POLICY BRIEF FOR CONSULTATION:

GENDER, EQUITY AND LEADERSHIP IN THE GLOBAL HEALTH AND SOCIAL WORKFORCE

About this Policy Brief

The health and social sector, with 234 million workers, is one of the biggest and fastest growing employment sectors in the world, particularly for women.[i] Women comprise 70% health and social care workers globally and around 90% of nurses. Women provide essential health services for around 5 billion people and contribute US$ 3 trillion annually to global health, half as unpaid care work.[ii]

> **Global health is delivered by women and led by men.**

Despite differences between countries and regions in the gender composition of the workforce, the default health and social care worker is a woman. That fact has important policy implications for health systems.

Gender inequity in health and social care work remains a challenge. Women may hold 70% of jobs in the health and social care workforce but they hold only 25% leadership roles. Global health is delivered by women and led by men.

In March 2019 WHO launched a landmark Report, '*Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health Workforce*'[iii] and a new global analysis[iv] of the social and economic factors, that examine the paradox of why relatively few women lead in a majority female profession?

The Report, a product of the WHO Gender Equity Hub of the Global Health Workforce Network, calls for urgent action to address gender inequities in the health and social care workforce in order to reach Universal Health Coverage (UHC) and other Sustainable Development Goals (SDGs) and targets.

An additional 18 million health jobs are needed to achieve UHC by 2030. Adding jobs to the workforce under current conditions, however, will not solve the gender inequities that exacerbate health worker shortages and undermine health systems.

Gender inequality is a pressing human rights and socio-economic issue – and it is also bad for our health.

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This Policy Brief builds on the Report's findings on gender, equity and leadership in the health and social workforce and is issued for consultation. We want to know what works. The Gender Equity Hub will use your feedback to develop a Policy Toolkit on Gender, Equity and Leadership in the Health and Social Workforce.
Please send your comments by 12 June 2020 to: geh@womeningh.org

1. Key Findings on Gender, Equity, Leadership in the Global Health and Social Workforce from *Delivered by Women, Led by Men*[v]:

+ Women are 70% of the global health and social workforce but hold only 25% senior roles.

+ Women are typically clustered into lower-status, lower paid jobs in health and social care.

+ Gender stereotypes and discrimination constrain women's leadership and seniority.

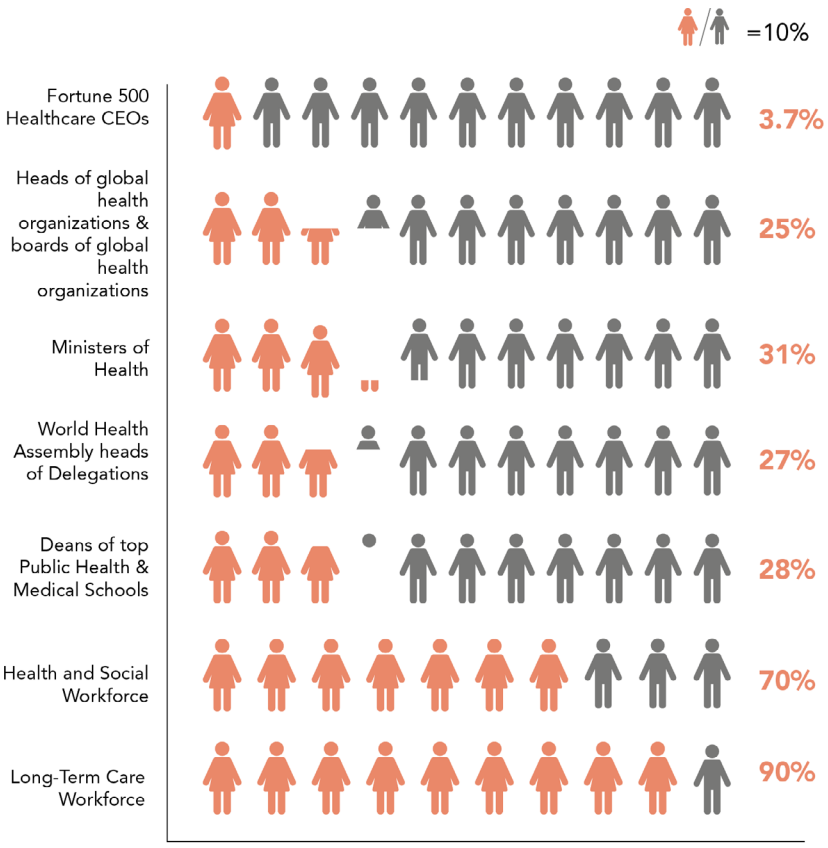
+ Women's limited opportunity to enter leadership can be compounded by the intersection with other identities such as race or caste, making it even harder for women from marginalised groups to attain leadership roles.[vi]

+ Health is highly segregated by gender. Globally, women are 90% nurses but a minority of surgeons.

+ Gender norms and stereotypes label some jobs as 'men's' or 'women's' work and drive segregation.

Figure 1 Global Health leadership pyramid

Women's representation in global health leadership, based on influence



> **Women are 70% of the global health and social workforce but hold only 25% senior roles.**

+ Nurses - 59% health workers – are significantly underrepresented in global and national health leadership. [vii]

+ Gender stereotypes deter men from entering nursing in all but 13 countries where male nurses outnumber female. [viii]

> **Unequal leadership opportunities for women in health reduce their career satisfaction, cause loss of morale and significant loss of lifetime income.**

+ A "glass elevator" (quick route to the top) has been reported for men in nursing who, although a minority, hold a disproportionate number of senior nursing roles. [ix]

+ Professions with a majority of women, including those in the health and social care sector, are given lower social value, status and pay.

+ Unequal leadership opportunities for women in health reduce their career satisfaction, cause loss of morale and significant loss of lifetime income.

> **Health is highly segregated by gender. Globally, women are 90% nurses but a minority of surgeons.**

+ Leadership matters at all levels – underrepresented voices, particularly women from the Global South and frontline cadres, are critical to informed global health decision making.

> **Countries need to adopt laws and policies that address underlying causes of gender inequity. The gender balance will not equalize on its own.**

+ The gender leadership gap in health is inequitable, a barrier to health systems and holds back achievement of the SDGs and UHC.

2. Why gender equality matters in health and social sector leadership

+ Significant gains from the participation of women at all levels in the health and social care workforce will be made by eliminating gender inequality, bias and discrimination.

+ Companies with diverse executive teams outperform competitors run by men only[x]. Women enrich health leadership with perspectives based on different life experiences.

+ Enabling nurses to lead health services has led to better health outcomes, retention and greater innovation.[xi] There are high opportunity costs from excluding women.

+ Global health is losing female talent, perspectives and knowledge. Health systems function better when the women who manage them have an equal say in their design and delivery.

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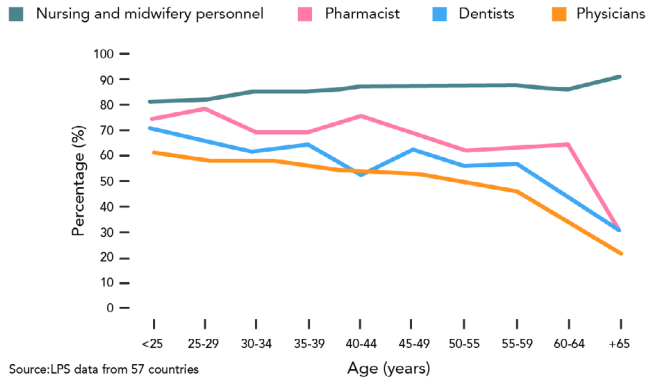
+ Fewer women in leadership partly explains why men earn 28% more on average than women in the health sector[xvi] (gender pay gap), leading to lifetime loss of income for women.

+ Women health workers report sexual harassment from male colleagues and patients. More female leaders will result in fewer cases of sexual harassment, thereby reducing harm to individual health workers and health systems.

Figure 2

Share of women health workers by age group for nursing and midwifery personnel, pharmacist, dentists and physicians



Source:LPS data from 57 countries

+ Women in health leadership expand the agenda, giving greater priority to issues such as sexual and reproductive health that apply to all but have the greatest impact on women and girls.[xii]

+ Most physicians, dentists and pharmacists under 40 are female[xiii]. The World Economic Forum estimates it will take 257 years to close the gender gap at work.[xiv] Faced with unequal chances to reach leadership, this younger cohort of women may leave the health sector.

+ More female leaders will increase the number of female role models and mentors for men and women, breaking stereotypes of men as 'natural leaders'.

> **The World Economic Forum estimates it will take 257 years to close the gender gap at work.[xv]**

+ Increasing female talent in health leadership will have wider benefits, enabling the expansion of the global health and social care workforce needed to achieve the SDGs, UHC and a Triple Gender Dividend seen in:

1. Better Health: equal opportunities and decent work will attract and retain female health workers, helping to fill the 18 million global health worker gap.

2. Gender Equality: investing in women to enter leadership and formal sector jobs in health will increase gender equality as women gain more income and decision making power.

3. Economic Growth: new jobs created in health will fuel economic growth and strengthen health systems and outcomes, all contributing to UHC and the SDGs by the 2030 end date.

> **Global health is losing female talent, perspectives and knowledge.**

3. Key issues: gender, equity and leadership in the health and social workforce

+ History matters: medicine was established as an all male profession with women formally excluded. Over centuries, women have gained entry to medicine. But in some countries the first female doctor only graduated in the 1940s and later for ethnic minority women.

> **History matters: medicine was established as an all male profession**

+ Women's representation in health has increased rapidly in the last 30 years, particularly in higher wage health care occupations.[xvii] In many countries, women are the majority of medical students.

+ Since women are 70% of the health and social workforce, we need to change the narrative - women are drivers of change, not only service users. Policy makers must recognise women's specific needs e.g. personal protective equipment designed to fit female bodies.

+ Findings on leadership are complex due to multiple professions within health and social care - medicine, nursing, midwifery, dentistry, pharmacy, physiotherapy, allied health professions, social care and frontline workers including community health workers and paramedics. Countries have diverse health systems with diverse staffing classifications.

> **…We need to change the narrative - women are drivers of change, not only service users.**

+ Findings are limited by major gaps in data and research, including sex-disaggregated data on leadership in the health and social workforce and on intersectional factors such as race.

+ Data on non-binary genders in health and social workforce leadership was not found. It is assumed that non-binary genders face significant discrimination and bias.

> **….Beyond gender parity, leaders of all genders must promote gender transformative policies to realise better global health**

+ Migration is a key issue for women in this sector -1 in 8 nurses globally practice in a country they were not born or trained in. The impact on women's leadership is not clear. [xviii]

Moving beyond gender parity to gender transformative leadership[xix]
Equal representation of women in leadership needs no justification in a workforce with 70% women. The Report, however, argues that beyond gender parity, leaders of all genders must promote gender transformative policies to realise better global health.

Gender transformative policies are defined in the Report as those that '**seek to transform gender relations to promote equality'**[xx]

Gender transformative leadership will be grounded in principles including:
- a framework for gender equality, women's rights and human rights
- challenging privilege and power imbalances based on gender that undermine health
- intersectionality, addressing social and personal characteristics that intersect with gender — race, ethnicity, geography etc — to create multiple disadvantages
- being applicable to leaders of any gender, not exclusively women leaders.

Gender transformative leaders in global health will aim to leave no-one behind in access to health and equally, aim to leave no-one behind in leadership and decision-making.

4. High impact practices on gender, equity and leadership in the global health and social workforce

High impact practices are divided here into four action areas:

4.1 Build a foundation for equality
4.2 Address social norms and stereotypes
4.3 Fix workplace systems and culture, not women
4.4 Enable women to achieve

4.1 Build the Foundation for Equality

All governments must create the legal foundation for gender equality to enable women to engage equally with men at work. Countries need to adopt laws and policies that address underlying causes of gender inequity. The gender balance will not equalize on its own.

This will include:

• **Removing restrictions on women's right to work.** Despite recent progress, 90 countries still have labour laws that restrict the types of jobs women can hold, and when and where they are permitted to work. In18 countries husbands have the legal right to prevent their wives from working.[xxi]

> **In 2019 Uzbekistan abolished a law that had banned women from working in 450 professions.[xxii]**

• **Prohibiting discrimination against women at work** and supporting collective bargaining for women. Men are more likely than women to be organised in trade unions.

> **Nepal introduced new labour law in 2019 making women's entry into the labour market easier by prohibiting discrimination in employment. Nepal also improved women's employment opportunities and pay by allowing women to work at night and prohibiting discrimination in remuneration for work of equal value and introduced 15 days of paid paternity leave.[xxiii]**

• **Ensuring equal pay for equal work and gender pay gap transparency** The World Bank concludes that over two thirds of countries could strengthen legislation on women's pay.[xxiv] A small but growing number of countries mandate employers to publish their gender pay gap and this transparency, especially when coupled with penalties for non-reporting, has catalysed action to reduce the gap.

> **In Iceland, companies employing 25 or more workers are required to obtain certification from the government confirming that they are paying women and men equally.[xxv]**

• **Parental leave and family friendly policies**: Women in the health and social sector are less likely than men to be in full-time employment. The average gender pay gap of 28% in the health workforce drops to 11% once occupation and working hours are accounted for.[xxvi] Laws that enable flexible working, subsidised or state funded childcare and parental leave are likely to enable more women in the health and social workforce to enter senior roles. Most countries allocate only small amounts of parental leave to fathers, if any, meaning childcare and domestic work are unlikely to be shared equally, freeing women to focus on career advancement.

> **In 2019 8 countries introduced paid leave for fathers for the first time. Canada's new parental leave is unusual in reserving 35 days for fathers. [xxvii]**

• **Laws against violence and sexual harassment at work**. Health workers are vulnerable to violence and every year, tragically, health workers lose their lives. Only 37% countries report measures in place to prevent attacks on health workers. [xxviii]
Sexual harassment at work is reported to be a major problem for female health and social care workers but rarely recorded or sanctioned. Studies have shown that sexual harassment reduces productivity, creates higher turnover and absenteeism and impacts patient care. Currently, 50 countries have no law against sexual harassment in the workplace. ILO Convention 190, likely to come into force in 2021 will be significant in encouraging governments to address violence and sexual harassment of all workers, including women in health and social care.

> **ILO Convention No. 190 and Recommendation No. 206** Argentina, Finland, Spain and Uruguay have formally committed to ratify ILO's new Convention launched in 2019 that provides an international framework to end violence and harassment at work.

4.2 Address social norms and stereotypes

Social norms and gender stereotypes drive much of the gendered segregation in the health and social workforce and the lower value put on professions that are majority female. Gender stereotypes of occupations and of leadership as a 'man's role' originate long before people join the workforce. Measures to combat gender stereotypes include:

• **Engage girls in STEM** (Science, Technology, Engineering and Maths), particularly in low-and middle-income countries to enable them to join health professions.

> **Organisations such as Girls Who Code, StemBox, Blossom, Engineer Girl, Girls Can Code in Afghanistan, @IndianGirlsCode, have successfully encouraged women and girls to explore male-dominated STEM fields.**

• **Targeted campaigns to attract under-represented groups.** Several countries have run targeted campaigns to break the stereotype of nursing as a female profession and attract male applicants.

> **The American Association for Men in Nursing: AAMN is a US network with chapters that encourages men of all ages to become nurses, supports male nurses professionally, highlights their contribution and supports research.**

• **Addressing gender equity, conscious and unconscious bias and stereotypes in curricula and training programmes for health and social care workers.** No examples were identified of medical school curricula addressing gender stereotypes. Such programmes would be particularly valuable for managers and senior staff.

> **The Unstereotype Alliance, convened by UN Women, is a global initiative bringing together partners to use the advertising industry to drive positive change. This industry-led initiative unites leaders across business, technology and creative industries to tackle the widespread prevalence of gender stereotypes in advertising.**

4.3 Fix workplace systems and culture, not women

Interventions in this area in the past have focused on training for women in areas such as self-esteem and self-presentation, on the assumption that women needed to be 'fixed' to compete in systems and cultures designed for men. This ignored the systemic inequality, bias and exercise of power that favoured men for leadership roles. Fixing workplace systems and culture will include:

• **Visible and accountable senior leadership:** Establish senior champions for gender equality in the workforce and include progress indicators in their performance management targets. This should include leadership on a zero-tolerance strategy for workplace bullying and sexual harassment.

• **Targets and quotas** to achieve gender parity in leadership where a gender(s) is underrepresented, taking an intersectional approach. Targets are voluntary and set at an organisation's own discretion. Quotas are mandated, set by an external body and imposed upon an organisation. Countries and organisations have set both quotas and targets for women in leadership, with quotas being the stronger measure. Quotas have been seen as an interim measure that could be lifted once equal numbers of men and women in leadership has become accepted as the norm.

> **France passed a law on quotas in January 2011. Approximately 2000 companies were required to achieve at least 40% representation of each sex on boards by 2017 with an interim quota of 20% by 2014. Failure to comply resulted in board elections being nullified and directors' benefits suspended.** [xxix]

• **Sensitise men to engage with and lead gender transformation in the health workforce.** Since men are the majority of leaders in health and social care, it will be essential to engage men as gender transformative leaders and as mentors for female staff.

• **Institute gender transformative recruitment and retention strategies.** There is a body of evidence to support gender sensitive recruitment, retention and performance management strategies that are standardised and transparent and aim to reduce bias through anonymised applications, gender balanced interview panels, non-discriminatory questions and recommendations on language in performance assessments. All aim to eliminate bias against one gender and other factors relating to identity, leading to fairer outcomes.

• **Adopt equal and family friendly policy framework.** As stated above, it is the role of governments to put in place a legal framework of equality law to enable women at work. Employers in health and social care should prioritise policies that enable women, who are the majority of the workforce, to advance in their careers on merit and balance work and home commitments without disadvantage. People who work flexibly or part time may be disadvantaged by being perceived as less committed to their jobs. Employers have an obligation to change this perception.

4.4 Enable women to achieve

• **Develop formal and informal networks for women's leadership development.** Training should focus less on 'fixing women' by imparting new skills and more on enabling women through access to information and opportunities.

• **Conscious public visibility of women in decision-making** and empowered positions to inspire other women and normalise female leadership in the eyes of all genders. Therefore, more female spokespersons, increased public, print and digital presence of women leaders.

• **Track and publish key metrics** like representation, hiring, gender pay gap and promotions by both gender and other aspects of identity. Transparency will enable women to better navigate their careers.

• **Develop peer support mechanisms.** These may be professional networks outside or inside work that give women peer support and strategies for career advancement.

> **The Lean-in organisation in USA** grew from a well-known book on increasing women's leadership. The organisation now supports 'Lean in Circles' all over USA where women can meet others for peer support. The organisation works particularly to enable women to recognise and tackle gender bias through policy tools, videos and other resources. Activities on '50 Ways to Fight Bias' are intended to give participants tools to address gender bias head-on.

5. The policy imperative – governments have committed to act

Governments have agreed to address work policies and culture, create decent work for women and close gender gaps in leadership and pay (gender transformative policy change) in the health and social workforce.

Commitments in the SDGs, the Global Strategy on Human Resources for Health, the joint WHO, ILO and OECD Working for Health Five Year Action Plan 2017 – 2021 and the Political Declaration from the 2019 UN High Level Meeting on UHC create a strong platform for change and set a timetable.

The commitments in the Five-Year Action Plan are to be delivered by 2021, and the SDGs, UHC and Global Strategy on Human Resources for Health are to be delivered by 2030.

The Working for Health Action Plan (below) specifically commits to gender-transformative policy that will accelerate equal representation of women and men in health sector management and leadership. The WHO Gender Equity Hub (below) was created to support the gender deliverables in the Action Plan.

> **Working for Health: Five Year Action Plan for health employment and inclusive economic growth 2017–2021 (WHO, ILO, OECD)**
>
> **"…Deliverable 2.1** Gender-transformative global policy guidance developed and regional and national initiatives accelerated to analyse and overcome gender biases and inequalities in education and the health labour market across the health and social workforce (for example, increasing opportunities for formal education, transforming unpaid care and informal work into decent jobs, equal pay for work of equal value, decent working conditions and occupational safety and health, promoting employment free from harassment, discrimination and violence, equal representation in management and leadership positions, social protection/child care, and elderly care)."

The Gender Equity Hub of the Global Health Workforce Network
WHO established the Gender Equity Hub (GEH) at the fourth Global Forum on Human Resources for Health in November 2017. The GEH, co-chaired by WHO and Women in Global Health, brings together key stakeholders to support implementation of the WHO Global Strategy on Human Resources for Health and achieve the deliverables of the Working for Health Five-Year Action Plan. GEH's mission is to accelerate gender-transformative progress on gender inequities and biases in the health and social care workforce to achieve the SDGs.

GEH priority areas are:
+ Leadership and governance
+ Occupational segregation
+ Gender pay gap
+ Decent work: free from bias, discrimination and all forms of harassment, including sexual harassment

Contact GEH: geh@womeningh.org
Join GEH: https://www.womeningh.org/gender-equity-hub
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