



# **BEYOND PARTICIPATION:** ADVANCING WOMEN'S INCLUSION IN HEALTH RESEARCH & DEVELOPMENT IN AFRICA

**RIGHTS. JUSTICE. ACTION.**  
For ALL women and girls.

## I. EXECUTIVE SUMMARY

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Africa is intentionally shifting from dependency to health security and sovereignty, as articulated in the African Union’s Agenda 2063<sup>1</sup>, Africa CDC’s *New Public Health Order*<sup>2</sup> and *Africa’s Health Security and Sovereignty Agenda*<sup>3</sup>. These frameworks call for stronger regional institutions, domestic financing, surveillance, and local manufacturing to correct global power imbalances exposed during COVID-19, including vaccine nationalism and export bans that left African countries at the back of the queue for lifesaving tools.

But sovereignty is not the only reason for increased and sustainable investment in the continent’s health R&D. In a world where pathogens move rapidly across borders and climate change is reshaping disease geography, Africa’s health R&D systems are no longer just about managing “local” diseases; they are part of the global solution space for outbreaks such as COVID-19, chikungunya, HIV and TB.

Realizing the vision of a health R&D system that not only serves the continent but contributes to the evolving global health context depends on how fully the continent mobilizes its own scientific talent. Women form a critical backbone of Africa’s health workforce and, according to UNESCO-linked data, account for roughly 47% of STEM graduates in African universities—one of the highest shares in the world<sup>4</sup>. Yet they remain significantly under-represented among science professionals (around 30% in Africa) with even smaller shares in senior leadership and decision-making roles<sup>5</sup>. Persistent gaps between AU gender commitments and actual implementation underscore structural barriers, not a lack of talent, are holding women back from research leadership and consequently robbing the continent of its full benefit from regional talent.

This policy brief examines women’s participation and leadership in health R&D in Africa, with a specific focus on Kenya, South Africa, Côte d’Ivoire and Senegal. Aligned with the the continental developed by Speak Up Africa, The Center for Gender Justice and Gawani Africa on meaningful participation—whose pillars are representation in leadership, enabling factors and areas of support that impact women’s participation in health R&D—it integrates statistical data, policy commitments, global evidence, and case studies for the four focus countries of the African Voices of Science (AVoS) initiative phase II. It asks where women are present in the health R&D value chain, where they are excluded, and why these gaps persist—setting out practical recommendations for the African Union, Africa CDC, Member States, funders and institutions to close them as part of Africa’s wider agenda for health security, innovation sovereignty and inclusive development.

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1 <https://www.nepad.org/publication/agenda-2063-framework-document>

2 <https://africacdc.org/news-item/call-to-action-africas-new-public-health-order/>

3 <https://africacdc.org/africas-health-security-sovereignty-agenda/>

4 <https://www.mckinsey.com/capabilities/tech-and-ai/our-insights/closing-the-loop-the-quest-for-gender-parity-in-african-tech>

5 <https://www.iicba.unesco.org/en/what-you-need-know-about-challenges-stem-africa>

## II. WHY WOMEN'S INCLUSION IN HEALTH R&D MATTERS

Africa's continental frameworks consider women's inclusion in science and innovation as a strategic lever, not a side issue. Agenda 2063 and STISA-2024 which recognize science, technology and innovation (STI) as central to Africa's socio-economic transformation explicitly highlight women's participation in science and technology as a key tenet of that vision. In parallel, Africa CDC's New Public Health Order and the Africa Health Security and Sovereignty Agenda frame health security and sovereignty around expanded local R&D and manufacturing capacity in addition to a capable health workforce and resilient institutions.

Women's under-representation in health R&D effectively means African countries are trying to build a knowledge-based, innovation-driven economy without a huge share of their trained talent effectively engaged<sup>6</sup>. cross-country analyses show that gender diversity is positively associated with economic growth, because mixed-gender teams generate more novel ideas and raise overall innovation capacity. Studies of R&D teams find that<sup>7</sup>-diverse R&D units are more innovative and more efficient, especially when tasks are complex and environments uncertain. Women's absence from the knowledge-production aspect of the health systems' continuum has direct consequences on how responsive and fair those systems are. Decades of gender bias in medical research, including the use of male bodies as the default in clinical research of cardiovascular disease, autoimmune conditions among other health challenges, produced gaps in biological understanding that systematically disadvantage women<sup>8,9</sup>. Recent reviews and policy studies show that such research gaps translate into misdiagnosis, under-treatment and poorer reported health among women<sup>10</sup>.

Finally, under-representation in leadership roles impacts priority-setting in research. A recent BMJ Global Health review finds that while investing in women's leadership is associated with better organizational performance, innovation and more equitable health outcomes<sup>11</sup>, women hold only about 25% of leadership positions in the global health space. In other words, when women are missing from health R&D funding panels and decision-making tables, African countries not only lose innovation and growth potential—they also end up with health systems and research agendas that are less aligned with half the population, undermining effectiveness and equity of health innovations.

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6 <https://pmc.ncbi.nlm.nih.gov/articles/PMC10088600/>

7 <https://www.sciencedirect.com/science/article/abs/pii/S0048733319302033?utm>

8 <https://pmc.ncbi.nlm.nih.gov/articles/PMC9043984/>

9 <https://www.sciencedirect.com/science/article/pii/S2667193X2500047X>

10 [https://www.europarl.europa.eu/RegData/etudes/STUD/2025/778519/IUST\\_STU%282025%29778519\\_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2025/778519/IUST_STU%282025%29778519_EN.pdf)

11 <https://gh.bmj.com/content/10/12/e021163>

### III. THE STATUS OF WOMEN'S LEADERSHIP IN HEALTH R&D IN AFRICA

#### 1. Representation

Across sub Saharan Africa, women constitute only about one third of the research workforce<sup>12</sup>, with wide disparities across Member States. While countries such as South Africa approach 40–45% women researchers, representation drops to 16.5% in Côte d'Ivoire and to 29.3% of academic staff in Senegal, where women remain markedly underrepresented in research governance structures<sup>13</sup>. Women are generally more present in life sciences and health disciplines but remain a minority in industrial R&D, regulatory science, and manufacturing—sectors that are central to the AU's New Public Health Order and the drive for health sovereignty. Leadership gaps are particularly acute: women are still the exception among principal investigators, department heads, institute directors, and members of high level scientific and regulatory committees<sup>14</sup>.

#### 2. Enablers

Across Africa, there is a growing set of policies and programs to support women in health R&D. UNESCO's gender-in-STI agenda calls on states to mainstream gender in science policy and funding and to collect sex-disaggregated data on researchers and grants<sup>15</sup>. The Science Granting Councils Initiative (SGCI) has helped councils in countries such as Kenya, Côte d'Ivoire and Senegal adopt gender mainstreaming frameworks and pilot gender-responsive grantmaking<sup>16</sup>, while initiatives like DELTAS Africa, AWARD and Grand Challenges Africa have introduced women-focused fellowships, mentorship and leadership training.

#### 3. Support

Everyday working conditions determine whether women stay, plateau or leave health R&D in Africa. Qualitative studies of African research institutions describe women juggling time and travel-intensive roles with disproportionate care responsibilities, leaving them with less protected time for publishing, grant-writing and networking, while male colleagues advance on more linear career paths<sup>17</sup>. Women report male-dominated networks, sexual harassment and bullying, opaque and inflexible promotion criteria, and extra “care” tasks in departments that do not count towards professional advancement, all of which erode retention and progression<sup>18</sup>. At the same time, initiatives which pair high-quality research training with structured mentorship, leadership development and gender-aware institutional support have been associated with increased visibility and research productivity among women<sup>19,20</sup>.

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12 <https://www.inasp.info/sites/default/files/2024-09/Status%20of%20African%20Women%20in%20Research.pdf>

13 <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0265413>

14 <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0265413>

15 <https://unesdoc.unesco.org/ark:/48223/pf0000388641>

16 <https://www.frontiersin.org/journals/research-metrics-and-analytics/articles/10.3389/frma.2022.814600/full>

17 <https://www.nepad.org/file-download/download/public/140073&ved=2ahUKEwj6utbOyquSAxVXT0EAHXiBKPEQFnoECAkQAw&usg=AOvVaw0MMp4Wzn0bUxbXuLHRdhLs>

18 <https://pmc.ncbi.nlm.nih.gov/articles/PMC8369615/>

19 [https://pmc.ncbi.nlm.nih.gov/articles/PMC8369615/?utm\\_source=chatgpt.com](https://pmc.ncbi.nlm.nih.gov/articles/PMC8369615/?utm_source=chatgpt.com)

20 [https://openresearchafrica.org/articles/4-42/v1/pdf?utm\\_source=chatgpt.com](https://openresearchafrica.org/articles/4-42/v1/pdf?utm_source=chatgpt.com)

In the case studies below, women echo these themes—describing how targeted mentorship, fair promotion processes and visible institutional backing made it possible to stay and thrive in the health R&D field.

#### IV. CROSS-COUNTRY INSIGHTS FROM AVOS CASE STUDIES



##### **CASE STUDY 1:**

##### **SOUTH AFRICA – NEAR PARITY IN NUMBERS, BUT THIN AT THE TOP**

*Professor Nothando Ngwenya - Head of Social Science and Research Ethics Africa Health Research Institute (AHRI)*

South Africa is close to numerical parity in research: women make up roughly half of all researchers and are strongly represented in health and biomedical fields. Yet women remain rare in senior leadership – as PIs, heads of department, institute directors and on key R&D committees. Enablers include a relatively strong policy and funding environment: a national STI and health research framework that names equity, women-only calls under South African Research Chairs Initiative (SARChI). However, everyday systems still work against women’s progression: care responsibilities, grant rules and age cut-offs that penalise career breaks, opaque promotion pathways, and publication metrics that reward linear, uninterrupted careers.

A promising initiative which has advanced women’s R&D leadership is the South African Women in Science Awards led by the Department of Science, Technology and Innovation which promotes visibility and provides a networking platform for young female scientists at a national level. Another initiative is the L’Oréal UNESCO For Women in Science National Young Talents Programme in South Africa, which combines research starter grants with structured mentorship and training to support early and mid career women researchers.

To increase the impact of these initiatives, I would recommend an adaptation of the national women-in-science award program by creating district-level awards for young women, with local winners feeding into provincial and then national recognition. I would also recommend scaling the L’Oréal-UNESCO For Women in Science National Young Talents program by building in paired mentorship between senior women researchers and younger scientists. Setting minimum thresholds for women’s representation on R&D decision-making bodies, leadership and capability training, and publishing the membership of committees to ensure transparency and accountability on gender balance, will collectively contribute to the deeper reform of funding rules, promotion systems and workplace culture needed to ensure women’s roles in health R&D leadership are meaningful rather than symbolic.



##### **CASE STUDY 2:**

##### **KENYA – STRONG GENDER LANGUAGE, WEAK RESOURCING AND A “MOTHERHOOD PENALTY”**

*Ms Julie Muriuki - Adjunct facilitator and consultant, Nia Delta*

In Kenya, there is a strong gender-aware policy framework on paper, but weak and uncertain resourcing coupled with a “motherhood penalty” in how research careers are organized. Women are highly visible in health service delivery and across the research pipeline, but still far less present where priorities and budgets are decided. Even when women lead research, their work often focuses on marginalised communities and implementation challenges that struggle to attract sustained funding. Long, inflexible working hours, limited childcare options and institutional cultures built around a “perfect

worker” with no care responsibilities make it difficult for many women to sustain a research leadership trajectory at home.

Promising initiatives that support women researchers range from fellowships and PhD support, to quantitative skills training, to emerging leadership programmes for women in health. But these sit on top of persistent structural constraints: underfunded national research mechanisms, dependence on external funders whose agendas may not align with local priorities, slow and centralised financial systems, and academic contracts that overload scientists with teaching or clinical work and leave little protected time for research.



**SCIENCE IS NOT A LUXURY BUT A NECESSITY; IT IS THE ENGINE THAT DRIVES ECONOMIC GROWTH, HEALTH RESILIENCE, FOOD SECURITY, AND CLIMATE ADAPTATION. WE MUST ALIGN OUR EFFORTS TO EMPOWER OUR INSTITUTIONS TO DELIVER IMPACTFUL, INCLUSIVE, AND ETHICAL RESEARCH**

**Prof. Shaukat (Ali) Abdulrazak**

*the Principal Secretary for Science, Research and Innovation (2025), Speech at NACOSTI High-Level Meeting*

To increase the impact of existing efforts, I would prioritise strengthening domestic funding for health R&D so that women-led, locally relevant research is not perpetually at the mercy of external agendas. I would also advocate for making “researcher” a valued public service career, with clear progression pathways and conditions that recognise care responsibilities, including flexible work arrangements and access to childcare. Finally, I would push for institutional reforms that guarantee protected research time and transparent promotion criteria, so that women’s talent in health R&D can translate into sustained leadership rather than short-lived participation.



### **CASE STUDY 3:**

#### **SENEGAL – CARRYING THE SYSTEM, BUT MARGINAL IN LEADERSHIP**

**Ms Marième Gueye** - *Researcher in biofabrication and regenerative medicine, Regenerative Medicine Center Utrecht*

In Senegal, women are highly visible in the health and social sectors but still under-represented along the health R&D pipeline and in high-responsibility roles. Girls remain less likely to enter STEM early, partly because they have limited exposure to science and few visible women role models. Studies of community health show that gender norms, literacy filters and local selection practices often steer women into the least secure, least remunerated roles, reinforcing the undervaluation of their labour despite their central contribution. In research and academia, women make up only about 29% of academic staff and are even scarcer in governing bodies, and although women’s presence in management within the Ministry of Health and Social Action has grown over the past two decades, senior leadership remains largely male, signalling that parity is still some way off.

Significant enabling frameworks, such as the National Strategy for Equity and Gender Equality (SNEEG 2, 2016–2026), and promising initiatives that support women and girls more broadly – from Women’s Voice and Leadership projects to university programmes that build entrepreneurial and leadership skills among young women – already exist.

However, these efforts are only loosely connected to health R&D, and there is little evidence that they are systematically resourced or monitored for their impact on women's presence in research leadership, clinical trials and regulatory spaces.



*I ALWAYS KNEW WOMEN WERE UNDER-REPRESENTED IN HIGH-RESPONSIBILITY ROLES, BUT ONCE I SAW THE DATA FOR SENEGAL IT BECAME PAINFULLY CLEAR JUST HOW MUCH WORK REMAINS TO ACHIEVE REAL EQUALITY.*

*Ms Marième Gueye*

To increase the impact of existing efforts, I would recommend reviving national spaces such as feminist and civic forums that bring together activists, scientists and policymakers to keep gender and leadership in health and science on the agenda. I would also prioritise practical leadership training for women in health R&D institutions and regular public profiling of Senegalese and African women scientists so their contributions are visible. Over the longer term, we need more deliberate outreach to girls in middle and high school to strengthen the STEM pipeline, and simple, standardised gender equality reporting by large organisations to encourage real change in workplaces that shape the health and R&D ecosystem.

## V. POLICY OPTIONS AND RECOMMENDATIONS

Evidence from the case studies and documented regional analysis, points to three priority levels where immediate and coordinated action is required: in regional governance level, national policy and financing environments, and institutional and funder practices. The recommendations to translate commitments on gender equality into measurable system level change are structured around the proposed women's health R&D scorecard and guided by the Beyond Participation framework.

### 1. Continental and Regional Level

#### 1.1. Institutionalize the women's health R&D scorecard

The African Union should adopt and institutionalize a women's health R&D scorecard within the AU monitoring architecture and Africa CDC's performance frameworks, as a companion to existing health and STI scorecards. Adoption should be accompanied by a harmonized indicator set, standard definitions, clear data sources, and a phased reporting calendar to minimize additional reporting burden. Member States would submit indicators on an agreed cycle using standard templates, with technical assistance available through Africa CDC and AUDA NEPAD, and data aggregated for continental tracking and peer learning.

#### 1.2. Establish a regional reporting and peer review mechanism

A structured regional reporting and peer review mechanism should be embedded in AU and Africa CDC governance calendars to review country performance on women's participation and leadership in health R&D. Member States would present scorecard results during scheduled STC sessions and Africa CDC governance meetings, followed by peer learning dialogues that surface practical solutions. An annual continental brief on women in health R&D, co issued by Africa CDC and the AU Commission, would synthesize trends, gaps and promising practices, enabling mutual accountability while remaining non punitive and improvement oriented.



### **1.3. Convene a regional community of practice on gender and health R&D**

To sustain implementation beyond reporting, a resourced regional community of practice (CoP) should be convened to bring together AVoS champions, women leaders in research and regulation, RECs, funders, and feminist/advocacy organizations. The CoP will co design iterative refinements to the scorecard, advise on priority interventions and investment cases, maintain a vetted roster of women experts for AU and REC fora, and broker south south learning. Terms of reference should ensure open membership, rotation of leadership, and transparent selection to prevent capture and duplication.

### **1.4. Put women in the driving seat of regional priority setting**

Regional priority setting instruments including continental R&D roadmaps, clinical trial platforms, and health innovation agendas should embed women in decision making roles, including as co chairs of governance and technical bodies, and designate women led African organizations as co architects rather than implementers. Selection should be competency based and transparent, drawing on expert rosters to ensure breadth of expertise across disciplines and geographies.

## **2. National Level**

### **2.1. Embed women's health R&D indicators in national STI and health research strategies**

Governments should embed clear, measurable indicators on women's inclusion and leadership in health R&D within national STI strategies, health research policies, and sector plans, aligned with the proposed AU and Africa CDC women's health R&D scorecard. National research councils and ministries of health should integrate annual reporting on women's representation among funded principal investigators, membership of R&D governance bodies, and public investment in women led and women focused research, in existing performance review and budget processes using harmonized national and regional indicators.

### **2.2. Strengthen domestic financing for health R&D**

Governments should strengthen dedicated health R&D budget lines within existing national budgeting frameworks with explicit recognition of women led, locally relevant research as a public good. Where feasible, a small, predictable share of pooled health revenues should be earmarked for research and channeled automatically to national research funds and health research institutes. Medium term targets should be set for increasing the share of clinical trials and priority studies financed by domestic resources, with progress tracked by gender of principal investigator.

### **2.3. Make "researcher" a high status public service career**

Governments should elevate research as a high status public service profession by fully operationalizing senior research scientist cadres, particularly in health, with remuneration, benefits and career progression comparable to specialist clinical roles. Promotion pathways should transparently recognize research productivity, leadership, team management, and mentorship, while national performance frameworks should include indicative targets for women's representation in senior principal investigator and research leadership positions to strengthen accountability across public research institutions.



## **2.4. Mandate gender disaggregated data and align with the regional scorecard**

All publicly funded research agencies, councils and regulators should be required to routinely collect, analyze and publish sex disaggregated data on applications, awards, leadership roles and committee membership, using existing information systems and reporting cycles. National indicators and timelines should be aligned with the proposed AU/Africa CDC women's health R&D scorecard to reduce duplication, facilitate regional aggregation, and enable meaningful comparison of progress across countries.

## **3. Institutional and Funder Level**

### **3.1. Funders: make gender a core design principle**

Funders should embed gender as a core design principle across the full grant cycle, requiring routine sex disaggregated reporting on applicants, awardees, and principal investigators, and publishing regular dashboards to show who benefits from funding. Dedicated funding windows should be established for women led health R&D and for research that addresses women's health needs and gendered health inequities, alongside simplified application processes and targeted proposal development support for early and mid career women researchers. Grant rules should be gender responsive, explicitly recognizing maternity and caregiving breaks in eligibility criteria, providing bridge and return to research funding, and allowing childcare and caregiving costs as eligible budget items so that protected research time is real rather than symbolic.

### **3.2. Institutions: create environments where women can stay and lead**

Universities and research institutes should create working environments that enable women to remain in, progress through, and lead health R&D careers. This includes formal policies for protected research time, transparent promotion and tenure pathways that explicitly account for maternity and carer leave, and flexible career trajectories that recognize the realities of combined teaching, clinical, and research roles. Institutions should also adopt and actively enforce anti harassment and anti bullying policies with safe, independent reporting mechanisms, and routinely audit workloads to prevent women from being disproportionately tasked with unrewarded administrative and pastoral work that undermines research productivity and advancement.

### **3.3. Ensure meaningful representation and influence in R&D governance**

Institutions should ensure meaningful representation of women in R&D decision making by setting minimum thresholds e.g. at least 40 percent, for women's participation on ethics committees, grant review panels, trial steering committees, and institutional boards. Representation should be reinforced by leadership and capability building support, to ensure women's participation carries real influence, and by publishing the membership and gender composition of these bodies to enable transparency and external accountability. These measures help shift governance norms from symbolic inclusion to shared authority over research priorities and resources.

### **3.4. Build recognition, mentorship, and local leadership pipelines**

Funders and institutions should invest in sustained recognition and leadership pipelines for women in health R&D by extending women in science awards and recognition to local and sub national levels, where early career talent often develops. Existing platforms—such as national young talent programs and international initiatives like L'Oréal-UNESCO For Women in Science—should be leveraged as entry points for structured, paired

mentorship between senior women researchers and early career women. Leadership and mentoring programs should be scaled through cohort based fellowships and training pathways that combine high quality research skills with networking, confidence building, and institutional advocacy, helping women transition from participation to leadership.

## VI. IMPLEMENTATION PATHWAYS AND ACCOUNTABILITY

This table highlights the core actions, lead actors and indicative timelines for implementing the women’s health R&D recommendations at continental, national, institutional and funder levels.

Priority Action	Lead Actors	Timeline
Adopt and institutionalize the women’s health R&D scorecard within AU and Africa CDC monitoring frameworks.	STC-HPDC & STC-ESTI; AU Commission (HHS & ESTI); Africa CDC Governing Board.	<b>Short term (0-2 years):</b> adopt scorecard, develop indicators and templates; ongoing annual reporting.
Embed a regional reporting and peer-review mechanism on women’s leadership in health R&D in existing AU/Africa CDC forums.	STC-HPDC & STC-ESTI; Africa CDC Secretariat; RECs.	<b>Short term (0-1 year):</b> agree modality; ongoing reporting at each STC cycle and annual regional brief.
Convene a regional community of practice (CoP) on gender and health R&D.	Africa CDC Secretariat; AU Commission (ESTI & WGYD); RECs; partners.	<b>Short term (0-1 year):</b> establish CoP; medium term (1-3 years): regular virtual sessions and outputs.
Ensure women hold meaningful decision-making roles (incl. co-chairing) in regional health R&D governance and priority-setting.	STC-HPDC & STC-ESTI; AUDA-NEPAD/AMRH; Africa Medicines Agency; Africa CDC; RECs.	<b>Short term (0-2 years):</b> update terms of reference; ongoing: apply gender thresholds to appointments.
Embed women’s health R&D indicators and targets in national STI and health research strategies.	Ministry of Health; STI ministry; National Research Council/Commission; Gender ministry/directorate.	<b>Short term (0-2 years):</b> integrate in next strategy revisions; ongoing annual reporting.
Mandate routine gender-disaggregated data collection and alignment with the regional scorecard.	STI and Health ministries; National Statistics Office; research councils; ethics/regulatory authorities.	<b>Short term (0-2 years):</b> adopt data requirements and align indicators; ongoing annual data collection and publication.

Priority Action	Lead Actors	Timeline
Make gender a core design principle in funding cycles, with dedicated windows for women-led and women-focused health R&D.	National and regional research funders; bilateral and multilateral donors; philanthropic foundations.	<b>Short term (0-2 years):</b> revise grant guidelines and introduce gender-responsive rules; ongoing portfolio monitoring.
Create working environments where women can stay, progress and lead in health R&D careers.	Universities; research institutes; teaching hospitals; public research centres.	<b>Short-medium term (0-3 years):</b> adopt policies on protected time, flexible careers and harassment; ongoing culture change.
Ensure meaningful representation and influence of women in R&D governance bodies.	Institutional governing councils; ethics committees; grant panels; trial steering committees; AU/REC governance bodies.	<b>Short term (0-2 years):</b> establish council composition requirements; define ongoing application of minimum thresholds.
Build recognition, mentorship and local leadership pipelines for women in health R&D.	Science and education ministries; universities; national academies; award bodies; international partners.	<b>Short-medium term (0-3 years):</b> adapt award schemes and launch leadership mentoring cohorts.
Strengthen domestic financing for health R&D, including dedicated budget lines and, where feasible, earmarked health revenues.	Ministry of Finance/Treasury; Ministry of Health; National Research Fund; Parliament.	<b>Medium term (1-3 years):</b> strengthen budget lines and pilots; <b>Longer term (3-5 years):</b> increase domestically funded trials.
Elevate 'researcher' as a high-status public service career with clear, gender-responsive progression routes.	Public Service Commission; Ministry of Health; STI ministry; national research institutes.	<b>Medium term (1-3 years):</b> develop and implement schemes of service and promotion pathways.