CLOSING THE LEADERSHIP GAP:
GENDER EQUITY AND LEADERSHIP IN THE GLOBAL HEALTH AND CARE WORKFORCE

POLICY ACTION PAPER

JUNE 2021

World Health Organization

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Global Health Workforce Network

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The literature review on gender, equity and leadership in the health and care workforce will be made public as part of a GEH policy bank.

Abbreviations

GEH	Gender Equity Hub
ILO	International Labour Organization
LMIC	low- and middle-income countries
PPE	personal protective equipment
SDG	Sustainable Development Goal
STEM	science, technology, engineering and medicine
UHC	universal health coverage
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. About this policy action paper

1.1 Unpacking the leadership paradox in health and social care

The health and social care sector is one of the largest and fastest growing employment sectors in the world, particularly for women *(1)*. Women provide essential health and care services for around 5 billion people and contribute an estimated US$ 3 trillion annually to global health; half in the form of unpaid work *(2)*.

Women comprise almost 70% of health and social care workers globally *(3)* and nearly 90% of the nursing and midwifery workforce *(4)* and yet it is estimated that they hold only around 25% of leadership roles in health *(3)*. This paper examines the paradox of why so few women are leaders in a majority female profession and explores actions that can be taken to redress this gender imbalance which impacts on health security and health and care delivery for all.

In March 2019 WHO launched a landmark report, *Delivered by women, led by men: a gender and equity analysis of the global health and social workforce (3)*. The report, a product of the WHO Gender Equity Hub (GEH) 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 Goal (SDG) targets.

The four thematic areas in the report were: gender parity in leadership; occupational segregation; decent work free from bias, discrimination and harassment, including sexual harassment; and the gender pay gap. In March 2020, building on the report, the WHO GEH launched a public consultation on "gender equity and leadership in the global health and social workforce".

"The leadership gap in health can only be closed by addressing the systemic barriers women face."

Following a literature review, the GEH is launching this policy action paper, incorporating feedback received from public consultation and focusing on pragmatic policy actions. The leadership gap between women and men in health can only be closed by addressing systemic barriers to women's advancement.

Since *Delivered by women, led by men* was published, the world has been hit by the COVID-19 pandemic, which has stress tested the resilience of health, social and economic systems in all countries and produced additional evidence and lessons on gender, equity and the health and care workforce, the subject of this paper. COVID-19 has had a profound impact on women in the health and care workforce and threatens to widen the leadership gap for women in the sector.

"COVID-19 threatens to widen the leadership gap for women."

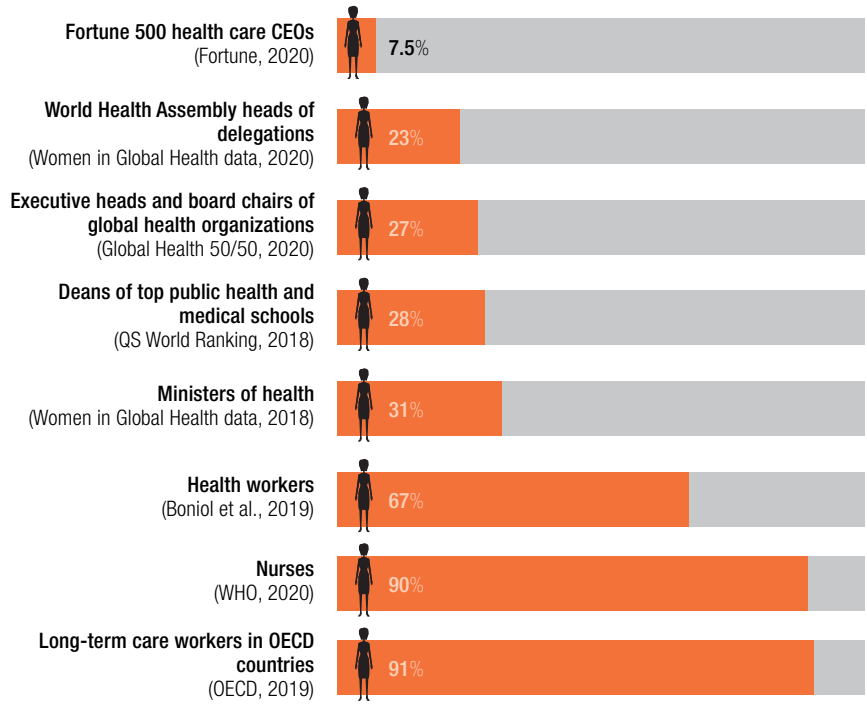
2. Mapping the problem: global health and care – delivered by women, led by men

Key findings on gender, equity and leadership in the global health and social workforce from *Delivered by women, led by men (3)* are:

- Gender leadership gaps are driven by stereotypes, discrimination, power imbalance and privilege.
- Women's disadvantage intersects with and is multiplied by other identities, such as race and class.
- Global health is weakened by excluding female talent, ideas and knowledge.
- Women leaders often expand the health agenda, strengthening health for all.
- Gendered leadership gaps in health are a barrier to reaching the SDGs and UHC.

Women are almost 70% of the global health and social workforce but it is estimated they hold only 25% of senior roles. Only 23% of national delegations to the World Health Assembly in 2020 were headed by women and fewer than 5% of the chief executive officers of Fortune 500 health care companies are female *(5)*.

Fig. 2.1 Women's representation in global health



Source: Adapted from Women in Global Health *(5)*.

"Women are almost 70% of the global health and social workforce, but it is estimated that they hold only 25% of 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.

Fewer women than men are organized into trade unions so they benefit less from social dialogue and collective bargaining, which could strengthen their working conditions and opportunities to enter leadership *(3)*.

"Health employment is highly segregated by gender. Globally, women are 90% of the nursing and midwifery workforce but a minority in surgery."

Women's limited opportunities to enter leadership can be compounded by the intersection with other identities such as race, ethnicity, caste, class, sexual orientation, gender identity, religion and disability, making it even harder for women from marginalized groups to attain leadership roles. These factors vary by context and culture.

Women find it harder to access training that would aid their career advancement because the cost, timing and location of training conflict with their responsibilities outside work and priority for training is given to male colleagues *(6)*.

Health and care work are highly segregated by gender. Globally, women are 90% of nurses and midwives, but a minority of surgeons.

Gender norms and stereotypes reinforce the idea that some jobs are "men's" or "women's" work and drive occupational segregation by gender.

Nurses – estimated to be around 50% of all health workers – are significantly underrepresented in global and national health leadership *(4)*.

In some countries a significant percentage of health and social care workers are migrant women who face additional discrimination and barriers to entry to leadership *(4)*. Many work overseas in lower grade roles than they left at home.

Gender stereotypes deter men from entering nursing in all but 13 countries where male nurses outnumber female *(4)*.

A "glass elevator" (quick route to the top) has been reported in some countries for men in nursing who, although a minority, hold a disproportionate number of senior nursing roles *(7)*.

Women commonly do not have the workplace policies and conditions they need to balance unequally distributed unpaid work at home with demands at work for entry to leadership roles. Women are more likely than men to work part time and, because of this, are often viewed as less eligible for leadership.

Majority female sectors, such as the health and care sectors, are often given lower social value, status and pay.

Gender bias is a significant factor in recruitment and promotion. Women may be discouraged from opting for higher status specialties in medicine, such as surgery, due to bias, stereotyping and discriminatory attitudes during training.

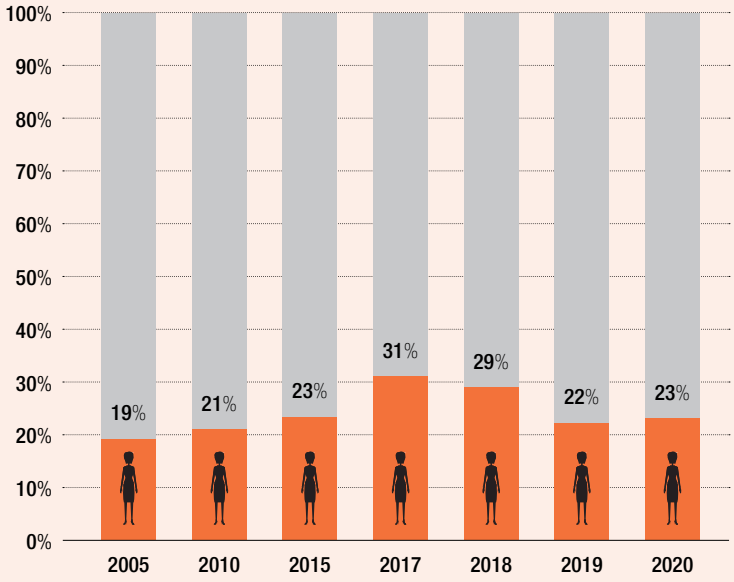
Unequal leadership opportunities for women in health reduce career satisfaction, cause loss of morale and significant loss of lifetime income.

Leadership matters at all levels – underrepresented voices, particularly women from the Global South, marginalized social groups and occupations with high patient contact, are critical to informed global health decision-making.

Women are marginalized in global health leadership – particularly, women from low- and middle-income countries

A study of 200 organizations active in global health found 73% were headed at the executive level by men. Women therefore held around one quarter of leadership positions, but women from low- and middle-income countries (LMIC) were particularly marginalized – holding only 5% of executive level roles in such organizations *(8)*.

Percentage of national delegations to the World Health Assembly headed by women



Source: Women in Global Health *(5)*.

3. The COVID-19 pandemic: women have provided much of the health and care in the pandemic but have not had an equal say in decision-making

3.1 Women not equally represented in COVID-19 decision-making

At the time of writing (March 2021), more than 110 million people have been infected by COVID-19, almost 2.5 million have died and the pandemic is far from over *(9)*. Women have made an extraordinary contribution to the pandemic response in all sectors, from science and vaccine development to health policy-making and delivery. Their expertise, however, has not been equally presented in the media. One study in February 2020 found that only one woman was quoted as an expert on the pandemic in the media for every three male experts *(10)*.

"An estimated 85% of national COVID-19 task forces had a majority of men as members."

In addition, women have not had an equal say in pandemic decision-making at global or national levels. Typically, national COVID-19 decision-making groups have had a small minority of women members. One study found 85% of 115 national COVID-19 task forces had majority male membership *(11)*. Including equal numbers of women in leadership (with women health and care professionals, as well as people from diverse social groups and geographies) encourages more informed decisions on all policy measures, including policies on lockdowns and maintenance of essential maternity services that impact particularly on women *(10)*.

"Women have not had an equal say in pandemic decision-making at global or national levels."

3.2 Women political leaders and COVID-19

Emerging research is examining whether women political leaders have been more effective in managing the response to COVID-19 than men and considered gendered differences in approach. The pandemic, however, is not over so it is only possible to assess early stage responses. Moreover, the sample of women heads of government is small. In January 2020 only 12 out of 193 countries (6.2%) had a woman as head of government *(12)*. Nevertheless, one study, in July 2020, found countries led by women had fewer COVID-19 deaths per capita, fewer days with confirmed deaths, a lower peak in daily deaths per capita, and a lower excess mortality *(13)*. The study concluded that women leaders had acted quickly, implementing measures of lockdown early on as recommended by national health experts. A second study concluded that, by June 2020, deaths from COVID-19 had been six times lower in countries led by women due to early, decisive action *(14)*. Another commentary contrasted the communication styles of male and female political leaders during the pandemic, noting women leaders spoke more frequently about impact at the local level or on individuals and social welfare services to cushion financial shocks, whereas male leaders used war metaphors and aggressive language more often than women *(15)*.

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Will COVID-19 reverse the progress women have made in health and care leadership?

The world entered the COVID-19 pandemic with a serious health worker shortage, including a global shortage of 9 million nurses *(4)*. Women health workers have stepped up to the challenge of COVID-19, coping with a surge in patients, staff shortages and risking their own health and lives, particularly since personal protective equipment (PPE) has been in short supply, non-existent or not designed to fit women's bodies (*16)*. Given their high representation as patient-facing health and care workers, women health workers have generally been the majority of health workers infected *(17)*. In July 2020, WHO reported COVID-19 related attacks on health workers in many countries, often related to misinformation, fear and stigma *(18)*. Reports have come from several countries of mental health issues, including suicides, amongst health workers who have been responding to COVID-19 and a future health burden of "long COVID" is inevitable *(19)*. COVID-19 has had a significant impact on the lives and physical and mental health of women health and care workers and there is reason to fear women may leave the profession. A 2020 study by the Royal College of Nursing (United Kingdom of Great Britain and Northern Ireland) found that around a third of nurses in the United Kingdom were considering leaving the profession, two thirds citing low pay and almost half citing their treatment during the pandemic (*20)*. COVID-19 could therefore widen the leadership gap in health and social care.

4. Gender equality in health and care sector leadership: marginalizing women from decision-making leads to worse health outcomes for everyone

Global health is losing out on women's talent, perspectives and knowledge. Health systems function better when women, who deliver much of the care, have an equal say in their design and delivery.

Women in health leadership can 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 *(21)*.

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

More women leaders will increase the number of women role models and mentors for men and women, breaking stereotypes of men as "natural leaders" *(22)*.

There are instances where enabling nurses to lead health services has led to better health outcomes, retention and greater innovation *(23)*. There are high opportunity costs from excluding women.

Companies with diverse executive teams outperform competitors run by men only *(24)*. Women enrich health leadership with perspectives based on different life experiences.

Fewer women in leadership partly explains why men earn more, on average, than women in the health sector, leading to lifetime loss of income for women *(25)*.

"Global health is losing out on women's talent, perspectives and knowledge."

"Health systems function better when the women who manage them have an equal say in their design and delivery."

Women health workers report sexual harassment from colleagues and patients *(3)*. More women leaders could result in fewer cases of sexual harassment, thereby reducing harm to individual health workers and health systems.

The World Economic Forum estimates it will take 257 years to close the gender gap at work *(26)*. Faced with unequal chances to reach leadership, younger cohorts of women may leave the health sector.

"The World Economic Forum estimates it will take 257 years to close the gender gap at work."

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Realizing the "triple gender dividend"

Increasing female talent in health leadership will have wide benefits, enabling the expansion of the global health and social care workforce needed to achieve the SDGs, UHC, and realizing 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 SDG targets by the 2030 end date.

5. Beyond numbers and gender parity: ensuring all leaders address inequality

History matters: medicine was established as a men's profession, with women formally excluded. Over time, women gained entry to medicine. But in some countries the first female doctors only graduated in the 1940s, and it was later for ethnic minority women. Women and men have lacked women role models in medicine.

"History matters: medicine was established as a men's profession."

Women's representation in health has increased rapidly in the last 30 years, particularly in higher wage health care occupations. In many countries, women are the majority of medical students *(25)*.

Since women comprise almost 70% of the health and social workforce, there is an opportunity for the sector to empower these women as drivers of change in sustainable and inclusive economic development.

"There is an opportunity to empower women in health and care as drivers of sustainable and inclusive economic development."

Policy-makers must recognize women's specific needs, such as PPE designed to fit female bodies *(27)*. Moreover, to recruit and retain women and enable them to achieve, workplace policies must fit the realities of women's lives.

Findings on gender and equity in the health and social workforce are limited by major gaps in data and research, including sex/gender-disaggregated data on leadership in the health and care workforce and on intersectional factors such as race and disability *(3)*.

"Beyond gender parity, leaders of all genders must promote gender-transformative policies to realize better global health."

Data on sexual identity and orientation of health and social workforce leadership is scarce. It is likely that, in most contexts, non-binary genders face significant discrimination and bias in the health and care sector.

Women are diverse – an intersectional approach is critical

Women are not a homogenous group and women from some social groups and geographies will have a significant advantage over some other women in terms of education and career advancement. Intersectionality describes the complex, cumulative way that different forms of discrimination combine, overlap or intersect – and are amplified when operating together. Women belonging to a socially marginalized race, class, caste, age, ability, ethnicity, sexual orientation or identity, may face far greater barriers to accessing leadership. In many contexts, women from lower socioeconomic backgrounds are clustered into lower status sectors in the health and care workforce. One study from United States of America found that black and Latina women in the health workforce earn less than white women in identical positions *(28)*. An intersectional approach is needed to unpack these differences and design policy measures to address the greater discrimination and disadvantage experienced by some groups of women. Sex-disaggregated data on the health and care workforce, however, is often not available and data disaggregated further by other social factors is even harder to find.

Moving beyond gender parity to gender-transformative leadership

Equal representation of women in leadership needs no justification in a workforce with a majority of women. Beyond gender parity, however, leaders of all genders must promote gender-transformative policies to realize better global health. Addressing gender inequality in the health and social care sector is not solely the responsibility of women leaders.

Gender-transformative policies are defined in *Delivered by women, led by men* as those that "seek to transform gender relations to promote equality". 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; and
- being applicable to leaders of any gender, not exclusively women leaders.

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

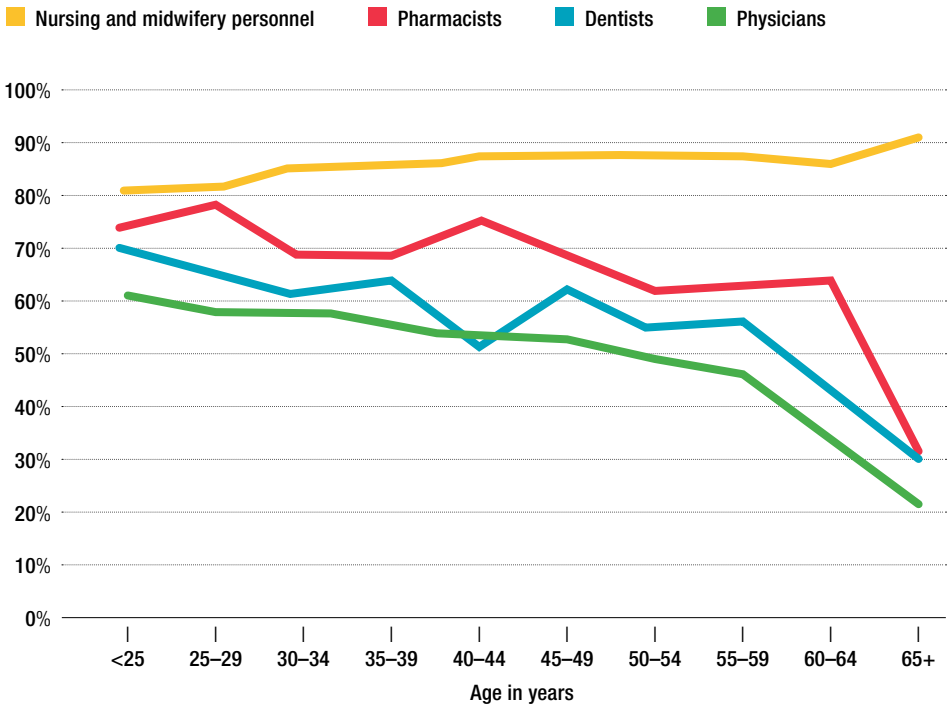
Source: A new vision for global health leadership *(29)*.

6. Drivers of the leadership gap in the health and care sector

6.1 No shortage of women

In health and social care there is no shortage of women in the age cohorts typically feeding into leadership. On the contrary, in many countries women are the majority of nurses, midwives, pharmacists, dentists and physicians under 40 years of age *(25)*.

Fig. 6.1 Share of women health workers by age group for nursing and midwifery personnel, pharmacists, dentists and physicians



Source: Gender equity in the health workforce: analysis of 104 countries *(25)*.

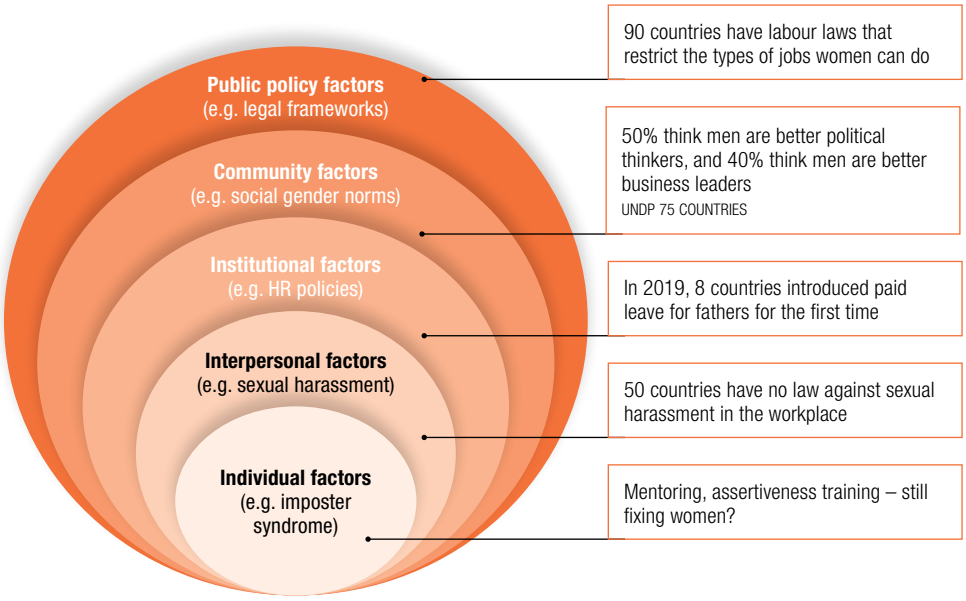
"In many countries, women are the majority of nurses, midwives, pharmacists, dentists and physicians under 40."

"A blockage in the pipeline stops women entering leadership in equal numbers to their male counterparts."

In most countries, the problem is not a shortage of women entering the leadership pipeline in the health and social care sectors, rather a blockage in the pipeline stops women entering leadership in equal numbers as men.

6.2 The ecological model: multi-layered factors impacting women's journey into leadership

Ecological model



Source: Women in Global Health *(30)*.

The ecological model in health *(31)* situates individuals in their social and public policy context and identifies factors at different levels that impact upon individual action, in this case, the entry of women into health and care leadership. The model highlights public policy environments and systemic social factors that enable or constrain what may be perceived as individual decisions.

The model above highlights how action is needed at all levels to enable women to enter leadership in the health and social care sector and the critical need to analyse barriers in specific countries and contexts because they differ significantly. Ninety countries, for example, have employment laws that restrict work women can do by law *(32)*. Fifty countries have no law against sexual harassment at work and therefore provide no protection for women in the health and care workforce *(32)*. However, a small number of countries have a paid parental law entitlement for fathers that enable parents to share childcare, meaning the careers of mothers are less disrupted by time spent out of work.

The ecological model illustrates that gender parity in leadership cannot be attained unless wider legal, social and cultural factors are addressed. The following framework for action therefore addresses barriers and enablers at all levels to provide optimal conditions for women to enter leadership in the health and social care sector.

7. A framework for change: four action areas to support women's leadership

7.1 Build the foundation for equality

Governments must create the legal foundation for gender equality to enable women to engage equally with men at work. Laws and policies that address underlying causes of gender inequity are needed. 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 employment laws that restrict the types of jobs women can hold, and when and where they are permitted to work. In 18 countries husbands have the legal right to prevent their wives from working *(32)*.

- **Prohibiting discrimination against women at work and supporting collective bargaining for women:** Women are more likely than men to work in non-unionized sectors, commonly the case in the care sector *(3)*. Younger workers in health and care are more vulnerable to insecure employment terms, unsafe working conditions and lower wages. Governments, employers and unions all have a significant part to play in addressing gender equity and discrimination through social dialogue and collective bargaining.

- **Ensuring equal pay for equal work and gender pay gap transparency:** The World Bank has concluded that over two thirds of countries could strengthen legislation on women's pay *(32)*. 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 *(33)*.

- **Parental leave and family friendly policies:** Women in the health and social sector are less likely than men to be in full-time employment. Laws that enable flexible working, subsidized 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, preventing women from focusing on career advancement.

- **Laws against violence and sexual harassment at work:** Health workers are vulnerable to violence and every year, tragically, health workers lose their lives as a result of attacks. Only 37% countries report measures in place to prevent attacks on health workers *(6)*. 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 *(3)*. Currently, 50 countries have no law against sexual harassment in the workplace *(32)*. The landmark International Labour Organization (ILO) Convention No. 190 *(34)* comes into force in June 2021 and will be significant in encouraging governments to address violence and sexual harassment of all workers, including women in health and social care.

ILO Convention 190 – work free from violence and harassment

In June 2019, the International Labour Conference adopted ILO Convention No. 190, the first international labour standard to address violence and harassment at work. Together with ILO Recommendation No. 206, it provides a framework for action and a unique opportunity to shape a future of work based on dignity and respect. Several countries have already ratified the Convention and others are expected to ratify as it goes live in June 2021. Many, including trades unions, nongovernmental organizations, professional associations and women's organizations in the health and social care sector, have campaigned for countries to ratify the Convention and implement its provisions at national level. Violence and harassment in the health and care workforce disproportionately impact women workers, causing them harm and damaging their careers.

- **Ensuring access of boys and girls to education, especially secondary education:** Such access feeds tertiary level training for higher status health workforce occupations. According to the United Nations Children's Fund (UNICEF) *(35)*, 132 million girls are out of school. Only 45% countries have achieved gender parity in lower secondary education and even fewer, 25%, have achieved gender parity in upper secondary education. Unequal access to secondary education limits the opportunities for girls in many LMIC to enter training for formal sector health jobs and, in turn, constrains training and recruitment of health workers to fill the 18 million health worker jobs needed to achieve UHC.

7.2 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 placed on professions that are majority female. Gendered stereotypes of occupations and of leadership as a "man's role" originate long before people join the workforce. Measures to combat gender stereotypes include:

- **Engaging girls in science, technology, engineering and maths (STEM):** Particularly in LMIC, such participation will to enable girls to join health professions. Although girls everywhere have made impressive gains in access to primary education particularly, it is critical they can access secondary education and are not deterred from taking STEM subjects by stereotypes that signify them as "male subjects". Qualifying in STEM subjects at secondary school level will generally determine entry to tertiary level courses and training for higher status health professions such as medicine.

> "Organizations 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 underrepresented 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 is a network with chapters that encourages men to become nurses and supports male nurses professionally *(36)*.

- **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, *(37)* 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."

Gendered social norms impact on women's leadership – around half of men and women think men make better political leaders than women

The United Nations Development Programme (UNDP) Gender Social Norms Index measures how social beliefs obstruct gender equality in areas like politics, work and education, and contains data from 75 countries, covering over 80% of the world's population. According to the Index, 91% of men and 86% of women show at least one clear bias against gender equality in areas such as politics, economic, education, intimate partner violence and women's reproductive rights. Around 50% of men and women interviewed across 75 countries say they think men make better political leaders than women, while more than 40% felt that men made better business executives. The Index shows that bias against gender equality is rising, including amongst younger men, with a backlash against gender equality recorded in Sweden, India, South Africa and Romania.

Source: Tracking social norms – a game changer for gender inequalities *(22)*.

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7.3 Address workplace systems and culture

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 change 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. Addressing 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 organization's own discretion. Quotas are mandated, set by an external body and imposed upon an organization. Countries and organizations 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.

- **Sensitizing 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.

- **Instituting gender-transformative recruitment and retention strategies:** There is a body of evidence to support gender-sensitive recruitment, retention and performance management strategies that are standardized and transparent and aim to reduce bias through anonymized 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.

- **Adopting an equal and family friendly policy framework:** As above, it is the role of governments to put in place a legal framework of equality law to enable women to reach their full potential at work. Employers in health and social care should prioritize 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 and an incentive to change this perception and engage the talent of women workers.

7.4 Enable women to achieve

Employers should put in place deliberate measures to enable women, who are the majority in the health and social care workforce, to apply for and achieve leadership positions equally and on merit. Such measures will include:

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

- **Increasing public visibility of women in decision-making:** This will inspire other women and normalize female leadership in the eyes of all genders. Measures to increase women's public visibility include organizations having more female spokespersons and increasing the public, print and digital presence of women leaders.

- **Tracking and publishing key metrics:** Transparency on metrics such as representation at different managerial levels, hiring, the pay gap and promotions disaggregated by both gender and other aspects of identity, taking an intersectional approach, will enable women to better navigate their careers.

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

- **Mentoring women in the pipeline:** Mentorship of early and mid-career women within the sector can equip them with insights, skills and motivation to compete for leadership roles. Mentors should be both men and women.

> "The Lean In organization grew from a well-known book on increasing women's leadership. The organization now supports "lean in circles" where women can meet others for peer support. The organization works particularly to enable women to recognize and tackle gender bias through policy tools, videos and other resources." *(38)*.

8. 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 *(39)*, the joint WHO, ILO and Organisation for Economic Co-operation and Development "Working for health" five-year action plan (2017–2021) *(40)* and the Political Declaration from the 2019 UN High Level Meeting on UHC *(41)* 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 by 2030.

The "Working for health" five-year action plan specifically commits to gender-transformative policy that will accelerate equal representation of women and men in health sector management and leadership. In November 2017, WHO established the GEH, co-chaired by WHO and Women in Global Health, under the umbrella of the Global Health Workforce Network. The GEH brings together key stakeholders to strengthen gender-transformative policy guidance and implementation capacity for overcoming gender biases and inequalities in the global health and social care workforce, in support of the Global Strategy on Human Resources for Health: Workforce 2030, and the gender deliverables in the "Working for health" five-year action plan.

"Working for health": a five-year action plan for health employment and inclusive economic growth (2017–2021) *(40)*

"…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/childcare, and elderly care)".

9. Everyone has a part to play: actions to support gender parity in health and care sector leadership

The process for researching this paper included a literature review and consultations on what works to close the leadership gap between women and men in the health and care sector. The following checklists, which are not meant to be comprehensive, are based on the information gathered.

Checklist for organizational leaders

- ✓ Be your own diversity officer – be a gender-transformative leader.
- ✓ Set timebound organizational gender targets and track progress.
- ✓ Acknowledge the work of women.
- ✓ Support initiatives to address stereotypes and unconscious bias.
- ✓ Support peer networks for women.
- ✓ Mentor and champion women.
- ✓ Ensure best practice in gender equal recruitment and performance management.
- ✓ Support family friendly policies, consult women on their needs and track take up and impact.
- ✓ Support collective bargaining and ensure women are equally represented.
- ✓ Publish gender pay gap data and data on leadership gaps.
- ✓ Publish intersectional pay and leadership data, e.g. by gender, ethnicity, LGBQT, disability etc.

Checklist for publishers, media and social media

- ✓ Journals: ensure gender parity in editorial reviewers and track data on gender of authors to ensure parity.
- ✓ Establish women's reference group to feedback on stereotyping/bias.
- ✓ Address and do not reinforce gender stereotypes – men are also nurses.
- ✓ Publish stories that change the narrative and celebrate women as drivers and leaders in health/care.
- ✓ Quote expert women and men in health and care in equal numbers.
- ✓ Protect women leaders from online threats and abuse.

Checklist for male allies

- ✓ "Lean out" – support women, make space for women and give women credit.
- ✓ Be gender aware in meetings; ask "Am I talking over and interrupting women?"
- ✓ Challenge gender bias, discrimination and harassment – do not be a bystander.
- ✓ Challenge gender discrimination against underrepresented groups, e.g. on race.
- ✓ Mentor, coach and sponsor women.
- ✓ Be aware of gender bias and assess performance of men and women equally.
- ✓ Do not make comments on a woman's appearance you would not make to a man.
- ✓ Promote and use opportunities for flexible working/parental leave to share childcare and unpaid domestic work equally.

Checklist for women

- ✓ Form alliances with other women for support and to catalyse organizational change.
- ✓ Take and create opportunities.
- ✓ Work collectively – women's organizations, professional associations, trade unions.
- ✓ Extend down the ladder – coach and sponsor women, especially from underrepresented groups.
- ✓ Be a role model of gender-transformative leadership for men and women to emulate.
- ✓ Cultivate leadership skills – strategic thinking, negotiation, political and power analysis.
- ✓ Challenge bias and discrimination.
- ✓ Do not be deterred by setbacks and build resilience to keep on going.

10. Final messages: building equity for health security and strong health systems

> It is time to stop trying to change women, and start changing the systems that prevent them from achieving their potential.
>
> **Antonio Guterres, Secretary-General, United Nations, 2020** *(42)*

- Global health and social care are **delivered by women and led by men.** We cannot address this inequality by changing women.
- There is **no shortage of women** in the health and care talent pipeline in most countries but gender inequality is systemic and will not change without deliberate action.
- Gender equal leadership in global health is the **foundation for UHC, strong health systems and global health security.**
- Organizations led by **diverse groups (including women) have better results.**
- Taking an **intersectional approach** is essential to understanding differences between women and factors such as race, caste, disability, class etc. that can multiply disadvantage.
- **Leaders set the tone,** and transparency is critical.
- **Commitments on equality in leadership have been made** in the SDGs and other global agreements and need to be delivered. Accountability is key.
- Beyond gender parity in leadership, **all leaders must be gender-transformative leaders** to catalyse change.
- **COVID-19 threatens to undermine the gains women have made** in health and care leadership.
- Since women deliver health and social care to around 5 billion people, **ensuring equity in health and care leadership is everybody's business.**

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