GLOBAL FINANCING FACILITY

TRANSFORMING HEALTH:

THE ROLE AND IMPACT OF WOMEN'S LEADERSHIP IN THE HEALTH SECTOR (THRIVE)

A MIXED METHODS STUDY

2025 Report

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Introduction

The Global Financing Facility (GFF) aims to address financing gaps in health systems to improve Reproductive, Maternal, Neonatal, Child, and Adolescents Health and Nutrition (RMNCAH-N) outcomes. The GFF strategy emphasizes gender equality and country leadership for improved health outcomes for women, children, and adolescents. In collaboration with Gavi, the Vaccine Alliance, the GFF supports evidence generation on the impact of women's leadership in the health sector. Despite being a significant part of the global health workforce, women are underrepresented in leadership roles, leading to gender biases in research and policymaking. Enhancing women's leadership can address these disparities and foster inclusive decision-making, benefiting global health systems and outcomes. Investing in women's leadership is thus crucial for equitable health outcomes and sustainable development.

Women leaders are navigating high-level decision-making spaces that are predominately dominated by men, such as boards, parliament, and national assemblies. The unique challenges they face in their roles as they navigate these spaces are well-documented, including gender bias and discrimination, lack of representation, work-life balance challenges, limited access to networks and mentorship, cultural norms and expectations, funding and resource inequities, the glass ceiling and glass cliff effect, invisibility of their contributions, sexual harassment, and often having their work unrewarded (Clark and Hawkes 2024; Smith and Sinkford 2022; Riche et al. 2023; Sabarwal et al. 2023).

In the context of these challenges, women leaders are conducting their leadership differently, also documented by this research. They are using different approaches and strategies to influence health policy and programmatic change within their countries.

Methods

We conducted a mixed-methods study to identify women leaders' influence and impact within the fields of RMNCAH-N and immunization across sub-Saharan Africa. Methods include: 1) a scoping review exploring women leaders' impact across diverse sectors, 2) a multi-country online survey, 3) key-informant interviews, and 4) in-depth case studies in 3 countries. Approximately 408 women and men leaders completed the survey, of which 163 also completed the Social Network Analysis. 35 women leaders were recruited to key informant interviews to discuss their areas of impact and influence within the RMNCAH-N and immunization spaces. Of these, 50% (n=17) primarily worked in RMNCAH-N, 24% (n=8) primarily worked in immunization, and 26% (n=9) indicated that they worked in both fields equally. The study is complemented by three case study countries – Ethiopia, Madagascar, and Zambia – with an additional 96 key informants who participated in in-depth semi-structured interviews, including women leaders (n=66), men leaders (n=21), community members who work closely with women leaders (n=7), and emerging women leaders (n=2). Results from this study are used to inform priority areas for investment in women leaders.

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Results

Women leaders influence health outcomes and impact through many of the same mechanisms that a leader would use regardless of their gender, such as through engagement in policy-making processes, engaging with decision-makers, fostering collaborations with international stakeholders, using evidence to inform decision-making, capacity building, and role modeling.

In the context of the challenges identified above, women leaders are conducting their leadership differently. They are using different approaches and strategies to influence health policy and programmatic change within their countries. While not every woman leader will achieve the same impact or conduct their leadership in the same way, in aggregate our evidence indicates that women leaders broadly are having unique and positive impacts on health outcomes. Because many women leaders will continue to face the challenges identified above, and not all women leaders will have the same priorities as those in our sample, the identified impacts below will not be automatic for all women leaders, nor will all women leaders be able to have the impact that they want.

Below we highlight areas demonstrating women leaders' unique contributions to RMNCAHN, the outcomes and impacts likely unachievable without them, and the mechanisms of influence or processes that help them achieve these results.

Prioritization of women-centric and/or neglected topics within policy and programming

Women leaders often focus on neglected and women-centric issues, such as women's health and the health of marginalized and vulnerable groups like out-of-school girls. An overwhelming percentage of question respondents strongly agreed/agreed (86.4%, n=152/176) that women leaders positively influence the prioritization of key issues related to women and girls (84.7%, n= 72/85 men and 87.9%, n=80/91 women). Regarding resource mobilization, 65.3% (n=113/173) of question respondents strongly agreed/agreed that women's leadership has increased investment in activities related to women and girls in their organization or field (68.7%, n=57/83 men; 62.2%, n=56/90 women).

For example, women leaders in Eswatini are advocating for the government to declare gender-based violence and violence against children a national disaster, despite resistance from male counterparts. In Kenya, a woman leader used new funding for HPV to vaccinate out-of-school girls, leading to the development of policies focused on key women's health issues and resource mobilization for these issues. Additionally, women leaders in Eswatini have developed sexual and reproductive health strategies and guidelines, filling gaps in maternal health strategy plans. In Kenya, lobbying efforts ensure that health budgets at the county level reflect the needs of children and mothers.

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Use of identity-derived power
"Identity-derived power" refers to the influence or authority individuals gain from aspects of their personal identity, such as gender, race, ethnicity, or lived experiences.

This power is rooted in the unique perspectives and credibility individuals have because of their identity, which can resonate with or represent specific communities. It allows individuals to shape policies or decisions in ways that reflect their unique vantage points.

The research shows how women leaders, for example, use their experiences as women, mothers, and caregivers to shape inclusive health policies with a nuanced understanding of the needs of women, adolescent girls, and children. Their ability to connect with families on a personal level, speaking as mothers, has led to tangible outcomes, such as the successful vaccination of over 200,000 children and the management of severe malnutrition cases in Cameroon. Women's identity also provides access to spaces that men traditionally cannot enter, such as women's help groups, homes, or maternal health centers. This access allows them to gain deeper insights into specific issues, build trust in the community, and advance grassroots advocacy.

Collective leadership
Other evidence generated shows how women leaders are able to use collective power to navigate male-dominated decision-making spaces and promote agendas that might face resistance from some men, including some aspects of the RMNCAH-N agenda. This collective effort has led to national policies like the National Health Act in Nigeria, gender-related policies, and the introduction of HPV vaccines in various countries. For example, when advocating for the Gender and Equal Opportunity (GEO) Bill, women gathered, protested, and held press conferences to push the bill forward despite some male opposition. They also use direct advocacy approaches like lobbying, protesting, and engaging with other
influential women, resulting in increased funding for neglected and women-centric issues. Building strong support systems and identifying with like-minded female leaders helps them overcome challenges and support each other.

Ethical engagement
Women leaders demonstrate ethical responsibility through transparency, commitment to inclusion, accountability, equality, and maximizing impact with limited resources. When asked about organizational outcomes, survey participants were most likely to strongly agree that women's leadership has positively influenced engagement with ethical initiatives (87%, n=194/223 overall; 90.2%, n=92/102 men; 84.3%, n=102/121 women) and diversity and inclusion (89.7%, n= 200/223 overall; 92.2%, n=94/ 102 men; 87.6%, n=106/121 women). Examples include prioritizing constituents' health over profits, conducting community outreach, and providing services to marginalized groups. These approaches have increased the representation of marginalized groups in decision-making,

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improving program inclusivity. Women leaders face additional scrutiny and must prioritize accountability and transparency to retain leadership roles. Despite more hurdles, they develop a strong sense of accountability and deliver with high commitment and role modeling, particularly evident in the HIV response.

Creating a supportive environment for women leaders

Our evidence shows that many women leaders actively seek to strengthen organizational capacity, structures, and policies to advance gender equality within their organizations and create a supportive environment for women leaders to thrive. These included activities to strengthen broader institutional structures and systems, such as advocating for equal pay, implementing sexual harassment policies, establishing flexible working policies, establishing family leave/ maternity leave policies, establishing nursing rooms for working mothers, conducting training, and capacity building activities and career and mentoring opportunities for women within the organization.

Survey respondents strongly agreed/agreed that women's leadership has positively influenced their organizational culture and climate (84.8%, n=190/224 overall; 86.4%, n=89/103 men; 83.5% n=101/121 women), the gender pay gap (55% overall, n =104/189; 59.6%, n=53/89 men; 51%, n=51/100 women), a diverse and inclusive workforce and policies (81.7%, n=156/191 overall; 84.6%, n=77/91 men; 79%, n=79/100 women), training and development (84.7%, n=166/196 overall; 82.8%, n=77/93 men; 86.4%, n=89/103 women), career and mentoring opportunities for women (84.2%, n=165/196 overall; 87.1%, n=81/93 men; 81.6%, n=84/103 women), as well as employee retention (64.3%, n= 144/224 overall; 71.6%, n=73/102 men; 58.2%, n=71/122 women) within their organization or field.

These initiatives create an enabling environment for women, helping them balance professional and personal responsibilities, particularly for those with caregiving roles. They also promote professional development and career growth and ensure job security for new mothers. As a result, these measures can lead to increased job satisfaction, higher retention rates, and improved productivity, ultimately ensuring that valuable talent is retained within the organization.

Intentional integration of gender within programs and services

Some women leaders are intentional about integrating gender within programs and services focused on addressing gender inequities at the program and service level. Activities include addressing the unique needs, rights, and preferences of women and girls, promoting women's empowerment, recognizing the role of men in women's health and wellbeing, and engaging with the community. Gender integration activities championed and implemented by women leaders have included ensuring women's representation as beneficiaries, engaging women in the community as implementers, and developing male engagement strategies. These initiatives

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have contributed to more inclusive health services and programs for children, adolescent girls, and marginalized groups, and the empowerment of women within the community.

Overall, survey respondents strongly agreed/ agreed that women leaders positively influenced the development of gender policy or policies within their field or organization (83.9%, n=146/174 overall; 88.1%, n=74/84 men; 80%, n=72/90 women), as well as investments on addressing gender barriers or reinforcing positive gender norms (67.2%, n=117/174 overall; 72.6%, n=61/84 men; 62.2% women, n=56/90). Respondents felt that women leaders' efforts have led to an increase in male engagement in health (71.7%, n=124/173 overall; 75.9%, n=63/83 men; 67.8% n=61/90 women), helped to reduce harmful gender norms and practices (79.5% overall, n=140/176 total; 84.7%, n=72/85 men; 74.7%, n=68/91 women), helped to reduce gender-based violence (79.3%, n=138/174 overall; 82.4%, n=70/85 men; 76.4%, n=68/89 women), and increased autonomy and decision-making power of women and girls (79%, n=139/176 overall; 82.4%, n=70/85 men; 75.8%, n=69/91 women) for the communities and populations they work with.

Advocating for women's representation within leadership roles

Within our sample, some women leaders were actively promoting the inclusion of other women leaders in male-dominated leadership spaces. When asked about organizational outcomes, 84.4% (n=189/224) of question respondents strongly agreed/agreed that women leaders have positively influenced opportunities for other women in their organization, and men (84.5%, n=87/103) and women (84.3%, n=102/121) have equally positive views, while 82.3% (n=144/175) of question respondents strongly agreed/agreed that women's leadership has positively improved women's involvement in the decision-making bodies, forums, and governing boards within their field, with both men (83.5%, n=71/85) and women (81.1%, n=73/90) having almost equally positive views.

By being gender-conscious in allocating duties and ensuring inclusive policies, they can empower women to have a voice, be involved in leadership, and build their experience. This increased representation can create a feedback loop where the presence of women in decision-making roles inspires and supports the rise of more women to leadership positions. This compounding effect amplifies the benefits and positive changes they bring to health, wellness, and organizational effectiveness, creating a virtuous cycle of empowerment and progress.

The power of networks

As part of the survey, we conducted a social network analysis (SNA) to document the extent and value of women's and men's networks. Leaders from non-governmental organizations (NGOs) and national-level organizations have the most influence within the network. Women have slightly broader networks with overlapping ties while men have more diverse networks and more efficient access to those networks. Women are slightly better connected to

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the most influential elements within the network including women at national-level government organizations, women at national-level NGOs, and men at national-level NGOs. Most connections were between elements of the same gender; while respondents connected with more members of their own gender, they did not necessarily value those members highly. Gender diversity appears to enhance collaboration, resource-sharing, and value creation.

Most respondents (59.5%, (n= 91/153)) perceived their network strength as strong, with 39.5% (n= 55/153) rating it as very strong, regardless of gender, organizational affiliation, or geography. Participants reported being very able to leverage their networks to improve organizations (51.9%, n= 69/133), advance careers (50%, n=68/136), design or change programs and policies (47.7%), and affect health outcomes (47.7%, n=63/132). Men were slightly more likely to leverage their networks to advance their careers (52.5%, n=32/61 men vs. 47.3%, n=35/74 women) but slightly less likely to believe that networks would help improve their organization (50%, n=30/60 men vs. 52.8%, 38/72 women).

Conclusion

Investing in women leaders can bring significant added value by addressing critical health risks for women and girls, ensuring that marginalized populations are not missed, filling persistent gaps in underrepresentation, and creating enabling spaces for women leaders to thrive. The evidence from this research shows that many women leaders prioritize neglected health issues, build trust with communities, serve as role models, and advocate for supportive policies and structures, ultimately advancing health outcomes and achieving public health goals. Investing in women leaders in the health sector can therefore lead to better health services, increased representation, and supportive environments that foster and retain valuable talent and benefit organizations and communities.

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Recommendations:

Impact Pathways	Recommendations
Impact Pathway 1: Women leaders increase funding for the issues they prioritize, which leads to reduced health disparities and improved RMNCAH-N outcomes.	**Recommendation 1:** Support women leaders to fundraise for the issues they prioritize, such as women-centric and neglected issues within policies and programs. Women leaders are shown to effectively mobilize resources for issues that affect women and girls in their organizations and fields, which can lead to reduced health disparities among hard-to-reach and marginalized groups and improved health outcomes, including reduced maternal and child mortality.
Impact Pathway 2: Women leaders' identity-derived power gives them access to women-only spaces and increases trust in services which has increased service utilization leading to reduced health disparities and improved RMNCAH-N outcomes.	**Recommendation 2:** Support women leaders' engagement with the community. Women leaders' experiences as women, mothers, and caregivers often enable them to access spaces within the community that men may not be able to access. This can increase communities' trust in health services leading to an increase in service utilization and intervention uptake. **Related SNA recommendation:** Facilitate connections between women across levels and contexts to share strategies and successes in leveraging identity-derived power.
Impact Pathway 3: Women leverage principles of ethical leadership leading to increased inclusivity of services and increased representation of key groups in decision-making. This leads to increased use in services which reduces health disparities and improves RMNCAH-N outcomes.	**Recommendation 3:** Promote and embed principles of transparency, accountability, and inclusive decision-making in governance structures, including in global health decision-making bodies, to foster more inclusive and representative service environments and ensure that all leaders equally engage in ethical leadership.

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Recommendations:

Impact Pathways	Recommendations
Impact Pathway 4: Women leaders prioritize gender-responsive programs and interventions that include both men and women. When services and programs are more inclusive, service utilization increases, leading to reduced health disparities and improved RMNCAH-N outcomes.	**Recommendation 4**: Champion gender integration activities implemented by women leaders, such as ensuring women's representation as beneficiaries, engaging women in the community as implementers, and developing male engagement strategies for health interventions. These initiatives can contribute to more inclusive health services and programs for children, adolescent girls, and marginalized groups, as well as the empowerment of women and girls within the community, which can ultimately increase program coverage and reach.
Impact Pathway 5: Women leaders create supportive environments for other women, generating gender-responsive policies and programs that improve organizational culture, and support the ongoing recruitment, retention, and growth of women leaders.	**Recommendation 5:** Support women leaders in implementing initiatives and policies to create more enabling environments for women, which can ultimately lead to increased job satisfaction, higher retention rates, and improved productivity, ensuring that valuable talent is retained and grown within the organization. **Related-SNA recommendation**: Support women leaders' networks to embrace the power of collective leadership within organizations to transform harmful environments and improve women leaders' retention and career growth in the health sector. **Related-SNA recommendation**: Conduct allyship training and embed allyship approaches into health organizations to foster connections between men and women. Engage men at national-level NGOs, one of the most influential types of people in the sector, to support allyship initiatives, call attention to women's leadership in health, and champion individual women leaders.

Introduction

The Global Financing Facility (GFF) was launched in 2015 to help address gaps in financing for health systems and interventions needed to improve Reproductive, Maternal, Neonatal, Child, and Adolescents Health and Nutrition (RMNCAH-N) outcomes. The GFF strategy promotes an increased focus on gender equality and country leadership for improved health outcomes for women, children, and adolescents.

Investments in gender equality in health have lacked efficiency due to a lack of inclusion of women's perspectives, gender-responsive and monitoring of programs to provide timely and evidence-based information, and support to a targeted prioritization within national health ministries and global organizations. Women make up the majority (70%) of health workers in the health sector globally. Yet, this is not reflected in global health leadership where women hold only 25% of leadership roles (Clark and Hawkes 2024). This lack of representation and participation can lead to gender biases in health research, policymaking, and the design and implementation of health programs (Riche et al. 2023; Hawkes and Baru 2024). Enhancing women's leadership can address these disparities and foster inclusive decision-making, ultimately benefiting global health systems and outcomes.

To inform investments in national and regional leadership, the GFF and Gavi, the Vaccine Alliance are collaborating to support evidence generation on the role and impact of women's leadership in the health sector.

What barriers do women leaders face?

Women leaders are navigating high-level decision-making spaces that are predominately dominated by men, such as boards, parliament, and national assemblies. They face unique challenges in their roles as they navigate these spaces. Well-documented barriers for women leaders include (Smith and Sinkford 2022; Riche et al. 2023; Sabarwal et al. 2023):

Gender bias and discrimination: Women encounter implicit and explicit gender biases that challenge their competence, leadership, and decision-making skills. Leadership is often stereotyped as masculine, tied to traits like confidence, ambition, and directness, while women are deemed overly emotional for such roles. These biases impact hiring, promotion, and recognition, limiting opportunities for women in leadership.

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Lack of representation: Women are underrepresented in senior leadership positions in health organizations, perpetuating a lack of role models and mentors for aspiring women leaders. This underrepresentation also influences decision-making processes and organizational priorities, sidelining women's health issues.

Work-life balance challenges: Balancing professional responsibilities with caregiving roles is a significant challenge for many women. Leadership positions can involve long hours, travel, and demanding schedules, which can conflict with family and caregiving duties. This challenge is compounded by insufficient institutional and home support for work-life balance, such as flexible working hours and parental leave policies, or lack of support from partners.

Limited access to networks and mentorship: Networking and mentorship opportunities are critical for career advancement. Many leadership positions tend to be filled through informal networks where women are underrepresented. Women also often lack access to informal network spaces that are traditionally occupied by men, such as after-work drinks and sports-related activities. Due to the lack of representation of women in leadership, many women do not have access to women mentors. And when women leaders do mentor, they are overstretched; this is particularly true for minority women.

Cultural norms and expectations: Traditional gender roles and societal expectations discourage women from pursuing leadership roles. Cultural norms may undervalue women's contributions, reinforce stereotypes about women's abilities, and create environments that discourage assertiveness and ambition. Funding and resource inequities: Women leaders often struggle with unequal access to funding and resources. This can stem from biases in funding mechanisms, lack of investment in women's health initiatives, or challenges in mobilizing resources for gender-focused programs.

Glass ceiling effect: Even when women achieve leadership roles, they may encounter the "glass ceiling," a metaphor for the invisible barriers that prevent women from reaching the highest levels of leadership. This can manifest in unequal pay, limited decision-making authority, or being assigned roles with less influence or visibility.

Glass cliff effect: Women tend to be asked to take on leadership roles during a precarious situation or when something needs fixing. Without adequate resources and trust, women leaders can rarely succeed in these situations.

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Invisibility of women's contributions: Women's achievements are often less visible or recognized compared to their male counterparts, making it harder for them to gain credibility and secure leadership roles. They are also sometimes not taken seriously by other leaders which can make their job harder.

Sexual harassment: Women leaders can face sexual harassment and objectification in the workplace, which affects their ability to do the work and advance.

Women's work tends to be less rewarded: Women are more likely to be asked to complete tasks that don't have a reward mechanism within the organization (i.e. committee service).

Despite these barriers, this research generates evidence showing that women leaders are making an impact and facilitating improved health and wellness for people.

THRIVE goes beyond these well-documented barriers to identify areas where women leaders are making an impact on health outcomes for women, children, and adolescents to inform investment, programming, and policy.

Study Objectives

We conducted a mixed-methods study to identify women leaders' influence and impact within the fields of RMNCAH-N and immunization across sub-Saharan Africa.

Results from this study are used to inform priority areas for investment in women leaders in health.

Methods

This mixed methods study included: 1) a scoping review exploring women leaders' impact across diverse sectors, 2) a multi-country online survey, 3) key-informant interviews, and 4) in-depth case studies in 3 countries. IRB approval was granted by Johns Hopkins Bloomberg School of Public Health. Participants were included in the study if they self-identified as a leader in RMNCAH-N and/or immunization within sub-Saharan Africa.

How did we define leadership?

Leaders are those who occupy a position that gives them influence and power over identifying priorities, providing strategic direction, allocating resources, and decision-making within the immunization and/or RMNCAH-N sector at either the sub-regional, regional, national, or continental level.

To identify as a leader, participants needed to answer 'yes' to one or more of the following questions. In your current role, do you have influence over:

- How decisions are made?
- Which priorities are identified?
- How funding is distributed?
- The strategic direction of your organization or institution?

Scoping review

The scoping review methodology is reported in the article *A scoping review on the impact of women's global leadership: evidence to inform health leadership* published in BMJ Global Health (Kalbarczyk et al. 2025).

Multi-country online survey

The survey was designed in Qualtrics, an online survey program, and distributed via email to leaders identified during a comprehensive stakeholder mapping exercise which is reported in BMC Public Health (Banchoff et al. 2025). Women and men leaders were recruited across sub-Saharan Africa. To ensure adequate representation, we calculated a sample size of 625 respondents. The sample size was determined based on the sample sizes in similar research as well as by using the sample size estimation formula for sample size for frequency in a population and correcting for smaller population size (Sample size n = [DEFF*Np(1-p)]/ [(d2/Z21-α/2*(N-1)+p*(1-p)]), with sample size assumptions being 95% level of confidence and 80% power, 1.5 design effect. While we sought to ensure that 50% of the sample size were women leaders, we recognized that on a global scale due to lack of representation of women leaders, we were more likely to capture 25% and aimed for a minimum of 25% of women respondents. The survey's sample size was determined by those who met the eligibility criteria and completed at least one survey section. While 742 individuals opened the survey and met the eligibility criteria, the final sample size was 408, which included respondents who met the eligibility criteria and answered at least 1 survey section.

Methods

Within the survey, participants were asked to identify the extent to which they agreed with a series of statements about women leaders' impact on key organizational, program, policy, gender, and health outcomes. These outcomes were informed by results from the aforementioned literature review. We also conducted a social network analysis (SNA) among survey respondents, which is a methodology used to better understand relationships and structures within a community or network. The SNA explored who leaders interact with based on the exchange of advice or professional support, how strong those ties are, and women leaders' perceptions of their impact, professional influences, and opportunities for leadership development. The survey's sample size was determined by those who met the eligibility criteria and completed at least one survey section. Analysis for each question was based on those who answered that question, and not on the total number of participants who submitted surveys.

The data were exported into the Statistical Package for Social Sciences (SPSS) for Windows for analysis. Descriptive statistics, including means, standard deviations, frequencies, and percentages, were calculated as appropriate. For categorical or nominal data, frequencies and percentages were reported, where frequency represents the number of participants in a specific category, and percentage indicates the proportion of the sample in that category. For interval or ratio data, means and standard deviations were computed. Participants rated their beliefs about the impacts of women leaders using a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). A response of "strongly agree" received a score of 5, while "strongly disagree" received a score of 1. To explore participant agreement further, responses of "strongly agree" and "agree" were combined to indicate agreement, while "strongly disagree" and "disagree" were merged to indicate disagreement. Descriptive findings were disaggregated by gender, primary affiliation, and African regions. The independent t-test was conducted for comparisons of the mean scores for two groups (women and men) whereas one-way ANOVA was conducted to compare the difference in means between two or more groups (primary affiliations and African regions) using the F-distribution.

Key-informant interviews

Key-informant interviews targeted a subset of women leaders who responded to the survey and indicated interest and willingness to participate in a follow-up conversation. Interviews lasted approximately 45 – 60 minutes and focused on how women leaders have contributed to and/or influenced agenda-setting and priorities, funding and how it is distributed, related health outcomes, and policies within RMNCAH-N and immunization.

A thematic analysis of all qualitative data was conducted. The analysis process began

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with an open coding method and then a priori themes were defined based on the overall goal of this study, with new themes emerging from the data added to the analysis. A codebook was developed in discussions among study team members. The codebook contained both a priori and emergent codes: a priori codes were derived from the study objectives and study guides; emergent codes were identified through reading the transcripts, debriefing, and reflections. Each transcript was read and coded independently. Quotes for each code were examined, and matrices and memos were used to organize and examine the information for patterns and to develop emerging interpretations.

In-depth case studies in 3 countries

Case studies were conducted in Ethiopia, Madagascar, and Zambia. These countries were selected on the basis of being amongst GFF-supported countries in Africa, with a mix of francophone and anglophone and a basis on activities on women's leadership. This included: (1) a historical review of RMNCAH-N policy, including a timeline for RMNCAH-N policy development and women leaders' involvement in policy development, (2) interviews with women leaders in these countries who were involved in RMNCAH-N policy and strategy development, (3) key informant interviews with other policy and decision-makers in the country, and (4) interviews with community members who have worked with women leaders. Comprehensive methods and results of these case studies are reported separately.

Findings were triangulated across the three methods above to generate an impact pathway (see Figure 1), highlighting the unique ways in which women use their leadership to influence priorities and affect gender, health, and organizational outcomes.

Limitations

This study had a number of limitations. Despite conducting a comprehensive online stakeholder mapping, we were only able to reach out to people via email, which means that leaders without an online presence were missed. Additionally, the sample size was lower than expected which was partly due to the length of the survey tool. The survey length led to a drop-off in respondents as many who opened the survey did not complete it. Not all respondents answered all questions within the survey, which led to different sample sizes for each question. In addition, the survey documented perceptions of impact rather than actual impact, which means we are not able to report on the actual impact within the survey findings. There was also likely a bias among those who decided to take the survey due to it not being a neutral topic, leading to respondents feeling strongly about the impact of women leaders one way or the other.

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It was challenging to recruit participants for the key informant interviews likely because they had already completed the online survey, resulting in a smaller sample size than expected. Most women in this field are accustomed to discussing barriers to leadership, requiring interviewers to spend time priming and redirecting respondents away from barriers during the interviews. Women are also less likely to document the impact of their work at an individual level due to a combination of social, organizational, and methodological factors. These include the emphasis on group-level analysis in research, gendered experiences in organizational settings, and differences in reporting behavior. These factors may have made it difficult for them to fully express the impact of their leadership.

Participant Demographics

Across Sub-Saharan Africa, a total of 550 women leaders and women-leader-adjacent individuals combined participated in the study (Table 1).

Approximately 408 women and men leaders met eligibility criteria and completed at least one section of the survey. Of these,163 also completed the Social Network Analysis (SNA).

Thirty-five women leaders were recruited for the key informant interviews to discuss their areas of impact and influence within the RMNCAH-N and immunization spaces. Of these, 50% (n=17) primarily worked in RMNCAH-N, 24% (n=8) primarily worked in immunization, and 26% (n=9) indicated that they worked in both fields equally.

In the study's three case study countries – Ethiopia, Madagascar, and Zambia – an additional 96 key informants participated in in-depth semi-structured interviews, including women leaders (n=66), men leaders (n=21), community members who work closely with women leaders (n=7), and emerging women leaders (n=2).

Methods

Table 1: All data sources

Data Source	Survey		SSA - KIIs	Case Study - KIIs		Total	
	n	*%*	*n*	*n*	*%*	*n*	*%*
Women Leaders	238	58.5%	35	66	68.8%	339	61.7%
Emerging Women Leaders	N/A		N/A	2	2.1%	2	0.36%
Men Leaders	169	41.3%	N/A	21	21.9%	190	34.3%
Community Members	N/A		N/A	18	7.3%	18	3.3%
Unspecified	1	0.2%	N/A	N/A		1	0.18%
Total	**408**		**35**	**107**		**550**	

Map 1: Respondents' country of primary citizenship

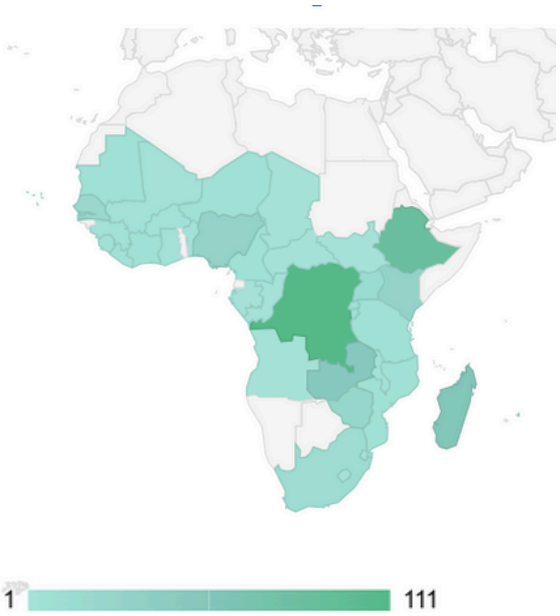


Table 2: Respondents' primary citizenship, by region

Primary Citizenship	n	%
East Africa	*292*	*53.1%*
Central Africa	130	23.6%
West Africa	113	20.5%
South Africa	15	2.7%

Findings

Women Leaders' Influence and Impact

Our evidence also shows that women leaders influence health outcomes and impacts through many of the same mechanisms that a leader would use regardless of their gender, such as through engagement in policy-making processes, engaging with decision-makers, fostering collaborations with international stakeholders, using evidence to inform decision-making, capacity building, and role modeling.

However, in the context of the challenges identified above, results indicate that women leaders are conducting their leadership differently. They are using different approaches and strategies to influence health policy and programmatic change within their countries. While not every woman leader will achieve the same impact or conduct their leadership in the same way, in aggregate we find women leaders broadly are having unique and positive impacts on health outcomes. Because many women leaders will continue to face the challenges identified above, and not all women leaders will have the same priorities as those in our sample, the identified impacts below will not be automatic for all women leaders, nor will all women leaders be able to have the impact that they want.

Below we highlight areas demonstrating women leaders' unique contributions to RMNCAH-N, the outcomes and impacts likely unachievable without them, and the influences or processes that help them achieve these results documented within the survey, key informant interviews, and case studies.

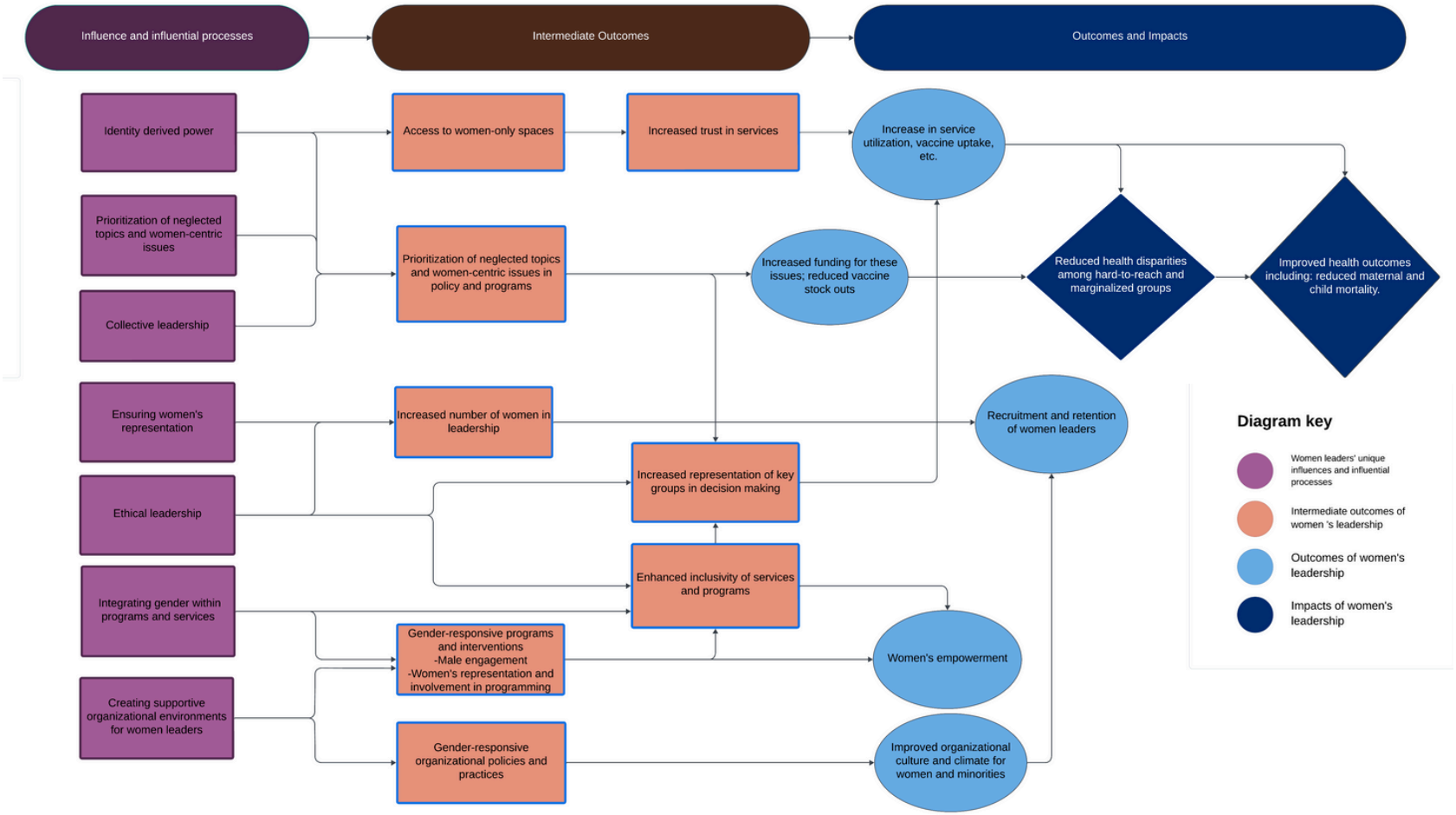
Our scoping review, conducted as a basis to inform the design of the THRIVE study, included 137 articles, only six of which focused on the healthcare sector – showcasing limited evidence documenting women's leadership in the health sector. The review found that women leaders have a positive influence on six areas of impact (Kalbarczyk et al. 2025):

1. Financial performance, risk, and stability
2. Innovation
3. Engagement with ethical and sustainability initiatives
4. Health outcomes
5. Organizational culture and climate, including reputation, employee retention, and team cohesion and communication
6. Influence on other women's careers and aspirations

Even those studies reporting mixed findings still largely pointed to positive results on women's influence, particularly when modified by other factors, such as better education, greater levels of experience, and opportunities to work with other women across an organization.

Figure 1: Women Leaders' Impact Pathway for Gender Equity and Health

This framework was generated from THRIVE study results, demonstrating the unique pathways women leaders use to achieve positive outcomes.



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Prioritization of women-centric and/or neglected topics within policy and programming

Women leaders' engagement often focuses on neglected and/or women-centric issues, such as women's health, or the health of marginalized groups such as out-of-school girls. An overwhelming percentage of question respondents strongly agreed/agreed (86.4%, n=152/176) that women leaders positively influence the prioritization of key issues related to women and girls (84.7%, n= 72/85 men and 87.9%, n=80/91 women).

"Right now, with other women leaders, we are championing for the government to declare gender-based violence and violence against children a national disaster. We are not succeeding because the men are all over the place saying, "Oh, we cannot commit," but we are not giving up." (W19_Eswatini)

"Recently when I got the new funding for HPV, I decided we were on it to reach out of school girls and unvaccinated girls, but no one mentioned about people enabled differently [...] so, I decided to request if I can use the same funding to look on people enabled differently, go to special schools, go to homes, home visits, try to vaccinate these girls." (WL01_Kenya)

This led to the development of policies focused on key women's health issues, resource mobilization focused on these issues, and programs and services targeted to women or marginalized groups. For example, one woman leader women leader in Eswatini advocated for the development of sexual and reproductive health strategies and guidelines.

Advocacy, sustainable funding, and partnerships in Zambia

In Zambia, many women leaders are recognized for their influence and credibility in effectively driving funding to the RMNCAH-N and immunization sector. The presence of high-level women in leadership positions plays a key role in shaping funding priorities and mobilizing resources.

Men leaders highlighted that women leaders bring unique strengths to fundraising. For example, women's proactive engagement with donors, particularly their ability to effectively communicate and connect with them, showcases their influence in mobilizing financial resources.

"Women can bring that unique voice on the table as we talking about fundraising and so we have seen a lot of women leadership going out there, talking to different donors to bring in more resources into the sector." (ML09_ Zambia)

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"When I joined [my organization], there was not any strategy plan for maternal health for these components [...]. Like, SRH strategy; there was not any strategy, and there were no guidelines, especially the family planning guidelines. There were no obstetric care guidelines." (WL27_Eswatini)

"We ensure that health budgets at the county level reflect the needs of children and mothers through lobbying efforts." (WL15_Kenya)

"My biggest contribution would have been to facilitate funding for community health workers to get training in providing long-acting contraception to the communities. This increased access for women. Women are able to get the long-acting contraceptives closer to their home. It has really increased the contraceptive acceptance rate. [...] This has made a huge impact in terms of increasing the quality of family planning services." (WL20_Ethiopia)

Commitment to innovation in Ethiopia

Women leaders in Ethiopia have played a key role in supporting and executing innovative ideas and investments to keep up with new information and changing contexts. They have been particularly supportive in encouraging small business ideas, such as establishing home-based care and special shelters for disabled individuals and those in need. Additionally, women leaders have collaborated with civic society and private sectors to create a banking system that is considerate of women's challenges. They have also utilized social media to increase the visibility and participation of women from various locations.

"Being a social entity and accepting new inventions and procedures — whether it's safe abortion, task sharing, or anything else — requires training and evidence. The credit for this success goes to women leaders." (ML08_Ethiopia)

New technologies adopted in the health system have facilitated participatory healthcare delivery, with community members attributing the implementation of these innovations to women leaders. Women leaders are seen as more open to embracing changes that improve healthcare, and their acceptance of new inventions and procedures has been crucial in advancing healthcare services. For instance, the successful integration of cervical cancer prevention into Ethiopia's national health program is a testament to their innovative leadership.

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"We had something called RBF—Result-Based Financing—where the government would give us funds based on our performance, particularly on indicators like maternal health outcomes. During our maternal death review meetings, we would look into why mothers were dying—many times it was due to lack of basic supplies at the facility. So, I would use the opportunity to influence my bosses to ensure that we listed and procured the necessary emergency items. This way, even when a mother came in with nothing, especially those with previous cesarean scars, we were prepared. Through the RBF funds and our performance, we could save lives by making sure critical supplies were available when they were most needed." (WL40_IR, Uganda)

In regard to resource mobilization, 65.3% (n=113/173) of question respondents strongly agreed/agreed that women's leadership has increased investment in activities related to women and girls in their organization or field (68.7%, n=57/83 men; 62.2%, n=56/90 women).

Use of identity-derived power

"Identity-derived power" refers to the influence or authority a person gains from aspects of their personal identity, such as gender, race, ethnicity, or lived experiences. This power is often rooted in the unique perspectives, insights, and credibility individuals have because of their identity, which can resonate with or represent specific communities. Identity-derived power allows individuals to shape policies or decisions in ways that reflect their unique vantage points.

Women leaders' experiences as women, mothers, and caregivers often enable them to shape inclusive health policies with a nuanced understanding of the needs of women and children.

"[...] women are concerned because we are mothers ourselves;[...], some of us have experienced these things ourselves; facility-based delivery. And so, you have an intricate link to the situation; it is not hearsay, and you know how important this is for other women." (WL11_Kenya)

Women leaders' ability to connect with families at a personal level through speaking as a mother had tangible outcomes, including the successful vaccination of over 200,000 children and the management of severe malnutrition cases.

"From 2019 to date we have vaccinated many children. We have screened over two hundred thousand children for malnutrition. We have managed more than two thousand severely malnourished children. Since we are mostly employed by the door

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-to-door we have time to talk with each family, I realized that talking to them as a mother has really helped them to be able to start changing behaviors." (WL02_Cameroon)

Women's identity also often provides access to spaces that men traditionally are not allowed to enter (i.e. women's help groups, homes, or maternal health centers), allowing them to gain deeper insights into specific issues these groups face, build trust in the community, and advance grassroots advocacy.

"When we talk about it in a different context, there are some settings that men will not be able to go to, no matter how passionate they are... They cannot reach the woman, and we are talking about our couples-end services here where we need to reach women. And so, for me, as a female I do not have the barrier that my male counterparts will have in reaching beneficiaries, which are mostly women and children." (WL06_Nigeria)

Collective leadership

Many women leaders use the power of the collective to overcome male-dominated decision-making spaces. That is, women can leverage their combined leadership power to promote agendas that might face resistance or ambivalence from men. This has contributed to the development of national policy, such as the National Health Act in Nigeria, as well as the development of gender-related policies and bills and the introduction of HPV vaccines in other countries.

"There was a time we went for the GEO Bill, the gender and equal opportunity bill. The men refused to follow us at all, at all. They refused to do anything about it, and we gathered women, we carried placards, went there. [...] We called the press conference called women, market women. And we [...] went to the legislator and they changed it and made it happen. (WL08_Nigeria)

In some cases, women used direct advocacy approaches such as lobbying, protesting, holding press conferences, and/or strategically engaging with influential women in their country. These strategies have resulted in increased funding for neglected and women-centric issues.

"But collectively, for the country, we are pushing an agenda that everybody should be doing anyway. We feel as the collective, and for us, it is moving the needle. It is moving the needle to include breastfeeding. It is moving the needle to include child nutrition. If you want to talk brain development, you cannot talk brain development without

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talking about healthy, well-nourished children, and the ECD sector was not talking this language." (WL31_South Africa)

"Firstly, it is also building a strong support system, identifying with like-minded female leaders. I have been fortunate, like in our region here, in our organization in our region, there are quite a number of female leaders. So, you know, you are able to talk, sometimes you check in, you realize you are not the only one facing this, then you help each other." (WL10_Zambia)

Women leaders' strategic engagement with influential women in Nigeria

In Nigeria, when women leaders were confronted with resistance or ambivalence from men decision-makers, particularly on issues related women's health or the inclusion of marginalized groups, they reported that they would sometimes seek support from women legislators or the spouses of male policymakers.

"But I am also going to say that women are also strategic. [...] we look for influencers. [...] we use influencers like the wives of policy makers to get decisions made." (WL06_Nigeria)

"[...] looking at cervical cancer you know we, when the vaccines came up...person X and I... did a lot of awareness creation. We went to the policy makers in terms of the highest body of the first ladies, you know the first lady of the country, and first ladies of the states, and tried to create awareness, tried to see how we can bring in the vaccine into the country." (WL12_Nigeria)

This led to shared advocacy and increased prioritization of neglected topics and women-centric issues in policy and programs.

Ethical engagement

Some women leaders show ethical responsibility through transparency, commitment to diversity, equity, and inclusion (DEI), maintaining accountability, and maximizing impact even with limited resources. When asked about organizational outcomes, survey participants were most likely to strongly agree that women's leadership has positively influenced engagement with ethical initiatives (87%, n=194/223 overall; 90.2%, n=92/102 men; 84.3%, n=102/121 women) and diversity and inclusion (89.7%, n= 200/223 overall; 92.2%, n=94/ 102 men; 87.6%, n=106/121 women) - two areas of impact that also emerged in the document review. In both questions, women were more likely to remain neutral, however the differences were not statistically significant.

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Women leaders cited multiple examples of prioritizing their constituents' health over financial profits by directly purchasing stock to ensure commodity availability, conducting additional community outreach in hard-to-reach areas, and providing services directly particularly for marginalized groups.

"I want my integrity and I want my space and I want to do things correctly because at the end of the day, I want to see the impact of what I have done. So I look back, and say this is the trail of what I have done." (WL12_Zambia)

These approaches led to increased representation of marginalized groups in decision-making, resulting in improved program inclusivity.

"This [success] was driven by women. I am not sure how men would have done it, but I owe the successes in the HIV response to most of the women leaders … women just tend to be on the move and they make a difference while men are still trying to conceptualize what is this all about, what is in it for us, women would have gone, like, 10 miles away." (WL27_Eswatini)

Women leaders are not necessarily more ethical than men but likely face additional scrutiny, they therefore may need to prioritize accountability and transparency to retain leadership roles.

"Even though women often have to overcome more hurdles to reach leadership positions—where a man might need to cross five steps, a woman may need to cross ten. Having navigated these challenges, women leaders develop a strong sense of accountability and deliver with a high level of commitment and role modeling." (WL03_Ethiopia)

Creating a supportive environment for women leaders

Many women leaders actively seek to strengthen organizational capacity and structures to advance gender equality within their organizations and create a supportive environment for women leaders to thrive. These included activities to strengthen broader institutional structures and systems, such as advocating for equal pay, implementing sexual harassment policies, establishing flexible working policies, establishing family leave/ maternity leave policies, establishing nursing rooms for working mothers, conducting training, and capacity building activities and career and mentoring opportunities for women within the organization.

Within the survey, question respondents strongly agreed/agreed that women's

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leadership has positively influenced their organizational culture and climate (84.8%, n=190/224 overall; 86.4%, n=89/103 men; 83.5% n=101/121 women), the gender pay gap (55% overall, n =104/189; 59.6%, n=53/89 men; 51%, n=51/100 women), a diverse and inclusive workforce and policies (81.7%, n=156/191 overall; 84.6%, n=77/91 men; 79%, n=79/100 women), training and development (84.7%, n=166/196 overall; 82.8%, n=77/93 men; 86.4%, n=89/103 women), career and mentoring opportunities for women (84.2%, n=165/196 overall; 87.1%, n=81/93 men; 81.6%, n=84/103 women), as well as employee retention (64.3%, n= 144/224 overall; 71.6%, n=73/102 men; 58.2%, n=71/122 women) within their organization or field. However, responses to the gender pay gap were more diverse, where a sizable proportion of both men (20.2%, n=18/89) and women (21.0%, n=21/100) strongly disagree/disagree that women leaders have positively influenced the gender pay gap.

"[...] we have been working on company culture that can be documented with a policy for maternity leave and what that looks like and giving fathers the opportunity to work from home for a few weeks after their babies are born. I think those things are all very progressive and add the message that we are then trying to send to larger corporates around. Allowing mothers to go and take their child to the clinic without having to take leave. [...] historically have not been in place." (WL18_South Africa)

"The other thing that we have done to ensure that we have gender mainstreaming, is creating opportunities for training for leadership, like we have the senior management courses for women. So that they also have the opportunity and have the ability to learn the management skills." (WL03_Kenya)

"[...] we have young women, we make sure that we have a nursing room in the office, you know, we used to empty one of our storerooms just to, where initially we named it the nursing room, then the guys complained, so it is a wellness room now. Where we just made it comfortable for those women who have babies, if they, someone needs to bring the child to the office, they can breastfeed, or if they need to pump, they can pump. You know, just making sure that we have such an environment in the office. And then, also, we have never had ramps, in case we have people who have disabilities, that has been done. We have a bathroom that is set up like that." (WL10_Zambia)

These initiatives can create an enabling environment for women, helping them balance professional and personal responsibilities, particularly for those with caregiving roles. They can also promote professional development and career growth

and ensure job security for new mothers. As a result, these measures can lead to increased job satisfaction, higher retention rates, and improved productivity, ultimately ensuring that valuable talent is retained within the organization.

Integrating gender within programs and services

Integrating gender within programs and services focuses on addressing gender inequities at the program and service level. Activities include addressing the unique needs, rights, and preferences of women and girls, promoting women's empowerment, recognizing the role of men in women's health and wellbeing, and engaging with the community. Gender integration activities championed and implemented by women leaders in our sample included ensuring women's representation as beneficiaries, engaging women in the community as implementers, and developing male engagement strategies.

"When I actually first joined [my organization], we didn't have a gender policy. So, that was 2019. We have over time grown to be more intentional. More gender intentional around the work, around the staff. Right now, early this year, [my organization] actually launched their gender strategy, which I also contributed to because I was part of the working group. That is important." (WL23_Uganda)

"The other way we have done so, much is to be able to use the kind of mothers who had a positive impact to serve as peer educators to other mothers. [...]. So, what we have done is when we work with your child and the child has a positive impact, as a mother, we involve you as part of the team. We have been involving them [mothers] to talk, to share their story, to be peer supporters. Some of them are the ones who are leading the mother-to-mother support group." (WL02_Cameroon)

"I met the leader of the men... to organize sensitization meeting [about child immunization] with the men. [...] we called it something about fathers or something. And the head of the men had to come out, called the men." (WL08_Nigeria)

According to our respondents, these initiatives have contributed to more inclusive health services and programs for children, adolescent girls, and marginalized groups, and the empowerment of women and girls within the community. In the example from Nigeria below, empowering women through their involvement within program implementation, directly helped to increase vaccination coverage within the community.

"[...] there was even a project we conducted some time ago, I think it was in 2018, 2017,

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when we got to the community, … their vaccination was very low. Very low. When we got it from the state and data, we thought about the strategy to use, we said, okay, let's use women. We empowered the women. The women became champions and got it done for us. By the end of the project, within six, not even at the end, within six months, it was increased. There was an evident 8% increase in two communities." (WL08_Nigeria)

"[…] with the role that I'm playing right now …influencing that level of policy, but the level of planning, micro-planning, especially to those who are left behind." (WL19_Eswatini)

"And also, supporting education for girls because in order to decrease the incidences of child marriage, you need to have an alternative opportunity for these young girls which is girl's education. That is one area where I thought that because of my own involvement in the different spaces as well as a group effort in the technical working groups, it is really influencing follow-up and impact on decreasing child marriage. And the impact has been that progressively child marriage incidents have been decreasing in the country. Still, we have some more work to do but there has been a significant decrease." (WL20_Ethiopia)

Overall, survey question respondents strongly agreed/ agreed that women leaders positively influenced the development of gender policy or policies within their field or organization (83.9%, n=146/174; overall; 88.1%, n=74/84 men; 80%, n=72/90 women), as well as investments on addressing gender barriers or reinforcing positive gender norms (67.2%, n=117/174 overall; 72.6%, n=61/84 men; 62.2% women, n=56/90). Question respondents felt that women leaders' efforts have led to an increase in male engagement in health (71.7%, n=124/173 overall; 75.9%, n=63/83 men; 67.8% n=61/90 women), helped to reduce harmful gender norms and practices (79.5% overall, n=140/176 total; 84.7%, n=72/85 men; 74.7%, n=68/91 women), helped to reduce gender-based violence (79.3%, n=138/174 overall; 82.4%, n=70/85 men; 76.4%, n=68/89 women), and increased autonomy and decision-making power of women and girls (79%, n=139/176 overall; 82.4%, n=70/85 men; 75.8%, n=69/91 women) for the communities and populations they work with.

Advocating for women's representation within leadership roles

Within our sample, some women leaders were actively promoting the inclusion of other women leaders in male-dominated leadership spaces. When asked about organizational outcomes, 84.4% (n=189/224) of survey question respondents strongly agreed/agreed that women leaders have positively influenced opportunities for other

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women in their organization, and men (84.5%, n=87/103) and women (84.3%, n=102/121) have equally positive views, while 82.3% (n=144/175) of question respondents strongly agreed/agreed that women's leadership has positively improved women's involvement in the decision-making bodies, forums, and governing boards within my field, with both men (83.5%, n=71/85) and women (81.1%, n=73/90) having almost equally positive views.

" [...] ensure that you are also in this leadership with your fellow women, that is we have ensured that even in the policies that are made in the facilities, when it comes to like in employment policies, you ensure that there is...representation of a woman...there is an adolescence representation there." (WL03_Kenya)

"It really starts with identifying women leaders and the women organizations, especially in the field that I work. Which is predominantly led by men. You know the medical field areas around public health, reproductive [health...]. You know, the field is dominated by men and most leaders in the field are men. So, we need to start by really prioritizing and looking for women. Because if we expect women will come to us, that has not been the reality. [...] To look for woman-led organizations or woman leaders and to meet them where they are. So, it is just taking one step further and to go to their space and encourage them, whether it is in the proposal writing process, they might need some technical support. So, availing the technical support that they need during proposal development. And then also, you know, provide them ... Building their confidence, but also capacity." (WL20_Ethiopia)

Increased representation of women in leadership can generate a feedback loop where the presence of women in decision-making roles inspires and supports the rise of more women to leadership positions. This compounding effect can amplify the benefits and positive changes they bring to health, wellness, and organizational effectiveness, creating a virtuous cycle of empowerment and progress.

"*I do think there is something about being a woman leader, showing up to a meeting, for example, with the immunization, say task team in a specific country, and being able to showcase the expertise and be an equal foot in. I should say with male leaders that sometimes it can bring a bit of shock value even to in the biggest countries or the most ... in the most unexpected places, because it helps to shatter some of these unconscious biases around what the role women play. So, to me, particularly working in LMICs, there is a role modeling function that women leaders play, how we directly relate to health outcomes. It helps to shatter some of these unconscious biases around gender and slowly changing the mindset of how the role women play and really breaking down slowly some of these barriers that continue to*

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exist, even amongst well-educated, learned people in many other countries that we work in." (WL41_Nigeria)

Shifting organizational cultures in Madagascar

Women leaders in Madagascar play a critical role in shaping organizational culture through teamwork, collaboration, and role modeling. Perhaps due to their own lack of mentors and pressure to "prove themselves" as capable, women leaders seem eager to create more receptive environments for emerging women leaders in the field. They take a holistic approach to team building and collaboration, by reinforcing shared decision-making, transparency, and personal development…despite any barriers that may arise.

"We must bring a positive influence among team and our staff and show that we are just, accessible, easy to talk with, determined, ready to fulfill our mission, full of energy, engaged, show integrity and personal results…whether there are resources or not." (WL02_Madagascar)

Women leaders promotes continuous learning and capacity building within their teams, encouraging staff to pursue personal growth and employing participatory methods to ensure alignment with organizational goals.

"Use clear and open communication, prioritize listening and sharing information, personal development, and transparency of governance, decision-making, and reporting… We had team building sessions, outings, and created quality moments so that the staff can realize that we are carrying out serious and quality interventions." (WL03_Madagascar)

The power of networks

Within the survey, 59.5% (n= 91/153) of respondents perceived that the strength of their entire network was strong, followed by 39.5% very strong, regardless of gender, organizational affiliation, and geography (n= 55/153).

Participants largely reported that they were 'very able' to leverage their networks to help improve organizations (51.9%, n= 69/133), advance careers (50%, n=68/136), design/change/improve programs and policies (47.7%, n=63/132), and affect health outcomes (47.7%, n=63/132) (Figure 2). Men were slightly more likely to indicate that were 'very able' to leverage their networks to advance their career (52.5%, n=32/61 men vs. 47.3%, n=35/74 women) but slightly less likely to indicate that networks would help improve their organization (50%, n=30/60 men vs. 52.8%, n= 38/72 women).

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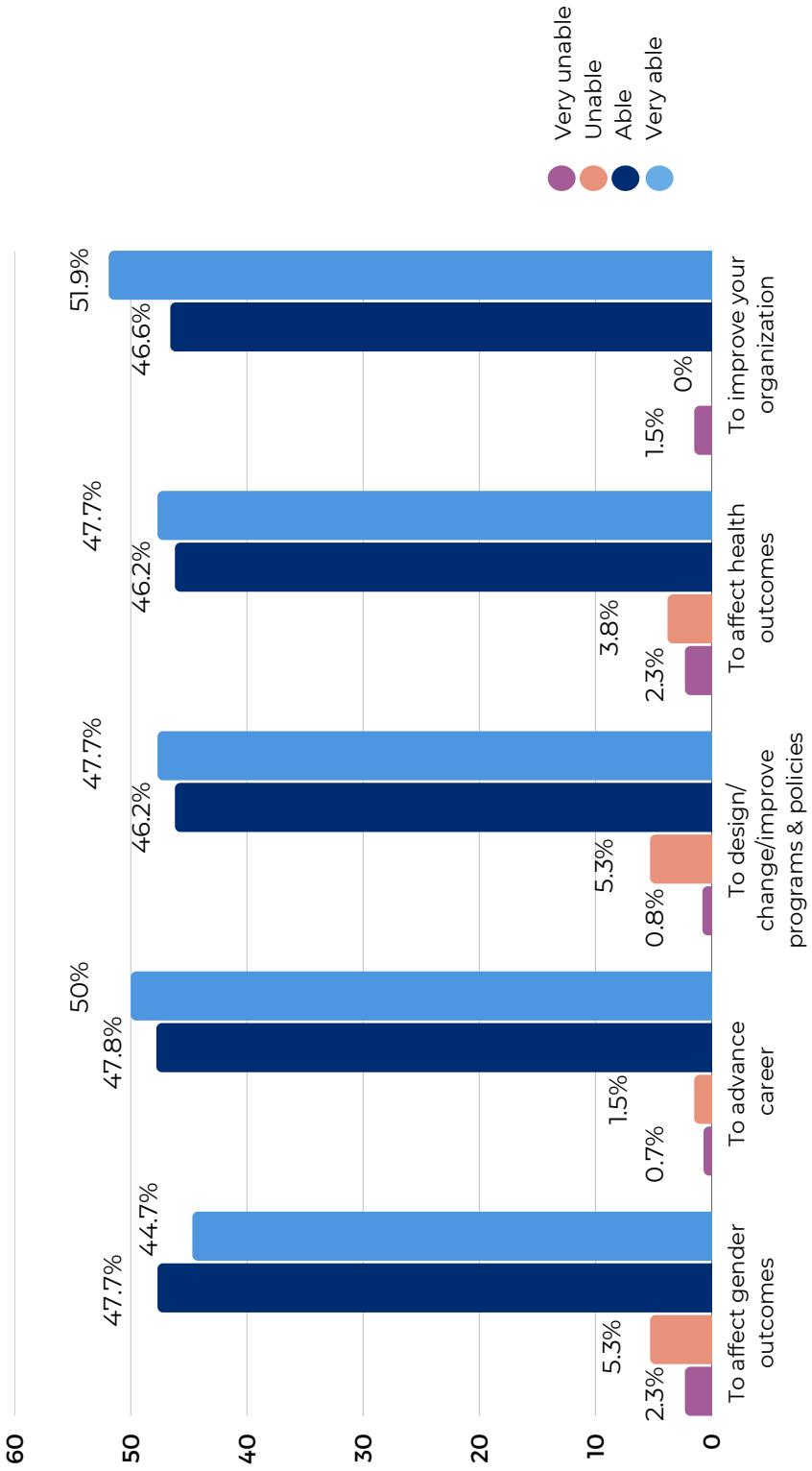
Figure 2: Distribution of participants who responded on the perception on the extent of impact they feel they are able to leverage their network to help meet the objectives.



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Social Network Analysis

We conducted a social network analysis (SNA) among respondents to the survey. SNA is a methodology used to better understand relationships and structures within a community or network.

We created different profiles based on the network members' gender, type of organization, and organizational level. All individuals with the same combination of these characteristics, such as women who work at community-level NGOs, are included within a single element, in this case, "Women-NGO-Community/facility".

In total, the network of leaders across sub-Saharan Africa had 280 unique connections between 72 elements. Connections occur when an individual who shares the characteristics of one element indicates they have a network member who shares the characteristics of another element. We calculated centrality measures, size, eigenvector, and reach (described in Table 2) to identify the most influential types of leaders and understand how they engage with their network members. These measures are assessed for strength (scores higher than average) or weakness (scores lower than average) by how they compare to each other relative to this specific network's characteristics.

Table 2: SNA Key Terms

Term	Definition in context of THRIVE SNA
Element	A type of leader that combines demographic characteristics. In this case, their gender, organization type, and organizational level i.e. women at national-level NGOs. This is represented visually as a colored shape in the figures.
Connections	Members of elements' network who they indicated are important to them/they engage with in their career, including by providing information, support, or advice, or otherwise influencing the elements' career i.e. women at national-level NGOs who engage with men at district-level government. This is represented visually as a line connecting elements in the figures.

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Table 2: SNA Key Terms, continued

Measure	Definition	Implication
Centrality	Measure of an element's overall influence in the network • *Degree*: the number of direct connections an element has • *Closeness*: an element's distance to other elements • *Betweenness*: how often an element acts as a bridge in the connection between two other elements	In general: • Elements with high degrees are the local connectors/hubs and have the largest number of direct connections, but aren't necessarily the best connected to the broader network because we are not considering the characteristics of their connections. • Elements with high closeness can spread information to the rest of the network most easily and usually have high visibility into what is happening across the network. • Elements with high betweenness have more control over the flow of information and act as key bridges within the network. They can also be potential single points of failure.
Size	The element plus the number of neighbors it has; number of elements instead of connections	--------
Eigenvector	How well-connected an element is to other well-connected elements; the element's influence based on its connections to other influential elements	In general, elements with high eigenvector centrality are the leaders of the network, though they may not have the strongest local influence.
Reach	The portion of the network within two steps of an element	In general, elements with high reach can spread information through the network through close friend-of-a-friend contacts.

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Organization Type

Key findings:

- *Leaders from NGOs, followed by those from government organizations, stand out with a prominent role in fostering connections and facilitating information flow across the network.*
- *NGOs have direct access to other organizations, enhancing their influence and network connections. They are also well-connected to other influential elements.*
- *Multilateral organizations play a moderate role, whereas private sector, academia, and faith-based organizations have limited influence in accessing and influencing the network and sharing information. This lack of connectivity may reflect limited collaborative tendencies or opportunities.*

Leaders from NGOs and government organizations stand out with the largest networks, the highest average degree centrality (16.33 and 11.73, respectively), and betweenness centrality (0.022 and (0.013), respectively). This indicates their prominent role in fostering connections and facilitating information flow across the network.

Closeness centrality is also highest for NGOs (0.42) and government (0.29), reflecting that NGOs have more direct pathways to other organizations. This may support their ability to influence and access the network. Multilateral organizations play an intermediate role (degree: 9.44, betweenness: 0.006), with a closeness centrality not too dissimilar to government leaders (0.26). This may reflect their moderate capacity to disseminate information and connect diverse organizational types. On the other hand, lower degree, betweenness, and closeness centrality among private sector (4.27, 0.001, 0.16), university (6.0, 0.001, 0.05), and faith-based organizations (2.57, 0.000, 0.00) show their limited influence in accessing and influencing the network and sharing information. This lack of connectivity may reflect limited collaborative tendencies or opportunities.

NGOs also exhibit the highest eigenvector centrality (0.023), highlighting their connections to other highly influential elements. Government (0.017), multilateral organizations (0.015), and universities (0.018) follow, while private sector (0.009) and faith-based organizations (0.007) again rank lowest. These findings demonstrate that leaders from certain organization types tend to be more connected to influential actors, strengthening their strategic positions within the network.

Organization Level

Key findings:

- *Individuals who work in national-level organizations play a critical role in bridging*

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- *... different parts of the network. They can also quickly access other members of the network.*
- *Those working at higher organizational levels (i.e. national vs. district) are more influential within the network: they act as facilitators of connection and help maintain network cohesion.*

Elements from national-level organizations exhibit the highest average degree, betweenness, and closeness centrality (14.63, 0.019, and 0.29, respectively), highlighting their extensive direct connections within the network, their critical role in bridging different parts of the network, and their ability to quickly access others in the network. These measures of centrality decrease progressively as organizational levels descend. These findings suggest that higher organizational levels, particularly national-level organizations, act as relatively major facilitators of connections and can play a fundamental role in implementing strategies and maintaining network cohesion.

Community/facility-level elements exhibit no closeness centrality (0.00), reflecting their limited influence in the network compared to higher levels. These stark differences in closeness centrality between leaders' contacts from top-level and lower-level organizations suggest a hierarchy where elements at higher levels maintain greater accessibility and influence. These patterns highlight the reduced ability of mid- and lower-level organizations to influence the entire network.

Network reach also increases with organizational level, meaning higher-level organizations may facilitate network-wide dissemination of information through "friends-of-friends". National-level organizations exhibit the highest eigenvector centrality (0.022), being the most well-connected to other highly influential elements. The high eigenvector centrality of national-level organizations reinforces their role as hubs of influence and decision-making.

Most Influential Network Members

The three most influential elements in the network are women at national-level government organizations, women at national-level NGOs, and men at national-level NGOs. Only women at national-level multilateral organizations have more reach than women at national-level government organizations. Figure 3 isolates the most well-connected element, women at national NGOs, demonstrating the diversity of leaders in her network. Arrows facing outwards indicate her 'influence' to another stakeholder, while arrows facing inwards represent other leaders who listed this element as a member of their network. These types of leaders coordinate the network and act as a key bridge, connecting other members within the network.

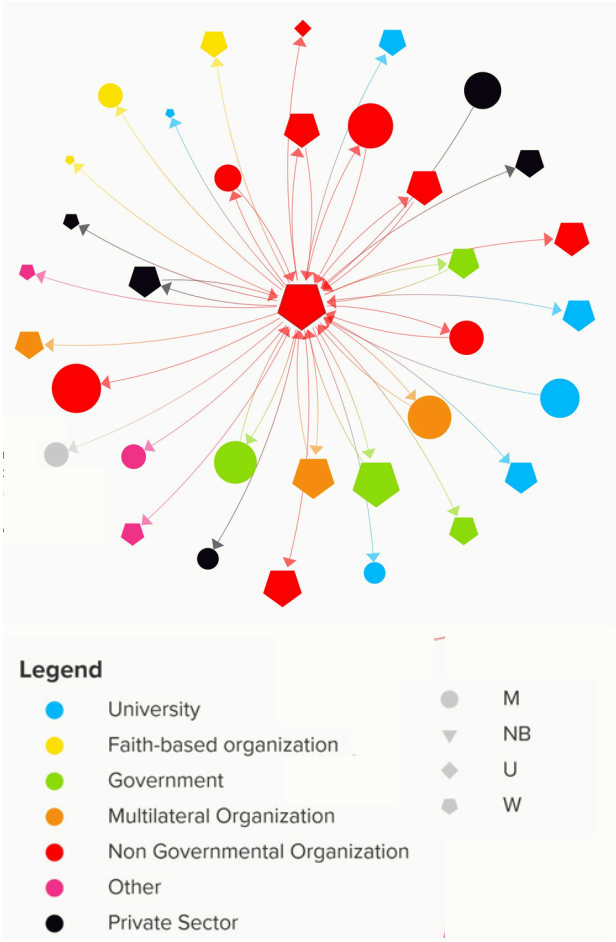
Findings

Gender

Key Takeaways:

- *Men may have more efficient access to diverse parts of the network. Systemic advantages or privileged positioning may allow men to navigate and influence the network more effectively whereas women might face barriers in accessing broader network pathways.*
- *Women are only slightly better connected to influential elements within the network.*
- *Women have slightly broader networks with overlapping ties, whereas men's networks are more diverse.*

Figure 3: Most influential network member



When analyzing the network by gender, women exhibit the greatest average network size (7.89) compared to men (7.83). This could mean women tend to be part of more tightly knit or overlapping groups with mutual ties (more "neighbors" in the "neighborhood"). Despite this, men demonstrate a marginally higher degree of centrality (8.37 vs. 8.08), suggesting a greater number of direct connections. This reflects that men's networks are made of up more unique connections (spread across diverse "neighborhoods").

Women only slightly surpass men in eigenvector centrality (0.02 vs. 0.01), suggesting stronger connections to influential elements within the network. However, men display higher closeness centrality (0.23) compared to women (0.17), suggesting more efficient access to diverse parts of the network. This means that they effectively access the network because of the diversity of their connections but might not necessarily be connected to the most influential nodes like women are.

Similarly, men have a higher reach than women (0.27 compared to 0.23), suggesting that men can impact a larger network segment because they can influence a broader subset through direct and indirect connections. The slightly lower reach for women may indicate barriers in their ability to build connections beyond their immediate

Findings

network, which could limit their influence and access to diverse resources in the network.

In the same vein, men have a marginally higher betweenness centrality (0.008 and 0.007, respectively), reflecting a slightly better strategic positioning in the network since they are more likely to act as gatekeepers. However, this small difference also reflects similarities in how women and men can act as bridges between other elements in the network and spread information.

Connections

Key findings:

- *Most connections occurred between elements with diverse characteristics, reflecting a heterogeneous network connected across Sub-Saharan Africa. This suggests that the network prioritizes cross-border and interdisciplinary collaboration among leaders of all genders, but that there may be a missed opportunity for strengthening tight-knit communities of RMNCAH-N and immunization women leaders within countries.*
- *Most connections were between elements of the same gender – approximately 89%. While respondents connected with more network members of their own gender, it may not result in particularly strong feelings or outcomes. Conversely, gender diversity appears to enhance collaboration, resource-sharing, and value creation, potentially due to complementary perspectives and strengths. This finding was driven by men referring to their professional relationships with women, acknowledging the benefit that women leaders bring to the health sector.*
- *Cross-organizational connections (69%) are valued slightly more and have a higher perception of their network's ability to enact change, despite having slightly lower communication frequency and nearly identical resource-sharing.*

Connections within the same country displayed higher averages across all metrics of network strength, including change-making (2.83), communication (2.45), resource sharing (2.77), and value (2.68), whereas elements from different countries had slightly lower metrics, such as change-making (2.60), communication (2.16), and resources sharing (2.50). Elements in the same country are likely to benefit from shared cultural, political, or organizational contexts, which may foster stronger communication, resource-sharing, and influence. Alternatively, cross-country interactions may present cultural or logistical barriers, though notably, their value remains comparable.

Findings

Different element typologies showed lower average scores across changemaker, communication, and resource-sharing than elements that were the same. The value of the connection was similar between both different and identical elements.

Most connections were between elements of the same gender – approximately 89%. The strength of these connections was relatively moderate for all metrics, including changemaker (2.55), communication (2.06), and resource (2.45), with value (2.60), showing that while respondents connected with more network members of their own gender, it may not result in particularly strong perceptions of strength or outcomes. However, connections between different genders (11%, n = 32), were viewed overwhelmingly positively with the highest scores indicated across all metrics (3.00 for each). Of these, approximately 72% of the connections between different genders were indicated from men leaders to women or contacts of an undisclosed gender, suggesting that they generally recognize the benefit and value of gender-diverse networks.

Organizational similarity, representing 31% of connections, provides a moderate level of collaboration and resource-sharing, supported by shared objectives and familiarity. Cross-organizational connections (69%) are valued slightly more and have a higher perception of their network's ability to enact change, despite having slightly lower communication frequency and nearly identical resource-sharing.
The results of the SNA can highlight areas of improvement and investment in women's leadership programs such as in facilitating connections between leaders from different organizational levels. Shifting power dynamics to inclusive governance and partnership-driven initiatives mitigates tokenistic inclusion of local leadership in decision-making. Most notably, fostering connections between genders through allyship training and inclusive networking events can enhance the existing capacity to create change by breaking down gender silos.

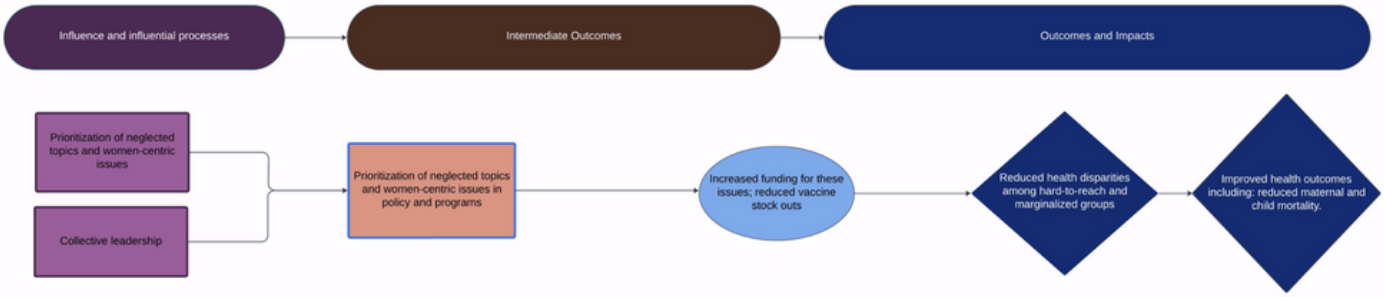
Conclusions

Our findings demonstrate that while women leaders influence health outcomes and impact through many of the same mechanisms that a leader would use regardless of their gender, they are using different approaches and strategies to influence health policy and programmatic change within their countries. While not every woman leader will achieve the same impact or conduct their leadership in the same way, in aggregate we find women leaders broadly are having unique and positive impacts on health outcomes. They can achieve these impacts in the context of the gender-based challenges that women leaders face. These impacts, however, will not be automatic for all women leaders, nor will all women leaders be able to have the impact that they want. Many women leaders will continue to face the challenges identified above, particularly if they are working in unsupportive environments, nor will all women leaders have the same priorities as those in our sample. Recommendations are provided below to support women leaders in having an impact on RMNCAH-N outcomes.

Recommendations

Recommendations are mapped to each of the impact pathways shown in Figure 1 to highlight ways in which women leaders' impact can be amplified and enhanced toward continued improvement of reproductive, maternal, newborn, child, and adolescent health outcomes.

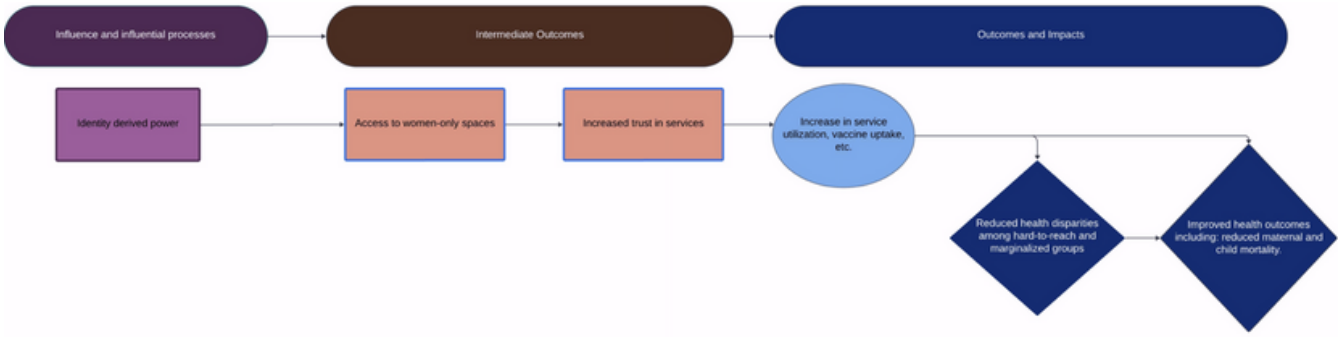
Impact Pathway 1: Women leaders increase funding for the issues they prioritize, which leads to reduced health disparities and improved RMNCAH-N outcomes.



Recommendation 1: Support women leaders to fundraise for the issues they prioritize, such as women-centric and neglected issues within policies and programs. Women leaders are shown to effectively mobilize resources for issues that affect women and girls in their organizations and fields, which can lead to reduced health disparities among hard-to-reach and marginalized groups and improved health outcomes, including reduced maternal and child mortality.

Recommendations

Impact Pathway 2: Women leaders' identity-derived power gives them access to women-only spaces and increases trust in services which has increased service utilization leading to reduced health disparities and improved RMNCAH-N outcomes.

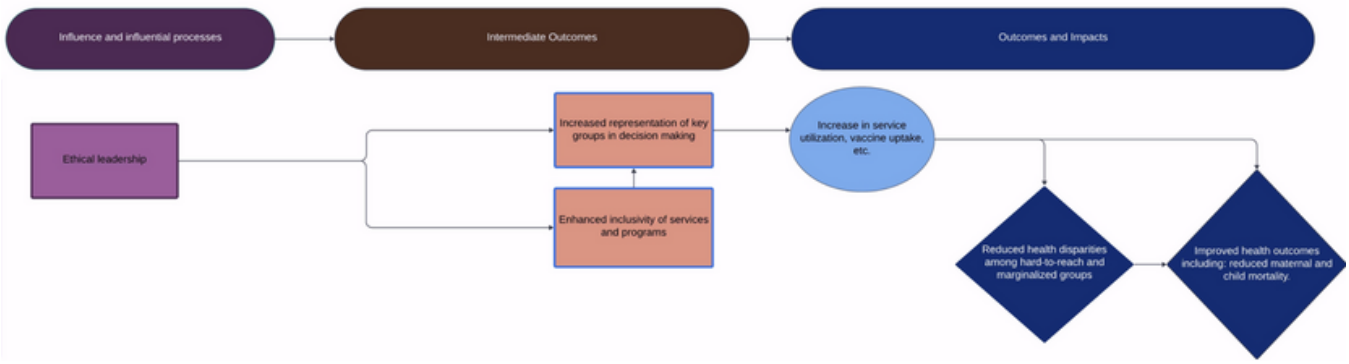


Recommendation 2: Support women leaders' engagement with the community. Women leaders' experiences as women, mothers, and caregivers often enable them to access spaces within the community that men may not be able to access. This can increase communities' trust in health services leading to an increase in service utilization and intervention uptake.

Related SNA recommendation: Facilitate connections between women across levels and contexts to share strategies and successes in leveraging identity-derived power.

Recommendations

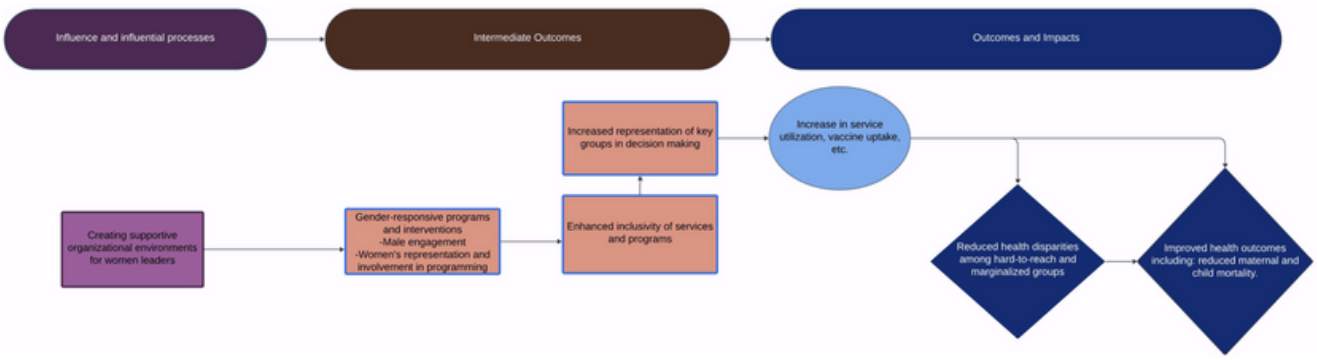
Impact Pathway 3: Women leverage principles of ethical leadership leading to increased inclusivity of services and increased representation of key groups in decision-making. This leads to increased use in services which reduces health disparities and improves RMNCAH-N outcomes.



Recommendation 3: Promote and embed principles of transparency, accountability, and inclusive decision-making in governance structures, including in global health decision-making bodies, to foster more inclusive and representative service environments and ensure that all leaders equally engage in ethical leadership.

Recommendations

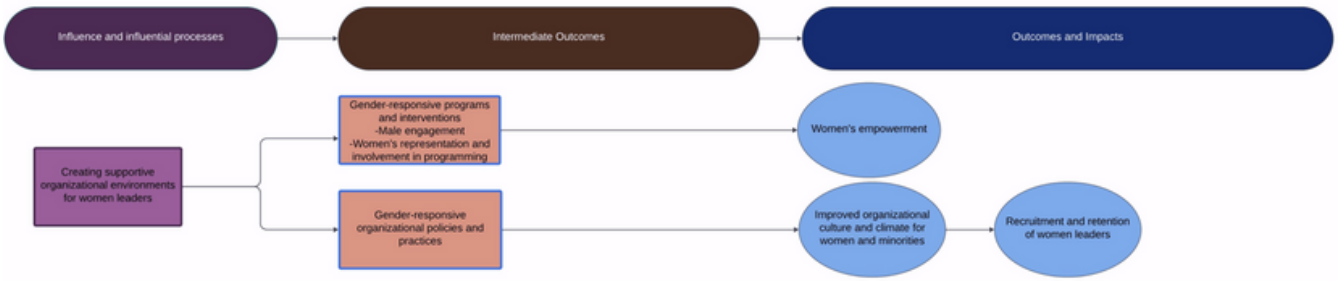
Impact Pathway 4: Women leaders prioritize gender-responsive programs and interventions that include both men and women. When services and programs are more inclusive, service utilization increases, leading to reduced health disparities and improved RMNCAH-N outcomes.



Recommendation 4: Champion gender integration activities implemented by women leaders, such as ensuring women's representation as beneficiaries, engaging women in the community as implementers, and developing male engagement strategies for health interventions. These initiatives can contribute to more inclusive health services and programs for children, adolescent girls, and marginalized groups, as well as the empowerment of women and girls within the community, which can ultimately increase program coverage and reach.

Recommendations

Impact Pathway 5: Women leaders create supportive environments for other women, generating gender-responsive policies and programs that improve organizational culture, and support the ongoing recruitment, retention, and growth of women leaders.



Recommendation 5: Support women leaders in implementing initiatives and policies to create more enabling environments for women, which can ultimately lead to increased job satisfaction, higher retention rates, and improved productivity, ensuring that valuable talent is retained and grown within the organization.

Related-SNA recommendation: Support women leaders' networks to embrace the power of collective leadership within organizations to transform harmful environments and improve women leaders' retention and career growth in the health sector.
Related-SNA recommendation: Conduct allyship training and embed allyship approaches into health organizations to foster connections between men and women. Engage men at national-level NGOs, one of the most influential types of people in the sector, to support allyship initiatives, call attention to women's leadership in health, and champion individual women leaders.

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