

# THE STATE OF WOMEN AND LEADERSHIP IN HEALTH



# EXECUTIVE SUMMARY

## TIME TO BUILD BACK EQUAL IN GLOBAL HEALTH LEADERSHIP

Records from early civilizations show women have long played an active role in medicine as healers, herbalists, surgeons, midwives, and more. Yet when medicine was formalized as a profession, women were banned from medical education and practice and had to fight their way back in. Today, women hold around 70% of health worker jobs globally, over 80% of nursing and midwifery roles, deliver the majority of unpaid care and domestic work in families and communities, and make the majority of health purchasing and usage decisions. Women's work - paid and unpaid - forms the essential foundation for health, well-being, and delivery of health systems.

Despite the contribution women make to health systems and supporting the realization of health for all, women hold only 25% of senior leadership roles in the sector. If leadership roles were allocated on 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 hold 75% of leadership roles but are only 30% of health workers. This gendered leadership gap is the **'XX Paradox'** that we examine in this report, drawing both on global data and country case studies from India, Nigeria, and Kenya.

Women are entitled to equal representation in health leadership as a right and matter of economic justice. Commitments have been made by UN Member States in global agreements dating back at least seventy years confirming women's right to equal participation in decision-making. Gender parity in leadership is a critical first step towards equity but additionally, health leaders of all genders should be as diverse as the people they represent. Not all groups of women are equally represented amongst women health leaders, with women from the Global South particularly, missing in global health leadership. Diversity in leadership is not only fair, it enriches health decision-making by expanding knowledge, talent and perspectives.



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*“A woman with a voice is by definition a strong woman. But the search to find that voice can be remarkably difficult”*

Melinda Gates



Fixing the gender gap in health leadership, however, goes beyond counting women. Diverse leadership in health stands to benefit all health systems' users. It is not solely a women's issue, and we cannot put the responsibility for change on the shoulders of women leaders alone. Fundamental change requires **Gender Transformative Leadership** by health leaders of all genders. Beyond gender parity in leadership numbers, all leaders in health must intentionally promote gender transformative policies and diverse leadership as the basis for strong and effective health systems. Who leads health is both a rights issue for women and a business issue driving health systems' effectiveness.

It is clear from the findings in this report that we must rethink the concept of leadership as being much broader than formal position and power within a hierarchy. 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.

They are, however, too often denied respect, recognition and reward. Women are proud of the contribution they make in the health sector, acutely aware of the injustices they face and demanding change.

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*“Sadly, men have it easier ... 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.”*

Doctor, India

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*“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 and so on.”*

Christine Lagarde,  
President of the European Central Bank

Women health workers want equal career progression and aspire to leadership roles and the benefits that go with them. Their morale and motivation inevitably suffer when they see 'male bonus syndrome', with male colleagues put on a fast track to the top.

In 2020 the context changed radically for all health workers when the pandemic put health at the top of the global agenda. Women, as the majority of health workers in patient-facing roles, played an exceptional part in responding to a fast-moving global health emergency. Women health workers typically managed a double burden during the pandemic of long hours, high stress and risk at work plus increased hours of unpaid care work at home and in the community.

The surge in very sick patients, excessive workloads and risk of infection and death with the pandemic came on top of the injustices women health workers were already facing at work: clustered into roles and sectors given low social value, paid around a quarter less than their male counterparts (with 6 million or more women working unpaid or grossly underpaid)<sup>3</sup>, and frequently experiencing violence and sexual harassment<sup>4</sup>.

***The default health worker is a woman, but she works in a sector designed for the 'default man'.***

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). And 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 unable to use the toilet on long shifts<sup>5</sup>.



The pandemic highlighted the critical role played by women health workers and exposed the urgent need for gender equitable and diverse leadership. Although women health workers were applauded at the start of the pandemic in many countries, regrettably, our evidence shows that women lost ground in health leadership in the pandemic. COVID-19 has reversed progress for women and girls in many areas of life, especially for women health workers. In the third year of COVID-19 significant numbers of women health workers are now burned out and leaving their careers. At the start of the pandemic there was an existing global shortage of 10 million health workers which COVID-19 now has deepened. Health workers lost their lives to the virus and significant numbers are unable to work, affected by 'long-COVID'.

A step change is now needed in gender equity in the health workforce to protect and retain the exhausted and demoralized women health workers who are essential for health systems and achieving global health goals, including Universal Health Coverage.

The 'Great Resignation' of women health workers currently underway in high income countries is expected to catalyze a highly damaging 'Great Migration' of trained health workers from the low-and middle-income countries with the most serious health worker shortages.

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*“We are at crisis point. The 10 million global health worker shortage at the start of the pandemic gets worse every day as exhausted and demoralized women health workers resign from their jobs. 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,**  
Co-Founder & Executive Director,  
Women in Global Health

In summary, the findings in this report demonstrate that the glass ceiling in health leadership may have cracked in places but the pace of change is too slow to significantly change the percentage of women in health leadership, even in the medium term.

As the percentage of women health professionals aged under 40 increases in many countries, we are in danger of failing a new generation of women by leaving intact the 'glass ceiling' into health leadership. New research in this report from India, Kenya and Nigeria confirms women are held back from health leadership by cultural gender norms, discrimination and ineffectual policies that are not working fast enough to redress historic inequalities.

The similarities in the barriers faced by women health workers in very different socio-economic and cultural contexts are marked, indicating systemic bias. Women's underrepresentation in national health leadership creates a further barrier for women in global health leadership since global leadership selections often depend on national pipelines of candidates.

Based on the findings in this report we believe the pandemic should be treated as a break in history, demonstrating the urgent need for gender-transformative change in the sector. 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

## THE TRIPLE GENDER DIVIDEND

The infographic consists of three circular icons arranged vertically on the left, each with a corresponding text block on the right. The top icon is teal and features a white heart above a white hand holding a pulse line, labeled 'HEALTH DIVIDEND'. The middle icon is light blue and features a white balance scale, labeled 'GENDER DIVIDEND'. The bottom icon is orange and features a white bar chart with an upward arrow and a dollar sign, labeled 'ECONOMIC & SOCIAL 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 findings of this report bear out the urgent need to address gender inequities in the health workforce, including the underrepresentation of diverse women in leadership. Women are demanding change and proposing solutions. **As the pandemic subsides, it is time to build back equal in global health leadership.**

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*“...if there are things that make a woman take leadership positions, it is to make change. Because we have what it takes, we have the vision, we have the passion for it, we have the strategies.”*

Nurse, Kenya

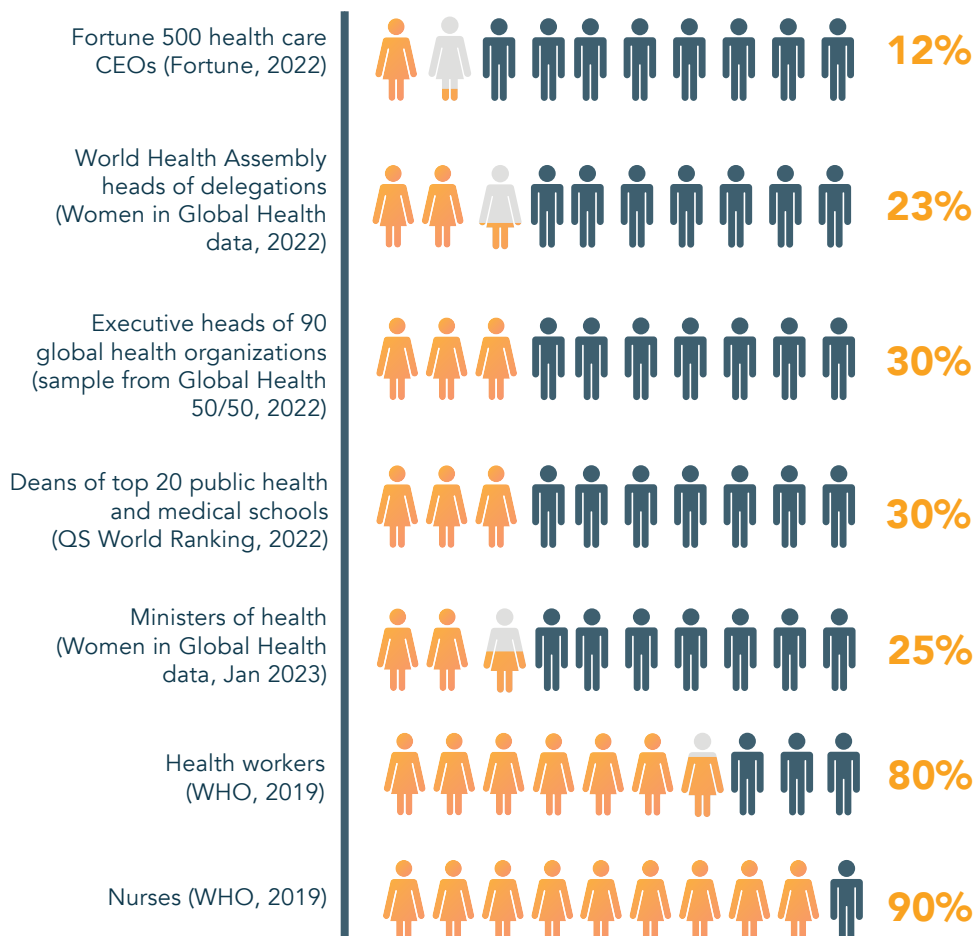
# KEY FINDINGS

SYSTEMIC GENDER BIAS IS BUILT INTO ORGANIZATIONAL POLICIES AND CULTURES - THE GENDER GAP IN HEALTH LEADERSHIP CANNOT BE FIXED BY FIXING WOMEN

## 1. GLOBAL HEALTH IS STILL DELIVERED BY WOMEN AND LED BY MEN - PROGRESS IS STALLING

- New WGH analysis confirms that over the last five years women’s share of leadership roles in global health 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 between 2018 and 2022 (from 5% to 12%), **the number of female ministers of health has decreased from 31% to 25%**, and the proportion of World Health Assembly (WHA) member state delegations led by women has fallen from 27% to 23%.
- WGH analysis<sup>6</sup> reveals that 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.** Women can have no faith that gender equality will be driven by evolution if they just wait patiently.

### Women’s representation in global health:



## 2. WOMEN HAVE LOST GROUND IN HEALTH LEADERSHIP DURING THE COVID-19 PANDEMIC - PROGRESS IS AT RISK

- The pandemic has turned the spotlight on women health workers, especially community health workers. However, it has also revealed the fragility of women's leadership in global health: **during WHO's Executive Board meeting in January 2022 only 6% of delegations were led by women** (down from a high point of 32% in 2020).
- Women have typically been excluded from decision-making at country level during the pandemic: **a WGH study in 2020 found 85% of 115 national COVID-19 task forces had majority male membership.** It appears that in emergencies, particularly, outdated gender stereotypes resurface with men considered 'natural' leaders.
- After three years of COVID-19, women health workers, who have been the majority in patient-facing roles, are burned out and traumatized. Understandably women are leaving the health sector at all levels in a 'Great Resignation', particularly in high income countries, which threatens to deepen the global health worker shortage crisis and reduce women's representation in leadership.



*"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)

## 3. WOMEN FROM MARGINALIZED BACKGROUNDS ARE MOST EXCLUDED FROM HEALTH LEADERSHIP - AN INTERSECTIONAL APPROACH IS NEEDED.

- Women belonging to a socially marginalized race, class, caste, age, ability, ethnicity, sexual orientation, gender identity or with migrant status, face far greater barriers to accessing and retaining formal leadership positions in health. It is common in many countries for women from marginalized races, castes, with migrant status etc. to be clustered into the sectors of health with the lowest status in the health system. Only one multilateral global health organization is led by a woman from a low-income country.
- Despite their critical roles in delivering primary health care and as community leaders, **women community health workers are marginalized from formal roles and leadership opportunities.**
- To break down the barriers to leadership for women in all their diversity, an intersectional approach is needed to understand the complex and cumulative nature of different forms of discrimination intersecting and combining to multiply disadvantage.

*"Lack of diversity and gender representation in decision-making at global, country and organizational levels means perspectives of some of the most vulnerable communities are often left out, limiting an effective response by failing to address the direct and indirect effects on women and girls and minorities, and failing to leverage their expertise and talent when it is needed most."*

## 4. ACROSS CONTEXTS AND CULTURES, WOMEN EXPERIENCE COMMON CHALLENGES IN ACCESSING LEADERSHIP

- Despite cultural and contextual differences, WGH research in India, Nigeria and Kenya 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 shift the powerful norms and biases that discriminate against women in their homes, workplaces and societies.
- Universal challenges reported included:
  - Pressure from families and spouses on women to limit their careers, linked to perpetuating gender norms around women’s role as caregivers:
  - Systemic and persistent discrimination in the workplace, especially in relation to motherhood:

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*“Women are meant to be in the kitchen, to take care of children and serve their men. That’s the attitude we have in African culture. So, it’s a struggle when women are taking positions of leadership because it is believed they are defying their usual position.”*

Doctor, Kenya

- Women in leadership face a **‘double bind’**: adopt behaviors and act more “like a man” or be overlooked:

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*“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.”*

Doctor, India

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*“I had to say no to promotion when I was pregnant... At that time, I regretted getting married and pregnant.”*

Head of Department, India

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*“...women have to work extra hard to command respect from men and some women struggle.”*

Doctor, Nigeria

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*“When women act like women, they are accused of being inferior. When women act like human beings, they are accused of behaving like men.”*

Simone de Beauvoir

Gendered stereotypes around leadership and its associations with qualities such as individual strength penalize women who may aspire to lead in a different, more inclusive and empathetic way.



## 5. MEMBER STATES HAVE MADE COMMITMENTS TO GENDER EQUALITY BUT IMPLEMENTATION IS SLOW

- Commitments in the Sustainable Development Goals (SDGs) 3, 5 and 8, 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 for 2030. They build on commitments made to gender equality in decision-making made in Conventions and global agreements dating back over 70 years.
- **WGH research found some countries may take over 100 years to reach gender parity in their WHA delegations if current estimated trends continue.**

Findings from India, Nigeria and Kenya uncover a widespread lack of policy implementation at the national level, including:

- In Kenya, the Constitution decreed 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:
- Despite being entitled to 26 weeks of paid maternity leave, women in India report related challenges:
- 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.
- Policies for preventing sexual exploitation, abuse, and harassment are inadequate everywhere and fail to protect women from the prolific abuse in the sector:
- Not all women are protected by laws and policies. For example, the all-women cadre of ASHA community health workers in India have no legal right to maternity leave, nor to make a complaint under India's Prevention of Sexual Harassment Act.



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*“...the biggest drawback for us as a country is the poor implementation, beautiful policies. But very poor implementation strategies.”*

*“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.”*

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

*In Kenya,  
“...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.”*

*“The protection is not there for us. When a doctor or nurse reports a beating or rape, they have protection under the law. If mentor mothers or CHWs report abuses in the community, we are open to attack.”*

Community health worker, Kenya

## 6. PROGRESS HAS BEEN MADE IN PLACES BUT THE 'GLASS CEILING' LARGELY REMAINS INTACT

- The major global health organizations 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 but only 5 out of 13 agencies are headed by women.** And only one of the 13 agencies is headed by a woman from a low-income country.
- Many of the leadership roles we are tracking in global health are determined at country level e.g. between 2018 and 2022 the proportion of World Health Assembly (WHA) delegations led by women has fallen from 27% to 23%. Nominations for Chief Delegates are decided individually by each of the 193 UN member states that send delegations to WHA. It will therefore be complex to influence the gender balance in these leadership roles.
- Women's place in health leadership varied between Kenya, Nigeria and India:
- 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 there remains a glass ceiling to 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 Centres are women.

- In India, women's representation in leadership roles in national health organizations averages 28% but this figure is skewed by the Nursing Council (76% women in leadership roles). In some organizations it is as low as 1%.

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*“You attend a meeting, and you're all in the same positions, but the women, you find are the ones being told to serve tea, you know, because it's what the society is used to. Even there somewhere, yes, a woman is in a leadership position, but they're told they cannot speak too much, you cannot be assertive.”*

Clinical Officer, Kenya



## 7. THERE IS A 'BROKEN PIPELINE' BETWEEN WOMEN WORKING IN NATIONAL HEALTH SYSTEMS AND GLOBAL HEALTH LEADERSHIP



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

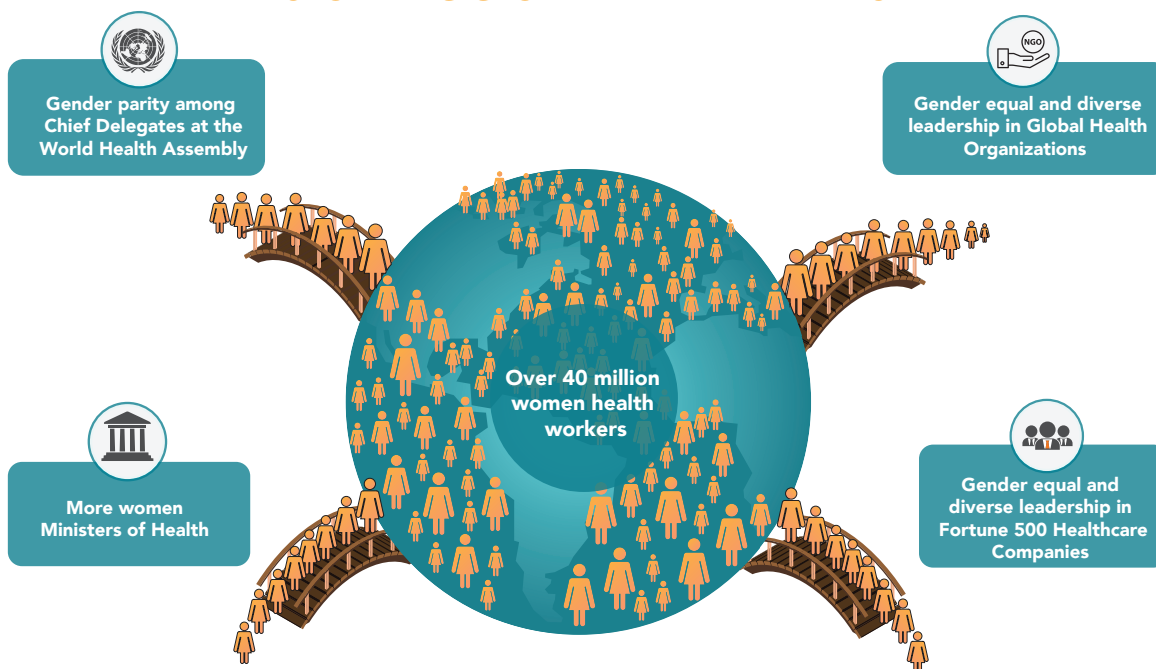
Doctor, India



*"To fix the multilateral system start by including women."*

- As long as men are the majority of health leaders at the national level and systemic bias against women continues, the global health leadership pipeline will continue to funnel more men into positions with global decision-making power.
- The issues women face in national health systems are reproduced at the global level where women are excluded from political processes and thus marginalized from the most senior appointments in global health.
- This is indicative of a wider issue in global governance where, women have been in charge for only 12% of the time since 1945; and despite recent progress, only one third of multilateral organizations are currently headed by a woman.<sup>8</sup>
- More diverse women recognized and supported in leadership at the national level will positively disrupt this status quo. Sustainable change to address gender unequal leadership in health requires intentional action at all levels of health from community to global.
- To access the most senior roles in global health, women need stronger networks to generate the political capital required to be sponsored for government and multilateral leadership roles.

### TRANSFORMING GLOBAL HEALTH LEADERSHIP



## 8. WOMEN KNOW WHAT THEY NEED TO SUCCEED, DECISION-MAKERS NEED TO LISTEN

- Women in India, Nigeria and Kenya participating in our research offered many solutions that would improve leadership opportunities for them and other women. For example, **supportive workplace policies**:
- Women recognized the importance of **collective action** to amplify their individual voices and support each other:

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*“I saw recently that at least 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.”*

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*“We should also support ourselves as women, we should support each other. ...if we come together as women, we can fight for our rights in institutions.”*

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

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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.”*

Wangari Maathai,  
first African woman to win  
the Nobel Peace Prize





## 9. THE BARRIERS TO LEADERSHIP FACED BY WOMEN ARE SYSTEMIC, ACTION IS NEEDED TO FIX SYSTEMS NOT WOMEN

- The default health worker is a woman but she works in a sector designed for the 'default man'.
- Medicine as a profession was originally designed for men only. In general, policies and organizational cultures, including career pathways, have never caught up with the needs of women based on their reproductive and socially defined gender roles. To illustrate, **72 countries do not mandate at least 14 weeks of paid maternity leave as set out by the 2000 ILO Maternity Protection Convention.**<sup>9</sup> Pregnant health workers in countries without paid maternity leave are at a serious career disadvantage compared to their male counterparts.

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*“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

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*“...that [maternity leave] slows you down. If you compare yourself with the male colleague whom you left at work, they could have even moved a job group ahead of you.”*

Pharmacist, Kenya

- 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.
- Women are urged to 'lean in' and create opportunities to be visible so they will be selected for leadership roles but the findings of this report show that the gender gap in health leadership will not be resolved by fixing one woman at a time. Change will be needed at all levels from individual to national legal and policy frameworks and global conventions.



## 10. WOMEN ARE READY TO LEAD AND ARE REDEFINING AND SHAPING LEADERSHIP

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***“I have broken many glass ceilings – so I know it can be done.”***

Helen Clark,  
former Prime Minister of New Zealand

Despite the challenges, women across our country studies’ described their aspirations to lead. Challenging masculine stereotypes, leadership is viewed as being more communal than individualistic, with traits such as dialogue, empathy and consensus-building valued. The words of our respondents resonate with women political leaders.

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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

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*“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

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*“So, 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

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*“...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

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*“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

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*“...we have been socialized to have men as the leader ... You have to go for it and fight for it.”*

Academic, Kenya

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***“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.”***

KK Shailaja,  
former Minister of Health, Kerela, India

# RECOMMENDATIONS

## GENDER-EQUAL LEADERSHIP IN HEALTH IS NOT A LUXURY, IT IS NEEDED NOW TO DRIVE UHC AND HEALTH SYSTEMS SECURITY

### 1. Enable women in all their diversity to lead

Closing the gender gap in health leadership will drive better health for all. Targeted actions are needed by governments to promote equity and validate all forms of women's leadership in health, including:

- Extending legal entitlements, including protection from sexual harassment and abuse; fair pay; and family friendly policies including maternity leave, to all women working in the health sector, including community health workers.
- Creating tailored leadership opportunities for women from marginalized backgrounds who may have missed out on formal education and qualifications. This will include establishing targeted programs to promote science, technology and math (STEM) among girls from underrepresented groups.
- Recognizing and rewarding women who are leading in their communities informally and providing opportunities for advancing into formalized career pathways.

### 2. Fast track actions to redress historic gender inequality in global health leadership

Increasing the number of diverse women in health leadership roles will not happen with time and evolution. Intentional action is needed, including:

- All-women shortlists, particularly for senior global health leadership roles that have never been held by a woman. This is especially needed for contests involving political processes that tend to marginalize women.
- Quotas are an effective strategy to increase the proportion of women in decision-making roles, whether in government or on boards.

### 3. Increase the visibility of women working in health

Despite being the majority of health workers and the face of health systems, qualified women candidates often lack visibility when it comes to leadership opportunities. Civil society and women's professional networks, including Women in Global Health, can support potential women leaders by:

- Creating open source lists/databases of women working in health at national and global level.
- Creating platforms for diverse women in health, especially women from the Global South and marginalized groups to engage in global health events and processes.
- Liaising with headhunters to connect them with qualified women.



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

The majority of leaders in health are men. Women are not responsible for achieving gender equity alone; men have a crucial role to play in being good allies for women and ending the systemic bias favoring the default man. Actions are needed by governments and organizations, including:

- Educating men and boys: include gender equality as a subject in school curriculums and training in workplaces.
- Elevating men who are gender transformative leaders to be advocates and visible role models. Celebrate men who challenge stereotypes and 'lean out' to make way for qualified women.
- Normalize paternity leave and other family friendly policies that shift gender norms to reduce the burden of care work for women.

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

Without urgent action, another generation of women in the health sector will be disadvantaged in their careers by the decision to have children. If women, not men, are assumed to be the default health worker policies will be designed for women's lives, and maternity leave and childcare support prioritized as essential employee benefits. Implementation of organizational policies to drive gender equality will include:

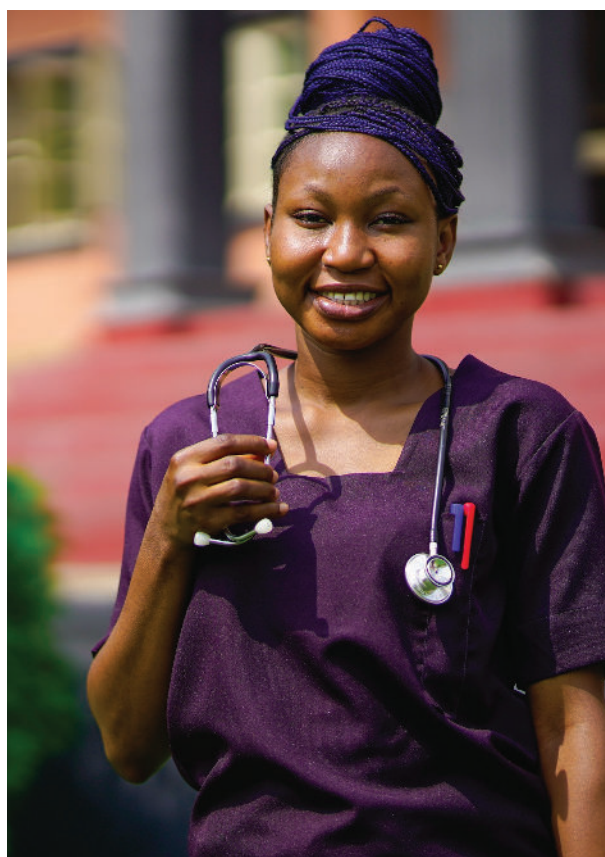
- Parental leave for women and men with entitlement to paid maternity leave in line with global minimum standards. Women in the USA currently have no entitlement to maternity leave.
- Zero tolerance of discrimination related to pregnancy. In the past year, Senegal has amended its Labor Code and now prohibits the dismissal of pregnant workers. 41 countries do not prohibit the dismissal of pregnant women.
- Support, including flexible working options for all parents and carers, to enable women to return to work. 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. 43 countries still lack this.

#### 6. Support women's movements to accelerate collective action

In the pandemic, health workers in around 100 countries went on strike for better protection and conditions. The all-women ASHA cadre of community health workers, went on strike in India to leverage better pay and PPE. Women are working together and demanding change but women's organizations typically lack financial and political resources:

- Global health donors should sustainability fund women's 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.





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

In general, there are large gaps in health worker data, especially data disaggregated by sex and other indicators to give decision-makers the evidence needed to inform policy. There is no robust sex-disaggregated data on gender equity in health leadership. Most governments do not collect sex-disaggregated data on health leadership. This report uncovered a wide range of areas for future research, and where better data is needed to inform action. WGH recommends:

- National research 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.
- More disaggregated data to understand the way different disadvantages intersect with gender in different contexts and manifest in leadership journeys.
- 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.
- Build the evidence base on how sexual exploitation, abuse and harassment adversely impacts women and leadership.

## 8. Address closing the gender gap in health leadership as the urgent and critical foundation for health systems security and health for all

Health systems remain under extreme pressure with COVID-19 still circulating, a backlog of preventative work including delivery of childhood vaccinations and routine screening plus waiting lists for deferred surgeries etc. At the same time, exhausted and demoralized health workers, especially women, are resigning from their jobs in significant numbers. There is an urgent need to put measures in place to protect and retain women health workers and build back health as an equitable sector to attract women to join and fill millions of vacant posts. We recommend:

- Collecting data and strengthening evidence to support the wider social and economic benefits of gender equity in health (the triple gender health dividend) to build a robust business case for gender equality as a sound investment in health.
- 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 the Global South.
- All health leaders adopting a gender transformative leadership approach to intentionally build equity in the health workforce and in global health decision-making roles.



# Final Word



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. Moreover, it is at crisis point due to the large and increasing health worker shortages. Health systems cannot run without health workers and the majority of health workers are women. Women health workers have made an exceptional contribution during the pandemic but health workers generally are exhausted. Women health workers are now resigning in significant numbers in high-income countries and this 'Great Resignation' is beginning to drive a 'Great Migration' of trained health workers out of low-and middle- income countries which have the greatest shortages.

Health workers in around 100 countries went on strike during the pandemic for improved pay, conditions and protection. Behind these demands, many are disillusioned and tired by having been subject to decisions made without consulting them that went against their professional training. Many women health workers have described the 'moral injury' in the pandemic of being on the frontlines with patients without the equipment, oxygen, medicines and beds to work to a professional standard in patient care. 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 XX Paradox will not change fast enough with time alone. Women working in health are being denied the fulfillment of their right to equal leadership, while health systems are being denied the expertise of leaders who know them best.

Health and care is one of the largest and fastest-growing economic sectors, employing 234 million people globally and 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. And 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. When we get this right, health can be an exemplary 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 excellent investment.



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

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

## About WGH



Women in Global Health (WGH) is the fast-growing women-led movement demanding gender equity in global health. While women represent 70% of the workforce and about 90 percent of front-line health workers, they hold just a quarter of leadership positions. Now with supporters in more than 100 countries and 45+ official chapters predominantly in low-income countries, Women in Global Health campaigns for equal representation for women in health leadership; equitable pay and ending unpaid work for women health workers; protection and safe and decent work; and the prevention of sexual exploitation, abuse and harassment. These are the essential foundations for strong health systems, Universal Health Coverage and global health security.



For more information: [www.womeningh.org](http://www.womeningh.org)

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