
UGANDA STAKEHOLDER ANALYSIS REPORT



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ACRONYMS

KIIs	Key Informant Interviews
NGO	Non-Governmental Organizations
INGO	International Non-Governmental Organizations
ICRW	International Center for Research on Women
NGO	Nongovernmental Organizations
NPO	National Policy Organizations
RQ	Research Question
SDG	Sustainable Development Goal
WHO	World Health Organization

EXECUTIVE SUMMARY

This report summarizes the findings of a study conducted in Uganda 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 desk reviews as well as key informant qualitative interviews with women in leadership roles in a variety of key public health organizations, institutions, and networks, including local and international non-governmental organizations (NGOs), universities, private businesses, 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 can work together.

While respondents generally agreed that rapid progress had been made in women's leadership participation in Uganda, citing politics as an example, they also frequently expressed the belief that gender parity in leadership was generally lacking in the country's public health sector workforce and several other areas. Respondents identified the following as major barriers to women's public health leadership in Uganda: a persistent culture of male dominance in leadership positions, a lack of strong support networks for women, ineffective organizational policies, a weak pipeline of potential women leaders, and a lack of work-life balance for women. Among the measures identified for overcoming these barriers were the development of enabling systems and policies for women to become leaders in the health sector; mentorship; collaboration with men colleagues and professionals in the health sector; and enhanced organizational systems and policies. Current efforts by the participating organizations to address barriers to women's leadership in the workplace involve modifying their staff recruitment and promotion processes; implementing training and mentorship programs; involving young women professionals in high-level meetings and key decision-making; supporting work-life balance; providing educational advancement; and encouraging further certification of women health professionals.

Building on the growing momentum for women's leadership in Uganda, addressing locally felt needs for bespoke women's health leadership mentorship and training activities, supporting the formation of a network of existing women public health leaders, targeting the next generation of women public health leaders, and collaborating with influential Uganda-based organizations working on women leadership in public health are all necessary next steps toward advancing women's health leadership in Uganda.

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 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 that 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.

Affecting organizational and societal changes is also key to addressing barriers for women in global health. WomenLift Health affects these levels through convening thousands of men and women to address issues and share solutions through its Speaker Series and Women Leaders in Global Health Conference.

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. 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.¹ Although accounting for an estimated 70 percent of the global health care workforce, women are underrepresented in health care leadership positions.² This inequality was recently emphasized by the World Health Organization (WHO), which stated that “women provide global health and men lead it.”³ Latest data from the World Economic Forum suggest that just 35 percent of the 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.⁴ 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.⁵

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.⁶ 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.⁷ Gender-diverse health leadership teams are also more innovative, more creative in problem-solving, avoid groupthink, and are more responsive to diverse customer needs. 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.⁸

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

Progress in women's health care leadership in Africa has been far too slow.⁹ The region experiences one of the world's most glaring shortages of women in health leadership roles.¹⁰ 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. Uganda has seen significant advances as well as obstacles in women's leadership engagement, making it an intriguing environment for examining the challenges and potential for women's health leadership. The country has a population of 45.74 million people, with slightly more than half of them being women. Uganda's Constitution guarantees gender equality and promotes affirmative action to correct inequities caused by history, tradition, or custom. The country has adopted national policies and guidelines over the years to enhance women's well-being and participation in national socioeconomic life. For example, the Ugandan Employment Act of 2006 protects expectant mothers by requiring employers to ensure that female employees have the right to a period of 60 days leave from work on full pay, referred to as "maternity leave," of which at least four weeks must follow childbirth or miscarriage. In the event of pregnancy or confinement-related illness affecting either the mother or the baby and making the mother's return to work inadvisable, the right to remains available within eight weeks of the date of childbirth or miscarriage. A National Gender Policy that calls for gender equality and women's empowerment in all areas of life, including the workplace, has also been adopted by the nation.

The current vice president (Jessica Alupo) and prime minister (Robinah Nabbanja) of Uganda are women. The proportion of women in the cabinet has been steadily increasing and is now at 43 percent. Additionally, women control 46 percent of the roles in local governments and 33 percent of the seats in parliament. The three ministerial positions in the Ministry of Health are now held by women, which is very noteworthy. In the Ministry of Education and Sports, two women hold the three ministerial roles. Under their and their predecessors' leadership, there has been a surge in the number of girls attending school and women obtaining university degrees in professions historically dominated by men. Furthermore, 75 percent of Uganda's legal framework for promoting, enforcing, and monitoring gender equality under the Sustainable Development Goal (SDG) criterion are in place.

Major gaps remain. As of December 2020, only 42.6 percent of indicators needed to monitor the SDGs from a gender perspective were available; Ugandan women continue to lag in leadership positions compared to men. For instance, in the legal profession in Uganda, only 23 percent of senior roles are occupied by women. There is also a concentration of women at the bottom of occupational hierarchies in public health facilities in Uganda. Men occupy 77 percent of the senior management jobs in public health and dominate clinical services, such as medicine. On the other hand, women dominate nursing and midwifery

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 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).

9 Fenny. 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>.

10 Jacqui Poltera and Jenny Schreiner, "Problematising Women's Leadership in the African Context," *Agenda* 33, no. 1 (January 2, 2019): 9–20, <https://doi.org/10.1080/10130950.2019.1613057>.

but are concentrated in lower positions.¹¹ Overall, the proportion of women in managerial positions and in senior and middle management positions currently stand at 25.5 percent and 31.8 percent, respectively. The 2022 labor force participation rate among females was 67.6 percent and 72 percent for men. Also, Uganda has more women in vulnerable, shock-prone, or insecure employments compared to men. In 2018, women in Uganda spent 14.6 percent of their day in unpaid work, relative to men's 7.5 percent.

According to a recent report by Women in Global Health,¹² several factors operating at multiple levels—individual, household, organizational, and societal—limit 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 Uganda, like many other parts of Africa, cultural norms favor men. Gender-equitable leadership in the health sector is especially important in low- and middle-income countries like Uganda, where health systems face complex challenges such as fragility, resource constraints, and high disease burdens. Uganda continues to battle with many socioeconomic and health challenges that can benefit from women's health leadership, including a persistently high maternal mortality ratio and high rates of child marriage, birth rate, violence against women, and unmet needs for family planning.

As Batson et al 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.¹³ Stronger and more sustained women's participation in health leadership in Uganda can help to consolidate and expand these gains.¹⁴ 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 Uganda, 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 Uganda, as well as the opportunities for collaboration and partnerships in such efforts.

11 C Newman, M Mugisha, and C Matsiko, "Uganda Ministry of Health Gender Discrimination and Inequality Analysis Report," Rapport Technique, 2012.

12 Women in Global Health, "Policy Brief: The State of Women and Leadership in Global Health: The XX Paradox."

13 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).

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

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.

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

To identify influential health organizations in Uganda 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, private sector, philanthropy, 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 19 organizations were identified for inclusion.

Key Informant Interviews (KIs)

Participants in the study were mostly women in executive or senior public/global health leadership roles in Uganda-based organizations identified through mapping activities; however, men were also included in the process. KIs 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 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 or women public health leaders in Uganda. Second, although research exists on the insights and perspectives of the upcoming generation of Ugandan female health leaders on these issues, that evidence has not been integrated in this report to give more nuance to the findings. Notwithstanding these drawbacks, the study offers important insights on the challenges and issues related to women’s health leadership in Uganda.

Overall, while this study provides valuable insights into the barriers and opportunities around women’s leadership in the public sector in Uganda, the limitations outlined above should be taken into consideration when interpreting the findings and generalizing them to other contexts.

Participants	
Sector	Interviews Conducted
INGOs	1
NGOs/NPOs	5
Government	4
University	2
Private	2
Multilaterals	1
Networks	4
Philanthropy	0
Totals	19

FINDINGS



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

While respondents generally acknowledged that some rapid progress has been made in women's leadership participation in Uganda, citing the political sector, they also frequently expressed the belief that gender parity in leadership was lacking in the country's public health sector and several other areas. Respondents identified five broad barriers to women's public health leadership in Uganda, namely the **culture of male dominance, difficulties in creating support networks for women, ineffective organizational policies, weak pipeline of potential women leaders, and the lack of work-life balance for women.**

Culture of patriarchy and male dominance

During the interviews, respondent spoke frequently about a persisting culture of patriarchy and male dominance in leadership in Uganda, which was supported by deeply ingrained cultural biases and stereotypes that favored men. Reportedly, this culture manifests in and permeates all levels of relationships in Uganda, from the family and household to public life. One respondent used a recently announced job position in her organization to highlight the dynamics of patriarchy in leadership. She observed that once the job advertisement was released, many employees publicly stated a preference for men to fill the post. She recalled her colleagues saying:

How I wish that this vacancy will not be filled by a woman. Because every time they will have issues: They will say "my baby is sick, I am pregnant, I have my family, I am ill, I have children going to school." She added that "even some colleagues at that level assume women will not be contributing equally because of those other roles women play. So, somehow there is that feeling that maybe women do not contribute as well as men" (Woman leader, Public Sector).

In general, data indicated that despite efforts to promote gender equality and diversity in the country, leadership was still considered a domain for men. In interview after interview, participants reported that many Ugandan local cultures and communities regard men as more capable, decisive, and assertive in leadership positions. Women, on the other hand, are deemed as followers, meek, and incapable of objectivity and strong leadership skills. This idea was seen to be prevalent in daily life. Respondents noted that women who are appointed or promoted to positions of leadership in Uganda tend to be viewed as incompetent or solely in such positions to do the bidding of men, rather than because they offer significant value to those roles. Summarizing this viewpoint, one respondent observed:

One of the key barriers for women to get into leadership is our belief and social construct that women are not or cannot make good leaders. So, a woman must struggle two to three times more than a male to prove her leadership ability (Woman leader, Professional Network).

Narrative data linked male domination in leadership to the higher proportion of men in senior leadership positions, the widespread overlooking of women for leadership positions, and women's lack of confidence in pursuing leadership roles in the public health sector. As one woman put it:

As I was saying, men are still the majority. So that is the first challenge that is making people feel like when you're a woman, and you cannot take the leadership role. Men are still the majority and this leads to many things. When it comes to appointing leaders, they ignore women and appoint their own

kind. This makes women lose confidence and begin to feel that they are not competent. You know, when you hear of a position and you feel like applying, then you see that most of the top people in that organization are men, you develop self-doubt. You ask yourself; do I really want this thing. You walk into a typical leadership meeting room in Uganda, and most of the people in the room are men. You can lose your confidence and some women can decide to stay away (Woman leader, Public Sector).

Respondents stated that the apparent shortage of women in leadership positions in public health organizations discourages women from pursuing leadership positions. It gives women the impression that there is no room for advancement or that their chances of reaching the top are small, leading to feelings of isolation and disengagement, and the preservation and perpetuation of gender imbalance in leadership roles. The male dominance culture was also linked to women's and girls' limited access to educational opportunities. Respondents remarked that families still invest more in the education of boys, to the detriment of girls, resulting in a weak pipeline of future women leaders. In the insightful words of one respondent:

Uganda culture also favors the education of men more than women. Families invest more to train their sons. So, this also creates a shortage of highly educated girls. If you look at the education pipeline, you'll find that women have got the short end of the stick for a long time. If you look in the sciences, women are less likely to go into the sciences than men, meaning that the pipeline is narrowed all the way from primary education, through secondary. This is largely due to culture (Woman leader, NGO).

Yet another respondent noted:

Women's leadership role in the health sector is very weak, but this shouldn't surprise us, because the health sector is mainly based on STEM (science, technology, engineering, and mathematics), right. And as you know, science, technology, engineering, and mathematics is an area where women and even the girl child has been deprived the most from the lowest level. Boys' education has been prioritized by many cultures, families, and communities for a long time. So, by the time, we'll even talk about women being at the leadership level, this must be addressed right from the primary level... If we can't have women and girls in STEM, from the lowest level, how do we expect to have them in leadership at the higher levels? So that is the major explanation (Woman leader, Professional Network).

The **absence of robust support systems and mentorship for women in public health** was another frequently mentioned barrier to women's public health leadership in Uganda. Respondents pointed out that for women to pursue and achieve leadership roles, they needed strong support networks. However, respondent noted that most Ugandan women in public health face substantial obstacles in building these networks. These networks were deemed to be crucial sources of mentors, references, supporters, recommenders, and nominators for prospective women leaders. Interview data suggested that in Uganda, few of these networks exist for women in public health, denying them the support and preparation they require to learn about the rigors of leadership, acquire the skills necessary to navigate boardroom and organizational politics, and wade through the challenges of leadership in male-dominated systems. As one respondent pointed out:

In this country, it is difficult to find a professional network for women in public health. So, women professionals in the sector have few places to go for advice and support. They have nobody or group to recommend them. They end up relying on men for recommendations and support.

Nobody teaches them how to play the game, prepares them for politics, or even holds their hand. You see what this does is that they travel alone. They thrive alone... They can get the skills in their work, but they don't get to learn how to lead. And if a position is available, such women are overlooked. People will say, "yes, she is a good doctor, teacher, midwife, or pharmacist, but what does she know about leading people? That's what they say (Woman leader, Public Sector).

Reportedly, men dominate many of the critical networks, including professional organizations, in which Ugandan women working in public health are members. In these networks, as interview data indicated, women professionals experience subtle or overt discrimination, microaggressions, and exclusion from decision-making processes. These harmful gendered practices reportedly hamper women's self-esteem, drive, and confidence, restricting their ability to pursue leadership roles. In the view of one participant:

Many of the women I speak with mention the difficulty in finding mentors and sponsors who truly understood their experiences and could provide them with meaningful guidance and support. The public health is dominated by men in terms of power. Many of these men don't believe in gender equality. Their attitudes towards their female colleagues are very negative (Woman leader, Public Sector).

Yet another observed:

The governance question within the hospitals where most of the board members are men and are more likely to be selected because they are more likely to lobby for promotions as opposed to women (Woman leader, Health Professional Network)

Work-life balance: Narratives indicated that Ugandan women in the health sector struggle to strike a balance between their professional and personal duties. In addition to their careers, society expects women to perform domestic tasks, including taking care of the family, husbands, their kids, and cooking. Respondents observed that these competing priorities, including raising and nurturing a family, frustrate women's career growth and leadership aspiration and roles. One respondent noted that these family responsibilities were a top reason why women fail to achieve leadership roles in public health, asserting that "where women have taken on senior positions, families have suffered and even broken down." Also, in the social and religious environments and spaces where women operate, they also often took on critical roles that interfere further with their career growth. One respondent noted:

The various roles of women as mothers, caretakers, and wives, and many other responsibilities limit their ability to upgrade their qualifications and thus be eligible and available for leadership positions (Woman leader, National Network).

In the view of another participant:

Women's roles as caregivers, workers, mothers, and the patriarchal society do not lend well to women advancing to leadership positions. Qualified women who want to take up leadership positions do not often get much support, instead they are penalized by system (Woman leader, Public Health Facility).

Balancing domestic and biological roles with jobs and career commitments was considered difficult. It often resulted in women's limited experience and interest in leadership roles. Interview data indicated that many healthcare workplaces provide little flexibility or tolerance for the unique issues that women encounter. Women were reported to be more prone to miss out on work-related travels, professional training programs, and participation in critical workplace meetings and decision-making processes due to the high burden of both professional and noncareer responsibilities. Sharing her personal experience, one of the respondents noted:

For me, I am a mother of one and my experience recently from coordinating a national health program is that I have been so limited because I am supposed to move around the country. But I cannot move with my child. Family issues can limit you, which is not the same with the men. If the program fails, nobody will remember that I have a child. And if I don't take the job, I won't have the exposure for the next big responsibility (Woman leader, Public Sector).

Another participant noted:

If you're in a senior role, as a woman, ordinarily, you know, there are certain issues that you have to pay attention to. Maybe you have a family and there are kids to take care of and your husband is also there. You can't just leave them and focus on your career. You can't just say 'I am traveling today, and you pack your bag and go. You can't even stay late to attend some office meetings. For men it is different...they don't necessarily have to handle these home issues (Woman leader, Public Sector).

And yet another pointed out:

At times, women also have the work balance between work and family, which is not easy. In this world, you get women who are working, and then at the same time, they have to take leadership roles. Some of them feel it is a bit ...too much on their side. So, getting into the leadership becomes a bit of a challenge (Woman leader, Public Sector).

Respondents stated that managing these multiple duties disrupts women's productivity, forcing them to work longer hours and for longer periods of time to advance professionally. It also made it harder for women to produce workplace results at the same level as their male counterparts, gain relevant experience and exposure, and participate in critical activities that may count toward future leadership roles. One respondent articulated the issue as follows:

Women do not produce any less work or output than their male counterparts. But women's output may be fragmented, or it may take longer for you to produce the same work because you're balancing multiple things at the same time. But by that time, the man has gotten ahead and may become the leader (Woman leader, Bilateral Organization).

Some participants mentioned insensitive organizational procedures and lack of intentional approaches to supporting women leaders in organizations as key barriers to Ugandan women's leadership in public health. Some public health institutions and organizations in Uganda reportedly lacked robust processes that address the special issues that women face or to mentor them into leadership roles. They were said to have unfair maternity policies, unsupportive male and female leaders, weak sexual harassment policies, insensitive travel patterns, unclear mentorship and advancement strategies, and inflexible promotion practices. As suggested by one respondent, such inequitable policies have an impact on women's potential to attain leadership positions.

Of course, some institutions don't make room for women to do their many roles and to be able to lead. If a woman must take time off, at times people will not give you a job. If you're pregnant and you are a health worker, they say oh, you're going to have to have six maternity leaves. When it is time for promotion or for a big role, they ignore you (Woman executive, Health Professional Association).

Another added:

Some organizations do not have strong gender policies. If someone makes advances to you as a woman and you say no, when your name comes up for recommendation for a position or promotion, they will say no. And you cannot report because the organization does not have effective ways to deal with these things (Senior staff, Academia).

According to interview results, these challenges significantly affect women's ability to reach or assume leadership positions. They strip women of their confidence and enthusiasm and limit their access to the training and experiences required for leadership. They also make women miss out on possibilities for career progress, which can harm their long-term ability to lead. Additionally, because of these obstacles, it often takes women longer than men to get to the point at which they are deemed qualified for leadership positions.

Interviewees identified many strategies for addressing the challenges regarding women's leadership in public/global health. These strategies include **creating enabling systems and policies for women to become leaders in the health sector, mentorship, working with men, embedding women's leadership in human resources processes, and improving organizational system and policies.**

Creating an enabling institutional environment for women leadership in health was identified as one of the strategies for building and supporting women's leadership in health. Respondents noted that many organizations in Uganda currently lack healthy environments for women to flourish as leaders. Women-unfriendly work environments include the lack of clear hiring, promotion, and reward systems; uncertain leadership pathway for women; poor promotion practices; poor diversity and inclusion practices; inadequate recognition of the contribution; potential of and challenges for women in male-dominated work environments; lack of clear quotas for women; and limited involvement of women in committees and decision-making. Creating an enabling environment, participants noted, requires the institutionalization of quotas particularly in the private health sector and the development of more women-friendly human resource systems. One respondent noted that her institution has recently created a system for at least 40 percent of committee representation for women.

Related to the issue of the work environment, participants identified the need to **embed women's leadership within organizational human resources processes** and to **improve organizational systems and practices.** Many organizations were noted to have human resource processes, systems, and policies that fail women and prevent them from seeking or attaining leadership roles. Improvements in organizational practices and policies would require women-friendly and fairer travel policies, internal training programs, support to women to navigate safety in the workplace, gender policies and policies related to sexual harassment, and support to women during pregnancy and maternity leave.

Participants mentioned **mentorship and training programs** as another strategy to build women's leadership in health. Respondents observed the lack of strong leadership and mentorship programs for women health leaders in Uganda. They emphasized the importance of such programs in supporting existing women leaders with the requisite skills and in preparing emerging women leaders for future management roles. Training and mentorship programs, according to the respondents, should focus on management skills, networking, boardroom politics, organizational policy development, and inclusive management approaches. Respondents also noted the need for programs to link established women leaders with emerging ones to enable them to build skills, gain exposure, learn, and network. Mentorship could also involve younger and mid-career professionals in high-level meetings to observe and learn, train them on how to manage high-level senior meetings, and build their confidence. Respondents also noted the need for a mentorship system that ensures that women in leadership positions can promote and mentor other women. Respondents considered advanced leadership training programs that incorporate workshops and seminars vital—thereby keeping established and emerging women health leaders' knowledge up to date, as described below:

Then (there is) the issue of career guidance, even if you enter as a leader, I think there is more need to be intentional. If I join at a senior level, there should be some intention to grow me into maybe a higher leadership role. And this also should start as early as our curriculum. There should be some kind of modification to the purpose; to see that these women or these young girls can be groomed. And maybe lack of documentation for those who have successfully gone through it. You can find my predecessor was a successful lady, but maybe she takes on a different assignment, and there is nowhere it is documented that these are

some of the tips as a woman that you can employ to manage in this environment that you go through. So there [is a] need for documentation that may be put there, especially by those successful women leaders. There are ways this can be done (Woman senior staff, Public Sector).

Another respondent added:

Women can be supported to go back to school for advanced programs or certificates. There are also project management courses, leadership certificate course for established women leader[s] or for young or inexperienced women professionals. Those courses should be established, or women should be supported to attend those where they exist (Woman leader, NGO).

Respondents mentioned that **working with male** public health executives, experts, and decision-makers was essential to changing negative mindsets regarding women's leadership and addressing the issues with women in leadership in the public health sector. Narratives indicated that due to long-term socialization practices, men and boys may hold on to negative attitudes regarding female leadership. Respondents viewed awareness creation and capacity building as possible strategies to help men learn to support their wives with domestic work and to support male professionals and leaders to embrace gender equality to become effective workplace mentors to women, encourage their aspirations for leadership, and support the development and sustenance of institutional and organizational cultures that value and promote female leadership and gender equality.



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

Responding organizations were taking a variety of actions to promote women's leadership, diversity, and inclusion. As some study participants noted, the National Gender Policy and the Affirmative Action measures of the government inspired some organizations to take steps to achieve gender balance in leadership and inclusivity. Some of the efforts currently undertaken by the participating organizations to promote women's leadership, inclusivity, and diversity included making changes to staff recruitment and promotion processes, implementing a training and mentorship program, involving young women professionals in high-level meetings and key decision-making, and supporting work-life balance, educational advancement, and further certification.

Participating organizations reported that they have made **changes to their recruitment practices to create more gender diverse and inclusive workplace teams**. Narrative data showed that some of these changes include sensitization activities for women's leadership and job advertisements, specifically urging women and other marginalized groups, such as refugees and persons with disabilities to apply, recruiting women for positions, encouraging and promoting women staff to fill vacant senior positions, creating internal organizational leadership quotas for women, and using more gender-balanced hiring teams. One respondent reported that:

The organization has also taken some steps to encourage women to raise their hands, even if they don't meet all the qualifications for the position. When we have such vacancies, we ask the women that are with us to indicate interest, and they're encouraged and can be promoted into the new position (Woman leader, Private Sector).

Leadership training and mentorship programs were also being implemented by the organizations to support women's leadership and diversity. Participants explained that these leadership-focused workshops and training programs aim to provide women with the skills and knowledge they need to grow and advance into leadership roles.

In some instances, some forms of mentorship programs have also been established to support and groom upcoming women professionals and leaders. Mentorship programs reported by the organizations involved networking platforms to build relationships among women and providing emerging and future women health leaders with support and guidance as they navigate their career paths and enhancing their visibility within and outside the organization. One participant noted:

We've been focusing on mentorship, supporting young women professionals, and helping them network with other women leaders. We expose them to other organizations too and link them to opportunities that will help them see what is happening out there (Woman leader, Bilateral Organization).

Offering additional examples of existing mentorship efforts to support women's health leadership, another respondent noted:

The way we do it in my organization is that we do leadership capacity building for those women who are in elective politics. So, you directly go and identify these women and prepare them for leadership. The thing with women, particularly women in health, but also in science generally, you find they are confined in their areas of specialty. It also depends on what level but like, from the lowest level, we train the women. You know the public health leaders start right from the community level, like the village health teams. These are the people who are nearest to the communities, nearest to the mothers. So, through capacity building, and information sharing. That's the contribution we make. But also thirdly, we work with them to advance the issues of women in the health sector, in the policy arena, issues of remuneration, and issues of facilities, because all these issues affect the motivation of women to get into leadership (Women's network leader).

Some of the organizations also reported **involving women, youth, and other groups in key organizational decision-making processes** as a strategy to foster diversity and inclusion and build the leadership skills of their women personnel. Generally, this strategy involved intentionally involving younger professionals in the development of organizational policies, having them join executive meeting sessions where key decisions will be made, getting them to lead discussions on major organizational decisions, and appointing them into organizational committees. As one respondent noted:

In my organization, when there is a key decision to be made, we no longer meet alone as the executive team to discuss, we are now bringing young female staff who may not hold any leadership roles into such meetings to come in and speak, observe, contribute, and learn how decisions are made. So, through these executive meetings, women realize and understand how decisions are made and how sensitive issues are addressed (Woman senior staff, Academia).

There were also reports that some organizations were implementing strategies to **promote work–balance** for women. These strategies took forms such as extended maternity and paternity leaves, flexible work hours, and support with childcare during work-related travels. Other strategies mentioned by the organizations were **equal pay policies, support, scholarship, and extended study leave period for women** to advance their education or to obtain advanced qualifications in their fields or in leadership courses.



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

Participating organizations were generally willing to collaborate with WomenLift to strengthen women's leadership in their institutions and in the country. Some of the identified areas for potential collaboration with WomenLift were:

Mentorship programs: Some participating organizations reported the need for bespoke leadership mentorship programs for women leaders and potential leaders. Mentorship programs targeted at women were considered rare but urgently needed in Uganda. Narratives suggested that WomenLift could be a partner in thinking through and establishing such programs within organizations and in Uganda as a whole.

Leadership training courses and workshops and sensitization programs: There was also an expressed need for accessible regular leadership training courses, symposia, and workshops for existing and potential women health leaders in Uganda. Programs to sensitize women and men, organizations, schools, and government officials and departments on the importance of female leadership were also considered critical in Uganda. While such leadership training courses, workshops, and sensitization programs were said to exist in other countries, they were absent or infrequent in Uganda. Women professionals seeking to attend leadership training courses in the Global North had to pay for them or obtain scholarships to help them attend. Respondents suggested the possibility of partnerships with WomenLift Health in designing and implementing similar sensitization programs, courses, and workshops locally. Suggested topics for such training courses included self-care for women leaders, leadership skills, monitoring and evaluation of leadership work, and management strategies.

Development of incentives, awards, and recognition for women leaders in health: The respondents emphasized the necessity for well-planned occasions or platforms to acknowledge, recognize, and celebrate women leaders. Such gatherings were considered essential for highlighting the accomplishments of female health leaders and fostering networking among them, inspiring new and upcoming female leaders, and advancing the cause of gender parity and inclusion in leadership. Respondents suggested the idea of secure spaces where women leaders and potential women leaders can safely meet, discuss their experiences, and create relationships. Narratives implied that WomenLift might assist in conceiving and launching such a program.

Research was another area identified for prospective partnership with WomenLift Health. According to respondents, more research is needed to better understand the obstacles, difficulties, and experiences faced by women in health leadership as well as the most effective strategies for helping them overcome these challenges. Additionally, research is needed on approaches to help more women become leaders and support existing women leaders, and for effective multisectoral advocacy and organizational engagement on gender parity in leadership.

RECOMMENDATIONS

While Uganda has made significant success in increasing women's participation in leadership, there is still major potential for improvement, notably in the public health sector. Actors interested in supporting the goal of women's public health leadership in Uganda should:

- 1. Build promptly on the growing momentum for women leadership in Uganda.** Currently, there is a strong interest in Uganda to promote women's leadership on a variety of fronts. Commitments to gender equality in leadership are growing across the country, from the national government to key public, private, and local and international institutions and organizations. These commitments offer an important opportunity for efforts to advance women's public health leadership through partnership, training, advocacy, research, and community/public engagement.
- 2. 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, among others, were all linked to social norms. Women's leadership advancement efforts in Uganda should focus attempts to address these harmful social norms through advocacy, capacity building, awareness creation, and other interventions.
- 3. Focus on local felt needs for bespoke women health leadership mentorship and training activities.** The study found a felt need for bespoke women's health leadership mentorship and training focusing both on existing leaders and the pipeline of future women leaders in public health. Participants in the study proposed that leadership and mentorship training programs tailored to women are urgently needed. Efforts to improve women's leadership in public health must prioritize these locally identified needs.
- 4. Support the formation of a network of existing women public health leaders.** While numerous Ugandan women have attained international and national acclaim as public health leaders and professionals, no forum exists to bring them together. Nonetheless, such a platform was deemed necessary by respondents for recognizing the achievements of female health professionals and promoting networking, inspiring young and incoming female leaders, and furthering the cause of gender balance and inclusion in leadership. The establishment of such a network will be a vital component of next moves toward promoting women's health leadership in Uganda.
- 5. Support efforts to expand the pipeline of future women in public health.** While Uganda has a strong pipeline of female public health professionals with the potential to lead the sector in the future, there is much opportunity for expansion. However, efforts to increase the number of female public health professionals in the country must occur simultaneous to addressing the barriers and challenges that may cause them and existing young professionals to miss out on future leadership possibilities.
- 6. Collaborate with influential Uganda-based organizations working on women leadership in public health.** Some Uganda-based local and international organizations are currently working hard to enhance women's public health leadership. Respondents identified influential organizations and institutions for collaboration, in addition to those that provided data for this study, are the Ministry of Health, the Medical Councils, the Uganda National Council for Science and Technology, the Joint Clinical Research Center, various professional associations of health practitioners (such as the Association of Uganda Women Doctors), the Nabagereka Foundation, The Ugandan Women Cancer Support Organization (UWOCASO), the Rotary Club, Center for Health Human Rights and Development (CEHURD), Action Group for Health Human Rights & HIV/AIDS (AGHA Uganda), World Vision Uganda, Reproductive Health Uganda, Sight Savers, and Mental Health Uganda.

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