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# RWANDA STAKEHOLDER ANALYSIS REPORT



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# TABLE OF CONTENTS

Acronyms	iii
Executive Summary	01
Introduction	02
Background	02
Study Design	06
Methodology	06
Findings	08
<b>RQ1:</b> What are the barriers and opportunities around women’s leadership in public/global health to address in the program design?	08
<b>RQ2:</b> What are current efforts that foster women’s leadership, diversity, and inclusion within organizations?	13
<b>RQ3:</b> What are the various ways organizations and the WomenLift Health program may work together?	14
Recommendations	15
Work Cited	16

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## ACRONYM

<b>FAWE</b>	Forum for African Women Educationalists
<b>ICRW</b>	International Center for Research on Women
<b>INGO</b>	International Non-Governmental Organizations
<b>NGO</b>	Non-Governmental Organizations
<b>PFTH</b>	Pro-Femmes/Twese Hamwe
<b>RQ</b>	Research Question
<b>SDG</b>	Sustainable Development Goal
<b>SOP</b>	Standard Operating Procedures
<b>WHO</b>	World Health Organization

## EXECUTIVE SUMMARY

This report summarizes the findings of a study conducted in Rwanda by the International Center for Research on Women in collaboration with WomenLift Health. The study is part of a multi-country effort to document the context, situation, prospects, and challenges of women's leadership in global/public health. Data for the report were gathered through a desk review of peer-reviewed and grey literature, as well as key informant qualitative interviews with leaders in a variety of critical public health organizations, institutions, and networks, including local and international non-governmental organizations (NGOs), universities, private sector, professional networks, and national health ministries and agencies.

The findings are summarized around three themes: (1) barriers and opportunities related to women's leadership in public health, (2) current efforts to foster women's leadership, diversity, and inclusion within organizations, and (3) various ways organizations and the WomenLift Health program may work together.

Study participants identified women's high burden of social and professional responsibility, gender bias, stereotypes, and cultural expectations, and a lack of career advancement opportunities for women, as critical barriers to women's leadership in health in Rwanda. Recommended solutions to these barriers were proactive governmental and organizational actions to ensure more female representation on relevant public health boards and committees, improved mentorship and leadership training opportunities, actionable organizational and institutional gender equity policies, support for women's access to higher education, and continuing gender equity and gender norms education and advocacy at multiple levels.

Efforts to advance women's health leadership in Rwanda needs to capitalize on the momentum created by Rwanda's forward-leaning gender policies, target the emerging pipeline of future female leaders, take advantage of the growing demand for structured approaches to mentorship, and collaborate with influential Rwandan organizations. Such influential organizations include Rwandan universities and medical schools, national health professional associations, Forum for African Women Educationalists (FAWE), Imbutu Foundation, Pro-Femmes/Twese Hamwe (PFTH), local health NGOs, UNICEF, and UN Women.

## INTRODUCTION

WomenLift Health, through support from the Bill & Melinda Gates Foundation, aims to accelerate the involvement of women in global health leadership by investing in and elevating talented mid-career women to become global health leaders. WomenLift Health believes that it is essential to contribute to transformative institutional and societal-level change by raising awareness about the value of women's leadership and catalyzing change through a portfolio of scaled interventions.

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

To inform the expansion of the Leadership Journey, WomenLift Health has partnered with the International Center for Research on Women (ICRW) to undertake a Stakeholder Analysis within East Africa to ensure the inclusion of local voices into its program design. Anchored in the principle of human dignity, ICRW advances gender equity, inclusion, and shared prosperity. ICRW's work uncovers the intersections of vulnerability and inequity that diminish opportunity for women and girls and documents proven solutions to these challenges. ICRW is committed to understanding how gender plays out in multiple areas of social life and interacts with key aspects of a person's identity to shape discrimination, privilege, and access to opportunities.

The findings and recommendations outlined below will be used by WomenLift Health to build a network of partners, identify best practices, and inform key priorities for future cohorts of the Leadership Journey.

## BACKGROUND

A thriving health sector is the foundation of sustainable economies. To ensure that the sector provides benefits to all, its leaders must understand how care delivery is changing, what reforms and innovations are required, and how to promote access to high-quality, gender-equitable care.<sup>1</sup> Although accounting for an estimated 70 percent of the global health care workforce, women are underrepresented in health care leadership positions.<sup>2</sup> This inequality was recently emphasized by the World Health Organization (WHO), which stated that “women provide global health and men lead it.”<sup>3</sup> Latest data from the World Economic Forum suggest that just 35 percent of leadership roles in the global health care industry are held by women. In 2019, only 25 percent and 20 percent of global health organizations had gender parity in their senior management and governance boards, respectively.<sup>4</sup> In 2020, only 44 percent were serving as Ministers of Health worldwide and Women Ministers of Children, Youth, and Families were much less in number.<sup>5</sup>

1 Jill Barr and Lesley Dowding, *Leadership in Health Care* (Sage, 2022).

2 World Health Organization, “Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce,” 2019; Roopa Dhatt and Ann Keeling, “Women's Leadership in Global Health: Evolution Will Not Bring Equality,” in *Women and Global Health Leadership: Power and Transformation* (Springer, 2022), 263–71; Women in Global Health, “Policy Brief: The State of Women and Leadership in Global Health: The XX Paradox,” *Women in Global Health Series: Gender Equity and the Health and Care Workforce*, 2023.

3 World Health Organization, “Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce.”

4 WHO, “10 Key Issues in Ensuring Gender Equity in the Global Health Workforce,” 2019, <https://www.who.int/news-room/feature-stories/detail/10-key-issues-in-ensuring-gender-equity-in-the-global-health-workforce>.

5 Women Political Leaders (WPL), “Women Health Ministers: Courageous and Ambitious Leaders during the COVID-19 Pandemic” (Brussels, Belgium, 2021), <https://www.womenpoliticalleaders.org/women-health-ministers-courageous-and-ambitious-leaders-during-the-covid-19-pandemic/>.

It is critical for global health to strengthen women's representation across leadership roles. Women dominate the healthcare consumer market.<sup>6</sup> Having more health leaders who understand care-seekers' needs, experiences, and perspectives can increase innovation and business opportunities. This is especially important in the emerging public health landscape, where digital technology, such as apps and other e-tools designed and developed primarily by men, is increasingly driving health services delivery and access.<sup>7</sup> Gender-diverse health leadership teams are also more innovative, more creative in problem-solving, avoid groupthink, and are more responsive to diverse customer needs.<sup>8</sup> When women hold health leadership positions, they prioritize the needs of marginalized groups, such as women, children, slum dwellers, and persons with disability, and allocate more resources to research on women's health issues, family welfare, gender equality issues, education, and nutrition.<sup>9</sup>

## Women's public health leadership in Rwanda: current situation, challenges, and opportunities

Progress in women's public health leadership in Africa has been far too slow.<sup>10</sup> The region experiences one of the world's most glaring shortages of women in health leadership roles.<sup>11</sup> While there are more women in healthcare across Africa, primarily in nursing and/or midwifery, very few are in positions of leadership—an indication of a women-dominated sector almost entirely controlled by men. Rwanda offers an interesting context for exploring women's participation in public health leadership positions. Following a devastating genocide in 1994 in which an estimated 800,000 people died, the country's administration, social fabric, and health system collapsed. As a result, Rwanda became the world's poorest country as well as the country with the world's highest child mortality and lowest life expectancy at birth.<sup>12</sup>

Nina Strohlic notes that while the world focused on the refugees of the genocide, "the Rwandans who remained in their own country were left to fend for themselves in a decimated nation. The population that stayed behind in the ruins was about 70 percent female."<sup>13</sup> Under President Paul Kagame, the leader of the rebel army that ended the genocide, a new constitution for Rwanda was adopted in 2003. This constitution made a commitment to "equality between men and women" and required that women hold at least 30 percent of legislative seats. Since then, "the traditionally patriarchal society has thrust its women into the role of rebuilding the country. They formed local councils, headed judicial proceedings, tilled the land, rose through the ranks of government,"<sup>14</sup> and drove Rwanda's remarkable and steady progress. In the 2003 election, women won 48 percent of the parliamentary seats, and together with a series of other policies on girls' education and women's empowerment, the country has since emerged as a model for gender inclusivity globally.<sup>15</sup>

6 Gretchen Berlin et al., "Women in Healthcare; Moving from the Front Lines to the Top Rung," McKinsey & Company, 2020.

7 L Loveth, "The Opportunities for Female Leadership in Health and Technology. Digital Health," Digital Health, 2020, <https://www.mobihealthnews.com/news/opportunities-female-leadership-health-and-technology>.

8 J Khuntia et al., "Valuing Diversity and Inclusion in Healthcare: Pathways to Equip Workforce.," JMIR Formative Research, 2022.

9 Ama Pokuaa Fenny, "Raising African Women Leaders in Global Health," *The Lancet* 392, no. 10165 (December 22, 2018): 2662–63, [https://doi.org/10.1016/S0140-6736\(18\)32841-1](https://doi.org/10.1016/S0140-6736(18)32841-1).

10 Ama Pokuaa Fenny, Kutisha Ebron and Anthony C. Andenoro, "Empowering Women in Healthcare Leadership: A Transformational Approach to Addressing Human Trafficking in Africa," *Journal of Leadership Studies* 16, no. 1 (June 1, 2022): 43–51, <https://doi.org/10.1002/jls.21804>.

11 Ama Pokuaa Fenny, "Raising African Women Leaders in Global Health."

12 Partners in Health, "Rwanda," <https://www.pih.org/country/rwanda>, 2022.

13 Nina Strohlic, "Two Decades After Genocide, Rwanda's Women Have Made the Nation Thrive," *The Daily Beast*, n.d., <https://www.thedailybeast.com/two-decades-after-genocide-rwandas-women-have-made-the-nation-thrive>. [https://gmo.gov.rw/fileadmin/user\\_upload/profiles/new/Gender%20%20Profile%20in%20Health%20Sector.pdf](https://gmo.gov.rw/fileadmin/user_upload/profiles/new/Gender%20%20Profile%20in%20Health%20Sector.pdf).

14 Nina Strohlic, "Two Decades After Genocide, Rwanda's Women Have Made the Nation Thrive," *The Daily Beast*, n.d., <https://www.thedailybeast.com/two-decades-after-genocide-rwandas-women-have-made-the-nation-thrive>.

15 Nicole de Paula, "Rwanda's Lessons on Gender Equality, Public Health, and Development," *The Economic Standard*, 2020, <https://theeconomicstandard.com/rwandas-lessons-on-gender-equality-public-health-and-development/>.

Currently, Rwanda has the highest proportion of women in national parliament (61 percent) of any country in the world. According to the 2021 National Gender Statistics report, 55 percent of government cabinet members and 30 percent of district mayors are women. In comparison to most sub-Saharan countries, Rwanda has a high proportion of elected seats held by women in deliberative bodies of local government (43.6 percent), a high proportion of women in managerial positions (28.6 percent), and a high proportion of women in senior and middle management positions (33.2 percent). It is also one of just two African countries that made the list of the top ten nations with the lowest gender gaps in the 2022 Global Gender Gap Index, which measures women's economic participation, educational attainment, health, and political participation in various societies. In addition, Rwanda presently ranks third among sub-Saharan African countries in the Women, Peace, and Security Index, which evaluates the security, justice, and inclusion of women across 170 nations.

UN Women reports that Rwanda has 91.7 percent of the legislative frameworks necessary to advance, uphold, and monitor gender equality as measured by sustainable development goal (SDG) indicators, with a particular emphasis on violence against women.<sup>16</sup> The country has also made significant strides in lowering adolescent births and meeting family planning needs. Rwandan women currently outperform men on several important socioeconomic indicators, including the poverty rate, which stands at 49 percent for men and 47 percent for women, and the unemployment rate, which is 17 percent for men and 13.9 percent for women. Additionally, the Global Engagement Institute notes that “not to be overlooked, however, are the women rebuilding the country at the grassroots level, from the income-generating cooperatives to the associations of young female entrepreneurs to the educational institutions preparing women for careers in politics, business and academia.”<sup>17</sup>

Evidence shows that the rising profile of women in Rwanda notwithstanding, a lot of work still needs to be done to achieve gender equality in leadership positions, particularly in the country's health sector. According to the Rwanda's Gender Monitoring Unit,<sup>18</sup> there are significant gender leadership disparities in the health sector. Women make up only 33.3 percent of the top management of the country's public health. In the Ministry of Health, women make up only 25 percent of senior management (director-general level) and 33 percent of director positions. Only 20 percent of senior management, 31.6 percent of director-level staff, and 34.3 percent of professional staff at the Rwanda Biomedical Center (the country's central agency for health implementation) are women. Women also make up 8 percent of hospital directors, 41 percent of heads of health centers, and 21 percent of doctors at the decentralized levels. Presently, men make up over 85 percent of Rwanda's public health sector specialists. Closing these gender gaps is essential for achieving gender-related SDG commitments in Rwanda.

The Women in Global Health<sup>19</sup> opines that several factors, operating at multiple levels—individual, household, organizational, and societal—fetter women's participation in health leadership roles in the developing world. Women applying for or accepting leadership roles must deal with family obligations and expectations. In Rwanda, cultural norms favor men. Uvuza points out that no matter how powerful Rwandan women appear to be in public, that power does not always extend into their own homes. They must not only perform domestic duties but also meet their husbands' expectations, which frequently require them to seek and obtain their husbands' approval before pursuing or accepting leadership positions.<sup>20</sup> Uvuza further notes that Rwandan women rarely have the option of

16 UN Women, “Rwanda” (UN Women, Not Dated), <https://data.unwomen.org/country/rwanda>.

17 Global Engagement Institute, “Women and Leadership (Rwanda) An Experiential Learning and Friendship Tour,” Announcement, Not Dated, <http://global-engagement.org/wp-content/uploads/2014/06/GEI-2014-P205-WomenLeadership-Rwanda.pdf>.

18 Gender Monitoring Office Republic of Rwanda, “Gender Profile in the Health Sector.”

19 Women in Global Health. Policy Brief: The State of Women and Leadership in Global Health: “Policy Brief: The XX Paradox.; 2023.” (WGH, 2023).

20 Justine Uvuza, “Hidden Inequalities: Rwandan Female Politicians' Experiences of Balancing Family and Political Responsibilities,” 2014.

hiring a maid or asking their husband to do more housework and that a Rwandan female politician could easily stand up in parliament, advocating for tougher penalties for sexual violence and subsidized maxi pads for the poor, while also being afraid to speak out about how her husband physically abused her or stopped her pursuing some positions.<sup>21</sup>

Gender-equitable leadership in the health sector is especially important in low- and middle-income countries like Rwanda, where health systems face complex challenges such as fragility, resource constraints, and high disease burdens. As Batson et al<sup>22</sup> point out, women's leadership in health is more than just an issue of equity; it is the missing link that can help countries address some of the health issues they face more effectively. According to current research, increased female leadership in Rwanda has improved gender wage equity, maternal/paternal leave, and gender-based violence policies and laws, enabling women to fully participate not only in government, but also in the country's economic life.<sup>23</sup>

Stronger and more sustained women's participation in health leadership in Rwanda can help to consolidate and expand these gains.<sup>24</sup> As data from the Rwanda's Gender Monitoring Unit suggest,<sup>25</sup> there are significant gender leadership disparities in the health sector. Rwanda is also currently strengthening its pipeline of women health professionals and leaders. Leveraging the leadership potential, talents, wealth of experience, and skills of both the existing and upcoming generation of health professionals is key to tackling the country's current and future health challenges. However, without a concerted effort to identify and eliminate the many obstacles that stand in the way of women's health leadership in Rwanda, the opportunities for change presented by gender-equitable health leadership will continue to be missed. The current research focuses on many topics, including the barriers, prospects, and efforts to promote women's health leadership in Rwanda and the opportunities for collaboration and partnerships in such efforts.

21 Gregory Warner, "It's The No. 1 Country For Women In Politics-But Not In Daily Life," Npr.Org. Last Modified July 29 (2016).

22 Amie Batson, Geeta Rao Gupta, and Michele Barry, "More Women Must Lead in Global Health: A Focus on Strategies to Empower Women Leaders and Advance Gender Equality," *Annals of Global Health* 87, no. 1 (2021).

23 Chimaraoke Izugbara et al., "The U.S. in Search of Gender Equity: Policy Lessons from around the World" (ICRW, 2022), <https://www.icrw.org/publications/the-u-s-in-search-of-gender-equity-policy-lessons-from-around-the-world/>.

24 World Health Organization, *Women and Health: Today's Evidence Tomorrow's Agenda* (World Health Organization, 2009).

25 Gender Monitoring Office Republic of Rwanda, "Gender Profile in the Health Sector."



# STUDY DESIGN

WomenLift Health, through the International Center for Research on Women, conducted the Stakeholder Analysis for Kenya, Rwanda, and Uganda. The objectives of the Stakeholder Analysis are to:

1. Conduct a desk review and analysis of existing data on women’s representation in the Kenya, Rwanda, and Uganda public health sector.
2. Identify and establish relationships with the individuals and organizations that are influential in the public/global health space in Kenya, Rwanda, and Uganda.
3. Draw upon their collective experiences to identify barriers and opportunities around women’s leadership in public/global health to address in the program design.
4. Understand current efforts to foster women’s leadership, diversity, and inclusion within organizations.
5. Understand various ways organizations and the WomenLift program may work together.

Study sample	
Sector	No of participants
INGOs	2
NGOs/NPOs	3
Government	1
University	4
Private	2
Philanthropy	0
Multilaterals	1
Networks	3
Total	16

In the findings, we will primarily focus on the last three research questions (RQs):



**RQ1:** What are the barriers and opportunities around women’s leadership in public/global health to address in the program design?



**RQ2:** What are current efforts that foster women’s leadership, diversity, and inclusion within organizations?



**RQ3:** What are the various ways organizations and the WomenLift program may work together?

## METHODOLOGY

### Landscape Analysis

To identify influential health organizations in Rwanda for the study, the study team compiled a comprehensive list of organizations by the eight identified sectors: international non-governmental organizations (INGOs), local Non-Governmental Organizations (NGOs)/National Policy Organizations (NPOs), university, multilateral, philanthropy, private sector, and government. The team used personal networks, as well as a review of pertinent literature and an Internet search of health-focused organizations and institutions, technical working committees, and civil society groups. Additional contacts of relevant organizations, governmental institutions, and professional associations were sought through careful searches of relevant government websites and consultations with a few well-known women health professionals. From a longer list, the study team, along with WomenLift Health, worked to prioritize based on balance across the sectors, level of influence, and diversity in stakeholder participation.

From the prioritized list, qualifying leaders from the identified organizations or institutions were contacted to inform them of the work of WomenLift Health and the study, and to ask for their participation. If they were not able to participate, the study team asked for an alternative contact within the organization. For organizations who declined, the team replaced them with the next organization on the prioritized list in the same sector to meet the overall sample target. A total of 16 organizations participated in the interviews.

## Key Informant Interviews

Participants in the study were mostly women in executive or senior public/global health leadership roles in Rwanda-based organizations identified through mapping activities. However, men were also included in the process. Key informant interviews with the participants sought information on barriers and opportunities related to women's leadership in public health, current efforts to foster women's leadership, diversity and inclusion within organizations, and various ways organizations and the WomenLift Health program may work together.

Interviews were typically one-hour long, audio-recorded, and transcribed. ATLAS.ti was used to thematically code transcribed interviews. Data analysis focused on examining narratives and responses related to the themes of current organizational investments in women's leadership, how these investments affect the work environment of women leaders, and opportunities for strengthening WomenLift Health's gender equality in public health leadership efforts. In the analysis, direct quotes are used to illustrate topical issues.

## Limitations

While this study provides valuable early insights into the barriers and opportunities around women's leadership in the public health sector, there are some limitations to consider. First, the sample size is small and may not be representative of influential public health organizations in Rwanda. Second, the study relies on interviews with leaders in "influential" health-focused organizations in Rwanda, which may limit the generalizability of the findings. It is not unlikely that the perspectives and experiences of these leaders will differ from leaders in less "influential" organizations and would have nuanced findings. Third, some of the interviews were conducted in Kinyarwanda and then translated into English. It is possible that important details got lost in translation. Notwithstanding these drawbacks, the study offers important insights on the challenges and issues related to women's health leadership in Rwanda.

## FINDINGS



### **RQ1: What are the barriers and opportunities around women's leadership in public/global health to address in the program design?**

Most study participants acknowledged the significant progress achieved by Rwandan women in shattering the glass ceiling in a variety of fields, including public health. To illustrate this progress, respondents frequently cited the high proportion of women in senior roles in the public and private sectors as well as the growing leadership role of women in almost all areas of the Rwandan society. Nonetheless, many respondents also noted that there was still a long way to go before gender parity in leadership will be achieved in the country's public health sector. Drawing from her personal experience, one participant illuminated some of the gender disparities that still exist in the leadership of the country's public health sector, noting that:

In my organization, there is an almost equal balance between men and women... But I am the only woman in top management, and there are three or four men, I think. So, you see, four men and then only me. So, hopefully we can have more equity for both genders at some point in the future (Woman leader, health practitioners' professional association).

And yet another respondent observed:

Though we have many women in leadership positions in Rwanda, we still have issues. The education of women is still low because at the beginning of high school or even primary education, the big percentage of students is women; but at the higher level of education, the representation of women becomes low (Woman leader, academia).

In general, the narratives revealed hurdles to women's leadership in Rwandan public health. **Women's significant load of social and professional obligation** as well as **gender bias based on stereotypes and cultural expectations** were the commonly stated barriers.

Judging by the data, the major barrier to gender equality in leadership roles in Rwanda's public health sectors is **women's high burden of social and professional responsibility**. Interviewees repeatedly indicated that women's roles in Rwanda continue to expand at various levels, and women's career success increases rather than decreases these multiple responsibilities. Professional women in Rwanda commonly juggle their careers with their responsibilities at home and community, including being caregivers, breadwinners, nurturers, mothers, wives, mediators, organizers, and community leaders. A respondent recounted her experience leading a government unit while also managing her domestic responsibilities. She had to rush home every day to breastfeed her newborn, cook for her family, and get her school-aged children ready for the next day. These many roles frequently left her exhausted and frustrated. She noted:

I think the main barrier is because we have other roles. Because of our cultural norms that influence us as women, you reach a level and you feel like you can stay in that position, you don't have that urge to compete for that next leadership level because you have a family to take care of, you know. You feel like maybe your husband is supposed to take this leadership post, you can stay at home look after children, I mean you feel comfortable.... Those family responsibilities prevent us from rising fast and taking leadership responsibilities at work (Woman Senior staff, public sector).

Juggling multiple responsibilities reportedly prevent women from dedicating time to pursuing activities that will expand their professional visibility, management expertise, and skills, including conducting research, attending

conferences and meetings, participating in on-the-job training activities, and networking. One respondent explains how combining motherhood, housewife roles, and professional work limits women's leadership:

You know when women should be taking on management positions and so on, that is also the time they are giving birth. We know that most of the time, the burden at home and of childbearing ... goes to a woman. What that means is that she takes a step back. They end up not aspiring a lot more. There are exceptions, but many women are not aspiring for those positions because of these challenges.... So, when they get married, they concentrate on taking care of the family, and they don't have enough time to pursue career education, training or mentorship that can allow them to develop leadership skills. High-level leadership roles may also require women to travel a lot sometimes within the country or sometimes even outside of the country. Some husbands don't like their wives to stay outside of the house for long because they are not trained to take care of the family when their wife is not around (Woman leader, health professional association).

Another participant also pointed out:

My perspective is that women are in the workforce as well as responsible for their homes, responsible for their families, their children and so on. You find that we sacrifice leadership positions because we are juggling family and professional lives. We don't strive for leadership because they require so much more time and we will not be able to care for our families, our children, our husbands or to balance. I might have a leadership position which requires me to work on the weekend which means I won't be there for my family. So sometimes, I think we sacrifice going up into leadership positions due to family responsibilities. In Rwanda, I find that a man will get a leadership position over a woman because he is not burdened with maternity leave and housework. So, they will promote the man. For the woman, they may think that she is going to be away from office for so long. They will take a man over the woman for these leadership roles (Woman leader, health professional group).

In the view of yet another respondent:

I find that these leadership positions require a lot. I must leave my children with their dad; I must leave instructions for their health and how to manage things. I find that we have so many responsibilities in our personal lives, in our work lives, that you end up losing a bit of one of them. You might lose on your promotion because you cannot go and work outside of Kigali. Yes – you end up losing those opportunities if you have younger children that you must be there for them (Woman leader, academia).

Multiple competing responsibilities also meant that women frequently declined to take up opportunities that will position them for leadership roles, as suggested below:

Even when we offer to send senior women professionals to further training or school, you will find that they will be torn between going and their family. They will say 'my job will be secure when I come back, but my family may be destroyed.' They find themselves trying to figure out how to balance everything, and most times, they just decide to put their family first (Woman leader, health professional group).

And, in the view of another respondent:

I think we have many different responsibilities that are professional, social, as well as cultural. So, when we are still young and in lower professional positions, it is bit easier for women, and you can give time to many things at home and the community, but going up to the higher position means more responsibilities at work. Sometimes you ask yourself, "am I able to do all these?" Because of the time all these things require, if I am asked to go to the field every day, every week, it becomes

hard to manage. We have children, husbands, and other community engagements and the society expects that I take care of all these roles (Woman leader, INGO).

**Gender bias and stereotypes** were another frequently mentioned barriers to women's leadership in public health in Rwanda. Despite the advances made by women in all sectors of society, narrative data revealed that there was still a prevalent assumption in Rwanda that leadership was the domain of men and that women were incapable of leading effectively. Respondents noted that women were often seen as emotional, tactless, unable to keep important secrets, erratic, and frequently lacking objectivity. These biases and stereotypes reportedly manifested in subtle ways, such as the exclusion of women from important conversations and decisions, or not considering them for sensitive leadership roles. In the view of one woman academic:

Women leaders are frequently subjected to gender bias and preconceived notions that impact their ability to lead and career advancement. You will find that our male leaders will say that certain positions are so sensitive and important for women to occupy. They say, 'that's not a position for a woman.' This prevents women from getting into key leadership roles. You will see that women are more likely to be allowed in those positions where men feel that there is nothing much at stake. There has been progress in addressing gender biases and empowering women leaders, but we still have a long way to go (Woman leader, academia).

Participants generally linked these biases and stereotypes to local cultural norms, noting that Rwandan cultures generally expect women to prioritize family roles over professional development and careers. As a result, openly ambitious women risk stigmatization in Rwanda. Women were expected to rely on men for recommendations or appointments to positions of power, leading to popular perceptions that women who openly express interest in leadership positions were power-hungry, looking to dominate men, and likely to use such positions for bad rather than good reasons. Women in positions of leadership were also expected to rely on the advice of men to avoid abusing their power or making mistakes. These normative expectations reportedly limited not only women's opportunities for advancement to leadership positions, but also their leadership aspirations. In the articulation of one interviewee:

Women still face many stereotypes, such as that they are not as competent as men, that they should prioritize family over career, and that they are too emotional to lead. If you are a woman and you show too much interest in leadership, rumor will start that you are trying to contest with men and that you have ulterior motives. Here, our culture sort of expects you to wait until men tell you to go for a leadership role (Woman leader, NGO sector).

A further obstacle to women's health leadership in Rwanda, according to the respondents, was **women's lack of confidence and self-belief in their capacity to lead**. Interestingly, narratives also linked women low in leadership self-confidence compared to the cultural norm of male superiority. As many interviewees noted, some women lack confidence and self-belief in their ability to lead because of pervasive gender biases and stereotypes, which frame leadership as a male domain and constitute women who aspire to top leadership positions as an aberration. One participant blamed women's lack of self-confidence on prejudice and culture. Speaking with specific reference to social norms and leadership, she noted that Rwanda cultures expect women to be humble and not overly ambitious. She noted that:

A woman is expected to say a few words, like, you know, be humbler. You only speak when you are 100 percent sure of your point. A man might fumble about their point and still be seen as confident. Sometimes, the confidence with which you speak is what propels you to those positions. But in Rwanda, women are not expected to be too confident or outspoken, yet the reverse is the case with men (Woman leader, NGO).

Other respondents observed that it was not uncommon for women in Rwanda to avoid putting themselves forward simply because they were women and felt unqualified or incapable of taking on leadership roles. One participant noted:

I think another barrier is that women and girls feel like they are not really born to lead because they have other roles and because of our culture norms which create the impression that leadership is for men. Women here can reach a level, and they can stay in that position. They don't have that urge to compete for the leadership level. They feel they will not do well. They lack the confidence and some of them will think maybe my husband or other men are supposed to take that leadership post, so that I can stay at home and do ABCD, like look after children. Even if you want to take that top role, you fear the family conflicts it may bring (Woman leader, NGO).

And yet another asserted:

There is this part played by our culture where women are not confident enough to pursue those positions, thinking that men are born to lead not women. They think men should lead. I don't believe it is different in the health sector. This factor plays a part (Woman leader, academia).

**Inadequate leadership, mentorship, and support** was also mentioned as a barrier to women's health leadership. Respondents stated that Rwandan women generally lack access to experienced mentors and networks that can provide them with career guidance and support. This was attributed, in part, to the country's low number of women in public health leadership roles, as well as a lack of supportive institutional and organizational systems. Many local health institutions and organizations in the country reportedly also lacked formalized mentorship and support programs that address the unique challenges that women face in health leadership roles. In many such organizations, women were said to lack supportive role models and systems to assist them in navigating the challenges of balancing personal and professional responsibilities. One participant claimed she knew "some institutions where once you are sick and get pregnant with these complications and then go on these repetitive sick leaves, they fire you." Another respondent noted that "some employers don't like to have a big number of females because they will give birth and take a long period not working for their institutions." Offering some background to the country's poor mentorship and support system for women leaders, a participant added:

After the genocide, the focus was not on giving women the skills to be leaders. Many women were just appointed into positions. And this has continued. Even in the private sector, they just appoint women to look good. But nobody is saying anything about preparing these women, giving them the skills to be good leaders. I don't know if there is any organization in the country that has a formal mentorship program for women to be leaders. Maybe there are, but they are very few (Woman senior manager, Public Sector).

Related to the problem of inadequate leadership mentorship and support was **women's underrepresentation in key decision-making positions in public health**. Respondents stated that a lack of sufficient mentorship for female health professionals has resulted in a situation in which few women are adequately prepared and skilled to take on leadership roles in the sector. As a result of female underrepresentation in key positions, women were reportedly discouraged from aspiring to high positions because they only see a few women who have made it to the top.

**Lack of sufficient opportunity for career advancement** was also reported as a barrier to women's health leadership in Rwanda. According to the interviewees, Rwanda has very few top public health leadership positions as well as limited number of public health institutions and organizations. Following the genocide, many of the country's top health institutions had to be reorganized and rationalized for efficiency. As narratives suggested, competition for the country's few public health leadership positions has become fierce, and men, reportedly, are frequently preferred for such positions of leadership. The view of one respondent was:

The lack of those opportunities for leadership positions may also be conditions which are not favorable to women due to our history. We have few women who have higher level of education. Also, the conditions set to get to those leadership positions often include criteria that women do not meet. Mainly, they are few because women have not gained higher education levels needed for the positions (Woman leader, academia).

Data from interviews suggested that the barriers to women's leadership can be overcome. Participants suggested that **proactive governmental and organizational actions could help to ensure more female representation on relevant public health boards and committees, more mentorship and leadership training opportunities, actionable gender equitable organizational and institutional policies, support for women's access to higher education, and ongoing gender equity and gender norms education and advocacy at multiple levels** were some of the suggested strategies for dealing with these challenges.

Despite advancements in women's leadership in Rwanda, interviewees stated that the **government must do more to ensure equitable female representation in key health decision-making committees and boards**. They also emphasized the importance of these boards and committees in ensuring fair and unbiased appointment and promotion practices in the public health sector. However, evidence from interviews indicated that women's representation in these important bodies is far from adequate.

Interviewees recommended **structured mentorship and leadership development programs for women** as critical ways for institutions and organizations to enhance women's leadership in the public sector. Respondents frequently mentioned management and conflict management skills, research competencies, scholarships targeted at mid-career women health professionals, linkage of women leaders to senior mentors who can share experiences and provide them sustained support, transferable mentorship skills, opportunities for networking, and access to support for building self-confidence as potential components of such mentorship and leadership initiatives. Respondents also suggested that institutions and organizations need to develop and set clear targets and monitoring mechanisms for the mentorship and leadership training support of women health professionals.

Data also suggested that Rwanda should continue to **challenge the social and cultural norms and biases that perpetuate gender inequality by building on existing gender norms and equity initiatives**. Stereotypes, biases, and inequitable norms about women's leadership, according to respondents, affect all aspects of life in Rwanda and require education, training, and advocacy to change. They proposed that efforts to address these norms be multifaceted, focusing on organizations, men, boys, women, girls, families, households, institutions, communities, and schools, and providing information and guidance on the importance of gender equality, as well as assisting citizens in identifying and overcoming biases that impede women's advancement. One interviewee argued that efforts to foster changes in norms "should be a continuous process from the families to primary school, even to nursery and should encourage females to know that they be whatever they want to be, continuing in higher school education, encouraging females to act or to work using their education, that they can also be pro-active and occupy any position in life" (Woman, professional association).

There was also the expressed need for **greater investment in women's access to higher education**. Respondents agreed that leadership positions, particularly in the health sector, often require a high-level educational attainment. They did, however, note that women continue to fall behind men in terms of access to higher education in Rwanda. Improving women's access to higher education was viewed as crucial for preparing women for future top positions and ensuring a strong pipeline of future female leaders.

Participants also recommended **institutional and organizational workplace policies** that clearly affirm gender equality and inclusivity, improve work-life balance, and support women in balancing professional and domestic responsibilities, including childcare responsibilities. Flexible work arrangements, extended maternity and paternity leaves, remote work options, and family friendly policies were mentioned as examples of such policies by respondents.



## RQ2: What are current efforts that foster women's leadership, diversity, and inclusion within organizations?

In general, data indicated that there were few strategic efforts to increase women's leadership, diversity, and inclusion within public health organizations. Several respondents were either unaware of such efforts in their organizations or stated that such efforts were not common. For instance, one respondent noted: "I wouldn't say that there is anything that is like a formalized system or policy for promoting in the institution," and another observed that "I don't know if any particular policies promote women's leadership in the health sector. I mean, I don't see any."

Respondents who expressed awareness of efforts to foster women's leadership, diversity, and inclusion within their organizations mentioned **mentorship and supportive organizational/institutional policies** as examples of such endeavors.

Some forms of **mentorship support activities** were reportedly being practiced in some organizations. These take the form of older and more established women health leaders lending support to emerging leaders and teaching them how to deal with organizational politics as well as encouraging younger women to aim higher and exposing them to skills for navigating barriers to their professional growth. Such support activities frequently included advising emerging women leaders on how to advance their careers and manage organizational politics, as well as making strategic decisions. However, as many respondents noted, these mentorship efforts were frequently informal and unstructured.

Respondents also indicated that some **organizations have implemented policies to enhance work-life balance, promote gender equality and inclusion, and enhance more women-friendly workplaces.**

Reportedly, some of the organizations have set specific goals for increasing the number of women in positions of leadership. These efforts conveyed a clear message that gender diversity was a top priority in those organizations, as well as creating a welcoming environment for women to thrive in leadership roles. Internal Standards Operating Procedures (SOPs) for recruitment and advancement, flexible work hours, support to expectant and breastfeeding mothers, and guidelines to ensure more gender-balanced management teams were other examples of pro-women organizational policies and activities that were being implemented. A respondent noted:

Our organization has internal Standards Operating Procedures (SOPs) for recruitment, those are in place, and they are promoting diversity and equity among the staff and what we are doing is just to respect and implement those SOPs (Woman leader, multilateral health institution).

Several respondents saw **Rwanda's 2003 constitution** as a critical component of the country's efforts to achieve gender equality and inclusivity, particularly in government health institutions. They noted that the momentum created by the constitution needs to be harnessed continuously to ensure that the vision of gender equality is kept alive in Rwanda. In the view of one participant:

As we know, Rwanda is the country with the highest representation of women in the parliament and this is something that is based on the enabling policy in place where the national constitution provides that 30 percent of decision-making positions should be reserved for women and so this enabling policy is in place. This is something very important for increasing the representation of women in health leadership positions. (Woman leader, multilateral health institution)





### **RQ3: What are the various ways organizations and the WomenLift program may work together?**

Several participating organizations expressed a willingness to collaborate with WomenLift to both broaden the frontiers of women in health leadership and to assist their employees, particularly women, in strengthening their leadership skills and capacity. Some of the identified areas for potential collaboration with WomenLift were:

#### **Mentorship programs:**

Participating organizations identified an urgent need for structured approaches to health leadership mentorship for women in Rwanda. As many organizations noted, there were few if any structured strategies for producing and supporting women health leaders in the country. Narratives suggested the possibility of working with WomenLift to address this gap.

#### **Leadership training courses and workshops:**

WomenLift's experience and expertise, according to interviewees, could be used to design and implement leadership and management training workshops and programs for women in health in Rwanda. Respondents noted that there are currently very few structured leadership training programs and workshops in Rwanda for aspiring and existing female leaders. Nonetheless, such a program was desperately needed. Effective communication, decision-making, team building, and conflict resolution are some of the suggested topics for such workshops. Universities and educational institutions in Rwanda were regularly identified as possible partners for WomenLift to create and deliver such courses.

#### **Sector-wide advocacy for women's leadership:**

Although Rwanda has made strides in women's leadership, respondents noted that these gains are not shared by all sectors within the country. Sector-wide advocacy was deemed strategic for both maintaining current gains and expanding women's leadership in the country. Participating organizations see an opportunity to collaborate with WomenLift in the development and delivery of media campaigns, community events, and social media outreach to address existing barriers and sustain the momentum of women's leadership in the country.

#### **Coordination of existing women's leadership efforts:**

Respondents suggested that WomenLift could also be a partner in coordinating the various ongoing organizational women's leadership development activities in the country. Respondents viewed existing organizational efforts viewed as haphazard, lacking a framework, and not contributing to any strategic goals. Respondents from organizations were unaware of efforts by peer organizations, and there was little cross-organizational learning. Respondents deemed supporting organizations to harmonize their women leadership activities critical to the quality and effectiveness of existing efforts.

## RECOMMENDATIONS

### 1. **Harness the existing national momentum for women's leadership in Rwanda.**

Rwanda has, by far, one of the most favorable environments in Africa for women's health leadership. However, emerging evidence suggests that the health industry is not making the best of the situation. WomenLift has a unique opportunity to capitalize on this momentum to advance gender equitable and inclusive leadership in the health sector.

### 2. **Target the emerging pipeline of future women leaders.**

Rwanda is stepping up efforts to increase the number of female health professionals, such as doctors, nurses, pharmacists, and medical technologists. Gender equitable admission policies are supported by institutions such as the University of Rwanda, the University of Gitwe, the Adventist University of Central Africa, and the University of Global Health Equity. Strategies and interventions to prepare these emerging female professionals for future health leadership roles are desperately needed.

### 3. **Target the social norms that suffocate female leadership.**

Respondents to the study emphasized the impact of socio-cultural norms in impeding women's leadership. Women's and girls' limited educational achievement and delayed progression in the workplace, women's lack of confidence in their competence as leaders, and unfavorable public impressions of women's leadership were, among others, all linked to social norms. Women's leadership advancement efforts in Rwanda should focus attempts to address these harmful social norms through advocacy, capacity building, awareness creation, and other interventions.

### 4. **Support the development of a coordinated women health leadership strategy.**

According to interview data, current organizational efforts in Rwanda to strengthen women's health leadership are disjointed and unsystematic. Rwandan public health institutions will benefit from assistance in coordinating their strategic efforts to support women's health leadership.

### 5. **Capitalize on the growing demand for structured approaches to mentorship.**

According to narrative data, many Rwandan public health institutions do not have structured mentorship programs for women health leaders. In general, responding organizations expressed a desire for well-designed and practical approaches to mentoring current and future female health leaders. It will be critical to capitalize on the emerging felt need for structured mentorship efforts.

### 6. **Collaborate with influential Rwanda-based organizations to build local capacity for women's health leadership.**

Several of the organizations surveyed in this study are working hard to advance women's health leadership in Rwanda. Other organizations identified as critical to the advancement of women's health leadership in Rwanda include Rwandan universities and medical schools, national health professional associations, PFTH, local health NGOs, UNICEF, Gender Monitoring Unit, UN Women, FAWE, Imbutu Foundation, and the United Nations Population Fund. WomenLift Health must form partnerships with these organizations to scale their work.

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