

THE STATE OF WOMEN AND LEADERSHIP IN GLOBAL HEALTH



INTRODUCTION

THE XX PARADOX: WOMEN ARE THE MAJORITY OF HEALTH WORKERS AND SHOULD BE THE MAJORITY OF HEALTH LEADERS

Women hold around 70% of health worker jobs globally, over 80% of nursing and over 90% of midwifery roles¹, deliver the majority of unpaid care and domestic work in families and communities, and make the majority of health purchasing and usage decisions. Women lead the delivery of health to 5 billion people and contribute an estimated US\$ 3 trillion annually to global health, half in the form of unpaid work.² Yet women hold only 25% of leadership roles in health.

If leadership roles were allocated proportionally (assuming that women and men have equal merit) then, since women are 70% of health workers, 70% of health sector leaders would be women. This is the opposite of the current situation where men are less than 30% of the health workforce but hold 75% of leadership roles. The default health worker is a woman, and the default health leader should be too. This is the 'XX Paradox' that we seek to explain.

There is no shortage of women in the health leadership pipeline; in most countries women are the majority of junior doctors, nurses, pharmacists and dentists. There are leaks in the pipeline that mean leadership is not inevitable for women in health. Men are promoted as women stand still in their careers, facing 'glass ceilings' to leadership roles at every level. A 'glass elevator' has been reported in some countries for men in nursing who, although a minority, hold a disproportionate number of senior nursing roles.⁴

Using an intersectional lens, this report explores how the primary target groups for most global health organizations and programs - women from low- and middle-income countries - are least represented in global health leadership. This is another dimension of the XX Paradox. In addition, we seek to highlight how leadership in health is as diverse as women themselves. Although the majority of women health workers do not hold formal leadership roles, women are driving change at all levels in health from community to global. At the same time, women want recognition, equal career progression and aspire to senior decision-making roles and the benefits that go with them. Diverse women working in health have an equal right to leadership; this includes the millions of women community health workers currently subsidizing global health with their unpaid work.⁵

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“Lack of representation is one symptom of a broken system where governance is not inclusive of gender, geography, sexual orientation, race, socio-economic status or disciplines within and beyond health – ultimately excluding those who offer unique perspectives and expertise.”

Dr Kim van Dalen et al.⁶



GENDER TRANSFORMATIVE LEADERSHIP

Gender inequity in health leadership is not solely a women's issue and we cannot put the responsibility for change solely on the shoulders of women leaders. Women should not need to change to compete in systems and cultures designed for men. Traditional approaches focused on encouraging women to be more assertive and 'lean in' but women experience backlash when they behave in ways that do not fit their gender stereotype.

If the status quo is to change, all leaders in health must intentionally promote gender transformative policies as the basis for strong and effective health systems. **Gender Transformative Leadership**, an approach for leaders of all genders, improves health outcomes by addressing the legal, cultural, and social barriers that prevent women working in health globally from attaining positions in management, leadership, and governance. It is based on principles including:

- > Promoting gender equity in all areas, moving beyond surface-level approaches and working towards meaningful and transformative change that tackles the root causes of gender inequity and reshapes unequal power relations.
- > Validating leadership across the health spectrum resulting in the redefinition and legitimization of leadership where it happens and is needed most.
- > Avoiding stereotypes or existing norms which act as barriers to women being acknowledged as leaders and getting access to leadership without having to adopt the patriarchal archetype.



"It's a question of not so much pushing the boys out of the picture, but making the whole frame bigger so that both men and women access the labor market, contribute to the economy, generate growth, have jobs..."

Christine Lagarde,
President of the European Central Bank

GENDER EQUITY IN LEADERSHIP WILL LEAD TO BETTER HEALTH FOR ALL



"Gender-equal representation is more than just a moral imperative. When gender representation moves beyond pure symbolism, it leads to smarter, ethical and more effective decision-making." ⁷

Gender and COVID-19 Working Group

Studies covering a range of periods and geographical settings consistently find that women politicians prioritize social welfare policy, family policy, and gender equality issues.^{8 9 10} Increasing the number of women in health leadership can expand the agenda, giving greater priority to issues such as sexual and reproductive health that affect women and contribute to gender inequalities.^{11 12} Data from 159 countries found governments with a higher share of women in parliament are more likely to pass gender sensitive laws, including laws on sexual harassment, rape, divorce and domestic violence.¹³ Yet, it will take more than 80 years to reach gender parity in governments at the current rate of progress; and there are only six countries where women hold at least half of seats in their lower or single chamber.¹⁴

When we get this right, the benefits of equal leadership for women in the health sector will bring economic justice for women and also catalyze a much wider **'triple gender dividend.'**¹⁵

The Health Workforce Potential: the 'Triple Gender Dividend'

HEALTH DIVIDEND

When women are enabled to enter leadership, their professional expertise and perspectives strengthen health systems and health delivery. An equal health workforce based on safe and decent work for all health workers and equal career progression for women, will attract new recruits to fill vacancies and retain expert women, providing a stronger foundation for health systems. This, in turn, will support achievement of global health goals such as Universal Health Coverage.

GENDER DIVIDEND

As more women enter leadership and formal sector jobs in the health sector, women health workers will gain income and autonomy, benefiting families. Early career men and women will also have more senior women role models, breaking gendered stereotypes of men as 'natural leaders'.

ECONOMIC & SOCIAL DIVIDEND

New jobs created and filled in the health sector will drive economic growth and have wider benefits for societies. A gender equal health workforce has positive impacts for everyone.

THE HEALTH WORKFORCE IS HIGHLY SEGREGATED BY GENDER

The health workforce has deeper occupational segregation by gender than many other economic sectors. Health has both **vertical occupational segregation** i.e. the under- or overrepresentation of women and men workers in senior roles in occupations – the subject of this report – and **horizontal occupational segregation** i.e. the under- or overrepresentation of women or men in occupations or sectors, typified by men being a minority in nursing in most countries and women being a minority in roles given higher status such as surgery. Occupational segregation contributes to a gender pay gap of 24% in the health sector globally, higher than in many other economic sectors.¹⁶ Furthermore, women are more likely than men to work in unpaid health roles such as unremunerated community health workers.¹⁷ The gender power imbalances resulting from occupational segregation create an enabling environment for sexual harassment at work, which is reported to be a major problem for women health workers but rarely recorded or sanctioned.¹⁸

RATIONALE

According to a recent UN report, it will take 140 years for women to achieve equal representation in leadership positions in the workplace.¹⁹ There is no reason for women in the health sector to wait that long. Health and care is one of the largest and fastest growing economic sectors, employing 234 million people globally.²⁰ It is one of the most important employment sectors for women. The challenge is not to attract women into the sector but to remove the barriers they face entering leadership roles. Women are entitled to equal representation in health leadership as a right and matter of social and economic justice. Women are proud of the contribution they make in the health sector, acutely aware of the injustices they face and are demanding change.

The pandemic highlighted the critical role played by women health workers and exposed the urgent need for gender equitable and diverse leadership. After three years, women health workers are burned out and traumatized. The inherent gender bias in health systems policy and practice was typified in the pandemic by personal protective equipment (PPE) shortages impacting women more than men because women were lower down the status hierarchy (e.g. in frontline community health worker roles). Also, PPE was largely modeled on the body of 'the default man', meaning it was a poor fit for women, leaving them exposed to infection and without personal dignity since they were unable to use the toilet on long shifts.²¹



"We are at crisis point. Women will not wait any longer. It is a tragedy for them and a tragedy for us all if we lose committed and highly skilled women health workers. If we truly want to build health systems that serve everyone, we need to redress the inequality that has side-lined women from leadership, and start listening to women."

Dr Roopa Dhatt,
Executive Director & Co-Founder,
Women in Global Health

An urgent step change is now needed in gender equity in the health workforce to protect and retain the exhausted and demoralized women health workers essential for health systems and achieving global health goals, including Universal Health Coverage (UHC).

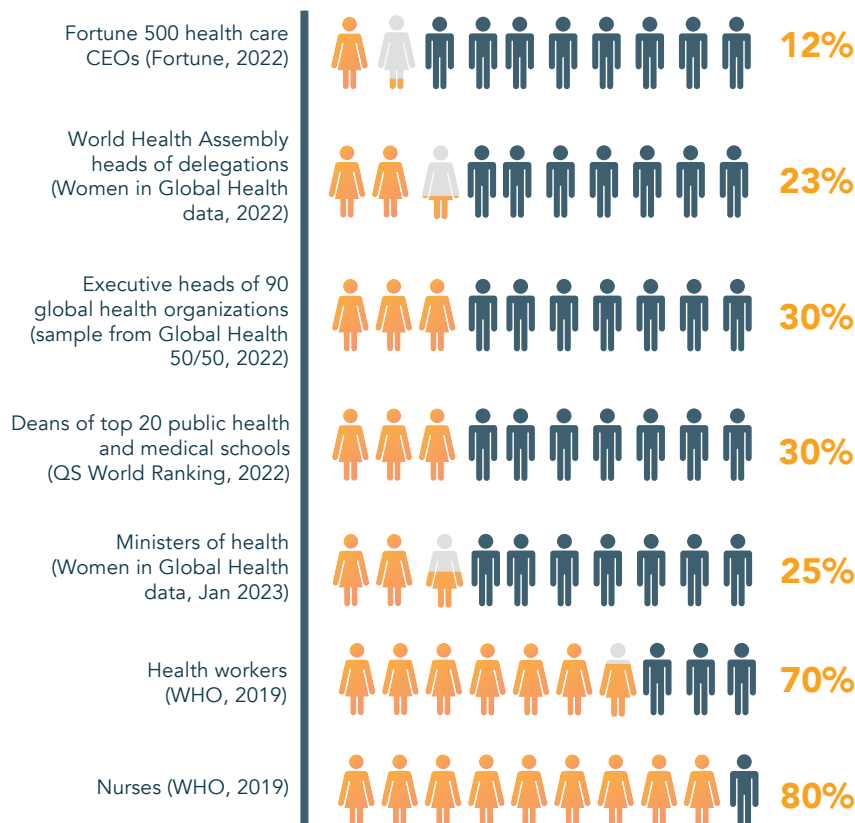
Despite the growing consensus that more women in global health leadership are needed urgently, little data exists on the lived experiences of the women who would rise to leadership.²² This report responds to this gap, presenting the State of Women and Leadership in global health, including new data from India, Kenya, Nigeria and elsewhere, to understand women's experiences - the barriers as well as their solutions.²³



FINDINGS

I. WOMEN REMAIN A MINORITY IN GLOBAL HEALTH LEADERSHIP: PROGRESS HAS STALLED

New WGH analysis confirms that over the last five years women's status in global health leadership has remained unchanged. Women still hold only 25% of senior leadership roles. While the proportion of Fortune 500 healthcare companies led by women has increased from 5% to 12%, the number of female ministers of health has decreased from 31% to 25%, mirroring the state of women's political leadership worldwide, where only a fifth of government ministers are women.²⁴ Between 2018 and 2022 the proportion of World Health Assembly (WHA) delegations led by women has fallen from 27% to 23%. WGH analysis reveals how 83% of delegations to the WHA over the last seven decades were composed of a majority of men, and no WHA had more than 30% of women Chief Delegates.²⁵



Women in Global Health Leadership Pyramid (2023)

Progress has been made in places but the 'glass ceiling' largely remains intact

The 13 major global health organizations²⁶ committed to The Global Action Plan (GAP) for Healthy Lives and Well-being for All have made progress towards gender parity in leadership; as of February 2023, women hold 61% of senior roles in GAP agencies.²⁷ However, only 5 out of 13 agencies are headed by women. The glass ceiling effect is especially evident among women from the countries most targeted by global health organizations: only 1 of the 13 agencies is headed by a woman from a low-income country.

²⁶ Gavi, The Vaccine Alliance, The Global Financing Facility for Women, Children and Adolescents (GFF), The International Labour Organization, The Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, UNDP, UNFPA, UNICEF, UNITAID, UNWOMEN, WHO, World Bank Group and World Food Programme.

Women's place in health leadership varied significantly between India, Kenya, and Nigeria.

- > In Kenya, WGH research found that despite the challenges of a highly patriarchal culture, women hold 42% of mid-level and 40% of top-level leadership positions in the health sector.
- > However, in Nigeria women face a 'glass ceiling' in reaching the most senior roles; around one third of leadership roles in health organizations are held by women but only 5 out of 30 national ministers/commissioners, and only 1 out of 28 Directors of Federal Medical Centers are women.
- > In India, women average around 28% in leadership roles across national health organizations, with the exception of the Nursing Council which has majority female membership and 75% of women in leadership roles. However, averages can be misleading and some organisations such as the Pharmacy Council of India have almost no women in leadership positions.

II. WOMEN LOST GROUND IN HEALTH LEADERSHIP DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic came on top of existing gender inequalities for women.^{28 29} Women health workers typically managed a double burden of high patient numbers, long hours, high stress and risk at work, plus additional unpaid care work at home and in the community. Health workers lost their lives to the virus and significant numbers are affected by 'long-COVID'.³⁰ Understandably, women are leaving the health sector at all levels in a 'Great Resignation', which threatens to deepen the global health worker shortage crisis of 10 million and reduce women's representation in leadership.

Lessons from previous outbreaks warn us that the impacts of excluding women and their perspectives from decision-making during the pandemic may have potentially fatal consequences.³¹ Without a critical mass of women at the table, lockdown policies did not always consider safe maternity and sexual and reproductive health services as essential care; access to safe abortion was also reduced for many women.³²

The COVID-19 pandemic has reconfirmed the urgent need for gender equitable and diverse leadership in health. However, the pandemic has also revealed the fragility of women's position in global health leadership: during WHO's Executive Board meeting in January 2022 only 6% of Executive Board members were women, down from a high of 32% in 2020. A WGH study in 2020 found 85% of 115 national COVID-19 task forces had majority male membership, showing how women have been excluded from decision-making during the pandemic, despite being the majority of workers in the sector.

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"It has slapped me in the face so much during this pandemic, the fact that the global health leaders are men. A lot of women tend to be No. 2s, so they don't quite have the decision-making power, the voice."

Dr Ayoade Alakija,
WHO Special Envoy for the Access to
COVID-19 Tools Accelerator (ACT-Accelerator)³³



III. APPLYING AN INTERSECTIONAL LENS SHOWS SOME GROUPS OF WOMEN ARE MOST EXCLUDED FROM HEALTH LEADERSHIP

The privileges and disadvantages that enable and hinder women's career progression do not affect all groups of women equally.³⁴ Even though challenges can be similar, other confounding variables - of geography, race, ethnicity, sexual orientation, socio-economic status, caste, class etc. - contribute to different lived experiences and opportunities for diverse groups of women.³⁵ Data from McKinsey & Company in the US illustrates how, despite being one in five employees at entry role, women of color hold only 5% of executive level 'C-suite' roles. On the other hand, the share of leadership posts held by white men grows from 23% at entry level to 59% in the C-Suite.³⁶ A study in the South African health sector supports this conclusion that race strongly intersects with gender in the lived experiences and career pathways of black female managers³⁷.

Depending on the context, additional barriers will be faced by certain groups of women. In some low-income countries, low levels of education and literacy restrict the level at which some women can enter the health workforce and prevent them from progressing to leadership. Despite their critical roles in delivering primary health care and as community leaders, women community health workers are typically excluded from formal leadership opportunities.

Women in Global Health's annual **Heroines of Health Awards** gives visibility to and celebrates the outstanding contribution made by some women health workers who are leading health but who are not in formal, leadership roles.

"A young white [man] was said to be more skilled to take the position I was fit for, only for me to end up having to train him. I am black and female. The dichotomies and biases in the workplace are horrible."³⁸



Ms Margaret Odera, community health worker, Kenya

For years an unpaid community health worker (CHW), Ms. Odera has campaigned for CHWs like herself to be recognized as essential members of healthcare teams and to be fairly compensated for their work. Ms. Odera's main focus is to form a national association for CHWs in Kenya. She successfully spearheaded the establishment of the Community Health Workers' Champions Network in Kenya, advocating for their rights to compensation and respect within the healthcare system. Her testimony has inspired over 1000 fellow CHWs to train as advocates.



Ms Ramatu Jalloh, community health worker, Sierra Leone

Ramatu has put frontline health workers on the world stage during the COVID-19 pandemic. Her passionate advocacy led to the COVID-19 Action Fund for Africa which initially raised \$USD 20 million to provide over 100 million pieces of PPE to hundreds of thousands of frontline health workers worldwide. Ramatu has inspired a growing network of CHW advocates from around the globe who watch her speeches and see how advocacy by CHWs for CHWs can be a true catalyst for change.

IV. ACROSS CONTEXTS AND CULTURES, WOMEN EXPERIENCE COMMON CHALLENGES ACCESSING LEADERSHIP IN HEALTH

Despite differences in culture and socio-economic contexts, WGH research in India, Kenya and Nigeria confirmed many common challenges related to leadership for women working in the health sector. Qualitative data from over 100 respondents confirms that action is needed at all levels to change the powerful gender norms and biases that discriminate against women in their homes, workplaces and societies.

CHALLENGE 1: GENDER NORMS AND ROLES LIMIT WOMEN'S PARTICIPATION AT WORK AND IN LEADERSHIP

The three countries studied for this report - India, Kenya and Nigeria - tend towards a patriarchal culture where gender norms and stereotypes treat leadership roles as men's roles while women are expected to take care of domestic chores. Patriarchal norms within families and communities can limit women's participation in the workforce.^{39 40} India has a low level of women's participation in the formal economy globally and within its own region, with only 24% of women in the labor force, compared to 79% of men.⁴¹ In sub-Saharan Africa, female labor force participation rates are stagnating despite rising female education.⁴²



"Since childhood, I have only heard this as gospel truth: 'Women's primary job is to take care of the household.' It is difficult to keep challenging this notion, even internally, when everyone around you keeps saying this. When I got married, my mother-in-law very explicitly told me that my job is to do 'Seva' (serve) for my husband and my future son."

Doctor, India

Study participants across the three contexts described how cultural norms hinder women from attaining leadership roles:



"You know our cultural environment does not really support women as self-starters. We are always taught to follow instead of lead. It takes a lot to overcome that."

Doctor, Nigeria



"They don't think of me as the first person for a leadership role because they don't think I will be able to organize and handle, for example, finances. Men feel that the work of a woman is to take care of children".

Respondent in WGH India Chapter research

Respondents in Kenya were aware of the impact of patriarchal attitudes, especially from spouses, have on women's professional ambitions. Expectations from spouses, families and communities can prevent women from applying or taking up positions, particularly if they have no support or encouragement from their immediate family.



"There are cultures which believe very strongly that women should not have leadership roles. And sometimes when you are in a leadership role, and your spouse is not in a leadership role, it already brings some conflict, it may impact even on your interactions in the home. And sometimes women may shy away from taking up those roles."

Doctor, Kenya

CHALLENGE 2: WOMEN EXPERIENCE DISCRIMINATION LINKED TO THE 'MOTHERHOOD PENALTY'

The 'motherhood penalty' refers to the various forms of discrimination encountered by working mothers and mothers seeking employment. Typically, human resources policies in health and other sectors have been designed to fit the 'default man', his life pattern and the gendered expectations of his role in society and the family. Workplace policies may therefore treat menstruation, pregnancy, miscarriage, breastfeeding and menopause as 'the exception' despite women being the majority in the health workforce. Even women without children can be disadvantaged in career progression by the assumption that they will have children in the future and are therefore 'less suitable' for promotion than their male peers. This is the operation of the '**male bonus syndrome**' where male health workers benefit from women being handicapped by rules and policies because they were designed for men.

The 'motherhood penalty' is one of the most persistent and overt forms of gender bias. Mothers, and potential mothers, suffer a penalty in the form of lower perceived competence and commitment, higher professional expectations, lower likelihood of hiring, being re-hired and promotion, and lower recommended salaries.⁴³ In Nigeria, respondents said that they had to forgo promotions as institutions do not make special arrangements for pregnant women and even actively find ways to penalize them. Women reported "being punished for falling pregnant" by being posted to remote locations after they returned from their maternity leave. In India, this doctor faces similar discrimination:

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" I had to say no to promotion when I was pregnant. I was advised complete bed rest due to early complications. I was offered a promotion then, but it was an out-station posting and it was difficult for me to take that position. I lost that opportunity. At that time, I regretted getting married and pregnant."

The double burden of roles and responsibilities at home and in the workplace, dictated by social expectations of a woman's gendered role, also create challenges for women aspiring to leadership:

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"...if you're overwhelmed with all the house chores, and there's no support, then you already are fatigued before you get to work and so you are not able to give your best. So, just being able to share some roles at work or even delegate if there is no support person so that you don't feel overwhelmed, so that you have energy to keep pushing in your leadership position."

Medical Doctor, Kenya

Returning from maternity leave can be a particularly challenging time, with little support given:

"The time post-delivery was particularly traumatic for me. I was torn between caring for my child and thoughts about my precarious position at work."

Nurse, India

"So, you turn down a lot because of pregnancy. And because of also nurturing, you know, nursing the baby. By the time you come back, you find that things have moved. Takes a lot of effort to come back..."

Doctor, Kenya

"Some things are really critical for us women. I know two women who have postpartum depression, and nobody seems to understand them."

Doctor, Nigeria

There is nothing 'natural' or inevitable about the discrimination women face at work in the health sector related to both their reproductive and gendered social roles. It is feasible to design workplace policies for all genders and their specific needs. Since women are the majority of health workers it makes business sense to design policies to meet their needs, which would enable women to compete equally for leadership roles and meet their human right to economic justice.

"Gender inequality is man-made, which means it can be changed."

Professor Asha George⁴⁴

CHALLENGE 3: GENDER STEREOTYPES AROUND LEADERSHIP DETER AND PENALIZE WOMEN

Interviews with women leaders across the three countries in this study demonstrate that perceptions of competent leadership are based on traits such as assertiveness, visible ambition, drive, self-reliance and stubbornness, seen as stereotypically male behaviors. Women leaders, however, may not be perceived as potentially competent leaders because those behaviors contradict stereotypes of femininity.⁴⁵

On the other hand, women leaders who adopt a more empathetic style of leadership can face a backlash for being "too emotional". Our data confirms that women's leadership is undermined by stereotypes:

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"When you're working with men, when you go to offices as leaders seeking for services, sometimes they look at you a certain way, like you don't belong. They look at you like you are a weak species."

Nurse, Kenya

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"...the women you find are the ones being told to serve tea, because it's what the society is used to. Even [when] a woman is in a leadership position, they're told they cannot speak too much, you cannot be assertive, just because of the society."

Clinical Officer, Kenya

Gender stereotypes that consolidate societal norms that women should be 'seen and not heard' mean that women are not elected to leadership positions in health:

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"You are not supposed to be heard, something like that. So, if you go for elections, let's use my college as an example, no woman has reached the level of Deputy Provost in the College of Medicine. And that is because during voting, they will outvote you."

Professor, Nigeria

Our research in Nigeria found that men are given more “grace to fail” than women. Women note that they must prove themselves worthy of their positions in a way that men are not required to do. Because leadership is perceived in the light of gendered stereotypes, women and men leaders can be judged by **different standards**. Studies show that women who excel in traditionally male domains are viewed as competent but less likable than their male counterparts.⁴⁶

WGH Pakistan research with 85 women health leaders revealed similar discriminatory experiences. Over a third of respondents said that they did not receive equal career advancement opportunities as men with the same experience and qualifications. Forty percent made note of ‘boys club’ as the most significant barrier to leadership, alongside nepotism and lack of women-friendly workplace policies. Gender-specific barriers to career progression were experienced by 65% of the women in the research.

Across the data from India, Kenya and Nigeria, women frequently reported that they feel they must work twice as hard to be taken seriously in a male dominated leadership environment.



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“Yes, men and women are held to different standards. It is assumed that because men only do out of home activities, they are better suited for leadership. Because my husband (also a doctor) works outside of home, he is called a ‘responsible’ person. But no one has ever called me responsible, even though I manage both home and work.”

Dentist, India

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“Sadly, men have it easier in certain instances. They need to work hard to prove their worth. But that is the end of it. But a woman needs to work not just extra hard but also prove at every instance that she has the capability to handle a leadership position in an equal or even better way than a man. This constant need to prove that she is as good or even better than a man in handling leadership challenges can be overwhelming and tiring.”

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“...the truth is that gender stereotypes still exist in our society and it certainly is a big challenge for every woman leader to break that wall of stereotypes and rise up. She needs to prove again and again that she can handle everything right from managing finances to driving a car to holding the top position of a company with absolute perfection.”

Doctor, Kenya

V. GOVERNMENTS HAVE MADE GLOBAL COMMITMENTS TO GENDER EQUALITY IN DECISION-MAKING BUT THESE WILL ONLY DRIVE CHANGE WHEN IMPLEMENTED

Commitments in the Sustainable Development Goals **SDG 3: Good Health and Well-Being**, **SDG 5: Gender Equality**, and **SDG 8: Decent Work and Economic Growth**, the Global Strategy on Human Resources for Health, and the Political Declaration from the 2019 UN High Level Meeting on UHC all create a strong platform for change for gender equality and set a timetable of 2030. They build on commitments made to gender equality in decision-making made in Conventions and global agreements dating back over 70 years. However, our research confirmed that these commitments are not being implemented fast enough or with enough accountability at national level.

In Kenya, the Constitution decrees that not more than two-thirds of the members of elective public bodies should be of the same gender yet this is not yet a reality: *"...beautiful policies. But very poor implementation strategies"*. Despite being entitled to 26 weeks of paid maternity leave, women working in private healthcare in India reported that while they are entitled to maternity leave in accordance with the law, it was not available in practice. Labor laws in Nigeria allow for a three-month maternity leave but it is not universally enforced.

However, respondents reported that when a woman led a unit or department, there were higher chances of receiving entitlements. In Nigeria, there are no policies recognizing needs around menstruation and menopause such as premenstrual syndrome. There are also no protections around health conditions such as postpartum depression.

Laws protecting women vary greatly across countries and are generally inadequately enforced, often failing to protect women. Simply introducing policies is inadequate. For policies to have a meaningful impact, there must be accompanying measures in place to facilitate implementation and foster a culture change. Laws covering sexual harassment and incidences of gender discrimination in Nigeria are described as *"scanty and vague"*.



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"...if you're a nurse and you have a baby- the government will not provide anything for you... It is sad."

Nurse, Nigeria

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"...all these policies, they're in place... but it's still happening..[until] women start occupying those [leadership] spaces, and making sure that those policies work."

Doctor, Kenya

In India, one head of nursing working in a public hospital shared how she was explicitly told by her supervising doctor that she would have to accept his sexual advances if she were to be promoted. If women do make complaints they suffer consequences.

The existence of loopholes⁴⁷ in such laws suggests that they may be difficult to access, or ineffective for certain cadres such as the one million all-women ASHA community health workers, who are not recognized as part of the formal workforce.

VI. GENDER EQUAL LEADERSHIP AT NATIONAL LEVEL WILL FEED FEMALE TALENT INTO GLOBAL HEALTH LEADERSHIP



“Being a woman, itself becomes a barrier... This decides every step, small or big, a woman takes.”

Doctor, India

Decisions made at country level determine who then goes forward to fill many leadership roles in global health. For example, WGH tracks the gender balance of leaders of delegations to the annual World Health Assembly (WHA), the world's highest health policy setting body. Nominations for those Chief Delegates, however, are not decided by WHO or any other global body, they are decided individually by each of the 193 UN member states that send delegations to WHA. **WGH's research on trends over time predicts that some countries may take over 100 years to reach gender parity in their WHA delegations, if current trends continue.**⁴⁸ In short, if governments do not nominate women to global health roles, their representation in key health decision-making bodies will continue to be unequal.

More diverse women recognized and supported in leadership at national level will positively disrupt this global pro-men's leadership bias and status quo. In order to access the most senior roles in global health, women need stronger political backing to generate the political capital required to be sponsored for government and multilateral leadership roles. The 'default man' bias in global health leadership perpetuates 'male bonus syndrome' where men continue to benefit unfairly from a clear route into leadership positions because well-qualified women have been excluded from the competition.

The situation in global health is indicative of a wider issue in global governance where new analysis from Global Women Leaders Voices for Change & Inclusion of 33 of the world's largest multilateral organizations finds that since 1945, only 47 out of a total 382 leaders were women (12%); and despite recent progress, only one third of these organizations are currently headed by a woman.⁵⁰

As long as societal gender barriers are not addressed and systemic bias against women continues, men, who are the vast majority of health leaders at national level, will continue to dominate global health decision making. The issues women face in national health systems are reproduced at the global level where women are often excluded from the political sponsorship needed when leadership appointments in health are confirmed by votes of member states or regional political blocs of states, for example in the election of WHO Regional Directors.

“To fix the multilateral system start by including women.”⁴⁹



VII. WOMEN KNOW WHAT THEY NEED TO ACCESS HEALTH LEADERSHIP

Women in India, Kenya and Nigeria participating in our research offered many solutions that would improve leadership opportunities for themselves and other women. For example, family friendly policies such as flexible working, enhanced parental leave, and childcare support, enable more equal sharing of work and childcare between men and women so that both can fulfil their potential at work. In addition, workplace policies are needed to meet the specific needs of women at work e.g. managing menopause and facilities for mothers returning to work.

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“...in our department, they have a mother's room, where you can express milk ... I think those are some of the things that can help improve participation of women in leadership.”

Nurse, Kenya

More women leaders will increase the number of women role models and mentors for men and women, breaking stereotypes of men as “natural leaders”.⁵¹ Women across the country case studies recognized **the importance of role models and mentors**.

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“...my mother was a community leader. ... seeing her take a leadership position at that young age, I grew up knowing that there is nothing that a woman cannot do.”

Nurse, Kenya

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“...actually, the person that inspired me is my former head of department, a professor of nursing from when I used to work in a hospital...she said, why should you languish here?... She identified the potential in me and made sure that I should be in the right place.”

Professor, Nigeria

The positive impacts of mentorship can have positive intergenerational effects.

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“...mentorship adds more knowledge. So, if I am a woman, and I've been mentored on something, I would also wish to mentor other women. So that in case the woman becomes a leader, at least there is some mentorship that a fellow woman leader gave to her. So, we don't keep our mentorship to ourselves, we share the knowledge that we get of mentorship.”

Nurse, Kenya

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“Those of us who have been privileged to receive education, skills and experiences and even power must be role models for the next generation of leadership.”

Professor Wangari Maathai,
Social, environmental and a political activist
and the first African woman to win the Nobel Prize.

In addition to individual support and mentorship, the importance of power and political analysis to identify where power lies in decision-making and **networks and collective action** have been recognized as key enablers of leadership for women.

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“Women in the medical profession are not well united and connected. If we were, there is no stopping us.”

Nurse, India

VIII. WOMEN IN HEALTH ARE SHAPING LEADERSHIP

Despite the common challenges reported, women across our country studies assert their right to equality in leadership and propose feasible policy solutions to address barriers faced by women. At the same time, they are aware that their perceptions of what makes a good leader are challenging gendered stereotypes of men as 'natural leaders' that place more social value on, for example, stereotypes of strength and aggression and undervalue traits considered more feminine, such as compassion and empathy. It is arguably another dimension of the XX Paradox that traits such as compassion are undervalued in leaders in the health profession which exists to care for people when they are at their most vulnerable.

Our findings show women in the health sector, who are leaders or aspire to be, reshaping the definition of health leadership in their work and rejecting gender stereotypical assumptions of what constitutes effective leadership in their sector. The words of our respondents below resonate with women political leaders who are also redefining leadership in their own terms.

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*“I think to be a leader, one should be able to **empathize and be approachable. Women are good leaders, in my opinion, because they are usually emotional and they connect with people sensitively.**”*

Head of Department, India

“

*“...the ability **to work with people, to understand people, to appreciate people, and to get people to do their very best** is one of the key qualities of leadership.”*

Medical Officer, Nigeria

“

*“...if you're a leader, you should be able to **mentor others who are around you to be able to either come to the same level that you're in or even surpass that level. And leadership, for me means innovation also, you should be able to come up with new ideas.**”*

Nurse, Kenya

“

*“Leadership is about setting an example and leading with care. You have to **set an example and become a guiding light and source of strength for future generations of women.** I think of it both as a personal and a political goal.”*

Doctor, India

“

*“It is always **the collective effort that ensures success.** Yes, I organized the health community and made multiple teams to ensure everything was done at the right time. But even in that, **I was not alone** -- we sought expert advice and held elaborate discussions with specialists. And I did not hesitate to make decisions.”⁵²*

KK Shailaja
Former Kerala State, Health Minister , India

“

“I hope I leave behind a belief that you can be kind but strong. Empathetic but decisive. Optimistic but focused. That you can be your own kind of leader.”

Jacinda Ardern
Former Prime Minister of New Zealand

RECOMMENDATIONS

The health sector is one of the biggest economic sectors in the world with millions of women working in very diverse country contexts. There are broad patterns across countries but also profound differences in levels of resourcing, the composition of the workforce and the position women hold in it. Any recommendations, therefore must be tailored to the specificities of the context and take an intersectional lens to analyze patterns of disadvantage in that context. Based on the findings from India, Kenya and Nigeria and our analysis of the global context, we have the following broad recommendations for addressing the XX Paradox of women's underrepresentation in health leadership:

i. Enable diverse women to lead

Expert women exist in the health sector with deep knowledge of health systems and often, with deep knowledge of the health of their communities. Governments and employers need to enable, not empower, these women by removing barriers put in their way:

- Create tailored leadership opportunities for women from marginalized backgrounds who may have missed out on formal education and qualifications. Recognize and reward women who are leading in their communities informally and providing opportunities for advancing into formalized career pathways.
- The millions of women working as community health workers but not included in the formal health workforce must have their roles formalized so they can better use their expertise and have the possibility of progression in their careers.

ii. Fast track actions to redress gender inequality in global health leadership

Women are not marginalized in global health leadership because they lack talent or merit. Historic disadvantage has clustered them into roles given lower status and lower pay. Intentional action is needed to rebalance the playing field, including:

- Promoting all-women shortlists, particularly for senior global health leadership roles that have never been held by a woman. With all-women shortlists, as the name suggests, only women are invited to apply and shortlisted in selection exercises. This guarantees that a woman will be selected for the role. Such affirmative action measures may be introduced as interim measures until historic imbalances have been eliminated.

- Introducing rotational leadership: In Kenya's public universities, an individual is only allowed to hold a position of leadership for a specified period after which another person must be considered. This scheme benefits women who may be prevented from accessing roles when people refuse to let go of power.
- Intentional, collective action by organizations: The 13 GAP agencies convene and strategize on measures needed to drive gender equal leadership in global health decision-making, especially increasing representation of the many talented and qualified women from low- and middle- income countries.

iii. Increase the visibility of women working in health

Women candidates often lack visibility when it comes to leadership opportunities. Civil society and women's professional networks, including WGH, can support potential women leaders by:

- Creating open-source lists/databases with publicly available information of women working in health at national and global level.
- Creating platforms for diverse women in health, especially women from low- and middle-income countries and marginalized groups to engage in global health events and processes.
- Working with headhunters to connect them with qualified women.

iv. Mobilize men to lean out and step up as allies, and end 'male bonus syndrome'

Men have a joint responsibility to help achieve gender equity and a crucial role to play as allies for women in ending the systemic bias that favors men as the default health leader. Men also have a special responsibility to drive change since they are the majority of health leaders. Actions are needed by governments and organizations, including:

- > Educating men and boys: include gender equality as a subject in school curricula and training in workplaces.
- > Increasing and making visible male gender transformative leaders who are advocating for gender equity.
- > Proactive coaching and mentoring of young professionals by male gender equity advocates from across the health sector.
- > Normalizing paternity leave and other family friendly policies that shift gender norms to share the burden of care work equally between women and men.

v. End the 'default man' bias; prioritize implementation of and accountability for policies that support women's lives

Implementation of organizational policies to drive gender equality will include:

- > Parental leave for all parents including paid maternity leave and job security for women.
- > Legal frameworks to ensure zero discrimination against women in the workplace, including protection for women from losing their jobs as a result of pregnancy or motherhood.
- > Flexible working options for all parents and carers, to enable women to return to work after having a child.
- > Safe spaces for lactating mothers, recognizing that the default women worker, unlike the default man, may need support for breastfeeding, as well as personal protective equipment (PPE) that allows for management of menstruation and menopause.
- > Strong legislation for addressing sexual harassment in employment with accountability measures to ensure enforcement.



vi. Support women's movements to accelerate collective action

Women's organizations – local and global – are best placed to support women and improve gender equity but lack the necessary political and financial resources.

- Donors should provide targeted funding in support of women's organizations, both for national and cross-border movements, and support the establishment of political networks for women and allies, recognizing them as essential contributors to health for all.
- Employers should promote peer support networks among women at all levels and for women from all backgrounds.
- Laws should support trades unions and collective bargaining in line with global conventions and best practice.

vii. Deepen understanding and the evidence base for policy with more research and data

This report uncovered a wide range of areas for future research, and where stronger evidence is needed to inform action. WGH recommends:

- All future research takes an intersectional approach, starting by generating more disaggregated data to understand the way different disadvantages intersect with sex and gender identity in different contexts and manifest in leadership journeys.
- Governments should collect and publish sex-disaggregated data on health leadership at all levels, and among different cadres.
- Further country studies to document and compare the state of women in health leadership in more countries.
- Implementation research to explore why policies are not working for women and to identify gaps e.g. on issues such as management of menstruation, menopause and breastfeeding, for further action.
- Targeted research with men to understand why bias persists and how to effectively communicate the need for gender transformative leadership and to mobilize allyship more effectively.
- Continue to build the evidence base on how sexual exploitation, abuse and harassment adversely impacts women and leadership.
- Collect data and strengthen the evidence to build a robust business case for gender equality as a sound investment in health as part of realizing the 'triple gender dividend'.



FINAL WORD



Time to build back equal in global health leadership

Women in Global Health undertook this research on the state of women's leadership and global health to assess the pace of change at global level, the impact of the pandemic and inform our recommendations with country experiences from India, Kenya and Nigeria. Our headline conclusion is that women are still significantly underrepresented in health leadership and that impacts negatively on women affected and on health systems. It is therefore everybody's business. Women in the health workforce are demanding change and demanding the right to compete fairly for leadership roles.

Commitments, now decades old, have confirmed women's right to equality in decision-making but change is slow and may have ground to a halt. Our findings from India, Kenya and Nigeria show that the gender imbalance in health leadership will not change fast enough with time alone. Women working in health are being denied their right to equal leadership, while health systems are being denied the expertise of leaders who know them best. The systemic bias exposed by this research illustrates how workplaces with human resource policies designed for the default man give men an advantage over women in access to leadership. Men gain from this **'male bonus syndrome'** because they are advantaged by the rules and also because women are eliminated from the competition.



"Right from day one, you are literally expected to do better than your brother, to do better than everybody else, but at the same time, you're told you're not good enough."

Doctor, Nigeria

Change will be needed at all levels from individual to national legal and policy frameworks and to global conventions. Closing the gender gap in health leadership is a critical foundation for strong health systems and health for all. Women in this research, however, are asking for more than simply policy measures that enable them to work more easily within existing gendered roles. They are asking for gender transformative policies measures, for example, family friendly policies that will intentionally, enable more equal sharing of work and childcare between men and women so that both can fulfil their potential at work.

The answer is not to 'fix women' to fit into workplace systems and cultures that favor men for leadership - male bonus syndrome - but to fix the systemic bias that creates barriers for women. Without urgent action, another generation of women in the health sector will be disadvantaged in their careers. All health leaders must adopt a gender transformative leadership approach to intentionally build equity in the health workforce and in global health decision-making roles. When we get this right, health can be an exemplar sector, generating gender transformative lessons for the rest of the economy. We know how to fix this and the potential gains for health systems, social change and economic growth make gender equity in the health workforce an unbeatable investment.



"It is a moral imperative to empower women healthcare workers and involve them in higher levels in global health leadership."

H.E. Maria Fernanda Espinosa,
member of the GWL Voices, Former President
of the United Nations General Assembly

About Women in Global Health



Women in Global Health (WGH) was founded in 2015 when four women in the health sector met on social media outraged that women are the majority in the sector but hold only a minority of global health leadership roles. Today, we are a registered 501(c)(3) nonprofit organization with 47 Chapters in 43 countries, over 6,000 members, and 100,000 supporters in over 100 countries. We are the largest and loudest women-led movement demanding gender equity in leadership, career opportunities, and pay; safe and decent working conditions; and gender equity in Universal Health Coverage and health emergency preparedness and response. We build alliances and our own movement so women in global health will be heard. We are working towards a world that enables women from all regions to be leaders in global health and catalysts for better health for all.

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ABBREVIATIONS

CHW: Community Health Worker

CSO: Civil Society Organization

GBV: Gender-Based Violence

HIC: High-Income Country

ICN: International Council of Nurses

ILO: International Labour Organization

LMIC: Low- and Middle-Income countries

NGO: Non-Governmental Organization

PPE: Personal Protective Equipment

PSEAH: Prevention of Sexual Exploitation Abuse and Harassment

SDG: Sustainable Development Goals

SEAH: Sexual Exploitation Abuse and Harassment

UHC: Universal Health Coverage

UN: United Nations

UNDP: United Nations Development Programme

WGH: Women in Global Health

WHA: World Health Assembly

WHO: World Health Organization

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