Nigeria. Not everything works in the space works here?" Or "these Westerners have come again?". So, I think it's very important. From my little experience with advocacy, we need to know: "how does it benefit them and how does it make them look good? Like, what are you bringing? What is the selling point to them so they can see how it's essentially worth their time.*
>
> **– Mid-level participant working in a LNGO**

B1c. Existence of Government Policies Addressing Women and Girl-child issues

The poor implementation of policies can positively impact women's leadership prospects and increase opportunities for women and girls. Notwithstanding, the existence of such policies is a win in the quest for gender parity in health sector leadership. The availability of these policies should be seen as an opportunity because it may be easier to push for requisite policy reforms and improved policy implementation than to advocate for the formulation of such policies in areas where they are non-existent. The National Gender Policy and the Child Rights Act are examples of existing policies and legislation that can facilitate the attainment of gender equity in leadership in health and other sectors.

We have a National Gender Equity and Social Inclusion Policy. While this is not exclusive to public health, it cascades down to all levels. For instance, about 50 per cent of commissioners are women in Kaduna State right now.

– Senior-level participant working in government

B1d. Ongoing Efforts to Address Societal Norms and Gender Stereotypes

The recent efforts by some religious and traditional leaders to publicly address societal norms and gender stereotypes that impact women's potential for leadership are commendable. Such measures provide opportunities to scale up efforts to increase the proportion of women with the capacity and aspiration to assume health sector leadership positions. For example, the Council of Traditional Rulers recently affirmed their commitment to support efforts to end gender discrimination and violence against women while promoting girl-child education.

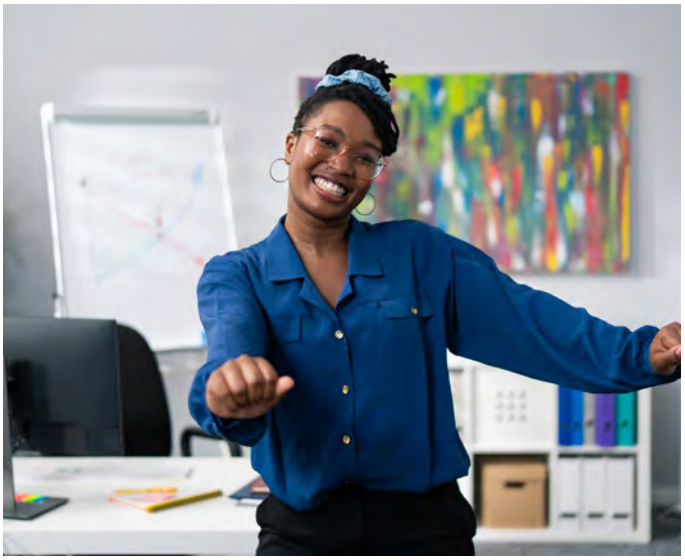
We're changing that narrative gradually, especially in northern Nigeria where even women's education generally is really low. We have the Almajiri-system, which also takes people's attention away from western education. But also, you have Bashiga, which is a cultural thing that prevents women from coming out of their houses without being covered or interacting in environments that allow them to interact with males, etc. So, there are cultural limitations within the north, and I think our Academy is helping to break through those limitations and increase the number of women in the tech and health spaces.

– Senior-level participant working in an INGO

B2. Organisational Opportunities

B2a. Women's Enthusiasm for Change

We found that most of the participants in the project were enthusiastic about supporting any efforts to increase the proportion of women occupying senior leadership positions in public health. They expressed willingness to work with WomenLift Health and other organizations with similar objectives at a personal or organizational level. This zeal for collaboration is a huge opportunity to advance women's capacity for leadership through their involvement in interventions such as fellowships and mentorship programs.



I mean, I don't see why not. It all sounds like positive work like I mentioned earlier. I think definitely there's no harm in female employees being given the opportunity to participate in leadership programs.

– Mid-level participant working in a LNGO

So, I'm open to any policy, anyone who can present me with anything I can do to further the activities of women so that they can rise to their peak.

– Mid-level participant working in government

So, there are different roles I can play. I don't want it to be like it is just one female voice in the room. So, in terms of mentoring people, I would love to. I don't mind as long as that person is willing to learn and willing to change their mindset. Mentorship is good work for me

– Mid-level participant working in government

B2b. Male Allies and Champions in Organizations

We found out that despite the male dominance of the leadership space in the health sector, many men support women with opportunities for capacity and professional development to prepare them for senior leadership roles in the health sector. Some men have been allies and mentors of women who have successfully risen to executive positions in public health organizations. The inclination of such men to advance the movement for gender equity in leadership is a positive finding. These men can be recognized as champions for women's leadership in health. They can be involved in training and mentorship programs, sway other men to support women's aspirations for leadership and ac-

knowledge women's capability and suitability for senior leadership roles in public health organizations. Another group of male allies for women's leadership are male spouses who supported their partners to aspire, pursue, and successfully assume senior leadership positions in the health sector.

> *I would say at my early years, what propelled me to where I am today, were my mentors, and they were all mostly males, I will have to be honest. And so, up to today, they are my number one champions. They are the ones who bring opportunities my way. And they're the ones who also, you know, pointed out clearly when I have made mistakes and also provided the support to own them. Along the line, I've met very, very outstanding female mentors as well, you know*
>
> **– Mid-level participant working in government**

> *My career has been advanced because I had male mentors who pushed me forward. My boss there pushed me all the time, but he was also very understanding and accommodating.*
>
> **– Senior-level participant working in an INGO**

> *They have proven to be great champions even though they are not females. I think they bring in the male perspectives as well. They are able to say: "okay, this is the way we think. These are the beliefs; these are the cultural practices that sip into our work life that we need to address". And they're able to come up with better ideas as to how to communicate some of these things to their fellow men without necessarily hurting their ego, but actually bringing about results and impact*
>
> **– Mid-level participant working in an INGO**

> *I have seen men playing a role in ensuring gender equity within the workplace and supporting or championing women moving into leadership opportunities. Not only is this heartwarming for the women, but it's also very encouraging. I think it creates an atmosphere that encourages other men to see beyond their ego actually and really try to create a common space for women*
>
> **– Mid-level participant working in an INGO**

> *I mentor a number of women myself at the organization and individual levels.*
>
> **– Senior-level male participant working in an INGO**

I have seen support in terms of women who probably need to go on stretch assignments on a rotation to another country, and their men are willing to go with them to travel with them. They say, you know, you got the better job. You go live your dreams. If you want me, I can come with you. If you don't need me, I'll stay with the kids. That helps in a big way

– Senior-level participant working in an INGO

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– Mid-level participant working in the private sector

B2c. Existing Organizational Policies and Positive Organizational Disposition to Change

In many of the organizations explored, there are DEI policies and guidelines to support women's leadership aspirations and advance gender parity in recruitment, promotion, and appointments. Some organizations had women-friendly practices (such as paid maternity leave and flexible working arrangements) to encourage women to keep their roles and aspire for leadership in public health organizations. Furthermore, we deduced that most organizations were positively disposed to change the status quo and reform existing policies to provide equal opportunities for senior leadership for their staff, irrespective of gender differences.

One of the performance assessment goals for everyone is about equity. You are assessed on if everybody on your team is equitably treated. People can give anonymous feedback on that. Applying the EDI policies as we work with each other is also assessed. If anybody feels a certain bias, they are free to express it anonymously. And if there is really a case, it'll be investigated.

– Mid-level participant working in government

My organization advocates not just for women to go on maternity leave but for men to go on paternity leave. We instituted paternity leave because we realized that women lack support systems. So, we're sending the men back home to go be with their wife and also take care of the child. I think that is a massive support system. Also, we have a flexible working policy; two to three days on-site and two days remote.

– Senior-level male participant working in an INGO

B2d. Organizational Mentorship and Peer Support

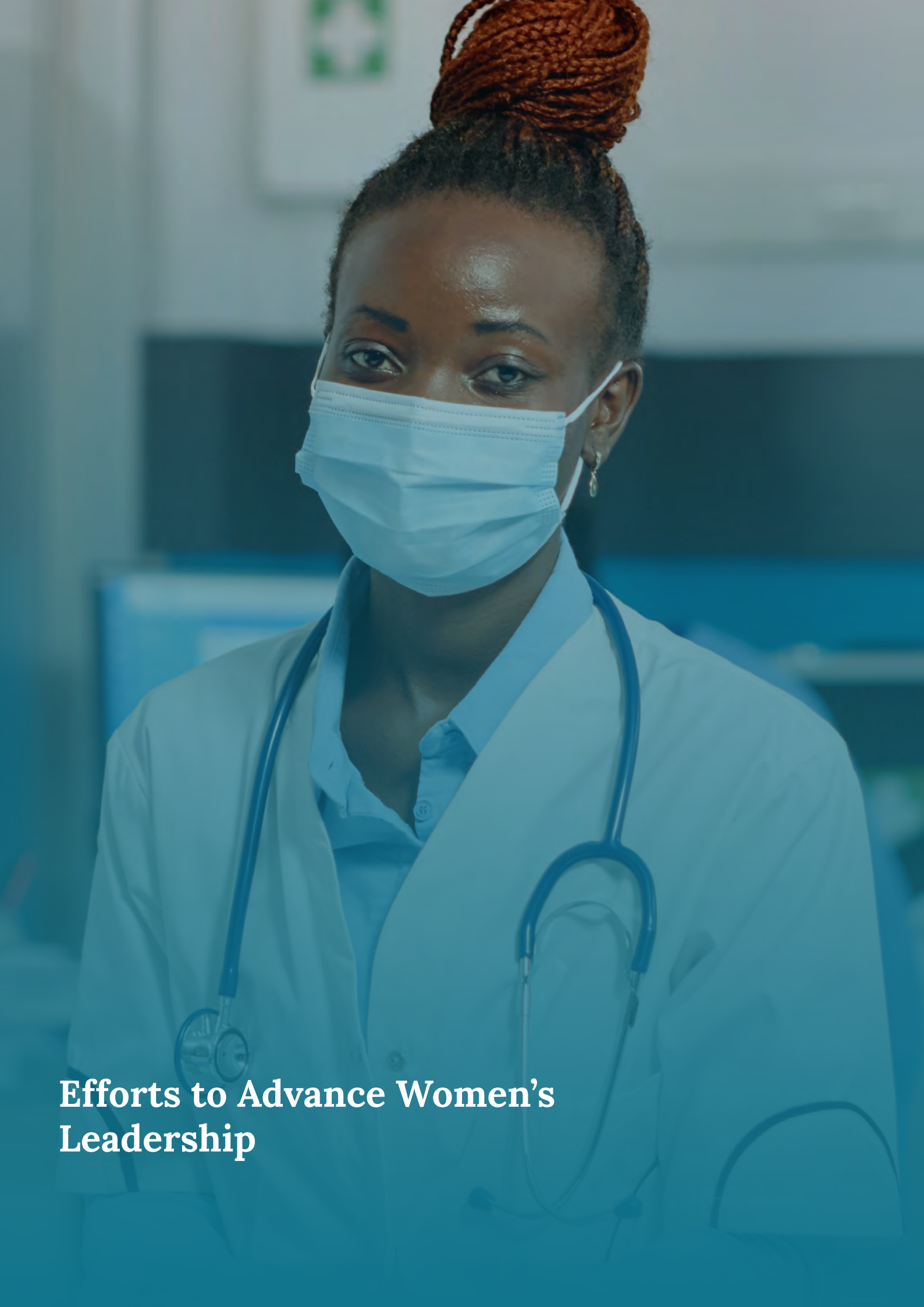
Some organizations have ongoing mentorship and peer support programs aimed at mid-career women to help them develop key leadership and professional skills needed for success in senior leadership roles. These programs adopt varying approaches, such as focused leadership capacity-building workshops and pairing mid-career women with senior management staff to execute tasks, attend meetings and present at conferences. These efforts are opportunities to advance women's leadership in organizations as ongoing organizational programs can be scaled up for increased impact.

We have structured formal and informal coaching for women.

-Mid-level participant working in the private sector

So, informally within the organization. There's a lot going on around informal coaching and mentoring.

-Senior-level participant working in government



Efforts to Advance Women's Leadership

Efforts To Advance Women's Leadership

Several efforts have been made at societal and organizational levels to advance women's leadership in the health sector. These efforts are outlined below.

National/Societal Efforts

A1. Formulation of Women-Centered Policies

The formulation of the National Gender Policy is a significant effort to bridge the gender disparity in Nigeria. The policy pushes an ambitious 50:50 affirmative action calling for gender equality in all elective and appointed positions in Nigeria[18]. The policy also proposes training women for leadership positions and institutionalizing the Gender Equality, Empowerment of Women, and Social Inclusion (GEESI) framework in all public institutions to drive gender equality, women's empowerment, and social inclusion[18]. Legislation like the Child Rights Act promotes girl-child education and prohibits girl-child marriage, though it has not yet been adopted in all states. Other policies to make the workplace more conducive for women include the recent approval of four months of paid maternity leave, and two weeks of paid paternity leave by the Federal Government, with some states like Ekiti, Lagos, Kaduna and Oyo approving six months of paid maternity leave.

> *I think the other points to be made have to do with, you know, breastfeeding and all of that. In public service, the first three months after you resume, you can still close at a certain time earlier than normal. So, these are examples of policies that, you know, local governments, national governments have adopted, which public health institutions key into.*
>
> **– Senior-level participant working in a LNGO**

> *So, there is a gender policy that was done at the national level, and there are a few states that have actually domesticated those. The gender policy, well, the implementation is neither here nor there, but at least we have a policy that will guide whoever is serious and at the helm of affairs to ensure that they implement the gender policy.*
>
> **– Senior-level participant working in government**

A2. Public Enlightenment Campaigns to address Stereotypes and Norms

In recent times, state and non-state actors have tried to discourage Nigerians from following stereotypes and gender norms that perceive leadership as the exclusive reserve of men. These efforts are led by the Federal and State Ministries of Women and Social Development and supported by several NGOs and multilateral organizations[35]. Several religious and traditional rulers have supported these public enlightenment campaigns and used their influence to encourage Nigerians to abandon negative stereotypes and norms that limit the opportunities for women to occupy leadership positions in different sectors and organizations. Local and international NGOs and bilateral and multilateral agencies like the FCDO and UN Women support these efforts[35].

A3. Formation of Women Coalitions and Professional Networking Groups

Advocacy for women's leadership and empowerment has gained momentum in recent years, with organizations like MWAN and Women in Global Health leading such efforts and building structures for women's empowerment and development across different parts of Nigeria.

> *But there are associations, you know, like the medical women's associations, there's obviously the nurses, the Nigerian Nurses Association, you know, those are like sort of mechanisms that exists to build the capacity of women in these disciplines, in the health sector, to then, you know, hopefully, take up leadership roles.*
>
> **– Senior-level participant working in an INGO**

> *I'm aware of female professional associations that support women, Medical Women Association of Nigeria (MWAN) for the medical doctors.*
>
> **– Senior-level participant working in government**

Organisational Efforts

B1. Formulation and Implementation of DEI Policies

Several Organizations have DEI policies that help advance gender equity in the workplace and give women equal opportunities to aspire for and occupy senior leadership positions. Some of these policies recommend DEI training for senior management staff to ensure that they run the organization through a perspective that prioritizes diversity, equality, and inclusion in different areas, including gender. In some organizations, staff can periodically appraise the implementation of DEI policies and make recommendations for improvements. We deduced that in a few organizations with strong leaders who were interested in supporting women to take up senior leadership positions, these leaders were able to influence organizational processes and policies to provide women with support and opportunities for leadership.

B2. Reservation of Specific Leadership Positions for Women and Affirmative Statements in Job Openings

As part of efforts to advance women's leadership in health and other sectors, some specific leadership positions are reserved for women. While this may be commendable as an effort to advance women's leadership, this practice may be linked to gender stereotypes that some positions are 'feminine' and, as such, should be occupied by women. This practice is more observable in government health institutions where the roles reserved for women are usually related to child health, nursing, and maternal health.

The study findings also revealed that several organizations are now more intentional in providing opportunities for women to take up recruitment and assume leadership positions. Many such organizations publicly indicate their preference for female candidates for advertised roles and encourage women to apply. These affirmative statements are positively impactful and can increase the number of women occupying leadership roles. This impact is because women with the requisite skill set and background are more likely to apply for senior management roles if they perceive that female candidates are preferred and that there is a reduced likelihood of bias against women in the recruitment process.

Some departments, agencies, NGOs are putting more women in leadership positions.

– Mid-level participant working in a LNGO

Since we belong to the disadvantaged group, what they can do is to say, okay, 35 per cent of all positions or 40 per cent of all positions should be reserved for women, and that should be adhered to strictly. It will help in increasing the number of women who participate in activities.

– Senior-level participant working in government

And I know most of the adverts that you see in the development sector, we see women are strongly advised to apply. So, I think things are changing from what they used to be. If you ask me more often than not, it's usually like maybe the parity for the women.

– Senior-level participant working in an INGO

That also brings me to the fact that some public health organizations have these equal-opportunity policies in place. And some of them are geared towards deliberately encouraging women to apply for roles during recruitment. We have positive affirmation statements in job postings, which help to encourage more women to apply. You see, just that statement alone makes a lot of difference. A woman who would probably not apply, but she sees that job posting, she says: "Okay, these people are likely to understand my situation better

– Senior-level participant working in an INGO

.. for us to be equitable, we must be intentional to say maybe when employing people, we need to reserve a percentage and some positions for women. Simple! It's a way to address the inequity that exists.

– Senior-level male participant working in an INGO

B3. Encouragement of Flexible Work schedules and Remote Work

Lately, many organizations have permitted flexible work schedules and allowed staff to work remotely as necessary. This flexibility has enabled many women to perform optimally and meet family responsibilities and obligations, leading to improved work-life balance. This practice became rapidly adopted since the advent of the COVID-19 pandemic, especially in non-governmental

organizations and is variable across organizations. Furthermore, many organizations allow their staff to take paid maternity leave for four to six months, while a few also allow paid paternity leave. With more women having an improved work-life balance, these efforts increase the likelihood of women retaining their positions and aspiring for senior leadership positions.

> *I think there's one that comes to mind that I think is even being triggered and now being amplified post-pandemic, and that is about flexible working hours. ..... And so, I think COVID is now making it easier for women to negotiate flexible working opportunities. And so, it's just really, for us to begin to take that more seriously. Like, what are the different archetypes of flexible working hours that we should be accommodating as long as people are productive, and they are meeting their deliverables.*
>
> **– Senior-level participant working in an INGO**

B4. Provision of Amenities to Support Women

A handful of organizations have made efforts to provide amenities that will make the workplace more accommodating to the peculiar needs of women. These amenities include lactation rooms, creches, nurseries, and baby changing rooms. Providing these amenities helps ease workplace pressure for nursing mothers and incentivizes women to retain their jobs and aspire for senior leadership roles in public health organizations.

> *Well, Nigeria has a very, I'll say, quite robust maternity policy that encourages women. So, I think there was an analysis that was done recently. And it shows that in Nigeria, the representation of women in leadership positions in both ministries as well as the NGO sector and private sector has been improving over the years. And I think it's because of that leave policy because even the private sector has to imbibe the national policy. If not, it would have been nearly impossible for women who have family to be in the workplace.*
>
> **– Senior-level participant working in an INGO**

> *We have an in-house creche. And they also buy services for older kids. Maybe you're in between house helps, you could apply to their HR, and then you start bringing your kids to that place, and then there's someone that's minding them until you close work, and you take them home with you. I saw it for the first time when I joined this organization because I didn't have it elsewhere. ..... Well, I'm happy that there's an organization that actually has something that provides that kind of support when it comes to women.*
>
> **– Mid-level participant working in a LNGO**

B5. Workplace Capacity Development and Mentorship Programs

Some organizations provide opportunities for their staff to receive training and mentorship to improve their professional skills and capacity for leadership and management. Although many of these organizations open such opportunities to male and female staff, some organize these training and mentorship programs primarily for their female staff. Some organizations' capacity development and mentorship programs include funding for workshops, training, conferences, and scholarships for further studies to help female staff gain international exposure, build confidence and expand their professional networks in preparation for senior leadership roles.

Working Together: Potential Points of Collaboration Between WomenLift Health And Stakeholders/Organisations in Nigeria

Working Together: Potential Points of Collaboration Between WomenLift Health And Stakeholders/Organisations in Nigeria

Most stakeholders who participated in the project were eager to support efforts to increase women's leadership in public health organizations and indicated their willingness to collaborate with WomenLift Health. The potential points of collaboration between WomenLift Health and stakeholders/organizations in Nigeria identified for this project are enumerated below.

C1. Engagement with Influential Stakeholders to Address Negative Stereotypes and Norms.

WomenLift Health can collaborate with stakeholders such as traditional, religious and political leaders to organize town hall meetings, workshops, and other public enlightenment events. Such events can reshape societal perspectives about women's leadership and address harmful stereotypes/norms and cultural/ religious beliefs that limit opportunities for women to occupy senior leadership positions.

C2. Leveraging Existing Advocacy and Professional Groups.

Existing groups that advocate for increased visibility, empowerment and professional advancement of women can be engaged and supported to reach more women who can be motivated to build their capacity and aspire for senior leadership positions. In addition, stakeholders can support more groups to kick off and coordinate with existing groups for synergistic impact.

> *...amplify it because whoever it is that tells stories writes history. So yeah, amplify it. Because the more you do that, the more people get to hear about it, the more women are inspired and through that, sharing more opportunities to women.*
>
> **– Senior-level male participant working with an INGO**

C3. Engaging Notable Female and Male Leaders as Champions for Women's Leadership

There are opportunities to collaborate with outstanding female leaders with successful careers in public health organizations to produce short documentaries and articles that will propel other women to aspire for senior leadership in the health sector. Men who have made significant contributions to support women's ascent to high-level management positions should also be engaged to encourage other men to support women's leadership aspirations.

But there are men that have been able to serve in key respectable public health positions that can be used as motivators to talk to their fellow men on various platforms.

– Mid-level participant working in an INGO

Men should be at the center of all this. Engaging men would work best in a group setting. Peer groups can be created for men to come together to discuss women's issues and how to support them.

– Senior-level male participant working in an LNGO

C4. Development of Leadership Training Curriculum and Programs

WomenLift Health can collaborate with stakeholders such as government, academia, and relevant organizations to develop a leadership training curriculum for capacity development to teach early and mid-career women key leadership skills. Such collaborations can develop a framework for a training program for women in different organizations.

So again, that curriculum we spoke about, storytelling needs to be a very important part of it. Okay? I don't care what anybody says. If you don't tell us, nobody has any idea what it is that you are doing. So being able to tell one story, whether through writing, public speaking, the radio, TV appearances, or social media, women need capacity in those areas because even a number of the female professionals I mentor are kind of shy about talking about their achievements. Well, you need to do that through storytelling. So, storytelling really has to be a part of that curriculum in today's world.

– Senior-level male participant working in an LNGO

C5. Coordinating a Women's Leadership Fellowship and Mentorship Program.

WomenLift Health can collaborate with multiple health sector players to set up a contextually tailored women's leadership fellowship and mentoring program for early and mid-career women in different health areas. The fellowship and mentoring program may include capstone projects, peer-to-peer mentoring, pairing senior female executives with mid-career women and micro-internships spanning a few weeks or months. The program may be co-funded with other organizations to provide conference and scholarship opportunities to advance women's professional development and expand their network.

> *I think what I would like is if WomenLift can go past just convening women for a year or six months and training them, but actually creating opportunities for people to assume those leadership positions. So where I'm going is that women need to be able to use their influence to network or use their network, their influence to have many of these big organizations create positions where if I say I'm currently a WomenLift fellow, then because I went to a Womenlift program, I moved from being a senior director to an executive vice president where I can attribute a huge chunk of that to the networking or the placement that came from being part of Womenlift. That's what I think is the most valuable.*
>
> **– Senior-level participant working in an INGO**

> *Mentorship is the biggest game changer in my opinion, but we need to be more creative and innovative about how we structure it...So, we need to be more creative about mentorship models.*
>
> **– Senior-level male participant working in an LNGO**

C6. Engaging Stakeholders and Organizations to Drive Policy Reforms

WomenLift Health can engage relevant organizations and agencies like the FMWSD and the FMOH to drive the review, adoption and implementation of policies that will address contemporary barriers and support women to build capacity and aspire for high-level management positions. Metrics for monitoring and evaluating policy implementation can also be collaboratively developed. WomenLift Health can also work with organizations to create a framework for Women's Leadership that can be incorporated into DEI policies and guidelines.

> *I feel like maybe the need would now be to contextualize the policy on gender diversity to be more specific to different countries. That would be my main recommendation.*
>
> **– Senior-level male participant working in an LNGO**

It shouldn't just be mere information provided in a document. And everybody says, "there's a policy right there!". But we need to make a conscious effort to break down that policy into actionable activities, have clear indicators for measuring those outcomes year in year out and holding organizations accountable for them. So internally within organizations, they need to be able to do that. But overall, within the healthcare system, we need to be able to come up with a policy for these women. We need to be able to see it as a major systemic issue that as a country should be willing to address.

– Senior-level participant working in an INGO

...it also means that society and families must also be intentional about ensuring that the boy child recognizes the place of a girl child. It's not about going ahead with all those patriarchal rules that men and boys play.

– Senior-level male participant working in an INGO

C7. Collaboration for Research

There can be collaborations between WomenLift Health and Research Institutions to generate further evidence on appropriate approaches to address existing barriers limiting women's leadership and emerging opportunities.

Don't forget that we don't have a lot of evidence, so right from the word go. They should be able to put modalities in place to be able to showcase evidence for what the program has achieved so that we can use it going forward.

– Senior-level participant working in government

C8. Engagement with Development Partners and Multilateral/Bilateral Organizations.

WomenLift Health can engage and organize joint programs and events with development partners, multilateral/bilateral organizations and international NGOs interested in advancing women's leadership in the health sector.

Recommendations

Based on the project's findings, the key recommendations and suggestions for WomenLift Health partnership and programming in Nigeria are listed below.

D1. Engage with relevant stakeholders to **design a structured fellowship/mentorship program** for Nigerian women in the health sector. The program should be mindful of the Nigerian context and sensitive to the cultural differences and peculiar needs across regions.

D2. Align and collaborate with existing advocacy and professional groups/organizations like MWAN to **strengthen and scale up ongoing women's leadership development programs** across Nigeria.

D3. Design and implement programs for high school and female university students to get them interested in public health and develop their leadership skills and aspirations to envision themselves as future senior leaders in health organizations.

D4. Collaborate with think tanks and research institutions to design and conduct research to get baseline data on women's leadership in the health sector. The research collaboration will also decipher contextually appropriate approaches to address existing barriers to women's leadership in the health sector and explore strategies to nudge organizations to advance gender parity in senior-level leadership.

D5. Partner with relevant stakeholders to develop a leadership training curriculum that aligns with the needs of early/mid-career women in the health

sector. The curriculum can guide the fellowship and mentorship programs and be adapted to engage female high school and university students. Modern technological channels, such as mobile apps, can extend the reach of WomenLift Health leadership training programs to numerous women within the health sector and beyond.

D6. Work with women leaders, academia, and other stakeholders to develop context-specific metrics for monitoring and evaluating the implementation of policies aimed at advancing gender parity and women's leadership in health and other sectors.

D7. Engage critical stakeholders (e.g. political, traditional and religious leaders, governments, academia) to design **strategies for addressing existing societal stereotypes and gender norms** that shape societal perspectives about women's leadership.

D8. Propel the government and health organizations to formulate, review and effectively implement policies that foster gender equality, eliminate gender pay gaps and provide equal opportunities for women to hold senior management positions in the health sector.

D9. Organize micro-internships (lasting a few weeks to months) that embed early/mid-career women in health organizations to work closely with senior female leaders to enable them to learn experientially and get inspired and mentored to aspire for high-level management positions.

D10. Build a community of practice of aspiring and established female leaders in public health through bi-annual regional convenings and annual or biennial conferences that provide periodic peer-to-peer learning, professional advancement, and networking opportunities for women. Such convenings can also be avenues to persuade women to jettison female workplace rivalry and allay any fears or insecurities that may prevent women from supporting each other.

D11. Collaborate with prominent successful female leaders of public health organizations in Nigeria to inspire young girls and early career women and help them build their confidence and stir their aspiration to become future health sector leaders. The engagement with these female leaders could include the development of documentaries or podcasts telling their stories about how they overcame barriers such as gender bias and societal stereotypes and personal inhibitions such as imposter syndrome and low self-esteem.

D12. Identify and work closely with noteworthy men who have significantly supported and mentored women to become senior leaders in the health sector. The men can be recognized as male WomenLift Health brand ambassadors and champions for women's leadership. WomenLift Health can work with them to produce documentaries/podcasts and speak at different fora to encourage other men to support women's aspiration for leadership in the health sector.

D13. Engage with men to encourage them to view women not as threats but as partners in progress. Men should be encouraged to support women's ascent to high-level leadership in public health organizations. The engagement with men should include workshops and meetings involving male champions of women's leadership who would encourage their counterparts to signpost women to leadership opportunities and the aspiration of their female counterparts and subordinates through mentorship. Discussions with

men should also focus on workplace issues such as toxic masculinity, gender-based violence, sexual harassment, and spousal support for women's leadership aspirations.

D14. Organize events for the CEOs of leading public health organizations in Nigeria to advocate for changes to work arrangements and organizational policies. Such engagements will make the organizations more responsive to women's peculiar needs and increase support for their leadership aspirations. Such engagements will also enable WomenLift Health to **advocate that organizations provide mechanisms for feedback on their implementation of DEI policies** and to report cases of gender bias, sexual harassment, and other predicaments that women may face in the workplace.

D15. Collaborate with relevant stakeholders and organizations to advocate for increased coverage of girl-child education, especially in northern Nigeria, with the highest number of out-of-school children and significant societal impact by stereotypes and norms against girl-child education and advancement.

D16. Leverage social media and mass media channels to reach out to Nigerians with messages to reshape their perspective about women's leadership that have been influenced by anti-women societal stereotypes and gender norms. These messages can be conveyed through documentaries and short videos that showcase women's barriers to leadership and existing opportunities that abound once the status quo is changed. Furthermore, these mass media channels can connect young girls and women with role models who inspire them and build their confidence, encouraging them to challenge negative stereotypes and norms and courageously overcome barriers limiting their prospects of becoming senior management leaders.

Conclusion

Gender disparity in health sector leadership continues to remain a challenge. Ironically, despite constituting over 70 per cent of the global health workforce, women occupy barely 5 per cent of executive-level leadership positions in public health organizations. In Nigeria, there are several barriers to women's leadership in the health sector, including negative societal stereotypes and gender norms, limited access to girl-child education, and poor implementation of gender-focused policies. Male dominance, unfavorable workplace practices, gender bias, inadequate workplace mentorship, and support for women stand out as other prominent barriers. Amid these challenges, there are opportunities to advance women leadership in the health sector. These opportunities range from women's enthusiasm to support efforts to advance their leadership aspirations, the availability of existing gender policies, the existence of female professional coalitions and advocacy groups and the willingness of men to be allies for advancing women's leadership in the health sector.

WomenLift Health can leverage these opportunities to make inroads into the challenge of low representation of women in senior leadership within public health organizations through strategic collaborations with key stakeholders and organizations. Recommendations for WomenLift Health partnerships and programs include broad stakeholder engagement, collaboration with existing professional coalitions to scale advocacy efforts, and organizing a WomenLift Health fellowship program tailored to the Nigerian context. Other recommendations are that men should be engaged as allies and incorporated into WomenLift Health programs and public enlightenment campaigns

organized to address harmful stereotypes and norms. At the same time, WomenLift Health should nudge critical stakeholders to prioritize advocacy for girl-child education/empowerment and the effective implementation of gender-based policies.

Although this report highlights the key barriers, opportunities and recommendations relevant to advancing women's leadership in the health sector, there is room for further research. Future research and the courageous implementation of the recommendations of this report by WomenLift Health can significantly increase the proportion of women occupying senior leadership positions in the health sector. Progress with this will enable Nigeria to advance closer to attaining the fifth SDG goal, which seeks to achieve gender equality and empower all women and girls.

References

1. Akinseinde M, Oreh A, Okonkwo C, et al. The need for women's leadership in global healt - The Nigeria experience. NEHW Health Watch. Published online December 9, 2020.
2. Dhatt R, Theobald S, Buzuzi S, et al. The role of women's leadership and gender equity in leadership and health system strengthening. Glob Health Epidemiol Genomics. 2017;2:e8. doi:10.1017/gheg.2016.22
3. UN Women. Claiming women's space in leadership. UN Women – Headquarters. Published March 2021. Accessed October 16, 2022. https://www.unwomen.org/en/news/stories/2021/3/ compilation-claiming-womens-space-in-leadership
4. Philippine Commission on Women. Gender Equality and the Sustainable Development Goals. Accessed October 16, 2022. https://pcw.gov.ph/gender-equality-and-the-sustainable- development-goals/
5. World Health Organization. Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce. World Health Organization; 2019. Accessed August 28, 2022. https://apps.who.int/iris/handle/10665/311322
6. Batson A, Gupta GR, Barry M. More Women Must Lead in Global Health: A Focus on Strategies to Empower Women Leaders and Advance Gender Equality. Ann Glob Health. 2021;87(1):67. doi:10.5334/aogh.3213
7. Coscieme L, Fioramonti L, Mortensen L, et al. Women in Power: Female Leadership and Public Health Outcomes during the COVID-19 Pandemic.; 2020. doi:10.1101/2020.07.13.20152397
8. Desvaux, G., Devillard, S., Labaye, E., Sancier-Sultan, S., Kossoff, C., de Zelicourt, A., & Barton, D. (2017). Women Matter, Time to Accelerate: Ten Years of Insights Into Gender Diversity.
9. McKinsey.National Population Commission. Nigeria Population Projections and Demographic Indicators - National and State: 2006 - 2022.; 2020.
10. Makama GA. Patriarchy and Gender Inequality in Nigeria: The way forward. Eur Sci J ESJ. 2013;9(17). doi:10.19044/esj.2013.v9n17p%p
11. Jaiyeola EO. Patriarchy and colonization: The "brooder house" for gender inequality in Nigeria. J Res Women Gend 2020 Vol 10 No 1 Pp 3-22. Published online March 2020. Accessed September 4, 2022. https://digital.library.txstate.edu/handle/10877/12908
12. Lockard CA. Societies, Networks, and Transitions : A Global History. Stamford, CT : Wadsworth, Cengage Learning; 2015. Accessed March 16, 2023. http://archive.org/details/ societiesnetwork0000lock_q9h1
13. Izugbara C. Patriarchal Ideology and Discourses of Sexuality in Nigeria. Published online January 1, 2004.
14. Aderinto AA. Subordinated by Culture: Constraints of Women in a Rural Yoruba Community, Nigeria. Nord J Afr Stud. 2001;10(2):12-12. doi:10.53228/njas.v10i2.582
15. Agbalajobi D. Nigeria's National Assembly: why adding seats for women isn't enough. The Conversation. Published May 2021. Accessed October 23, 2022. http://theconversation.com/ nigerias-national-assembly-why-adding-seats-for-women-isnt-enough-161514
16. Aluko Y. Gender and Women's Political Leadership in Nigeria. Niger J Sociol Anthropol. 2011;9:37-54. doi:10.36108/NJSA/1102/90(0160)
17. Orisadare MA. An Assessment of the Role of Women Group in Women Political Participation and Economic Development in Nigeria. Front Sociol. 2019;4. Accessed September 4, 2022. https://www.frontiersin.org/articles/10.3389/fsoc.2019.00052

18. National Gender Policy (2021 – 2026). Federal Ministry of Women and Gender Affairs.

19. Federal Republic of Nigeria.Alliances for Africa. Full implementation of 35% Affirmative Action of women in public governance/Leadership. AFA. Published May 31, 2018. Accessed October 24, 2022. https:// alliancesforafrica.org/full-implementation-of-35-affirmative-action-of-women-in-public- governance-leadership/

20. THISDAYLIVE. Implications of Rejecting Gender Equality Bills. Accessed October 24, 2022. https://www. thisdaylive.com/index.php/2022/03/31/implications-of-rejecting-gender-equality- bills/

21. Federal Ministry of Health Nigeria. Nigeria Health Workforce Country Profile.; 2018.

22. USAID. Gender Equality and Social Inclusion Analysis.; 2021.

23. Nneka Chukwumah, Alice Umweni. Gender Disparity and the Dental Profession in Nigeria: A 10-year Follow-up Study. Nigerian Journal of Dental Research. Published online 2017. Accessed September 15, 2022. https://www.ajol.info/index.php/njdr/article/view/217447

24. Sheryl Sandberg. Lean In: Women, Work, and the Will to Lead. WH Allen; 2013.

25. Okafor E, Fagbemi A, Hassan A. Barriers to women leadership and managerial aspirations in Lagos, Nigeria: An empirical analysis. Afr J Bus Manag. 2011;5.

26. Mobolaji JW, Fatusi AO, Adedini SA. Ethnicity, religious affiliation and girl-child marriage: a cross-sectional study of nationally representative sample of female adolescents in Nigeria. BMC Public Health. 2020;20(1):583. doi:10.1186/s12889-020-08714-5

27. Npc NPC, ICF. Nigeria Demographic and Health Survey 2018 - Final Report. Published online October 1, 2019. Accessed March 16, 2023. https://dhsprogram.com/publications/ publication-fr359-dhs-final-reports.cfm

28. Literacy rate, adult male (% of males ages 15 and above) - Nigeria | Data. Accessed March 16, 2023. https://data.worldbank.org/indicator/SE.ADT.LITR.MA.ZS?locations=NG

29. Literacy rate, adult female (% of females ages 15 and above) - Nigeria | Data. Accessed March 16, 2023. https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS?locations=NG

30. Oyeyemi F. Federal High Court upholds 35% affirmative action for Nigerian women. Daily Post Nigeria. Published April 6, 2022. Accessed October 24, 2022. https://dailypost.ng/2022/04/06/ federal-high-court-upholds-35-affirmative-action-for-nigerian-women/

31. Nigeria: Mothers demand longer maternity leave – DW – 06/10/2022. dw.com. Accessed October 24, 2022. https://www.dw.com/en/nigerias-working-mothers-want-longer-maternity- leave/a-61329596

32. FG increases maternity leave to four months - Punch Newspapers. Accessed October 24, 2022. https:// punchng.com/fg-increases-maternity-leave-to-four-months/

33. HeForShe: Movement for Gender Equality. UN Women – Africa. Accessed October 24, 2022. https:// africa.unwomen.org/en/where-we-are/west-and-central-africa/nigeria/he-for-she

34. National Gender Policy 2006. Federal Republic of Nigeria. Amana Printing Ltd; Abuja: 2007. Federal Ministry of Women Affairs and Social Development.

35. Women Political Empowerment (WPE). UN Women – Africa. Accessed April 30, 2023. https://africa. unwomen.org/en/where-we-are/west-and-central-africa/nigeria/women-political-empowerment

Appendix

Appendix 1: List of Participants' Organisations

1. Federal Ministry of Health
2. National Blood Transfusion Service
3. National Primary Healthcare Development Agency
4. National Health Insurance Authority
5. Kaduna State Ministry of Health
6. Federal Medical Centre, Taraba
7. Lagos State Ministry of Health
8. National Obstetric Fistula Centre, Bauchi State
9. FHI 360
10. Management Sciences for Health
11. Clinton Health Access Initiative
12. International Vaccine Access Centre
13. Chemonics International
14. Save the Children International
15. Results for Development
16. Medical Women Association of Nigeria
17. Women in Global Health Nigeria
18. Society for Family Health
19. Pink Health Foundation
20. Health Strategy Delivery Foundation
21. KNCV Tuberculosis Foundation
22. National Association of Nigerian Nurses and Midwives
23. Nigeria Health Watch
24. Technical Advice (TA) Connect
25. Human Health Education and Research Foundation
26. Centre for Disease Control and Prevention
27. World Health Organization
28. Bill and Melinda Gates Foundation
29. AMP Health
30. E-Health Africa
31. Private Sector Health Alliance

Appendix 1: Interview Guide for Stakeholder Analysis

Background

This WomenLift Health project aims to provide insights into the public health landscape for women's leadership in Nigeria and identify existing institutional challenges and opportunities. Key informant interviews are being conducted to provide the needed insights. We ask that you please go through the participant information sheet and be willing to provide voluntary informed consent to participate in the interview. All interviews and responses will be confidential and anonymous, and guided by ethical best practices.

Interview Questions

This interview will focus on the following:

- Nigeria's overall public health landscape and your organisation's programming or external-facing work
- Practices and policies concerning women's leadership in your organisation
- Possible areas of future engagements and collaborations that support and provide opportunities for more women to step into leadership positions in Nigeria's public health space

General Issues

1. Could you provide brief insights on your organisation's role in the health sector?

2. Data shows that while women comprise 70 per cent of the workforce in global health, their representation at the leadership level is low compared to their male counterparts. What do you think could explain why there is such a low representation of women in leadership in the health sector?

3. In your context, what current gaps and barriers exist for women to reach leadership roles and grow into senior levels? Follow-up questions about cultural norms, family responsibilities, travel requirements, workplace confidence, gender roles, education etc.

4. Are you aware of any enabling systems and policies that currently exist to support women to become leaders in the public health sector? Follow-up questions about mentors, professional networks, education, career ladders, formal or informal support, communities of practice etc.

5. How could more women be supported to step into leadership positions? Follow-up questions may be asked about skills, qualities needed, and perceived challenges.

6. What role do/could men specifically play in promoting/supporting women into leadership roles within public health? How can they be allies? Do you have examples of men promoting women to take leadership roles within your organisation?

Institutional Issues

7. Does your organisation specifically support women's growth and provide an enabling environment for them to grow into leadership

positions? If yes, can you share how this is done? What have been the successes and challenges associated with these efforts?

8. Do institutional policies or efforts exist in your organisation to promote diversity, equality, and equity for women within its staff? If yes, please describe.

9. Do you know of any specific challenges in your organisation that prevent women from growing into leadership positions?

10. Do you think your organisation could do more to address gender equity issues? What more can they proactively do to advance women into leadership positions?

Future engagement and collaboration

11. Do you think your organisation could be interested in working with WomenLift Health in the future to advance women's leadership in the health sector? If yes, what possible areas of collaboration do you see?

12. Are you aware of any organizations with innovative policies or practices promoting women's leadership in health? If yes, can you tell us more?

13. As a global health leader, what are your personal goals and aspirations? What would you need to achieve your goals and expand your influence? **OR**

NB: For senior-level participants, ask differently - "What were your personal goals and aspirations when you were in the mid/early stages of your career? What would you have needed at that time to achieve your goals and expand your influence?

14. If you were to participate in a leadership development programme targeting Nigerian women working in public health. What results or benefits would you hope to gain?

15. How could senior public health leaders within and beyond your organisation be engaged in a leadership development programme targeting women working in public health?

16. Is there anything else you would like to discuss that is related to the advancement of women's leadership in the Nigerian Public Health Sector?

17. Quick Yes/No questions about:

- Paid Maternity leave,
- Paid Paternity Leave,
- Mentorship/Coaching programmes (General and Women-Focused),
- Flexible schedules,
- Childcare benefits

NB: Questions to be asked carefully, especially for senior-level participants)

Thank you for your time.

Appendix 3: Project Management Team

Background

The Stakeholder Analysis Project for Nigeria was commissioned by WomenLift Health, monitored and supported by Bixal and executed by Nextier as the local in-country partner. The three organizations jointly managed the project. The list below outlines the key persons who were responsible for the management of project.

ORGANIZATION	NAME	ROLE
WomenLift Health	Dr. Norah Akongo Obudho	Health Integration and East Africa Director
	Shagun Sabarwal	Global Monitoring, Evaluation and Learning Director
Bixal	Annie Schwartz	Director, Monitoring, Evaluation and Learning
	Eyerusalem Tessema	Specialist, Monitoring, Evaluation and Learning
Nextier	Dr. Francis Ifeanyi Ayomoh	Principal Investigator/Project Lead
	Dr. Uju Onyes	Co-Principal Investigator
	Patrick O. Okigbo III	Strategic Project Advisor/Principal Partner
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