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Barriers and Bridges: Women and Leadership in the Sierra Leone Public Health Sector

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Abstract

Purpose: The study examined gender and leadership in the public health sector to understand equality practices and the extent to which women are being considered for top leadership roles in the MoH.

Methodology: A mixed-method cross-sectional study design was used, including document reviews. A total of 402 respondents (grade 9-14 civil servants) completed the online survey, and 18 purposively selected individuals were interviewed. SPSS version 25 and Braun and Clarke's (2006) step-by-step framework for performing thematic analysis were used for the quantitative and qualitative analyses, respectively.

Findings: There is a perception among the participants that women are inadequately considered for senior and top management positions in the MoH. There is a significant relationship between gender and perceptions about women being considered for leadership positions, X^2 (3, N = 402) = 8.88, p < .05. However, the relationship between gender and the other variables (professional roles and service grade) shows no statistically significant difference *($p > 0.05$)*. Participants shared practices they perceived as barriers to women's advancement to leadership positions. The findings from documents review in relation to gender representation across the various functional roles in the MoH, however, revealed significant effort by the leadership to close the gender gap in compliance with the mandated 30% women's representation by 2023 GEWE Act. Overall, women account for 34% and 22% in the senior management level and the top management level, respectively. The political leadership has a 33% female representation, while the professional and administrative leadership remains male-centric, with no female representation. The proportion of females that are currently serving as directors and program managers are 29% and 47% respectively. The least represented roles by women are the District Medical Officer and Medical Superintendents, with only 12% and 14% female representation, respectively. Despite the perceived barriers to women's career and leadership advancement in the MoH, the 2023 GEWE Act is considered an opportunity towards bridging the gender gap in the public health sector. It is imperative that gender equality and women's empowerment initiatives go beyond token measures and result in meaningful and measurable changes in advancing women to top leadership positions not only in the public health sector, but also in all government ministries, department, and agencies.

Unique Contribution to Theory, Practice and Policy: Utilizing Acker's Gendered Organizational Theory, this study examined the barriers and opportunities for women's career advancement to senior leadership positions in the public health sector. This is the first study in post-war Sierra Leone to examine the gender landscape in the MoH. This study is significant to policy and practice for providing insights on the barriers and facilitators for women's career advancement in the MoH. The study findings demonstrate the importance of multi-level strategies that address the entrenched gender norms and systemic barriers that undermine women's career advancement to senior leadership positions in the public health sector.

Keywords: *Gender, Gender Equality, Glass Ceiling, Leadership, Public Health, Women's Leadership*

JEL Codes: *I14, I18, J71*

INTRODUCTION

An essential part of an individual's identity is his or her career. Career makes the individual an independent entity in the social structure of our society. Such identity and individuality should not be constrained through gender bias and should be something that every person has access to without any gender stereotypes acting as a barrier. However, society historically has prescribed roles for men and women based on their gender, and notably leadership roles have been assigned to men (Ely & Rhode, 2010). There is apparently a shift in the role of women in the 21st century as more women are taking up roles and jobs that were hitherto reserved for men and these include leadership roles and jobs in sciences (Bierema, 2016). The major contributors to this shift, according to Bierema (2016), is the increasing number of women achieving higher education, which is enabling women to compete with their male counterparts in the labour market. Furthermore, the global agenda of promoting gender equality, as in the Sustainable Development Goal 5.5, which states: *'Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic, and public life,'* and many other progressive gender-sensitive policies have enhanced women's agency and advanced them to leadership positions in the society and organizations (Damman et al., 2014). The challenges, however, remained. According to the 2024 Global Gender Gap index a score of 68.5% for all the 146 participating countries (Global Gender Gap Report, 2024). According to the report, the lack of meaningful, widespread change across all the countries slows the rate of progress to attain gender parity. The 2030 Sustainable Development Goals (SDG) aspiration for gender parity is far-fetched, as according to current projection, it will take 134 years to reach full parity- roughly five generations beyond the 2030 SDG target (Global Gender Gap Report, 2024).

Gender Equity and Public Health

In Sierra Leone, the Ministry of Health (MoH) is the key health service providers in the public sector. The MoH has a central responsibility in coordinating actions by the Government to ensure adequate investments for the education and employment of a health workforce that is adequate in numbers, equitably distributed throughout the country, and appropriately supported by the health system in order to deliver quality health care services to all Sierra Leoneans. Equal access to employment is crucial both for global economic growth and for the empowerment of women. Gender equality in the workplace can promote more female engagement and retention in the workforce. Further, it makes it easier for them to obtain important managerial positions and develop their own businesses. However, despite these positive developments, women continue to face challenges in accessing not only employment, but also surviving and thriving in the workplace. As reported by Smith and Sinkford (2022), women represent 70% of the health and social care sector global work-force but only 25% of senior global health leadership roles. They noted that, since 2018, there has been a lack of meaningful change in the gender equality policy arenas at global health organizations that has led to significant increases in women serving in global leadership decision-making senior positions. At the global, regional, and national levels, women continue to be disproportionately underrepresented in senior leadership positions when compared to men within organizations and in the wider society (Haile, Emmanuel & Dzathor, 2016). Research indicates that inherent patriarchal systems hinder efforts to place women in leadership positions (Arar, 2013; Damman et al., 2014; Young & Chang, 2015).

In the health sector, gender disparities are driven by unequal power relations, social norms, and differential access to resources and decision-making (Ouahid et al., 2025). These disparities

manifest across the health system: women may face delays in receiving care due to financial dependence or caregiving responsibilities (Ouahid et al., 2025; Heise et al., 2019); men may underutilize preventive services due to norms around masculinity (Samulowitz, Gremyr, Eriksson, & Hensing, 2019); and gender-diverse individuals often encounter stigma, discrimination, and legal barriers that limit access altogether (Weber et al., 2019). These inequities not only result in worse health outcomes for marginalized groups but also create inefficiencies—overburdening emergency care, undermining disease prevention efforts, and eroding trust in health systems (Sen & Östlin, 2008). When health systems do not address these structural inequities, they fail to deliver care that is effective, inclusive, and equitable for all (Sen & Östlin, 2008). Ensuring gender equity is, therefore, an important dimension for access and utilization of health services in the spirit of leaving no one behind and universal health coverage. To enhance women's representation in leadership positions across all spheres of the public sector, the Sierra Leone government enacted the 2023 Gender Equality & Women's Empowerment (GEWE) Act. The law mandates improvements in women's access to finance, employment opportunities, equal pay, maternity leave, and political representation, including a 30% quota for women's representation in all ministries, departments, and agencies (MDA). It is expected that the Serra Leone public health sector will promote women's career development and progression in line with the GEWE Act.

Post-war Gender Equality and Women's Empowerment Reforms in Sierra Leone

Gender inequality in Sierra Leone was heightened by the 10-year civil war in addition to long-standing social and regional disparities (McFerson, 2012). During the civil war, traditional norms that marginalized women were exacerbated, and sexual abuse was used as a weapon of war (Rubio-marin, 2006). But postwar reforms advocated by the Truth and Reconciliation Commission (TRC) galvanized political commitment to advancing gender equality through education, legal protection, and economic opportunities. Following the TRC's recommendations, the government enacted a series of "Gender Acts" between 2007 and 2009, the 2019 Sexual Offences Act, and the 2023 Gender Equality and Women's Empowerment (GEWE) Act among others, are collectively strengthening women's agency and decision-making autonomy.

The 2023 GEWE Act, which has been described as a "revolutionary" law for women's rights and empowerment, mandates improvements in women's access to finance, employment opportunities, equal pay, maternity leave, and political representation, including a 30% quota for women in all government ministries, departments, and agencies (MDAs), and promote the development of gender-sensitive budgets (UNWOMEN, 2025). The GEWE Act prohibits employers from dismissing women on the grounds of pregnancy, from discriminating against them, and reiterates the ban on sexual harassment. Prior to the adoption of the GEWE Act, women held only 11% of parliamentary seats (Kayembe, 2023). Followingit's the implementation of the GEWE Act, alongside other post-war gender reforms, Sierra Leone has recorded a 14.5% increase in the number of women elected to Parliament, and 34% of the elected councilors at the local level were women, marking a significant increase from 18.7% in the 2018 elections (UNWOMEN, 2023). Further, in the current cabinet of 31 ministers, 9 (29%) are female (GoSL, 2025). The adoption of this law demonstrates the government's commitment to its international obligations under signed and ratified human rights treaties for the promotion and protection of human rights. However, the extent to which the GEWE Act and other gender-related laws have translated into health-sector leadership outcomes is yet to be examined.

Problem Statement

The Sustainable Development Goals (SDG) and other international legal frameworks emphasize the need for gender equality globally. However, challenges persist in advancing women's chances for equal representation in the leadership of both public and private organizations as their male counterparts. Sierra Leone faces the same situation where women are underrepresented in public sector leadership positions. Reasons for such disparities are many. Women face barriers in attaining leadership positions in society and organizations stemming from early socialization and stereotypes that assign different roles for men and women (Tabassum & Nayak, 2021). Such socialization, according to Acker's (1992) Gendered Organizational Theory, influences what happens in organizations, thereby creating barriers and a "glass ceiling" that hinder women's advancement in organizational hierarchies. Even though women in Sierra Leone are 51% of the population (Statistics Sierra Leone, 2019), they face many discriminatory practices, highlighting unequal rights, roles, and socio-economic outcomes (Rubio-marin, 2006).

In a bid to promote women's empowerment and gender equality, post-war reforms led to the enactment of gender-sensitive laws and women's empowerment initiatives. The 2023 GEWE Act is the latest bill that ensures a 30% quota of women's representation in every government institution. Following the GEWE bill, the leadership of the MoH appointed a gender adviser that is tasked to ensure the operationalization of the act in the public health sector. Despite several funded initiatives by both government and international partners, women in Sierra Leone are still grappling with deeply entrenched historical challenges, including limited access to education and economic opportunities, as well as gender-based violence (Cullen, 2020). Women's leadership and political participation are still limited, and discriminatory laws and institutions create structural barriers that restrict women's opportunities for leadership (UNWOMEN, 2025). There are also capacity gaps that make women less likely than men to have the necessary education, experience, and resources to become effective leaders Furthermore, succession planning practices, which provide equal opportunity to both male and female personnel to find a place at the helm of leadership in any organization (Ali et al., 2019), have been reported to be inadequate in the Sierra Leone public health sector (Kanu, 2025). This makes it difficult for women in the leadership pipeline to attain their leadership aspirations in the MoH. Gender equity is imperative to the attainment of healthy lives and well-being of all, and promoting gender equity in leadership in the health sector is an important part of this endeavor (Dhatt et al., 2016; Kalbarczyk et al., 2025). This empirical research therefore, examines women and leadership in the Sierra Leone public health sector. The study's outcome will shed light on the current situation of women's participation in the management of the public health sector to inform the operationalization of the 2023 GEWE Act.

Purpose: To examine women's consideration for leadership positions in the public health sector

Specific Objectives:

1. To conduct a gender landscape analysis on the leadership of the MoH
2. To understand the barriers and opportunities (bridges) for women's career advancement in the public health sector.

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LITERATURE REVIEW

Conceptual Framework

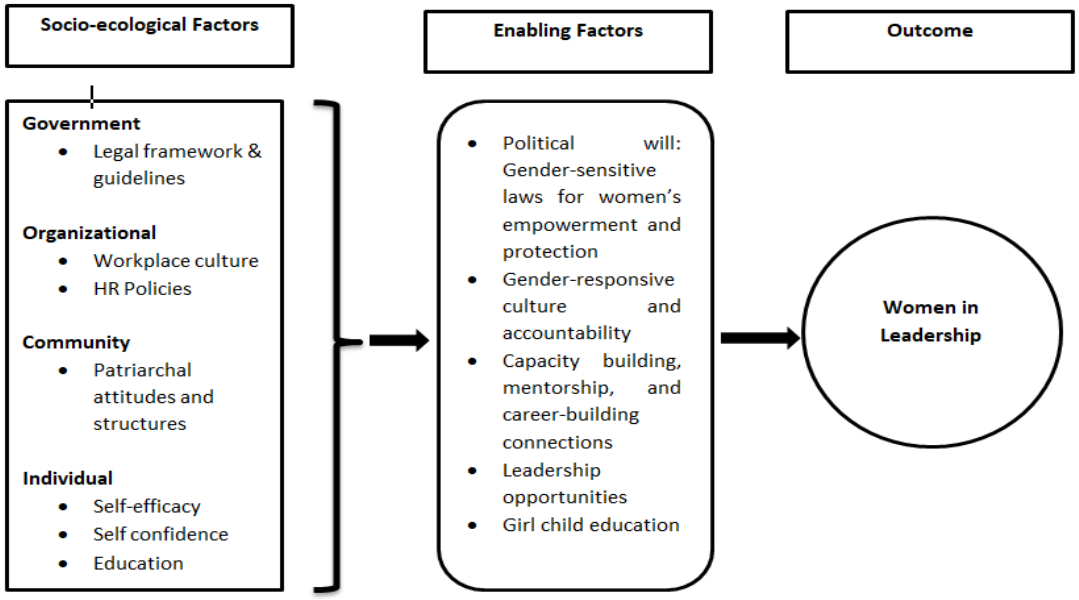

Figure 1: Conceptual Framework

Using a socio-ecological lens, the conceptual framework identifies systemic barriers and facilitators to women's career advancement and possible associations among them under four dimensions as follows: individual, community, organizational, and wider society (national government). It highlights factors that can influence or hinder women's career growth in society. On the individual level, a woman's level of education, self-confidence, and self-efficacy are vital for career growth. At the community level, patriarchal attitudes and structures often serve as barriers to women's growth. At the organizational level, workplace culture and human resources practices have great influence on women's career growth. From a wider society perspective, national legal frameworks and guidelines on women's empowerment and protection are critical for women's career development. The conceptual framework identifies enabling factors that are essential for women's career growth and ultimately a place at the leadership level. These factors include the political will to promote women's protection and empowerment, gender-responsive culture and accountability, girl child education, career development and networking opportunities.

Theoretical Framework

This study is anchored on Acker's (1992) Gendered Organizational Theory. The Gendered Organizational Theory holds that there are systemic barriers with a basis of sexism that hinder the advancement of women to top leadership roles. Acker's (1992) Gendered Organizational Theory explains the persistence of male advantages in organizations and how societies in the contemporary world perceive organizations. It provides a basis for understanding why inequality between men and women persists and the permutations of gender and power in organizations. The Gendered Organization Theory asserts that society and its values inextricably link to organizations. This implies that the conception of organizations mirrors the societal interpretation of gender and gender roles. According to the theory, gender disparities persist even in organizations with progressive policies that promote equality between men and women. This is why the underrepresentation of women in executive positions in organizations

persists, whereby perpetual discrimination against women results in an imbalance in power relations. The theory argues that gender discrimination is overt or hidden in organizations' processes and practices. Similarly, sexuality, in its diverse forms, is implicit in organizational operations and practices (Shafritz et al., 2016). These processes and practices manifest in many dimensions: the gender patterning of jobs, wages for the individuals, and power for those in leadership, hierarchies, and subordination; the interactions of those in powerful positions, and the mindsets of individuals constructing the understanding of the organization (Shafritz et al., 2016). Acker's (1992) Gendered Organizational Theory is crucial for the current study, as it helps explain gender disparities as societal and organizational constructs resulting in the underrepresentation of women in leadership.

Empirical Review

Perceptions of Men's and Women's Leadership Styles

Sinclair (2014) defined leadership as not a position or a person but a process of influence, often aimed at mobilizing people towards change - for example, in values, attitudes, approaches, behaviors, and ideologies. Leadership, according to Sinclair, could be exercised by anyone in an organization, not just the CEO, because, at its core, it is just empowering others to act in their interests. However, there are gender perceptions in leadership that play a significant role in the workplace. According to Stringfellow (2017), the perception differences between men and women are significant. Men may believe that when jobs are scarce, they have a priority over women for available positions (Stringfellow, 2017). Men may also believe that they are better political leaders and better business executives compared to women (Stringfellow, 2107). Evidence has however, indicates that women perform equally well as men, (Chang 2017), with significant literature showing that women can be more effective in leading (Bart & McQueen, 2013; Vo et al., 2020).

Perceptions of men's and women's leadership styles in various organizations do merit some awareness of the differences in styles, abilities, and effectiveness. Many researchers conducted comparative reviews of the leadership styles used by female and male leaders to differentiate men's and women's leadership styles. For instance, Wille et al. (2018) found that women are more democratic leaders, while men are more autocratic in their approach to leadership. Several studies have also reported that female leaders are consistently linked with transformational leadership styles, arguing that more women leaders than male leaders display transformational traits (Alzougool et al., 2020; Nash et al., 2017). Purkayastha et al. (2020) posit that women are capable leaders who are as successful as men and hence deserving of opportunities to take on leadership roles in society. In essence, gender should not matter when it pertains to leadership positions; gender diversity should be the primary focus for all leaders.

Glass Ceiling

Chisholm-Burns et al. (2017) defined the glass ceiling as the invisible barrier women face as they attempt to advance through various careers. Metaphorically, the glass ceiling is impenetrable, and often women are often denied senior-level management positions. Invisible barriers can cause some managers to fail to notice female employees for promotion to the next higher position. Often, when women try to advance within careers for which they both trained and obtained a higher education degree, they are not successful. According to Allen et al. (2016), more women than men have academic degrees that should qualify them for advancement, but women continue to face challenges in advancing their careers in both the private and the public sectors. Existing literature illustrates that the level of emancipative forces within a country can facilitate or hinder women as they attempt to advance to senior leadership

positions (Brieger et al., 2019). This is aligned with Welzel's (n.d.) Theory of Emancipation, which links the balanced distribution of resources between men and women with substantial economic, social, and political rights to women's advancement to leadership. Finding a solution to the paucity of women in leadership requires organizations' acknowledgement of the problem. While barriers such as glass ceilings are diminishing, it is incumbent upon women to remain educated and technically competent while competing for challenging leadership positions.

Research Gap

On the recognition that sexual violence and female suppression practices are exacerbated during conflicts, rebuilding efforts of conflict-ravaged nations include the protection and empowerment of women to promote gender equality. In the case of the 10-year civil war in Sierra Leone (1991-2001), huge investment was directed by government and development partners to address gender issues - protecting and empowering women. A range of post-war gender-sensitive laws have since been enacted to protect and empower women. With the 2023 Gender Equality and Women's Empowerment (GEWE) Act, a noticeable increase in women's representation in the political landscape is observed. Little is, however, known about the extent to which ministries, departments, and agencies (MDAs) in Sierra Leone are closing the gender gap at the leadership level. The current study, therefore, sought to understand the current situation on women's representation in the senior leadership positions in the public sector, using the MoH as a case study. It is expected that the study findings would contribute to the operationalization of the 2023 GEWE Act in Sierra Leone and in similar post-war settings with a view to elevate women in leadership roles.

METHODOLOGY

Study Setting- The Sierra Leone Ministry of Health

This study was carried out nationwide across the 16 districts of Sierra Leone, focusing employees of the Ministry of Health (MoH). The MoH, the key health service provider in the public sector, has a central responsibility in coordinating actions by the government to ensure adequate investments for the education and employment of a health workforce that is adequate in numbers, equitably distributed throughout the country, and appropriately supported by the health system in order to deliver quality health care services to all Sierra Leoneans. On the governance of the health sector, the national level is politically led by a Minister and two Deputy Ministers. The Ministry has two different divisions: a professional division and an administrative division. The professional division is led by the Chief Medical Officer (CMO) and has nine directorates. A Director who coordinates health programmes and activities leads each directorate. The administrative division is led by a Permanent Secretary (PS) and coordinates five directorates. At the district level, a District Health Management Team (DHMT) is responsible for the overall health planning, implementation, coordination, monitoring and evaluation of health services under the leadership of the District Medical Officer (DMO) across the country's 16 districts. The DMO is responsible for overseeing all primary care services, while the Medical Superintendent of each district government hospital is responsible for overseeing care provided at hospital level. The active stock of health workers in Sierra Leone is 11,732 personnel (WHO, 2019). The density of doctors, nurses, and midwives is estimated to be 12.3 per 10,000, compared to a global threshold of 45 per 10,000 identified by the World Health Organization as generally necessary for the attainment of a high level of service coverage compatible with the attainment of universal health coverage objectives (WHO, 2019).

This is a cross-sectional study with a mixed-methods approach, targeting full-time, pin-coded civil servants between grades 9 and 14 within the public health sector. The data collection for both qualitative data and quantitative data was done simultaneously. Document reviews were also conducted to examine the gender differences in key functional roles in the MoH. The survey instrument is an online questionnaire using a 4-point Likert scale with a focus on women's consideration for leadership positions in the MoH. For the qualitative study, a semi-structured guide was used for the interviews, which were conducted largely in English. All interviews were audio-recorded with the participants' consent. A total of 402 respondents, drawn from the national level, district health management teams (DHMTs), hospitals, and health training institutions, completed the survey. This total represents 32% of all 1,264 targeted participants. For the qualitative interviews, a purposive sample of eighteen (18) participants was targeted among the eligible MoH personnel for this study. SPSS version 25 was used for the quantitative data analysis. Braun and Clarke's (2006) step-by-step framework for performing thematic analysis and MAXQDA 22 software were used for the qualitative data analysis. A local ethics approval from the Sierra Leone Ethics & Scientific Review Committee (SLESRC) was sought and granted for this study.

RESULTS

The findings of the quantitative and qualitative components of this study, based on responses from 402 respondents for the survey and 18 respondents for the interviews, are presented.

Demographic Characteristics of Survey and Interview Participants

Regarding gender, out of 402 participants, 63.2% (n=245) and 36.8% (n=148) are male and female, respectively. In terms of age, out of a total of 402 participants, those below age 25 years were least represented, 0.5% (n=2), while those between 35 and 44 years old were the largest group with 129 (32.1%), followed by 55 years and above with 126 (31.3%). The mean age of the participants is 45 years *(M=45.08; SD=9.04).* For the educational levels of the participants, the majority, 45.5% (n=183) hold postgraduate master's degree, followed by holders of undergraduate degree (bachelors); 35.6% (n=143); while 15.4% (n=62) and 3.5% (n=14) are holders of professional certificates/diploma and doctorate degree, respectively. On the professional cadres/roles of participants, the majority, 54.9% (n=221) are allied health professionals, followed by nurses at 23.4% (n=94). Administrative staff is the least represented in the survey at 4.5% (n=18). On the civil service employment grade, the majority of the respondents are upper middle-level personnel (grades 9-10), accounting for 84.1% (n=338), followed by senior-level personnel (grades 11-12), 14.4% (n=58), and top-level personnel (grades 13-14), 1.5% (n=6).

Table 1: Socio-Demographic Variables of Study Participants (n=402)

Variables	Categories	N (%)
Gender	Female	**254** (63.2%)
	Male	**148** (36.8%)
Age	Below 25 years	**2** (0.5%)
	25-34 years	**20** (5.0%)
	35-44 years	**129** (32.1%)
	45-54 years	**125** (31.1%)
	55 years and above	**126** (31.3%)
Education	Certificate/Diploma	**62** (15.4%)
	First degree	**143** (35.6%)
	Masters	**183** (45.5%)
	Doctorate	**14** (3.5%)
Professional Cadres & roles	Allied Health Professionals*	**221** (54.9%)
	Medical Doctors	**69** (17.2%)
	Nurses	**94** (23.4%)
	Administrative Staff **	**18** (4.5%)
Service Grades	Grades 9-10 (Upper mid-level)	**338** (84.1%)
	Grades 11-12 (Senior level)	**58** (14.4%)
	Grades 13-14 (Top Management)	**6** (1.5%)

**Allied Health Professionals apply to CHOs, EHOs, Laboratory technicians, Pharmacists, Nutritionists, etc*

***Administrative Staff applies to non-health professionals (e.g. accountants, procurement,, and HR officers etc)*

Figure 1 below shows the distribution of gender and respondents' qualifications. Across the various educational qualifications, men outnumbered women. Of the 143 respondents with bachelor's degrees, females account for 28% (n=40), while 44% (n=80) of the females are among the 183 participants with master's degrees. 4 (29%) out of 14 participants with a doctorate degree are female.

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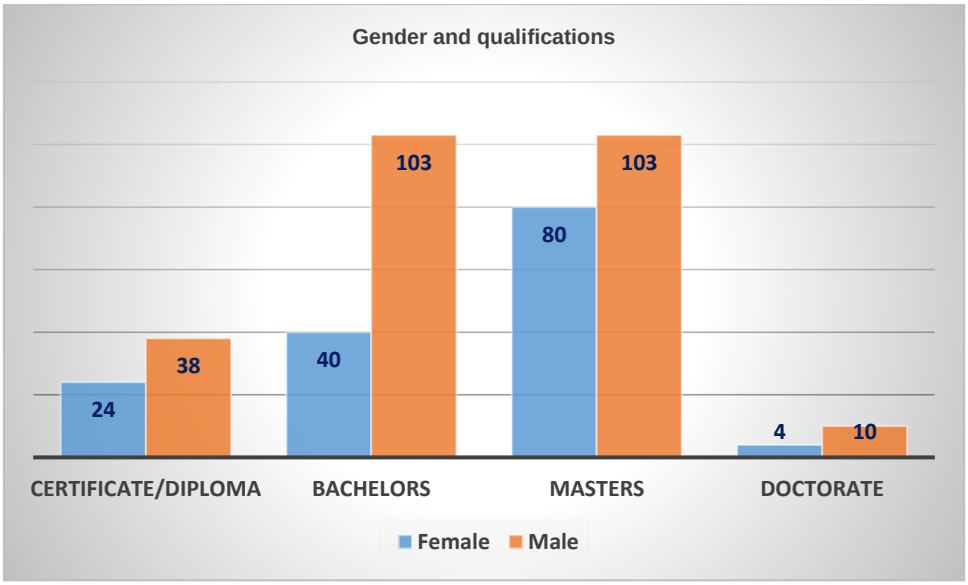

Figure 1: Gender and Educational Achievements

Figure 2 below shows the distribution of gender and respondents' grades in the civil service. Women were under-represented in all the grade categories. Of the 338 upper middle-level personnel, 64% (n=215) and 36% (n=123) of the respondents are male and female, respectively. Among the senior and top-level personnel, 40% (n=23) and 33% (n=2) are females, respectively.

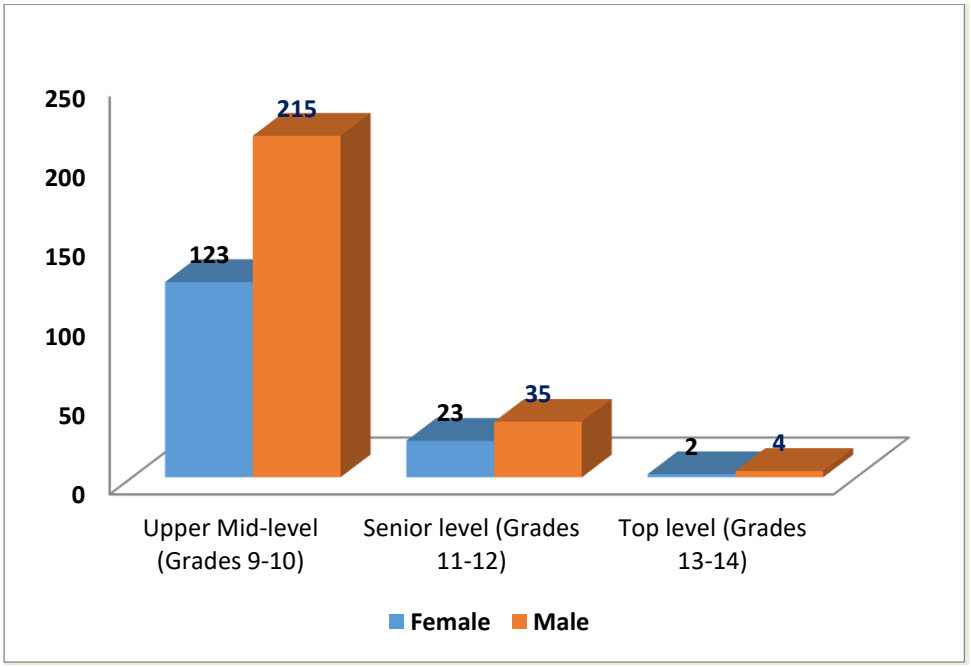

Figure 2: Gender and Service Grade Distribution

Table 2: Distribution of the Demographic Characteristics of the Interview Participants (n=18)

Socio-demographic variables		**N (%)**
Gender	Male	**10** (55.6%)
	Female	**8** (44.4%)
	Medical Doctors	**4** (22.2%)
Professional roles	Nurses	**6** (33.3%)
	Allied Health Professionals *	**4** (22.2%)
	Administrative staff **	**4** (22.2%)
Grade	Grades 9-10 (Upper mid-level)	**4** (22.2%)
	Grades 11-12 (Senior level)	**10** (55.6%)
	Grades 13-14 (Top Management)	**4** (22.2%)

**Allied Health Professionals apply to CHOs, EHOs, Laboratory technicians, Pharmacists, Nutritionists, etc*

***Administrative Staff applies to non-health professionals (e.g. accountants, procurement,, and HR officers etc)*

Among the participants for the qualitative interviews, the majority, 55.6% (n=10), are male. Nurses formed the majority, accounting for 33.3% (n=6) among the professional cadres, and there were four (4) representatives each for medical doctors, allied health professionals, and administrative staff. For the service grade, 55.6% of the participants were between grades 11 and 12.

Perceptions on the Status of Women and Leadership in the MoH

To assess the perceptions of women's consideration for leadership positions in the MoH, a quantitative survey and qualitative interviews were conducted. Furthermore, documents were also reviewed to examine the proportion of women in the current leadership of the MoH at national and district levels.

Quantitative Survey

For the quantitative survey, a 4-point Likert scale was used in the online questionnaire as follows: 1= Very poorly, 2= Inadequate, 3= Adequately, and 4= Very well. The descriptive statistics reveal that women are "inadequately" *(M=2.05, SD=.72, n=402)* considered for leadership positions in the MoH. The frequency distribution of the responses reveals that out of 402 respondents, a total of 271 (67%) believed that women are "very poorly" and "inadequately" considered in leadership positions in the MoH. A total of 131 (33%) of the participants believed that women are "adequately" and "very well" considered in leadership positions. In essence, both female and male participants viewed this factor differently (figure 3), as more males, 68.3% (n=71), than females, 31.7 % (n=33) think women are "adequately" considered for leadership positions. Similarly, more males, 74.1% (n=20), than females, 25.9% (n=7), think women are considered "very well" for leadership positions. Among those who believe that women are "inadequately" considered for leadership positions, the majority were men, 63.3% (n=140). However, among those who selected "very poorly", the majority were women, 27 (54.0%).

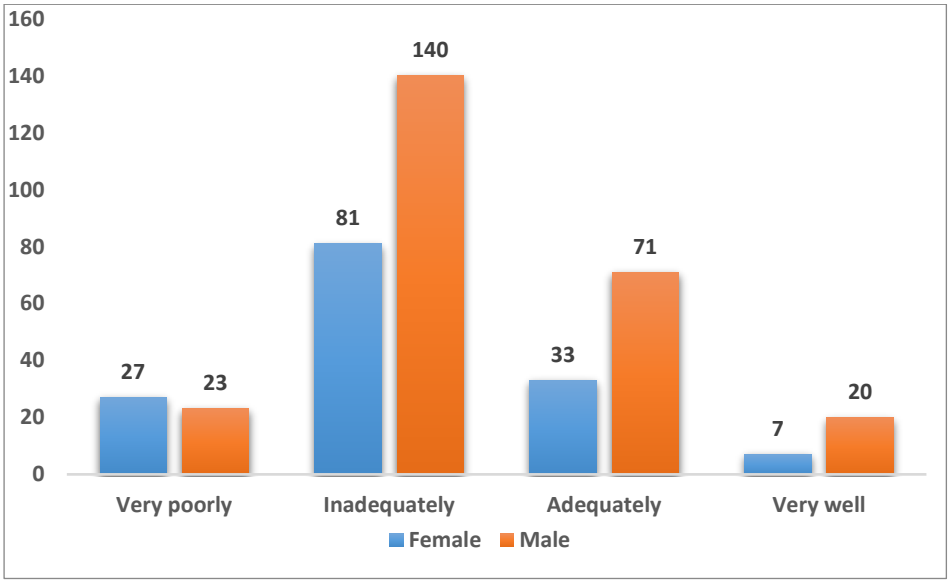

Figure 3: Gender Distribution of Considerations for Women in Leadership Positions

A chi-square test of independence was performed to examine the relationship between gender, professional roles, service grade, and the perception of women's consideration for leadership positions in the MoH. There is a significant relationship between gender and perceptions about women being considered for leadership positions, X^2 (3, N = 402) = 8.88, $p < .05$. However, the relationship between the other variables (professional roles and service grade) shows no statistically significant difference *($p > 0.05$).*

Document Review

A review of documents was done to assess the proportion of women in leadership positions across professional and administrative functional roles in the MoH. Excluding the non-pin-coded staff, such as political appointees and consultants, as well as roles below grade 9, a total of 96 functional roles, comprising substantive and deputy positions at national and sub-national levels, were examined. Figure 4 shows that women are less represented in the different service grades. A sharp drop is observed from the senior level (grade 11-12) to the top management level (grade 13-14). Only 22% of women are represented at top management of the MoH compared to 34% at the senior management level. This shows that the "leaky pipeline"- a phrase commonly used to describe the progressive loss of capable women from more senior roles in organizations (Resmini, 2016) - exists in the Sierra Leone public health sector, with lower participation of women in leadership as compared to their male counterparts at the top management level.

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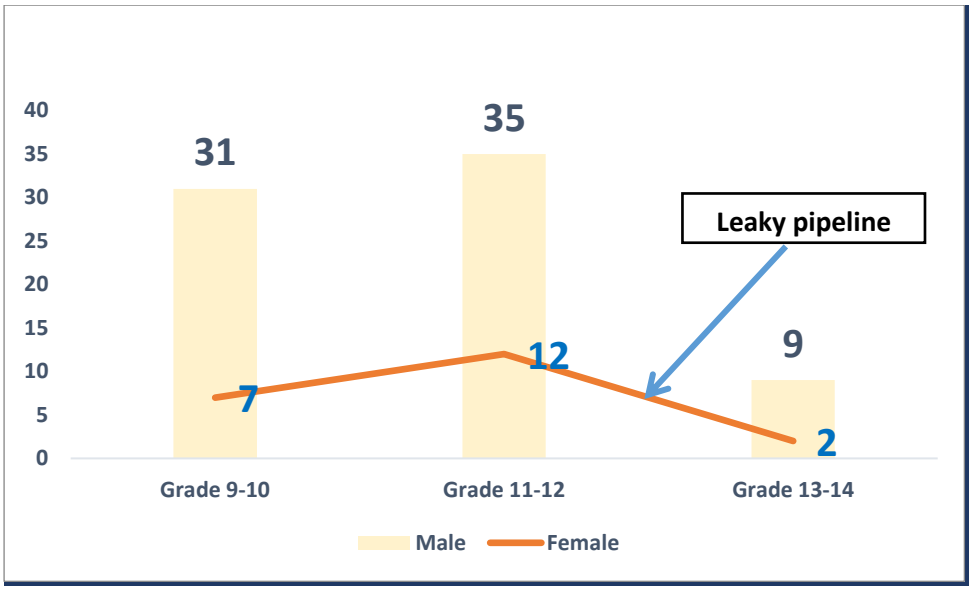

Figure 4: Service Grade and Gender Distribution

Table 3 below shows the gender distribution across the various functional roles (including political appointments but excluding deputy positions for Directors, Program Managers, DMOs, and Medical Superintendents in the MoH). The women's representation in the political leadership is currently at 33%, while the professional and administrative leadership remains male-centric. More women, 47% serve as program managers than in any other functional role. Women account for 29% of all directors. The least represented roles by women are the roles of DMOs, where only 12% are female DMOs; and 14% are female Medical Superintendent. As pointed out by several participants, the under-representation of women in the DMO and Medical Superintendent roles may be closely linked to family concerns, limiting the movement of women to take up leadership roles in the districts.

Table 3: Functional roles and gender

Functions	**Male**	**Female**	**Total**
	N (%)	**N** (%)	**N** (%)
Political leadership*	**2** (67%)	**1** (33%)	**3** (100%)
Professional and Administrative leadership**	**4** (100%)	**0** (0%)	**4** (100%)
Directors	**12** (71%)	**5** (29%)	**17** (100%)
Program Managers	**9** (53%)	**8** (47%)	**17** (100%)
District Medical Officers (DMO)	**14** (88%)	**2** (12%)	**16** (100%)
Medical Superintendents (MS)	**25** (86%)	**4** (14%)	**29** (100%)
** Minister (1) and Deputy Ministers (2)*			
*** CMO (1), Deputy CMOs (2); and the Permanent Secretary (1)*			

Qualitative Interview

Participants' accounts in the qualitative interviews were also mixed in relation to women's consideration for leadership positions in the MoH. There are overwhelming concerns that women have been historically sidelined in getting to the top management level in the MoH. Some of the participants think there are barriers that prevent women from advancing their careers in the MoH.

"Gender consideration, in my opinion, is zero. Women are denied the top roles based on the perception of being poorly educated. They think women cannot perform as their male counterparts, and this is not true." ***(Female, Admin Staff)***

"At the MoH, women are hardly considered for leadership positions. In my opinion, the factors that affect women's growth in the MoH are largely patriarchal, and the MoH is seen as a doctors' ministry. Women are not or rarely considered for DMO roles, for example. Also, there is no equal share of opportunities like scholarships to grow in the system; these are often reserved for the male-dominated medical doctors." **(Female, Nurse).**

Two (2) female participants, a medical doctor and a nurse, pointed out that women are often limited by family concerns in taking up some leadership roles, especially at the district level.

"Honestly, some of us are constrained to move to the district due to family reasons. For example, going to the provinces as DMO or Medical Superintendents poses challenges to the family, especially when you have school-going children" ***(Female, Medical Doctor).***

"Accommodation and good schools are a challenge in some districts. So women sometimes prefer working in the city [Freetown] even when they are promoted." ***(Female, Nurse)***

The views of men on gender considerations for leadership roles in the MoH are slightly different.

"In the MoH, women are always considered once they can perform. Women are sometimes held back due to family reasons when they cannot move. We are trying to push women to the top. They have to be smart and brave to navigate their way to the top. We have seen women serving as DMOs and Program Managers **(Male, Medical Doctor).**

"I don't think the system is deliberately preventing women from getting to the top. Of course, there are factors affecting a number of women in top roles, and these begin right at secondary and university education when women normally choose soft courses. But there are more chances today with the government GEWE bill to get women at senior-level positions in the civil service and political appointments." **(Male, Admin Staff)**

The majority, however, cited the government's Gender Equality and Women Empowerment (GEWE) Act and its operationalization in the ministry as an opportunity (a bridge) for women to compete with their male counterparts for senior-level positions.

"In this ministry, there is no gender equity at all levels, as men dominate in all positions. We saw it in the challenges faced by women to serve as DMOs, Medical Superintendents, Managers and Directors. These positions are dominated by men. The gender mainstreaming effort by the government through the GEWE Act is facilitating career growth for women." **(Female, Nurse)**

"Women have been deprived of career advancement in the MoH for a very long time. With the GEWE Act being implemented in the ministry, women are gradually being appointed to senior -level roles as directors and program managers." **(Female, Nurse).**

"The fact is that, the GEWE aspirations will not be automatic. It is going to take time. In the MoH, the leadership is very supportive of the agenda, and pretty soon, we are going to see changes with women finding their place at the decision-table." **(Female, Allied Health Practitioner)**

"Women have held the perception that top management roles are tough and are reserved for men. Thanks to the GEWE Act, this perception is gradually changing as more women are now coming forward to compete for senior leadership roles." **(Female, Nurse).**

A particular respondent is, however, concerned about getting women to senior roles despite the GEWE Act.

> *"The gender mainstream agenda through the GEWE Act is facilitating career advancement for women in the MoH. The problem, though, is that the positions are advertised, ignoring those on the pipeline. Some women do not have the qualifications, so we are still seeing men continue to hold the top-level positions based on their qualifications and political connections."* **(Female, Nurse)**

Discussions

This mixed-methods study examined gender equality practices and the extent to which women are being considered for top leadership roles in the public health sector, situating findings within a conceptual framework that emphasizes the interplay between the individual, community, organization (workplace) and the wider society (national policy environment). The current study attempted to understand gender equality practices and the extent to which women are being considered to assume top leadership roles in the MoH. Participants' perceptions were that women are "inadequately" considered for leadership positions in the MoH. The findings from document reviews in relation to gender distribution across the various functional roles in the MoH, however, revealed significant efforts to close the gender gap in line with GEWE's 30% quota for women's representation. Women account for 34% and 22% in senior management level and top management level, respectively. A 12% drop of women's representation was observed from the senior management level to the top management level. This shows a lower women's participation at the top management level as compared to their male counterparts.

The perceived lack of gender equity and male dominance in the ministry was overwhelmingly cited by participants, including men. As noted by Osituyo (2018), female employees are rarely found in senior-level decision-making roles in the public service sector. Rather, they are concentrated in larger numbers at the lower management levels in the workplace. The leaky pipeline, a term that characterizes the consistent decline in women's share of positions when climbing the career ladder (Moak et al., 2020; Kasey, 2019) was found in the MoH. According to Osterloh and Rost (2025), this phenomenon exists in both the private and public sectors and in all countries, and the Sierra Leone public health sector is no exception. The Osterloh and Rost study, comparing the leaky pipeline across various fields, shows that men and women in different fields have different preferences that shape their careers, family dynamics, and partner choices. Globally, there is strong evidence that suggests the marginalisation of women in leadership positions in all sectors of the economy (Khwela, Derera, & Kubheka, 2020). The low gender considerations for leadership positions in the public sector as found in this study are common especially in developing countries.

The study by Abate and Woldie (2022) reported that, despite the growing participation of women in areas of public life in sub-Saharan Africa, social norms and cultural barriers are persistently limiting women's participation in leadership roles in the public sector. According to the authors, work-life imbalance, discriminatory organizational structures and practices, conflict, and instability are some of the hurdles that women have to overcome before they assume senior leadership roles. In Ghana, Adongo et al. (2013) found that women are underrepresented in both the private and the public sectors. The authors noted that, men tend find it difficult to assign leadership responsibilities to women, especially for roles that require autonomous decision-making. Khwela and colleagues' (2020) comparative study on women leadership in the private and public sectors in South Africa found that the glass ceiling effect

exists in both sectors, hindering women's progression to leadership positions. In the healthcare sector, Guptill and colleagues (2018) reported that women account for over 75% of the workforce, but they are still grappling with challenges of equal opportunities and career advancement despite their professional gains and qualifications. Overall, women in global health face specific and unique challenges to reaching leadership roles, including lack of mentorship, gender biases, harassment, and gendered networks, institutions, and processes (Downs, Reif, Hokororo, & Fitzgeral, 2014). Effort is needed to address socio-cultural and workplace barriers to women's advancement in their careers, especially in the public sector. In Sierra Leone, the 2023 Gender Equality and Women's Empowerment (GEWE) Act, which guarantees 30% female representation in all spheres of the civil service and political appointments is considered an opportunity to reduce the gender gap in top management positions in the MoH and the overall public sector.

CONCLUSION AND RECOMMENDATIONS

Conclusion

The study sought to gain a deeper understanding of the status of women's representation at the senior management level in the Sierra Leone public health sector. While participants' accounts revealed several challenges that hinder women's progression to senior leadership positions in the MoH, there are, however, notable steps being undertaken by the MoH leadership to reduce the gender gap. The 2023 GEWE Act is considered an opportunity that is facilitating women's representation in senior management roles in the MoH. Achieving gender equity in the leadership of the Sierra Leone public health sector is crucial for designing inclusive and effective interventions and strengthening health system resilience and responsiveness. It is imperative that gender equality and women's empowerment initiatives go beyond token measures and result in meaningful, measurable changes.

Recommendations

Closing the gender gap in the public health sector leadership requires more than individual efforts; it needs a collective push to ensure that women with comparable skills to their male counterparts have the same opportunities and rights in their pursuit of career advancement. Using a socio-ecological lens, this study's recommendations focus on addressing the systemic barriers to women's career advancement at the individual, community, organizational, and societal levels as follows:

Socio-ecological Level	Strategies	Possible Actions
Societal (National Government)	Operationalize the GEWE Act and other gender-sensitive laws	i. Provide strong political support, including funding for the operationalization of the GEWE Act. ii. Guarantee funding for the implementation of gender-sensitive monitoring and networking programs designed to increase women's development. iii. Foster effective succession planning and management (SPM) practices in the public sector to ensure promotions are merit-based in the MOH.
Organizational (Ministry of Health)	Strengthen workplace policies that support gender equality	i. Promote the transformation of the MoH's culture towards gender equality, non-discrimination, and the values of respect and tolerance ii. Promote equal participation between men and women in all representative, leadership, and decision-making positions by adhering to the minimum GEWE 30% quota on women's representation. iii. Track progress on the implementation of the GEWE Act, using metrics such as promotion, retention after maternity leave, and female leadership representation
Community	Cultural transformation through civic education and awareness campaigns	i. Promote functional literacy by eliminating gender differences in access to education. ii. Foster gender equality through educational programs and promote positive image of women in leadership. iii. Empower women through grassroots movements, support networks, and advocacy groups to confront and dismantle societal norms and deeply ingrained gender stereotypes in communities, and provide women with the tools to succeed.
Individual	Leadership development initiatives for women	i. Expand leadership training and support network for women ii. Establish incentivized formal peer support and mentorship programs for women iii. Promote successful female leaders as models and advocates

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