DELIVERED BY WOMEN, LED BY MEN:

A GENDER AND EQUITY ANALYSIS OF THE GLOBAL HEALTH AND SOCIAL WORKFORCE

Human Resources for Health Observer Series No. 24

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Delivered by women, led by men: A gender and equity analysis of the global health and social workforce.

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Foreword: Women in Global Health as co-chair of Gender Equity Hub

On behalf of Women in Global Health I am delighted to receive this important report and acknowledge the many expert partners who gave their time to generate the evidence that will underpin gender equality in health, and therefore better global health.

When I graduated as a medical doctor I knew I was standing on the shoulders of the pioneer women who had fought their way into medicine and carved a path for me and other women. In some countries this is very recent history, since women did not qualify as doctors until the 1940s.

Today women account for 70% of the health and social care workforce and deliver care to around 5 billion people. But as this report shows, despite progress, women remain largely segregated into lower-status and lower-paid jobs in health, are subject to discrimination, and, in some contexts, are under the constant threat of violence. Global health is delivered by women and led by men, and that is neither fair nor smart.

Large numbers of women in health are working without the protection of legislation to guarantee them decent work and equal pay. Many are underpaid or unpaid. The gender pay gap in the health sector is higher than other sectors despite it being a female-majority profession.

Disadvantage is multiplied by the intersection of gender with race, ethnicity, caste, or religion – depending where you are in the world.

We cannot wait for the global health system to correct its own course. Approximately 40 million new health and social care jobs will be needed by 2030 to keep up with changing demographics and increased demand for health. Around 18 million health and social care jobs must be filled in low-income countries to reach the Sustainable Development Goals (SDGs) and achieve the game-changing ambition of universal health coverage. Gender-transformative change is needed to stop the leakage in the pipeline and loss of female ideas and talent. Similarly, we want to increase male talent and perspectives in fields such as nursing where men are underrepresented.

Doing things differently by addressing gender inequities in global health and investing in the global health and social workforce will have a wider multiplier effect, offering a "triple gender dividend" comprising the following.

- **Health dividend.** We can fill the millions of new jobs that must be created to meet growing demand and reach universal health coverage and the health-related SDGs by 2030.
- **Gender equality dividend.** Investment in women and the education of girls to enter formal, paid work will increase gender equality and women's empowerment as women gain income, education and autonomy. In turn, this is likely to improve family education, nutrition, women's and children's health, and other aspects of development.
- **Development dividend.** New jobs will be created, fuelling economic growth.

This gender dividend, once realized, will improve the health and lives of people everywhere. The health and social care worker shortage is global. This is everybody's business.

As co-chair of the Gender Equity Hub with WHO, Women in Global Health are pleased to work in the vanguard with WHO and our partners to catalyse gender-transformative policy change for better global health.

Dr Roopa Dhatt
Co-chair of the Gender Equity Hub
Executive Director and co-founder of Women in Global Health

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Abbreviations

AFRO	WHO Regional Office for Africa
EMRO	WHO Regional Office for Eastern-Mediterranean
EURO	WHO Regional Office for Europe
G7	Group of Seven
GDP	gross domestic product
GEH	Gender Equity Hub
ILO	International Labour Organization
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
SDG	Sustainable Development Goal
SEARO	WHO Regional Office for South East Asia
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

Executive summary

Demographic changes and rising health care demands are projected to drive the creation of 40 million new jobs by 2030 in the global health and social sector. In parallel, there is an estimated shortfall of 18 million health workers, primarily in low- and middle-income countries, required to achieve the Sustainable Development Goals (SDGs) and universal health coverage. The global mismatch between health worker supply and demand is both a cause for concern and a potential opportunity. Since women account for 70% of the health and social care workforce, gaps in health worker supply will not be closed without addressing the gender dynamics of the health and social workforce. The female health and social care workers who deliver the majority of care in all settings face barriers at work not faced by their male colleagues. This not only undermines their own well-being and livelihoods, it also constrains progress on gender equality and negatively impacts health systems and the delivery of quality care.

In November 2017, the World Health Organization (WHO) established the Gender Equity Hub (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 workforce, in support of the implementation of the Global Strategy on Human Resources for Health: Workforce 2030, and the Working for Health five-year action plan (2017–2021) of WHO, the International Labour Organization (ILO) and the Organisation for Economic Co-operation and Development (OECD).

In 2018, the GEH identified and reviewed over 170 studies in a literature review of gender and equity in the global health workforce, with a focus on four themes: occupational segregation; decent work free from bias, discrimination and harassment, including sexual harassment; gender pay gap; and gender parity in leadership.

This report will inform the next phase of the work of the Global Health Workforce Network GEH, which seeks to use these research findings to advocate gender-transformative policy and action.

Key findings from the four thematic areas of the review

The key findings in each of the four thematic areas covered by the GEH review are summarized in Figure ES.1 and covered in detail in Chapters 3–6 of this report.

Overarching findings and conclusions from the review

In addition, the report identified eight overarching findings and conclusions, summarized in Figure ES.2 and further elaborated in the text below.

- Most of the 170 studies found and reviewed in this report come from anglophone high-income country contexts and are unlikely to be applicable to other contexts.
- There are gaps in data and research from all regions but the most serious gaps are in low- and middle-income countries. This is a major concern, since the most rapid progress in health is needed in low- and middle-income countries to reach the SDGs, attain universal health coverage and achieve the health for all targets by 2030.
- Widespread gaps in the data and literature were found in countries of all income levels on implementation research, application of gender-transformative policy measures, and good practice on addressing health system deficiencies caused by gender inequality.
- Major gaps and lack of comparable data were found in countries from all regions. Examples include sexual harassment and gender pay gap data.
- Studies were limited in methodological approaches. Few used an intersectional approach to examine how gender disadvantage in the health workforce can be compounded by other social identities such as race and class.

Figure ES.1 Key findings of GEH review of female health workforce, by thematic area

Figure ES.2 Overarching findings and conclusions of review

- Occupational segregation by gender in the health sector, driven by gender inequality, is pronounced, and in turn is the foundation for other gender inequalities identified in this report (such as the gender pay gap). Although women hold around 70% of jobs in the health workforce they remain largely segregated vertically, with men holding the majority of higher-status roles. Female health workers are clustered into lower-status and lower-paid (often unpaid) roles and are further disadvantaged by horizontal occupational segregation driven by gender stereotypes branding some jobs suitable for women (nursing) or men (surgery). Women are triply disadvantaged by social gender norms that attach lower social value to majority female professions, which, in turn, devalues the status and pay of those professions.

- Despite women being the majority of the global health and social workforce, the role of women as drivers of health is often unacknowledged. This contributes to a lack of priority given to addressing gender inequality in the health and social workforce. Gender-transformative policies and measures must be put in place if global targets such as universal health coverage are to be achieved. Also largely unacknowledged is the burden of unpaid health and social care work typically done by women and girls. Women's unpaid work forms an insecure foundation for global health.

- A key conclusion of this report is that gender inequality in the health and social workforce weakens health systems and health delivery. These gender inequities, however, can be fixed, and an alternative, positive future scenario is possible.

Adopting gender-transformative policies, addressing gender inequities in global health, and investing in decent work for the female health workforce offer a wider social and economic multiplier – a "triple gender dividend" – comprising the following.

- **Health dividend.** The millions of new jobs in health and social care needed to meet growing demand, respond to demographic changes and deliver universal health coverage by 2030 will be filled.

- **Gender equality dividend.** Investment in women and the education of girls to enter formal, paid work will increase gender equality and women's empowerment as women gain income, education and autonomy. In turn, this is likely to improve family education, nutrition, women and children's health, and other aspects of development.

- **Development dividend.** New jobs will be created, fuelling economic growth.

This triple gender dividend will improve the health and lives of people everywhere. The health and social care worker shortage is global, and addressing gender inequality in the health workforce is everybody's business.

Key messages from this review

The following key messages emerged from this review.

- In general, **women deliver global health and men lead it.** Progress on gender parity in leadership varies by country and sector, but generally men hold the majority of senior roles in health from global to community level. Global health is predominantly led by men: 69% of global health organizations are headed by men, and 80% of board chairs are men. Only 20% of global health organizations were found to have gender parity on their boards, and 25% had gender parity at senior management level. Health systems will be stronger when the women who deliver them have an equal say in the design of national health plans, policies and systems.

- **Workplace gender biases, discrimination and inequities are systemic, and gender disparities are widening.** In 2018 it was estimated that workplace gender equality was 202 years away – longer than 2016 estimates. Many organizations expect female health workers to fit into systems designed for male life patterns and gender roles (with, for example, no paid maternity leave), and many countries still lack laws on matters that underpin gender equality and dignity at work, such as sex discrimination, sexual harassment, equal pay and social protection.

- **Women in global health are underpaid and often unpaid.** It is estimated that women in health contribute 5% to global gross domestic product (GDP) (US$ 3 trillion), out of which almost 50% is unrecognized and unpaid. The World Economic Forum *Global gender gap report 2018* estimates the average gender pay gaps by country at around 16%. The unadjusted gender pay gap appears to be even higher in the health and social care sector, estimated at 26% in high-income countries and 29% in upper middle-income countries. The gender pay gap in men's favour is nearly universal and largely unexplained. It has a lifelong economic impact for women, contributing to poverty in old age. In sectors that are female dominated, work is typically undervalued and lower paid.

- **Workplace violence and sexual harassment in the health and social sector are widespread and often hidden.** Female health workers face sexual harassment from male colleagues, male

patients and members of the community. It is often not recorded, and women may not report it due to stigma and fear of retaliation. Violence and harassment harms women, limits their ability to do their job, and causes attrition, low morale and ill-health. In Rwanda, female health workers experience much higher rates of sexual harassment than male colleagues, and in Pakistan, lady health workers have reported harassment from both management and lower-level male staff.

- Occupational segregation by gender is deep and universal. Women dominate nursing and men dominate surgery (horizontal segregation). Men dominate senior, higher-status, higher-paid roles (vertical segregation). Wider societal gender norms and stereotypes reinforce this. Occupational segregation by gender drives the gender pay gap and leads to loss of talent (for example, with few men entering nursing).

Key recommendations

- It is time to change the narrative. Women, as the majority of the global health and social care workforce, are the drivers of global health. Research and policy dialogues on gender and global health to date have neglected this reality and have focused on women's health and women's access to health (both vitally important). It is critical to record and recognize all the work women do in health and social care – paid and unpaid – and bring unpaid health and care work into the formal labour market. Women form the base of the pyramid on which global health rests and should be valued as change agents of health, not victims.

- Gender-transformative policies should be adopted that challenge the underlying causes of gender inequities. Such policies are essential to advancing gender equality in the health and social workforce. Adding jobs to the health workforce under current conditions will not solve the gender inequities that exacerbate the health worker shortage, contributing to a mismatch of supply and demand and wasted talent. Policies to date have attempted to fix women to fit into inequitable systems; now we need to fix the system and work environment to create decent work for women and close gender gaps in leadership and pay.

- The focus of research in the global health and social workforce should be shifted. Research priorities must prioritize low- and middle-income countries; apply a gender and intersectionality lens; include sex- and gender-disaggregated data; and include the entire health and social workforce, including the social care workforce. Research must go beyond describing the gender inequities to also evaluate the impact of gender-transformative interventions. Such research will aid understanding of context-specific factors, including sociocultural dimensions. Moreover, research focused on implementation and translation into policy is needed to assess the viability and effectiveness of policies and inform gender-transformative policy action.

- A mid-plan review should be aligned with the independent review of the Working for Health five-year action plan for health employment and inclusive economic growth (2017–2021) and the medium-term fiscal plan that is to be carried out in 2019 to mark the midpoint in the five-year action plan. This proposed review would involve WHO, ILO and OECD, assess progress on deliverables on gender equality, and recommend steps to ensure delivery of action plan commitments by 2021.

SECTION 1. APPROACH
Chapter 1. Introduction

1.1 Background

At present, over 234 million workers staff the health and social care sector globally *(1)*. The health and social care sector is the fastest growing employment sector for women, with women comprising seven out of ten health and social care workers *(1)*.

On average, the share of women working in the health and social care sector is nearly twice their share of the total workforce. Although the proportion of women in the workforce has steadily risen in the last quarter of a century, industry segregation patterns persist. In 2013, while the proportion of women in the workforce worldwide was only 39.5%, the proportion of women employed by the global health and social sectors amounted to 70.3%. Figure 1.1 provides a breakdown of female employment in the health and social sectors compared to the workforce as a whole across global regions *(1)*.

As the main providers of health, women deliver health care to around 5 billion people globally and contribute US$ 3 trillion annually to global health *(2)*. However, approximately half of this contribution is in the form of unpaid care work *(2)*. The reduction of mortality rates across all age groups over the past half century is largely due to the underrecognized contribution of women to health and social care *(3, 4)*. This report highlights a critical opportunity to address the gaps in our understanding of the challenges posed by gender inequality in the global health workforce. Gender analysis in global health has primarily focused on the point of service delivery and quality of care. This has largely ignored the fact that women are not only recipients of health care but are the primary drivers of health globally. This report aims to move forward the agenda of gender equality in the global health workforce. We recognize, however, significant gaps in research and data, particularly from low- and middle-income countries, that limit our evidence and conclusions.

It is essential to understand the gender-related trends and dynamics in the health workforce if we are to build resilient health systems and achieve universal health coverage *(2)*. Despite global momentum and progress on gender equality, systemic challenges, gender biases, and inequities persist in the global health workforce, predominantly to the disadvantage of women. The women who run health systems do not have an equal say with men in their design and delivery. These significant challenges have been linked to health system inefficiencies that impact the health worker training and supply pipeline, recruitment, deployment, retention, and attrition, and contribute to health workforce distribution imbalances between the formal and informal health workforce, as well as between the public and private sectors *(5)*. As a result of women in the health workforce being largely clustered into lower-status and underpaid (or unpaid) jobs, health systems lose female talent, perspectives and morale.

WOMEN COMPRISE 7 OUT OF 10 SOCIAL HEALTH CARE WORKERS

It is essential to understand the gender-related trends and dynamics in the health workforce if we are to build resilient health systems and achieve universal health coverage

The women who are employed in global health are working in very diverse health systems, settings and socioeconomic contexts. In general, the current inequality between men and women in the health workforce globally reflects the following.

- Women's employment rights in many countries are not protected by legislation governing critical areas such as equal pay for equal work, non-discrimination and collective bargaining.

- Medicine was established as a male-only profession and it has taken time for women to overcome discrimination against their entry to the profession, senior posts and better-paid specialisms.

- Unequal access of girls to education in many low- and middle-income countries, particularly to secondary schooling, has limited their access to training for formal health sector jobs.

- Gender stereotypes and norms common to all societies have driven occupational segregation, sorting men and women into different kind of jobs. For example, nursing is predominantly a women's job with men accounting for only 10% of those entering the profession, whereas men hold the majority of jobs in surgical specialties.

- Health systems and work conditions have been established to suit men's life patterns and not women's; for example, many health workers have no paid parental leave entitlement.

- Female health workers face a burden of bias, discrimination, sexual harassment and violence not faced by their male counterparts, and often not recorded or addressed.

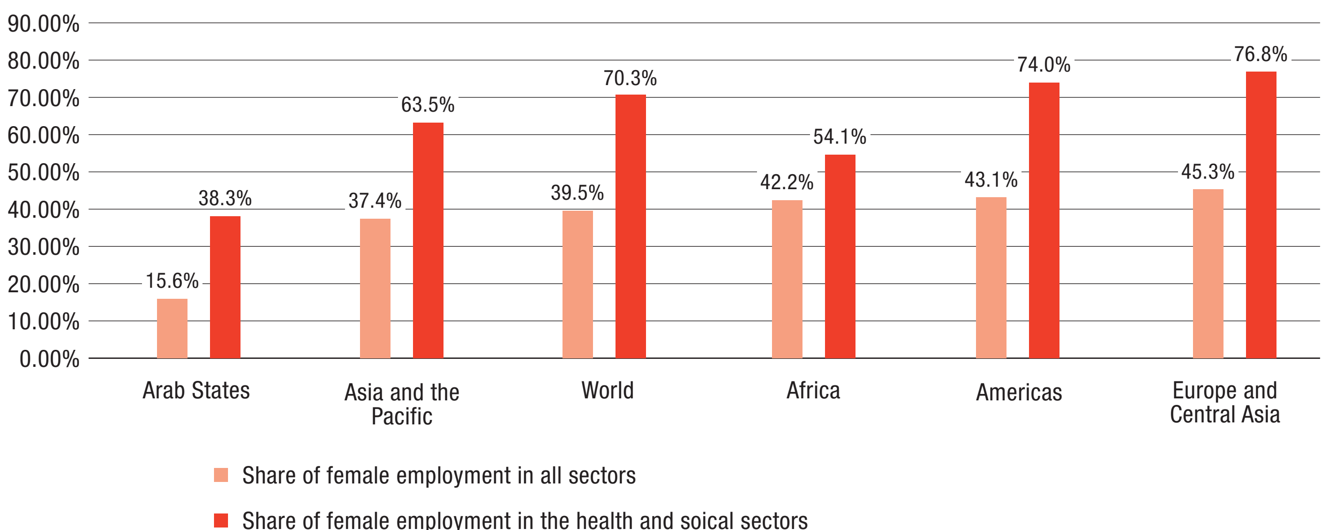
- There is a lack of data and research to highlight gender gaps in critical areas and to drive accountability and policy change.

- Political will and incentives are lacking for politicians and decision-makers in health systems to adopt the gender-transformative leadership and measures necessary to drive equality among people of different genders, and among other marginalized identities based on race, caste, class, ethnicity or religion.

All these factors have been obstacles to gender equality in the health workforce.

According to projections of the World Health Organization (WHO) Global Strategy on Human Resources for Health *(6)* and the World Bank, 40 million new jobs in health and social care will be created globally by 2030 to meet rising demand driven by demographic changes, while a shortfall of 18 million health workers will need to be addressed, primarily in low- and lower middle-income countries, by 2030 to enable countries to reach the Sustainable Development Goals (SDGs) and achieve universal health coverage *(7, 8).* To address this shortfall, major investments in the health workforce and acknowledgement of women's contributions as drivers of health care are needed. The WHO SDG Health Price Tag study estimates that investments of US$ 3.9 trillion are needed by 2030 to increase the prospects of achieving the health-related SDGs (investing US$ 51 per capita in upper middle-income countries, US$ 58 per capita in lower middle-income countries and $76 per capita in low-income countries) *(9).* About half of these investments are required in the form of

Figure 1.1 Share of women employed in the health and social sectors compared to share of women employed in all sectors by ILO region, 2013



Source: International Labour Organization *(1).*

training, educating and employing health workers *(9)*. Investing in the health workforce maximizes women's economic empowerment and participation, extends universal health coverage, contributes to global health security, and also has a powerful multiplier effect on economic growth *(10)*. Moreover, addressing gender biases and inequities in the health workforce is essential not only for achieving SDG 5 (gender equality) and SDG 3 (health and well-being), but also for achieving other SDGs, such as SDG 4 (quality education) and SDG 8 (decent work and inclusive economic growth) (Figure 1.2) *(11)*.

As health systems around the world are facing a growing mismatch between health worker supply and demand, the time is right for the global health community to take collective action. Recent global health and workforce strategies are recognizing the critical importance of addressing the gender challenges of the health workforce as key to achieving universal health coverage by 2030, and maximizing women's economic empowerment and participation. This evidence is facilitating a new narrative on the health workforce, shifting the focus from health as a cost and a drag on the economy to health as an investment and multiplier for inclusive economic growth *(3)*.

The three major global efforts seeking to address the health workforce and gender are as follows.

- WHO Global Strategy on Human Resources for Health: Workforce 2030. The Global Strategy was developed to advance progress towards attainment of the SDGs and universal health coverage by ensuring equitable access to health workers. The Global Strategy calls for the alignment of gender, employment, education and health with national human resources development and health system strengthening strategies *(6)*. It argues that the projected global deficit of health workers, coupled with rising demand to create approximately 40 million new health care jobs by 2030, uniquely positions the health and social sector to offer substantial and tangible opportunities for decent work, gender equity and greater women's labour participation.

- United Nations High-Level Commission on Health Employment and Economic Growth. The High-Level Commission, established by the United Nations Secretary-General in 2016, made the following recommendation, reaffirmed by the 61st session of the Commission on the Status of Women (2017) and the Milan Group of Seven (G7) meeting (2017) *(3)*:

Maximize women's economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.

Figure 1.2 Sustainable Development Goals

- **Working for Health five-year action plan (2017–2021).** Through the Working for Health five-year action plan, WHO, the International Labour Organization (ILO) and the Organisation for Economic Co-operation and Development (OECD) have agreed to support the implementation of the High-Level Commission's 10 recommendations. The recommendations and action plan identified (a) the development of gender-transformative global policy guidance and (b) support to build implementation capacity to overcome gender biases and inequalities in the education and health labour market as two key deliverables to maximize women's economic participation and empowerment *(12)*. Gender-transformative policy requires a series of actions to be embedded at every stage of policy action (Figure 1.3 and Figure 1.4) *(12)*.

With multiple stakeholders prioritizing gender equity, it is of utmost importance that the approach to implementation is systematic, coordinated and evidence based. To facilitate this process, the WHO Global Health Workforce Network established the Gender Equity Hub (GEH).

Figure 1.3 Health workforce and gender: a theory of change

Concerted, tri-partite social dialogue

Improved health labour market data, analysis and evidence

Enhanced national health workforce strategies

Sustainable domestic and international investments

Transformation and scale up of education, skills and decent job creation towards a sustainable health workforce

Source: Based on WHO *(12)*.

Figure 1.4 Working for Health programme: a global movement for gender-transformative workforce development

1 Vision: Accelerate progress towards universal health coverage and the SDGs by ensuring equitable access to health workers within strenchened health systems

2 Goals: (1) Expansion;
(2) TRansformation of the health and soical workforce

3 Orgs: ILO, OECD, World Health Organization

4 SDGs: 3, 4, 5, 8

5 Work streams:
(1) Advocacy, social dialogue and policy dialogue
(2) Data, evidence and accountability
(3) Education, skills and jobs
(4) Financing and investments
(5) International labour mobility

Source: Based on WHO *(12)*.

1.2 Gender Equity Hub (GEH)

The development of evidence-based gender-transformative global guidance and its implementation requires a collective and concerted effort. The WHO established the GEH at the fourth Global Forum on Human Resources for Health held in November 2017. The GEH brings together key stakeholders to support the implementation of the WHO Global Strategy on Human Resources for Health and to achieve the deliverables of the Working for Health five-year action plan. The purpose of the GEH is to accelerate large-scale gender-transformative progress to address gender inequities and biases in the health and social care workforce in order to achieve the SDGs. The GEH works in tandem with the other thematic hubs of the Global Health Workforce Network, focused on topics identified as crucial for progressing the WHO Global Strategy and the Working for Health programme.

The GEH is co-chaired by WHO and Women in Global Health. Women in Global Health is a not-for-profit organization built on a global movement that brings together all genders and backgrounds to achieve gender equality in global health leadership. The GEH includes members from a range of global health stakeholders, including intergovernmental and multilateral agencies, civil society organizations, academic and research institutions, think tanks, foundations, the private sector, and individual experts. Its main objectives are to advance knowledge, data and research on gender and the health workforce; develop tools to promote gender-transformative approaches; and accelerate progress on addressing gender inequities and bias. The four key GEH priority areas were identified through a consultative workshop held at the fourth Global Forum on Human Resources for Health (Box 1.1). The major activities of the GEH were defined by examining areas of comparative advantage, identifying gaps in existing work, and addressing high-priority needs. Additionally, key activities needed to drive evidence-guided policy change were identified (Box 1.2).

Box 1.1 Global Health Workforce Network Gender Equity Hub: priority areas

- Occupational segregation
- Decent work: workplace free from bias, discrimination and all forms of harassment, including sexual harassment
- Gender pay gap
- Leadership and governance

Box 1.2 Global Health Workforce Network Gender Equity Hub: five key activities

- Mapping: global evidence on good practice
- Data, evidence and accountability: evaluating current data and evidence, and identifying gaps for future research and development
- Policy tools: developing policy briefs and tools
- Dissemination: advocacy, social dialogue and policy dialogue to disseminate evidence, policy tools, advocacy kits, accountability scorecards and guidance to other Global Health Workforce Network hubs
- Implementation: facilitating implementation of policy through policy workshops, business solutions and private sector engagement

1.3 Rationale for gender analysis on the health workforce

Most of the evidence and research on gender in health has focused on the demand dimension of health care, such as barriers to service access experienced by women and the impact of health expenditure discrimination on women *(13)*. The evidence base is relatively thin on the gender dimensions of the health care delivery side and the workforce. In particular, evidence from low- and middle-income countries is limited. There is also little evidence available on the social workforce. Where available, research in this area rarely extends beyond simple sex disaggregation into the more critical aspects of gender power relations in health systems and their implications for working practices, career patterns and occupational choices *(13, 14)*.

A gender-based analysis of the health workforce is important for health systems research. For research to instigate social and policy change for better health, it should aim “to transform institutions, structures, systems, and norms that are discriminatory” *(15)*. In recent years different forms and frameworks for researching gender relations have emerged, including calls for adopting an intersectionality lens that considers, in addition to gender, other identity factors that contribute to discrimination. Other approaches, such as substantive equality, emphasize the importance of considering the effects of past discrimination, recognizing that rights, entitlements, opportunities and

access are not equally distributed throughout society, and there is sometimes a need to treat people differently to achieve equal results.

For research to instigate social and policy change for better health, it ought to aim "to transform institutions, structures, systems, and norms that are discriminatory".

A gender-based analysis of the health workforce is also urgently needed to ensure that the expansion of health systems in the SDG era capitalizes on the opportunity to transition to gender-transformative health systems. Since this scale-up will focus on addressing the projected global shortage of health and social care workers by 2030, and women are the majority of workers in these sectors, gender analysis is critical to creating new jobs that will attract and retain women workers. Investing in evidence on gender aspects of human resources for health can inform global health policy-makers and institutions and encourage them to apply a gender lens to the health workforce. Effective gender-transformative health workforce policies will address discrimination and rights abuses (such as sexual harassment) that contravene good employment practice and law, eliminate the gender pay gap, address occupational segregation and increase gender-equal leadership. Gender analysis of the female health and social care workforce will enable realization of a wider gender dividend by bringing more women into paid, formal labour market jobs with a positive multiplier for the health, education, nutrition, income and empowerment of those women, their families and communities.

With global health policy responsiveness to gender lagging behind, more evidence on the gender dimensions of the health workforce is needed to support the development of evidence-based, gender-transformative health policies and actions across global health systems and institutions.

Chapter 2. Objectives and methodology

2.1 Objectives

The main objectives of this literature review are:

- to identify the available data and evidence from the literature (published and grey) on addressing gender inequities in the health workforce;
- to examine case studies, policies, tools, and strategies and their impact on addressing health workforce gender inequities and occupational segregation issues;
- to map programmes, initiatives, stakeholders, campaigns and intersectoral opportunities across the public and private sectors of relevance to addressing gender inequities and biases in the health workforce;
- to synthesize lessons learned from the evidence, programmes, initiatives and campaigns.

2.2 Methodology

Coupled with a global call for case studies, the GEH undertook a comprehensive review of peer-reviewed articles, policy briefs and programme interventions to evaluate gender and equity research within the health workforce globally. Although the GEH prioritizes gender and equity within the global health and social care workforce, the literature on the social care workforce was not explored in this report, given the limited material available. The process was as follows.

1. The GEH conducted a global call for best practices from December 2017 to January 2018. All articles, policy briefs, programmes and other interventions received were analysed. The GEH received a total of 25 submissions through this call, which included peer-reviewed publications, programme interventions, and policy briefs. All these submissions were included in the review.
2. Following the completion of the call for submissions, the GEH members provided further publications and articles to guide the literature review during February 2018 and March 2018. A total of 98 articles were received after removing duplicates.
3. A comprehensive and robust literature review was conducted from December 2017 to July 2018 utilizing a keyword search of the PubMed and Google Scholar electronic databases. Keywords used to perform the search included the following: gender, intersectionality, bias, discrimination, inequalities, harassment, sexual harassment, violence, stereotyping, gender wage/pay gaps, occupational segregation, gender parity, women's leadership in global health, health workforce, technology, corporate and finance. AND/OR Boolean operators were used to search the databases. A total of 100 additional articles were found after removing duplicates from step 1 and step 2.
4. For the articles retrieved in steps 2 and 3, paper titles and abstracts were examined using the following inclusion criteria:
   - studies published in peer-reviewed journals
   - published in the year 2000 and beyond
   - English language publications
   - articles for which the full text was available or accessible to us
   - articles that provided evidence from three other sectors: technology, corporate and finance.

Studies evaluating gender and equity dimensions in the workforce, and articles pertaining to the health workforce, were prioritized.

The search ended upon saturation of the findings.

5. A total of 170 articles were included in the review after performing steps 1 to 4.
6. We applied a structured evidence matrix and extraction tool to extract findings from the 170 articles in eight months from December 2017 to July 2018.
7. A draft report was made available for consultation from May 2018 to July 2018.

2.3 Limitations

There is a vast amount of literature, policies and programmes on gender in the workforce. However, when the scope of the search is narrowed to English language literature on gender in the health workforce, the amount of material is much more limited. The members of the Global Health Workforce Network GEH (see Annex 1) provided extensive research articles and materials to ensure the review was comprehensive. We received and reviewed very few programmes and even fewer policies during this review, with the shortage being particularly apparent for low- and middle-income countries. Literature from the social care sector was not included in this review but will be considered in subsequent reviews. Overall, there were some common trends in the limitations of the overall body of literature on gender and the health workforce, as described in the following paragraphs.

Intersectionality

The review was unable to apply a truly intersectional lens to gender in the health workforce as the evidence predominantly focused on gender, but did not provide further intersectional review, or provide additional understanding of the impact of factors such as class, race, ethnicity or religion on the health workforce.

Geographical focus

More reviews of the health workforce, particularly women in medicine, have been undertaken in the United States of America, and to some extent in Europe. However, there is limited evidence for gender in the health workforce across other regions. Additionally, there is no comprehensive global review of gender in the health workforce available. It is important to note here that the review only took into consideration evidence in English, which also imposed some limitations on the geographical scope of the evidence.

Occupational focus

The literature demonstrated a focus on women in medicine, particularly in the leadership and governance thematic area. There was limited literature on the social workforce. Within medicine, there was also a focus on specific specialties, in particular surgery. In recent years, there has been more evidence emerging on nurses, midwives and community health workers, though there is still limited information about the experiences of women in other occupations throughout the health workforce.

Sex- and gender-disaggregated data

Studies that evaluate discrimination as an aspect of gender are very challenging. In many research studies, discrimination remains implicit. The lack of data disaggregated by sex and gender within global health further elevates the problem. This has resulted in limited attention to gender discrimination within the health workforce.

Focus on women

The overwhelming majority of studies available look at gender and the health workforce focusing on women. The experiences of men and non-binary people were not found in any of the materials reviewed.

There is a need to shift the narrative and research focus away from traditional or mainstream approaches that examine the deficits in female characteristics or the perceived positive attributes of male leadership, behaviour and job preferences towards a more transformative approach that investigates the root cause of gender inequalities embedded in systems of discrimination, bias, norms, institutional systems and pay policies.

While the review was focused on the health sector to ensure that it was manageable and useful, additional evidence was drawn from other sectors included in the review methodology (such as technology, finance and corporate).

Finally, while the evidence focused on barriers that affect women in the health workforce, there is very limited information and few case studies on the application of evidence-based recommendations and policy actions to address these barriers. Many of the recommendations or solutions put forward in the evidence were based on barriers or drawn from the literature reviewed but were not tested. Further implementation research is required to assess their viability and effectiveness.

SECTION 2. KEY FINDINGS

Chapter 3. Occupational segregation

3.1 Key messages

- Occupational segregation impacts service delivery and the health system by limiting full participation of all genders in all aspects of the health workforce, fostering greater gender inequities.
- Both horizontal and vertical occupational segregation by gender are found globally in the health sector but vary depending on the context and history of the country. Occupational segregation has its roots in two cultural ideologies: gender essentialism and male primacy.
- Occupational segregation by gender is driven by long-standing gender norms that define caring as female work and portray men as more suited to technical specialisms in medicine.
- Gender discrimination is a primary reason for women not entering higher-earning medical specialties or taking leadership roles, while gender stereotypes deter men from joining female-majority professions such as nursing.
- The horizontal and vertical dimensions of occupational segregation combine to cluster women into lower-paid and lower-status work, with a lifelong impact on their earnings and economic security in old age.
- Female-dominated professions, including caregiving and nursing, tend to be given lower social value by gendered social norms, and are therefore associated with lower pay and prestige.

3.2 Occupational segregation: literature review

Occupational segregation is the first of the four workforce themes prioritized by the GEH. The concept of "sex segregation" was first introduced by Gross (1968) to elaborate the differences in the kinds of jobs men and women undertake, on the basis of both supply-side factors such as personal choice and demand-side factors such as discrimination in the workplace *(16)*. Prior to this the word "segregation" was used primarily in reference to separation of races. Segregation is a fundamental pathway to social inequalities that not only separates different groups based on their demographic characteristics such as gender, race or class, but also forms a basis for discrimination and bias *(17)*.

Occupational segregation impacts all genders and their experiences in labour markets. Gender segregation manifests itself in various forms, ranging from a narrower set of choices and job opportunities for specific genders to stereotypes that result in gender pay gaps and reinforce unequal power structures within a society *(18)*. It is one of the most enduring aspects of labour markets across the world and exists in diverse political, economic, cultural and religious settings *(17)*.

Women account for 70% of the health workforce, but they are mostly concentrated in nursing and midwifery professions, while far fewer are physicians

There are two types of occupational segregation: horizontal segregation and vertical segregation *(19)*. The levels of segregation are determined by size of occupation, gender composition of the workforce and distinctions in occupational settings *(16)*. It is important to assess segregation by examining both within occupational categories and across categories. For example, women account for 70% of the health workforce but they are mostly concentrated in nursing and midwifery professions, while far fewer are physicians *(20)*. According to UN Women, globally women are concentrated in service jobs (61.5%) as compared to agriculture (25%) or industry (13.5%), and women occupy fewer leadership roles as parliamentarians (23%) or as chief executive officers (4%) compared to men *(21)*. Figure 3.1 depicts women's share of selected occupations in the United States in

2012 *(22).* While women are highly represented as dental assistants, nurses, and even pharmacists, they make up less than half of the physicians and surgeons in the United States *(22).*

Patterns of occupational segregation, especially women's participation in the formal labour market, vary significantly by region and country, and are influenced by culture, income levels, local law and other factors such as education or qualifications. Figure 3.2 highlights how occupational segregation can vary significantly by country, as evidenced by the share of female doctors in each OECD country *(23).*

The gender stereotype that assigns men the role of breadwinner while women are prescribed the role of homemaker and child care is still dominant and pervasive in many cultures. This stereotype remains the leading cause of occupational segregation, as it either devalues women's contributions in the labour force or limits their participation in the workforce. Moreover, a range of inequities emerge as a result of gender segregation; for example, female-dominated jobs are associated with lower salaries, fewer on-job trainings and limited opportunities to exercise authority (16). The concept of occupational segregation is applicable to all people, regardless of whether they live in high-income countries or low-income countries *(17).* However, the patterns of segregation may differ. For example, in high-income countries women are concentrated in health, education, wholesale and retail, while in low-income or lower middle-income countries they are concentrated in the agriculture sector *(21).* Occupational segregation in the health and education sectors is significantly more disproportionate in high-income countries compared to upper middle-income, lower middle-income, and low-income countries, as seen in Figure 3.3 *(24).*

Occupational segregation has historically been attributed to factors such as investments in human capital, social norms and stereotypes, comparative advantages men have over women due to their physical and biological characteristics, and the differences in income levels between men and women *(25).* Women have had to struggle to gain their basic rights to education and economic opportunities *(26).* Women were also banned from entering different professions, including medicine. For example, in the United Kingdom, women were not allowed to enrol in medical schools until the late 19th century. Realizing that the only pathway for women in the United Kingdom to enter the medical profession was through nursing education, Elizabeth Garrett gained her nursing qualification in 1865 and later became the first woman to qualify as a doctor *(27).* The first woman to register as a medical doctor in the United States was Dr Elizabeth Blackwell in 1858, and even then, she obtained a foreign degree to do so. In some countries it took until the 1940s before a woman was able to qualify as a doctor. Restrictions on women's entry to specific professions and types of work continue today but vary significantly across regions.

Men and women also spend very different amounts of time on unpaid care work, with women spending between 2 and 10 times more time

Figure 3.1 Women's share of selected occupations (2012)

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Pre-Kindergarten Teachers
Dental Assistants
Registered Nurses
Libraians
Cashiers
Bus Drivers
Pharmacists
Photographers
Mail Carriers, Post Office
Physicians and Surgeons
Lawyers
Computer Programmers
Civil Engineers
Carpenters

Source: Based on data from Hegewisch and Hartmann *(22).*

Figure 3.2 Share of female doctors by OECD country (2015)

Japan
Korea
Luxemburg
United States
Iceland
Australia
Belgium
Chile
Switzerland
Turkey
Italy
Greece
Canada
Isreal
Ireland
New Zealand
France
German
United Kingdom
Norway
OECD34
Austria
Sweden
Denmark
Spain
Netherlands
Portugal
Czech Republic
Hunary
Poland
Slovak Republic
Finland
Slovenia
Estonia
Latvia

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0%

Source: based on data from OECD Health Statistics 2018.

Figure 3.3 Male and female employment (%) in health and education sectors (2015)

35%
30%
25%
20%
15%
10%
5%
0%

Low Income
Lower-Middle Income
Upper-Middle Income
High Income

Male Employment
Female Employment

Source: Based on data from ILO *(24)*.

on unpaid care compared to men, depending on the country. This unequal division of unpaid care work is associated with gendered social norms of femininity and motherhood *(28)*. Time use surveys or data reveal that women spend more time on unpaid care and household work compared to men *(29)*. In general, women carry out almost three more hours of unpaid work per day than men *(29, 30)* (Figure 3.4). For example, women are expected to take care of their families, home, children, or elderly relatives. In lower-income countries, women are more likely to spend time on chores such as collecting firewood and water; travel related to household activities; or grocery shopping *(29)*. Unpaid care work is directly correlated with occupational downgrading, whereby women remain segregated into part-time or vulnerable working conditions *(31)*. Figure 3.5 displays a breakdown of minutes per day spent on paid and unpaid work between men and women in selected OECD countries *(32)*.

Unpaid and informal work makes up nearly half of women's contributions to the global health sector. In 2015, the Commission on Women and Health analysed data accounting for more than half of the world's population and found that women's financial contribution to the global health system amounted to nearly 5% of global GDP. Of this contribution, nearly half was for unpaid work, as shown in Figure 3.6. Dr Felicia Knaul, Director of the Harvard Global Equity Initiative, announced that the "findings on women's paid and unpaid financial contributions to health worldwide only begin to explore and quantify the work of women as health professionals in the paid health care labour force, and their unpaid work to support health and prevent illness undertaken in their own homes, in the homes of others, and through volunteering in the health sector" *(2)*.

While women's contributions to the global health care sector makes a substantial difference to countries' economies, as well as individual and societal well-being, the ratio of paid to unpaid work means that

Figure 3.4 Average work day and unpaid work, men and women

1 Hour 30 Min

7 HRS, 47 MIN

4 Hour 47 Min

8 HRS, 39 MIN

Unpaid work

Source: Based on data from World Economic Forum *(30)*.

Figure 3.5 Paid and unpaid work (minutes per day) for men and women, by OECD country

Turkey
Mexico
India
Portugal
Italy
Australia
Japan
Ireland
Poland
Slovenia
Austria
Germany
Hungary
New Zealand
Spain
United Kingdom
Netherlands
Canada
South Africa
Estonia
Belgium
Denmark
United States
China
France
Finland
Korea, Rep.
Norway
Sweden

800 600 400 200 0 200 400 600 800

Work (minutes per day)

Unpaid work, men
Unpaid work, women
Paid work, men
Paid work, women

Source: World Economic Forum 2017, based on data from OECD social protection and well-being database.

nearly half of this work remains unrecognized and unaccounted for in decision-making. Unpaid or informal health care work, often critical to a society's health care system and well-being, routinely goes unvalued. For instance, in Spain, 88% of all health work is unpaid *(33).* The burden of unpaid work in health and social care, which falls mainly upon women and girls, limits their access to both education and paid work in and beyond the care sector, forming a "unpaid care work-paid work- paid care work" circle as shown in Figure 3.7. *(34)*

Since women and girls from socially disadvantaged groups carry a disproportionately large burden of unpaid care work; it affects both the type and quality of jobs that are available to them and reinforces their disadvantage. *(34)* These unfavourable conditions impact gender equality both within the labour market as well as in unpaid care contributions; resulting in gender segregation of jobs.

The segregation of people into occupations based on gender is reinforced by two culturally determined narratives *(35).*

- Gender essentialism: the belief that men and women are different and have different working styles and skills. This assumes, for example, that women have a natural tendency for caring, nurturing jobs while men are more inclined to be managerial or mechanical.
- Male primacy: the belief that men and boys are naturally more dominant and more status worthy compared to women and girls. Gendered barriers restrict women and girls from entering male-dominated occupations such as surgical care, while there are barriers that restrict men from entering female-dominated occupations such as education or social care *(35).*

Despite making progress towards gender equality, equal engagement of all genders in certain occupations and levels of decision-making is limited. In their book Occupational ghettos, Charles and Grusky argue that while egalitarian forces have reduced vertical segregation in "non-manual" jobs (managerial, sales or service jobs), horizontal segregation persists due to gender essentialism as women remain concentrated in non-manual jobs in the post-industrial era while men dominate the skilled trades *(36).* Women are entering male-dominated jobs at a faster rate than men are entering female-dominated occupations. Less than 10% of all registered nurses in the United States are male, though that proportion has been steadily increasing over the past 50 years, as seen in Figure 3.8 *(37).* While women face gender-based discrimination and the "glass ceiling" limiting their advancement in male-majority jobs, men who enter female-majority professions have advantages that may speed their promotion, referred to as the "glass escalator" *(38).*

Figure 3.6 Financial value of women's contribution to the global health system, as part of global GDP

2.35%
2.47%
Global GDP
Unpaid
Paid

Source: Langer et al. *(2).*

Figure 3.7 The cycle of unpaid care work–paid work–paid care work

Levels and distribution of unpaid care work impact the conditions in which unpaid carers enter and remain in paid work, and influence working conditions of care workers.

UNPAID CARE WORK

PAID WORK

PAID CARE WORK

Gender equality in the labour market, including in women's participation, employment and working conditions also imply positive outcomes for care recipients.

Care workers in adequate numbers and working conditions contribute directly to gender equality in the world of work and the redistribute unpaid care work.

Source: ILO *(34).*

The ILO 2018 report on world employment highlights that women in low- and middle-income countries are in more vulnerable forms of employment compared to men, and there are fewer employment opportunities for young people (below the age of 25 years) *(39)*. In Arab States and northern Africa, women are twice as likely to be unemployed as men *(39)*. One reason for this is labour laws that restrict women from entering certain fields. Women face more institutionalized restrictions in the workplace in some regions compared to others, such as South Asia, Middle East and North Africa, as seen in Figure 3.9 *(40)*. These differences hinder progress on gender equality. A report commissioned by the European Union determined that an acceptable level of gender gap for "gender-neutral" occupations would be a mix of men and women between 40% and 60% *(41).* The United Nations has put this benchmark between 45% and 55% *(42).*

Trends in the labour market have changed significantly, with most countries projecting growth in women's participation in the labour force. But it is a concern that globally, women's labour force participation has declined on average by 2% between 1990 and 2017 *(43).* Only high-income countries have shown an upward trend during this period, while low-income countries have fluctuated between downward and upward trajectories. While there are many variations between countries, the trend for the middle-income, low- and middle-income, and lower middle-income categories of countries is for a decline in women's formal labour market participation *(43).* There are many possible explanations, one being that as families increase their income there is pressure for women to revert to the traditional stereotype of a homemaker, or that in economic recessions women are often the first group pushed out of the formal labour market into the informal sector.

Globally, women's labour force participation has declined on average by 2% between 1990 and 2017.

3.3 Occupational segregation by gender in the global health workforce

Women in the global health workforce have an inverted career pyramid (44). Gender differences in participation in the global health workforce are driven by men's greater access to education, training and the formal labour market; historical discrimination against women's access to higher-status and higher-paid specialties, which manifests in a lack of female role models, gender stereotyping and,

Figure 3.8 United States share of nurses who are male (1970–2011)

12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

1970 1980 1990 2000 2006 2011

- Share of registered nurses who are male
- Share of licensed practical and vocational nurses who are male

Source: United States Census Bureau *(37).*

Figure 3.9 Percentage of economies that restrict women's employment, by type of restriction

- Jobs deemed hazardous, arduous or morally inappropriate
- Industry-specific restrictions (eg. in mining or construction)
- Restrictions on working during night hours

OECD High-income
East Asia & Pacific
Latin America & Caribbean
Europe & Central Asia
Sub-Saharan Africa
South Asia
Middle East & North Africa

0% 10% 20% 30% 40% 50% 60% 70%

Source: World Bank *(40).*

in some countries, formal restrictions on women's work during night hours; women's greater burden of unpaid reproductive work, which may deter them from entering some specialties; cultural stereotypes that deter men from aspiring to join majority female professions such as nursing; and gender discrimination against women in entry to higher-status specialties and leadership roles.

Globally, women are highly concentrated in primary care, nursing and midwifery, with significant variation between countries. This is an example of horizontal segregation, such as Denmark, women make up 90% of the nursing and midwifery professionals *(20)*. In addition, women account for one third of all physicians within the United States, while in Scandinavian countries women make up 45–56% of doctors, and in the Russian Federation 70% of physicians are women *(45)*. Despite a large proportion of female physicians in Russia, studies noted that far few were found to be in prestigious specialties, tertiary care and academic medicine. *(45)* The percentage of women in dentistry globally is projected to increase to 28% by 2030 (46). Horizontal segregation leads to the feminization of certain medical specialties *(47)*; women are more likely to choose the fields of paediatrics, paediatric surgery, obstetrics, gynaecology, oncology and dermatology *(48–52)*.

Globally, women are highly concentrated in primary care, nursing and midwifery, with significant variation between countries

Moreover, gender inequality within the medical workforce remains highly contested, particularly for surgical specialties, as only one third of women doctors select surgery compared to men *(53)*. One reason for this is the perception that surgical specialisms are a male domain where toxic masculinity is common, creating a hostile work environment for women. The #MeToo movement in the United States has encouraged women in medicine to come forward and share their experiences of harassment in hospitals and operating rooms *(54)*. The higher numbers of men pursuing internal medicine and hospital specialisms, plus the higher numbers of women pursuing family practice, obstetrics and gynaecology, has resulted in the gender-based segregation of men and women in medicine in the United States *(55)*. Women are increasingly entering obstetrics, while their numbers in breast surgery and urology remain low.

While there is plethora of literature investigating why men and women studying medicine pursue different specialties, most of these studies have been conducted in the United States or the United Kingdom. This limits our understanding of the factors explaining why more and more women are being excluded from different health care specialties *(53, 56)*. With large gender gaps in wages and leadership positions in health care, it is critical to understand the drivers of these patterns of occupational segregation *(57–59)*.

Horizontal segregation also impacts women in health across all occupations. In the United States, women in nursing and medicine work the same number of hours as men but earn 78% of their male counterpart's earnings *(60)*. Women health workers tend to work fewer hours than men in countries where data are available, except in the Russian Federation, where they were found to work longer hours *(60)*. In Canada, when primary care providers were compared by gender, women self-reported fewer hours of work than men, saw less patients and delivered fewer services. However, using hours as an indication of work impact did not reflect the realities that women were more likely to spend longer with their patients, and to address more problems during each visit *(61)*.

In the United States, women in nursing and medicine work the same number of hours as men but earn 78% of their male counterpart's earnings.

3.4 Factors that lead to occupational segregation

There is no single factor that can unilaterally explain gender segregation in education and the labour market *(62)*. Boxes 3.1, 3.2 and 3.3 highlight some of the individual, organizational and societal factors contributing to gender segregation.

3.5 Why occupational segregation matters

Global health policy-makers and decision-makers need to understand the factors that lead to the clustering of men and women in certain jobs. Studies have shown that organizations that adopt policies to attract, develop, compensate and retain the best talent will be the ultimate winners *(81)*. However, an analysis of the gender-related

Box 3.1 Individual factors contributing to gender segregation

EARLY DEVELOPMENT AND FAMILY RELATIONS

Early development impacts the career choices people make.

Examples

- Gender-biased toys given to children influence their interests and career choices *(63).*
- Demographics and personal values are associated with gender differences in specialty choice *(55, 64).*

WORK–LIFE BALANCE

Control of lifestyle and work–life balance influence specialty preference for women *(49, 65, 66)* and men *(67).*

Women's greater burden in terms of household work, responsibility for family, child care and protected time for breastfeeding is considered one of the drivers for occupational segregation *(55, 68).*

Examples

- Often workplaces do not have private space for feeding mothers *(69).*
- In comparison, due to decreased societal expectations of child care, men with children see less impact on their careers compared to women. Women on the other hand often have to struggle to balance expectations *(70).*

CHOICE AND INTERESTS

Gender norms also influence occupation choice and interest as students – women are encouraged to pursue a career choice based on idealism, where men are more likely to be influenced by the prospect of a good income or prestige *(48).*

Example

- The #MeToo movement has enabled many American women in medicine to come forward and admit that they chose a female-dominated specialty over a male-dominated specialty just to avoid exposure to toxic working environments.

Box 3.2 Organizational factors contributing to gender segregation

WORKING HOURS

Work scheduling challenges – such as long training hours and inflexible rotation schedules – conflict with the societal expectation that women are the primary caregivers in their families.

Examples

- It has been shown that the more inflexible or time consuming a specialty is, the more likely it is to be male dominated, as in the case of surgery *(2, 71, 72).*

WORKING CONDITIONS (AUTONOMY, WAGES, JOB SECURITY, HEALTH AND SAFETY)

Working conditions can lead to gender segregation.

Examples

- Women in male-dominated sectors tend to experience gender discrimination, differences in task allocation, fewer opportunities for promotion and lower salaries at higher frequencies *(73).*
- Fear of workplace discrimination or selection bias leads women to take lower-paying jobs.

ROLE MODELS

The paucity of female role models and lack of successful women in surgical specialty is the most often cited reason for reduced interest in surgery among female medical students.

Example

- One study found that only 35% of female medical students could identify a mentor during surgical clerkship; while in another study found that among female surgical students who had mentors, 90% had a male mentor as compared to female mentor. *(74, 75).*

INSTITUTIONAL POLICIES

Social policies such as parental leave, maternity leave, and subsidized child care also influence the career choices of men and women *(76)* and ways in which they organize personal lives *(68).*

Box 3.3 Societal factors contributing to gender segregation

GENDER STEREOTYPES

There are gender stereotypes that define characteristics of female-dominated jobs.

Examples

- There are expectations that women may be willing to take on more tasks, are less inclined to complain, and are more patient with monotonous work. Women's lower participation in labour unions keeps women in low-paying, flexible roles and in jobs that involve less decision-making *(77).*
- Overall, gender stereotypes drive institutional policies, for example with regard to parental leave, care leave, and availability of child care facilities. The lack of gender-responsive policies, combined with societal expectations, means lower retention and recruitment of women *(41).*
- The fact that certain medical specialties conform with traits seen as traditionally masculine also deters women from joining, for example the existence of the so-called "male surgeons' club" *(78).*
- When men enter occupations that are traditionally more feminine they can experience setbacks in prestige and pay. Men with children are more likely to avoid these occupations *(79).*

DISCRIMINATION

Sex and gender are important considerations for hiring and promotion *(77).*

Examples

- Women may be discouraged from taking surgery as a specialty due to discriminatory attitudes during training rotations in general surgery *(52, 78).*
- Women discriminating against women may perpetuate the cycle of gender disparity, especially within surgical care *(80).*

policies of 140 global health organizations found that only 43% had specific policies in place to promote gender equality in their workplaces, including strategies to support women's career paths. In fact, 30% of these organizations did not even mention workplace gender equality in their policies (Figure 3.10) *(82).* The time is right for global health systems and organizations to reflect on their strategies and design systems and structures that create conducive working environments where all members of the workforce can thrive and achieve their full potential.

Occupational segregation is an important workforce priority because it can lead to loss of talent and diverse voices from the workforce. Gender segregation is one of the major reasons behind shortages and surpluses of workers across occupations, as women tend to be concentrated in roles seen as caring and nurturing, while men are in technical or managerial jobs. Gender segregation is also an established source of gender inequality, as it reinforces some of the gender stereotypes associated with men's and women's gender roles, working styles and competencies. It is also linked to economic empowerment and poverty. Women often have less coverage for social protection, such as pensions, due to their absence from the labour force. They are also prone to higher levels of employment in unpaid or part-time jobs and have less access to quality employment *(39).* Men are more concentrated into higher-paying jobs in the private sector and in sectors that are less willing to provide protected leave for care needs, such as child care or elder care. Social stigma is attached to men entering more female-dominated jobs. These stereotypes limit women's participation in labour markets and, on the other hand, put significant pressure on men to not take leave, such as parental leave, when it is available to them *(18).* Gender segregation also results in lower salaries and worse working conditions in occupations dominated by women *(17).*

Gender segregation also affects the educational choices of men and women and the type of specialties they choose during medical training. Gender segregation in the health workforce has implications for the development of strong and resilient health systems that are capable of tackling health needs worldwide *(83).* The number of women enrolled in medical schools has increased over the years. Recent data from the Association of American Medical Colleges in the United States show that in 2017 women outnumbered men in medical colleges for the first time in history *(84).* Since 2015, female enrolment has increased by 4% while male enrolment has decreased by 6.7%, which indicates that the future of medicine and global health is female *(84).* However, an increase in enrolment at medical schools does not necessarily ensure a supply of health care professionals to meet population needs. For example, women continue to be underrepresented in the fields of surgery and surgical subspecialties, a trend that is found not only in the United States, but also in Canada, the Netherlands and the United Kingdom *(53, 80).*

Gender segregation in the health workforce has implications for the development of strong and resilient health systems that are capable of tackling health needs worldwide.

Figure 3.10 Do organizations have workplace gender policies?

43% have specific measures in place

30% make no reference to any measures or commitments

15% simply comply with laws

12% commit to gender equality but lack specific measures

Source: Global Health 50/50 *(82).*

Organizational structures or systems need to create enabling environments for all genders. As more women are getting trained and educated, we need to create job opportunities where all workers regardless of their gender can thrive. Similarly, we need to change mindsets around men entering female-majority jobs such as nursing. There is a need to remove labels such as "male dominated" and "female dominated" from the health and social care workforce vocabulary if we are to adopt gender-transformative approaches within the health and social care sector and achieve gender equality in this sector. Failure to address the shortage of health workers will have a crippling effect on poverty alleviation, development, and economic growth, as well as stalling progress on the SDGs and universal health coverage.

Chapter 4. Decent work without discrimination, bias and sexual harassment

4.1 Key messages

- A large percentage of women in the global health workforce face discrimination, bias and sexual harassment.
- Women are more likely to face sexual harassment in the workplace than men. For example, in the United States 30% of female medical academics reported accounts of sexual harassment compared to 4% of men.
- Many countries, particularly low- and middle-income countries, do not have a legislative framework to support gender equality at work, including laws to prohibit sexual discrimination and sexual harassment at work.
- While the #MeToo movement has encouraged more open discussion of sexual harassment in some countries, it remains a serious and widespread abuse causing attrition, loss of morale, stress and ill-health for survivors.
- Female health workers in conflicts or emergencies or working in remote areas can face violence in the course of their work, with a number of female health workers severely injured or killed every year.

> *"To reduce the gender gap and add up to US$ 6 trillion to the global economy by 2025, nations must eliminate gender biases and inequities for women at work, including in the health labour market."* James Campbell, Director, WHO Health Workforce Department, December 2017

4.2 Decent work: introduction

Decent work is the second of the four workforce themes prioritized by the GEH. SDG 8 – Decent work and economic growth – sets the agenda for full and productive employment and decent work, and for promotion of sustained, inclusive and sustainable economic growth for all as key to alleviating poverty, protecting the environment, and ensuring people's well-being *(11).* Decent work involves creating conducive work environments built on the principle of equal opportunities for all, free of discrimination, bias or harassment, including sexual harassment. This is an important goal that is a cross-cutting theme across other forms of inequalities, including occupational segregation and the gender pay gap. In the context of this paper, decent work includes work free from discrimination, bias and sexual harassment, and with equal pay within the health care workforce. The gender pay gap is discussed in Chapter 5. Addressing discrimination and bias within the global health workforce is an important step towards achieving gender equality and building stronger and resilient health systems that uphold the basic principles of human rights *(5).*

> *"By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value."* SDG 8, Decent work and economic growth, Target 8.5

With 40 million new health jobs to be created by 2030, the overarching objective is now to create jobs differently, according to the principles of decent work, and to meet the targets in SDG 8, especially Target 8.5. Currently, the majority of women in the global health workforce work under conditions that do not meet the standards for decent work, not least because of the near universal gender pay gap. So, the objective must also be to ensure that both new jobs and existing jobs in the global health workforce are upgraded to meet decent work standards, not only because it is the right thing to do but also to create a stronger foundation for better health for all.

While modern workplaces are far less dangerous and demanding than they were historically, they are manifesting discrimination and bias in subtle ways *(85).* There is a large body of research that shows women face discrimination in almost every field of science and engineering *(86).* The discrimination also varies based on career stage and field

(86). As a result, men and women have different work experiences even if they work in the same organization. For example, the expectation to work long hours, to be constantly available, to adapt to rigid career tracks and to have inflexible work schedules creates stress, reduces morale, and conflicts with the work–life balance of employees. Women are more likely to face these challenges to work–life balance than men. The difficulty of keeping up with these growing expectations pushes women to take up part-time jobs, or remain segregated into female-majority jobs, or take leave from work (85) to fulfil their caring roles at homes. Women have been observed to move towards professions that offer greater flexibility. They often have to trade off flexibility and earnings (87). Men and women may start off with the same salaries or lower gender pay gaps, but the gap increases over the course of their career due to career interruptions and differences in job experience or number of hours worked *(87).* The penalty for taking leave or time out is huge and accounts for about 67% of the total penalty from career interruptions *(87).* Highly trained women pay a higher price for returning to work after leave *(88, 89),* and working mothers are perceived to be less committed to work due to their family obligations and hence considered less desirable for hiring or promotion *(90).* When it comes to hiring or promotion decisions, gender bias against female candidates favours male candidates *(91).*

Some women at the workplace face an additional dilemma of "double jeopardy" – a double burden of discrimination, not only on account of their gender, but also because of their race or caste *(92).* Most of the expectations at work result from the gender norms and stereotypes to which men and women are assigned. As a result, men gain opportunities while women more often lose both in career progression and earnings.

4.3 Decent work in the global health workforce

The gender and power relationships that exist within and outside the health system create differences in exposure and vulnerabilities among men and women that lead to reproduction of inequalities within the health system *(84).* Power relations, based on hierarchical health systems that "rank" the value of each profession and each person, create a workplace environment that fosters a lack of decent work conditions.

Workplace violence and discrimination is also linked to the social norms that create gender hierarchies and imbalances, starting from home and progressing to society at large. Women face a disproportionate burden of violence and discrimination across all sectors *(80, 93).*

4.4 Discrimination

There are many forms of gender discrimination, including direct discrimination (for example, excluding women from decision-making and training opportunities); indirect discrimination (for example, exclusion of informal or home-based health workers from protective labour laws); sexual harassment; gender stereotyping that limits women to inferior roles and informal care roles (as in the case of community health workers); vertical and horizontal occupational segregation; wage discrimination; and benefits and working conditions discrimination *(5, 94).* Gender discrimination and inequality are key barriers to entry, re entry and retention of female health workers *(5).* Caregiver discrimination is prevalent in many forms, for example, by fee demotion for pregnant students, who are often left behind in their curriculum or practicum; or by prohibiting pregnant students from continuing education *(95).*

Literature suggests that gender discrimination and gender inequality within organizations are linked to low morale, low self-esteem, and lower productivity for the workers, and affects mental and physical health *(5, 96–98).* This gives rise to health system inefficiencies that obstruct the pipeline of qualified and skilled health workers, create recruitment challenges, and lead to absenteeism, attrition and maldistribution of the health workforce *(5).*

Gender discrimination and gender inequality within organizations are linked to low morale, low self-esteem, and lower productivity for the workers, and affects mental and physical health.

Female-majority jobs often face a greater burden of discrimination. For example, the WHO report on midwives' voices *(99)* highlights how power structures and gender dynamics should be restructured to address the needs of midwives. Midwives provide high-quality care to women, newborns and their families, but many are frustrated with their lack of voice and power to bring change. Of the nurses in the study, 36% reported not being respected by their seniors, 32% said they would like to be heard or listened to, and about 37% of midwives faced harassment at work *(99).*

Women's childbearing and family obligations also prevent them from undertaking health trainings or scholarships or enrolling in schools *(95),* often because training is not set up to accommodate the needs of workers with care responsibilities.

4.5 Bias

Women are more likely to face bias at work. It is important to note that gender is only one intersection, and that many women experience additional bias due to their race, ethnicity, culture, regional, caste or class. These types of bias lead to a double burden or "double jeopardy" faced by women with additional marginalized identities *(92).* Men can also face bias in female-majority jobs, which may result in lower status.

Gender bias in global health academia is well established. One study found that both men and women have a subtle bias towards women when it comes to hiring and promotion. Another study found that letters of recommendations are written differently for men ("his research") and women ("her teaching") *(100).* These biases exacerbate gender gaps in academic medicine. For example, women represent only 20% of deans in the top 25 global schools of medicine and 36% in the top 25 global schools of public health *(101).* Academic publishing is also a gendered system, with fewer women represented on editorial boards and as peer reviewers *(102).* Women are likely to publish less during the first decade of their scientific careers compared to men *(103).* This is evident from data revealing that men authored about 70% of the total publications on Web of Science between 2008 and 2012 *(104).*

4.6 Sexual harassment

Sexual harassment refers to unwelcome sexual advances or requests for sexual favours, whether verbal, physical or visual. There are many forms of sexual harassment: it may include hiring, firing and promotion decisions subject to provision of sexual favours, unwanted sexual advances, touching, sexual violence, and inappropriate comments or obscene remarks, which generally create a work environment for women that is hostile, intimidating and demeaning.

Men also face sexual harassment at work but women suffer the majority by far. For example, in the United States, 30% of female medical academics reported sexual harassment compared to 4% of men (Figure 4.1) *(105).* Of those who reported harassment, 47% stated that these experiences negatively impacted their career development *(105).* Female health and social care workers face harassment and violence from three sources – male colleagues, male patients and the wider community, including visitors to facilities or men in the community if they are outreach workers. The stigma in reporting cases in the health professions has created a misperception that sexual harassment cases are rare. But health systems are no exception. Nurses and community health workers have commonly been subject to sexual harassment despite the work environment being predominantly women *(106).*

Sexual harassment against female health workers appears to be a universal phenomenon. Migrant female health workers can be particularly vulnerable to violence and harassment, as can female health and social care workers in domestic settings. A review in Rwanda found that approximately 39% of health workers had faced at least one form of workplace violence, such as verbal abuse, bullying and sexual harassment, in the 12-month period prior to the study, with women disproportionately affected *(83).* In Nepal, 42% of health workers reported experiencing sexual harassment in the form of verbal and physical abuse, and almost two thirds of the health workers reported being harassed by their senior male colleagues *(96).* Lady health workers in Pakistan reported experiencing sexual harassment from both senior and junior staff, including management *(107, 108).* In the Republic of Korea, 19.7% of women in nursing reported experiencing sexual harassment, noting that the operating theatre was the most frequent place for this to occur *(109).* Women are likely to experience sexual harassment, even if they are higher in the traditional medical hierarchy. In a survey of physicians in the United States, 30% of those surveyed reported having faced a personal incident of sexual violence in the workplace *(106).* Threats of violence or harassment do not only come from sources internal to the health system; for example,

Figure 4.1 Percentage of United States medical academics reporting sexual harassment

	Percentage
Men	4%
Women	30%

1,066 recipients of NIH academic career development awards

Source: Based on Jagsi et al. *(105).*

community health workers in Kenya experienced threats of violence by husbands when providing HIV testing to wives. Cases of rape were also reported, leading to calls for security services to accompany community health workers *(108).*

Women are likely to experience sexual harassment, even if they are higher in the traditional medical hierarchy.

Sexual harassment in the workplace is difficult to combat on a global scale, given the vast differences in laws and policies addressing or penalizing sexual assault around the world. Figure 4.2 depicts the number of countries that have no laws, civil remedies, or criminal penalties for workplace sexual harassment *(110).*

Harassment is prevalent in academic medicine as well. A meta-analysis of studies on harassment and discrimination in medical training showed that around 60% of students and trainees experienced discrimination and sexual harassment during their training period *(111, 112).* A recent report from the National Academies of Sciences, Engineering, and Medicine raised concerns about the prevalence of sexual harassment in academic sciences, engineering and medicine, which threatens the integrity of education and research in these fields *(113).* The survey findings from this survey found as high as 50% of female medical students experiencing sexual harassment from faculty or staff at one of the universities in United States .

Conflict-affected countries or remote settings present unique risks to women in health care, where they are highly vulnerable to violence *(114).* In Cambodia, women in conflict-affected areas face reported risks to their personal safety, and loss of family contact *(115).* In Pakistan, female polio outreach workers have been murdered and attacked, not only causing tragic loss of life *(116)* but also stalling elimination of polio from the country. A young midwife in Nigeria was abducted and killed in October 2018 *(117).* Failure to protect front line female health workers in conflicts and emergencies inevitably restricts services to highly vulnerable women desperately in need of all health services but particularly during pregnancy and childbirth.

In Pakistan, female polio outreach workers have been murdered and attacked, causing not only tragic loss of life but also stalling elimination of polio from the country.

Sexual harassment is so prevalent it cannot be treated as an individual occurrence or aberration and needs organizational

Figure 4.2 Inadequacy of global sexual harassment laws

59 countries do not have laws prohibiting sexual harassment in the workplace

100 countries do not have civil remedies for sexual harassment in the workplace

110 countries do not have criminal penalties for sexual harassment in the workplace

Source: Council on Foreign Relations *(110).*

strategies, based on law, to address culture, prevention, accountability and support to survivors. Very few organizations keep systematic data on cases and outcomes, making it difficult to analyse the extent of sexual harassment and its impact on female health workers, and to build policy measures to eliminate it. While the #MeToo movement has built momentum towards raising the profile of sexual harassment and assault, it remains a source of stigma and taboo. The onus of proving guilt too often falls on the shoulders of the survivor. Since power remains the underlying motive behind acts of sexual harassment and violence at work *(118)*, survivors are often silenced or risk facing retaliation. Where there are no proper guidelines or policies to address incidents of sexual harassment, cases may be dealt with on an ad hoc basis, often favouring the perpetrator, who is likely to be more powerful in the system *(119).*

Due to imbalances of power, fear of not being believed, and the prospect of retaliation, survivors of harassment have often remained silent. But with the #MeToo movement, the focus has rightly shifted to addressing all forms of harassment in the workplace, including sexual harassment *(120).* Issues that were once considered taboo can now be more openly discussed in workplaces in some countries *(121).* While this gives a unique opportunity to global health policy-makers to agree and commit to institutionalizing policies and culture change to eradicate all forms of harassment and discrimination, there are still many contexts where discussions of sexual harassment are culturally inappropriate, and where women are either silenced or face the threat of losing their jobs if they report harassment (Box 4.1).

Box 4.1 Origin of the #MeToo movement

The #MeToo movement first originated in 2007, when Tarana Burke, an African American woman, launched a campaign to reach out to sexual assault survivors in underprivileged communities *(122).*

This campaign turned viral when actress Alyssa Milano converted it into a hashtag and called on followers to share their stories of sexual harassment and assault on Twitter using the phrase "Me Too" *(122).*

Alyssa Milano

If you've been sexually harassed or assaulted write 'me too' as a reply to this tweet.

Me too.

Suggested by a friend: "If all the women who have been sexually harassed or assaulted wrote 'Me too.' as a status, we might give people a sense of the magnitude of the problem."

4.7 Why addressing decent work in the global health workforce matters

Bias and discrimination rob women of opportunities but also rob health systems of female talent. This becomes everybody's problem because it impacts the quality of health systems used by all genders. Creating safe and enabling work environments where all genders can work to their full potential has huge implications for the economic productivity and well-being of populations. It would improve health workforce recruitment and productivity, as well as retention. It would also have positive effects on quality of care, which would improve patient outcomes and health system efficiencies. It is the fundamental right of health workers to have freedom to express their opinions and be able to participate and engage in improving the conditions of the health workforce. Ensuring workplaces where all female health workers are assured of safety, dignity and respect is essential to addressing global health worker shortages, meeting health care demands, and unlocking wider social and economic potential.

Creating safe and enabling work environments where all genders can work to their full potential has huge implications for the economic productivity and well-being of populations.

Sexual harassment in the workplace has a variety of negative impacts on female health workers, including on their physical and mental health. Studies have shown sexual harassment experienced during medical training can influence decisions on specialty and residency programme selection *(95).* Furthermore, this effect extends beyond the individual experiencing harassment to the health system as a whole. Examples of systemic consequences include impediment of health workers' advancement, increased stress and decreased morale and productivity, and a limited pool of health workers to deal with today's health challenges *(5, 123).* In a world needing to create an additional 40 million health and social care sector jobs there is an immediate need to record, prevent and address the causes of sexual harassment, not only because it is a human rights violation but also because it results in attrition, loss of female talent, and reduced morale and productivity. The perception that certain types of work or sectors are likely to make women vulnerable to the risk of violence and sexual harassment will affect recruitment and health worker supply. Current levels of sexual harassment are diminishing patient outcomes and creating major inefficiencies in health systems.

Chapter 5. Gender pay gap

5.1 Key messages

- Most of the gender pay gap remains unexplained by factors such as age, experience, education, number of hours worked, or specialty choice. This suggests discrimination and bias against women and in favour of men.
- The unadjusted pay gaps in health and social care, estimated at 26% in high-income countries and 29% in upper middle-income countries, are higher than other economic sectors.
- Occupational segregation by gender, with women tending to be clustered into lower-status and low-paid sectors and specialisms in health, is associated with a gender pay gap in favour of men.
- Equal pay for equal work legislation and strong collective bargaining, absent in many countries, are essential for addressing the gender pay gap in the health sector.
- The gender pay gap results in lower lifetime income for women, reduced access to pay-related social and health benefits (where they exist), and increased poverty for women in older age.
- Women's economic inclusion, and therefore closing the gender pay gap, is critical to achieving the SDG overarching objective of leaving no one behind.

5.2 Gender pay gap: introduction and background

The gender pay gap – the third theme prioritized by the GEH – refers to the difference in average earnings between men and women. Equal pay refers to men and women performing the same role receiving the same pay – that is, equal pay for work of equal value (Figure 5.1).

Gender pay equity was first defined by the ILO Equal Remuneration Convention, 1951 (No. 100), which aimed to ensure that the work done by men and women was compensated equally *(124–126)*. The Convention was the first of its kind, recognizing that women were on the front line of production during the Second World War in many countries and that there was a need to address gender pay discrimination if equality was to be achieved *(125)*. Almost 70 years later the Convention is still relevant, as differences in pay remain the most prevalent form of discrimination against women.

Figure 5.1 Equal pay versus the gender pay gap

EQUAL PAY VS. THE GENDER PAY GAP

Means that mean and women performing the same role must receive the same pay

$ = $

Indicates the difference in average earnings between men and women

*for representation purposes only

Currently, awareness of the gender pay gap and the implications for women of unequal pay are of higher profile politically than ever before, and a global framework for action has been set within the SDGs. SDG Target 8.5 aims to achieve "equal pay for work of equal value" by 2030. Also, 2017 saw the launch of the Equal Pay International Coalition, a multistakeholder partnership including ILO, UN Women and OECD, established to drive concerted action to close the gender pay gap. WHO is currently working with the ILO to analyse labour force survey data for around 104 countries to generate more insights.

At the meeting of the G7 held in Canada 2018, commitments were made to prioritize action on the gender pay gap as a way to achieve economic equality. Measures such as prohibiting employers from asking about previous salaries and ensuring some form of transparency on pay determinations were prioritized. Following this, gender equality and women's empowerment, including reducing the gender pay gap, have been put onto the agenda for the 2019 G7 meeting in France *(127)*. Similarly, recognizing that no Group of Twenty (G20) country has yet closed the gaps in women's economic participation, a political commitment was made by the G20 to reduce these gaps by 25% by 2025 *(128)*.

The SDG uses average hourly earnings for men and women as its measure (Indicator 8.5.1). Differences in the methodology used lead to different estimates of the gender pay gap. A 2018 ILO report on the gender pay gap comparing average (mean) hourly wages for men and women from 73 countries found a global gender pay gap of 16% *(129)*. Using a measure comparing median earnings of men and women, however, increased the gap to 22%. A complementary measure, the weighted gender pay gap, allows for the clustering of men and women into different occupations, analyses gaps in occupational subgroups and then weights them reflecting the size of each subgroup in the total workforce. Using this methodology, the mean hourly gender pay gap identified by the 2018 ILO data was positive in all but two countries, and the mean hourly global gender pay gap increased from about 16% to 19% *(129)*. Clearly, adopting the same measure would facilitate cross-country comparisons.

It is important to control for the difference in hours worked by men and women and divide total compensation by hours worked to assess the gender pay gap, since men may work more hours than women. Women are more likely to work part time than men where the option is available. Hourly wages, however, do not include bonuses, stock options, and other forms of compensation that may be included in annual salaries, particularly for higher-level positions. Since men are more likely to hold positions of leadership where such benefits are available, total compensation is a better measure than hourly wages *(130, 131)*.

It is also important to note that the gender pay gap, by definition, measures paid work and so omits the substantial amount of unpaid health and social care work done by women. In Lesotho, in response to the increase in HIV/AIDS, women were expected to take up most of the informal and predominantly unpaid care. There was no expectation that men would work for free *(108)*. Including unpaid work would substantially increase the gender pay gap between men and women.

UN Women concluded that globally women earn 77 cents for every dollar earned by men – a gap that will take an estimated 70 years to close *(132)*. In high-income countries women earn 75% of the pay of their male counterparts, and in low-income countries, 83% *(133)*. ILO's 2018 report found significant differences between countries, with the mean hourly gender pay gap ranging from 34% in Pakistan to –10.3% in the Philippines, meaning that women in the formal labour market in the Philippines earn 10% more on average than men *(129)*.

Globally women earn 77 cents for every dollar earned by men – a gap that it is estimated will take 70 years to close.

Most of the studies evaluating the gender pay gap and the factors contributing to wage differentials between men and women have been based on data from high-income countries, especially the United States. Due to limited data from low-income countries, there are very few cross-country or regional comparisons. Currently the few comparative studies that exist have compared high-income countries, such as European countries *(134)*.

As shown in Figure 5.2, the OECD collects data on the gender wage (pay) gap for selected countries, with the highest gender wage (pay) gaps found in Republic of Korea 34.6 %, Estonia 28.3%, and Japan 24.5 %, and the lowest found in Romania 1.5 %, Costa Rica 3.0 % and Luxembourg 3.4 % *(135)*. Despite limitations, the current evidence provides lessons to draw from and highlights the need for more research to understand the factors driving variations in the gender pay gap across and within countries and occupations, particularly in low-income countries.

Figure 5.2 Gender wage gap by country

Romania
Luxembourg
Bulgaria
Slovenia
Denmark
Norway
Colombia
Hungary
France
Ireland
Spain
Cyprus
Netherlands
Portugal
Slovak Republic
Czech Republic
Finland
United States
EU (28 countries)
Latvia
Japan
Korea

0 10 20 30 40

Note: 2017 or latest available data; based on data from OECD 2017 (https://data.oecd.org/earnwage/).

5.3 The gender pay gap in the global health workforce

In global health there is limited evidence on the gender pay gap and an urgent need to understand it better. Evidence from low- and middle-income countries is particularly limited. The 2017 *Global gender gap report* estimated the average gender pay gap by country at between 16% and 21% *(30, 127)*. Figures from the ILO, however, on the unadjusted gender pay gap in the health and social care sectors, estimate it at higher than other sectors, at 26% in high-income countries and 29% in upper-middle countries *(1)*. Employment sectors with a majority of female employees, such as health and social care, are typically given lower social value and paid less. More evidence with better methodologies is needed, particularly from low-income countries, to identify gender pay gaps in the health and social sectors, assess the causes and translate evidence into effective policy measures.

The gender pay gap varies across different occupations within health care. In the United States, the health care industry has one of the largest gender pay gaps for any sector, and there are also large differences in wages between professions in health *(134)*. In the United States, the number of women pharmacists has increased but the gender pay gap persists *(136)*. The gender pay gap still existed amongst academic pharmacists, even after allowing for qualifications and years of service. Similarly, the number of women taking up anaesthesiology in the United States is increasing but female anaesthesiologists still earn 25% less than their male counterparts compared with a 17% gap for all physicians *(137–139)*. One study conducted in medical faculties in the United States concluded that women were less likely to become full professors compared to men and earned lower wages even after controlling for observable factors *(140)*. A recent survey of 65 000 physicians in the United States revealed that women doctors earned an average of 27.7% less than their male counterparts in 2017, a total average of US$ 105 000 less in a year *(141)*. One study from Australia found the average gender pay gap to be 16.7% *(142)*. Even in health sectors where women play a large role, such as dentistry, they continue to earn less than their male colleagues *(45, 143)*.

A study from Australia showed that gender pay gaps tend to be wider in high-paying jobs, and that men receive higher returns to schooling compared to women *(142)*. Association between the gender pay gap and "family gap" is also significant *(144)*. While pay for fathers increases with the number of children, every additional child a woman has is associated with a drop in pay *(144)*. The most likely explanation for this is that men with children are considered to be more committed to their work, and thus deserving of and more

likely to be offered higher wages, whereas women with children are considered less committed. Gaps vary, based on income levels, with wider gaps amongst low-income women. Thus, the women who can least afford it are not seen as deserving by employers and perceived to lack commitment *(142, 144).*

Research also highlights that the gender pay gap between men and women in medicine is connected with gender differences in specialty choice and hours worked. However, recent studies suggest the gender gaps in physician salaries persist even after controlling for specialty, practice type, and hours worked *(138)*. Women physicians also faced trade-offs between career and family: one study found that women physicians earned 11% less if they were married; 14% less if they had one child; and 22% less if they had more than one child *(145).* On one hand, there are studies that show the gap in wages converges after controlling for observable factors such as specialty and numbers of hours worked; while other studies show a disparity in physicians' starting salaries. Limitations in these studies, due to methodological differences or lack of comparable data, make it difficult to draw conclusions, except that more and better research is needed to identify gender pay gaps by men and women in comparable jobs, medical sectors and levels, and the drivers of those gaps.

Figure 5.3 *(37)* shows the average female nurse earnings as a percentage of men's earnings, indicating that on average across all nurse occupations women earned only 91% of what men earned.

Figure 5.3 Female earnings as a percentage of men's earnings among full-time, year-round nurses (2011)

Registered nurses
LPN/LVN
Average (all nurses)
Nurse anesthetists
Nurse practicioners
84 85 86 87 88 89 90 91 92 93 94

Source: United States Census Bureau *(37).*

5.4 Factors that contribute to gender pay gaps

Research shows that both microeconomic and macroeconomic factors affect the gender pay gap, and that there is a pay difference between men and women regardless of the industry or profession studied. Additionally, non-employment-related factors, such as gender, race and ethnicity, create advantages for certain people, while disadvantaging others *(146).* Disability is likely to be another important factor. It is critical, depending on the context, that the gender pay gap is analysed with an intersectional lens.

Initially, human capital factors associated with greater work productivity, such as years of education, training, skill sets, number of hours worked and years of work experience, were thought to be major drivers of gender pay gaps. However, recent studies show that even after controlling for such observable factors the gender pay gap remains, and a large portion of the gap remains unexplained *(142, 147–150).* The 2018 ILO *Global wage report (129)* decomposed the gender pay gap by human capital attributes, characteristics defining job in a sector, and the type of workplace, and found considerable variation between countries; however, on average, education and other labour market factors explained relatively little of the gender pay gap *(129)*. The ILO concluded: "The unexplained part of the gender pay gap generally dominates almost all countries, irrespective of income group. In high-income countries, education contributes on average less than 1 percentage point of the gender pay gap, through it contributes much more in some individual countries."

"The unexplained part of the gender pay gap generally dominates almost all countries, irrespective of income group. In high-income countries, education contributes on average less than 1 percentage point of the gender pay gap, through it contributes much more in some individual countries." 2018 ILO *Global wage report*

The ILO concluded that this finding on education should not be surprising, since in many countries women have higher educational levels than men in the same occupational sectors but earn less. Although lower-income countries and middle-income countries may have a large percentage of women with low levels of education, those women tend to be clustered in the informal rather than the formal labour market, and so do not impact gender pay gap figures. The report puts forward several drivers of the gender pay gap: the fact that women are not paid equally for work of equal value; the

clustering of women into female-majority jobs and sectors giving less value and lower rewards; and the "motherhood gap", which varies widely between countries and may be related to a number of factors that affect working mothers, including constrained choices of more "family-friendly" jobs, reduced hours, career interruptions, or gender-biased hiring and promotion. Data from the report estimate that the motherhood pay gap ranges from 1% or less in Canada, Mongolia and South Africa to as much as 30% in Turkey *(129)*. The drivers for these significant differences need to understood and built into policy measures.

Feminist economists have argued that use of gender as a dummy variable in labour market analysis and wage regressions fails to account for processes in which gender intersects with other social stratifiers and how it shapes individual experiences of men and women within the workforce as well as society at large. These theorists argue that deeper understanding of discrimination is required in labour market analysis, using feminist thinking *(151, 152)*. An important issue is the gendered social value given to professions and jobs, which attaches greater value and rewards to work typically done by men than to work typically done by women. This is highly relevant for "caring professions", such as nursing, which are female-majority occupations.

Gender pay gaps are pervasive among all sectors, but they are greater in private organizations compared to public sector and non-profit sectors *(153)*. It has been argued that this is because the public sector is expected to act as a model employer that is more equitable and value based *(154)*.

Occupational segregation and job sorting by sex remain the leading factor linked to the gender pay gaps, particularly in the health and social care sector. Findings on occupational segregation in the health sector are outlined in Chapter 3 of this review. Occupational segregation is a dominant phenomenon within labour markets, with women more likely to enter teaching and nursing jobs while men enter more technical and mechanical professions. However, evidence on trends in occupational segregation are not always available to policy-makers, meaning they cannot make a connection between low-paying jobs, in which women are often employed, and gender pay gaps *(94, 134, 155)*. Moreover, as stated above, a large part of the gender pay gap remains unexplained. This means that studies have found gender pay gaps in labour market analysis even after controlling for observable factors such as specialty choice, work hours, or other characteristics, and a large part remains due to "unexplained factors" in the regression model *(142, 147–149)*. Discrimination as well as subtle and unconscious bias are often difficult to control for, and are likely to be major drivers of gender pay gaps. However, putting these complex terms in an "unexplained" error term is problematic, as it gives no explanation on which to base policy *(151)*. These gender biases have implications for women's careers, hiring rates, salaries and promotions; hence, these unseen and unfair barriers women face in the health care labour market will need to be addressed if we are to reduce gender pay gaps *(86, 134)*. Better research and context-specific data are needed to deepen our understanding of gender pay gaps within the health and social sector.

Gender biases have implications for women's careers, hiring rates, salaries and promotions; hence, these unseen and unfair barriers women face in the health care labour market will need to be addressed if we are to reduce gender pay gaps.

The fact that there are gender pay gaps in health care is a major cause for concern at many levels as it implies that women, despite being the majority of the global health workforce, are still unable to gain respect and job status equal to their male counterparts. It is estimated that almost US$ 160 trillion is lost globally due to gender differences in earnings between men and women *(162)*. Thus, the gender pay gap remains a huge global health concern, since building stronger and more resilient health systems would require that those health systems enable women to participate in the workforce to their full potential.

5.5 Why is addressing the gender pay gap in the global health workforce important?

Addressing the gender pay gap is critical to achieving fair and resilient health systems. Gender differences in income have long-term economic implications and lead to a gender wealth gap and poverty for many women in old age *(163)*. Wealth inequalities are gaining interest among scholars as wealth accumulation increases financial stability, opportunities, and purchasing power *(164)*. Financial stability and empowerment are also important factors in seeking health care and continuing treatment, especially for women *(165)*. The gender pay gap therefore has implications for women's own health outcomes. Addressing gender equality and the elimination of discriminatory practices in the workforce are closely linked.

Box 5.1 Factors contributing to gender pay gaps: key themes

INDIVIDUAL FACTORS

Differences in education, training, skills

Gender pay gaps exist even after controlling for differences in education, skill set, and training. The gaps widen with higher levels of education for women, while men receive higher returns on schooling. Factors such as age, experience, specialty choice, and practice settings also do not explain the gap *(142, 156–158).*

Differences in work experience

The gender pay gap widens with seniority *(159)*. This phenomenon was found to be true for both physician and non-physician groups of women *(140)*. Large deficits in rank for senior faculty women were confirmed in logistic models that accounted for a wide range of other professional characteristics and achievements, including total career publications, years of seniority, hours worked per week, department type, minority status, medical versus non-medical final degree, and school *(140)*. Gender gaps are also wider for higher-salaried jobs *(66)*.

Differences in numbers of hours worked, or part-time versus full-time work

Gender pay gaps are prevalent across almost all occupations but differ significantly in size. One factor that is associated with this difference is whether an occupation is male dominated or female dominated, with male-dominated jobs being higher paid. Among the many reasons for this is the difference in total number of hours worked, with women working fewer hours than men. Women face constraints in balancing paid work with family responsibilities; hence they either opt out of the workforce or take up part-time work. Women with children pay what is known as a "motherhood penalty", whether as a single or married parent, as they are likely to work less hours than men. The penalty is higher for women with low-paying jobs. Married men and those with dependent children, on the other hand, gain a "fatherhood bonus" and have been found to earn higher wages than single men *(142, 158, 160).*

INSTITUTIONAL FACTORS

Occupational segregation

Industrial and job sorting of men and women into specific types of jobs substantially contributes to men's higher compensation, especially in the United States and Europe. Women are concentrated in primary health care, low-grade and low-paying jobs, the public sector, and part-time employment *(94, 134, 155).* Low awareness of occupational segregation and the gender pay gap contributes to maintaining the status quo *(161).*

Workplace authority

The pay gap widens at executive levels and with higher levels of education.

Hiring and promotion

Subtle unconscious biases in hiring and promotion processes have implications for women's careers and advancements that impact their earning potential.

Collective bargaining and unions

Men tend to be more likely to be part of networks and unions. Collective bargaining has been shown to be effective in negotiating comparable salaries. When men participate in unions and women are not union members, then even the same hourly wages may lead to pay differentials. Female-dominated jobs and sectors are still largely non-unionized, which has also led to gender pay gaps *(134).*

Within the health workforce, it is important to address the gender pay gap for multiple reasons, including the following.

- The gender pay gap is directly linked to poverty, as it has implications for lifelong financial stability. Poverty affects women at disproportionately higher rates compared to men *(166)*, and eliminating the gender pay gap could halve poverty levels for women *(167)*.

- Earning lower pay means lower pensions and less income from social security for retired women compared to retired men *(168)*. Similarly, it means women qualify for lower disability and life insurance benefits.

- Wage differences lead to lower morale and motivation to work longer hours, or may cause women to quit the health workforce altogether. With the majority of the health care workforce being women, this has serious implications, as women may be more likely to opt for working shorter hours and part-time jobs. With a major and growing global shortage of health workers, addressing the gender pay gap will improve the health workforce labour supply, support achievement of universal health coverage, drive economic growth, and help meet the health care needs of the global population.

- Societal expectations of gender roles may lead women to either delay marriage and childbearing until their thirties or to forgo it completely. This phenomenon has long-term implications for the health and well-being of societies *(169, 170)*.

- Understanding patterns of the gender pay gap in a particular context will drive solutions and more inclusive labour markets for women. For example, if the widest gender pay gap is amongst low-paid women workers, then minimum wage legislation, social protection for women on the boundaries of the informal and formal labour markets, and support for collective bargaining will be critical. If the widest gap is amongst women in higher-status jobs or mothers or fathers, then other policy solutions will be needed.

Despite advances in policies and reductions in the gender pay gap over the years, a significant difference persists, calling for global action to address the problem. In a recent survey on equal pay conducted in the United States, it was found that almost one third of Americans were not aware that the gap existed and men were twice as likely to think it did not exist compared to women *(156)*. In another study, 80% of men thought their salaries were comparable to those of women, compared to 41% of women who felt their incomes were comparable to those of men *(171)*. Thus, there is a need to increase awareness of the problem in order to address it.

A major conclusion on the gender pay gap from this review is that existing data and evidence are too scarce and not sufficiently comparable to use as the foundation for policy measures in most countries. Too much remains "unexplained", and we need to move beyond simple measures of the gender pay gap to more complex methods that adjust for occupational segregation of men and women (both horizontal and vertical), take an intersectional approach relevant to the social context, and include the large numbers of women working outside the formal, paid labour market. In the health sector, addressing occupational segregation (Chapter 3) and the gendered leadership gaps (Chapter 6) will both be critical to reducing gender pay gaps.

Chapter 6. Leadership

6.1 Key messages

- Women make up 70% of the global health workforce but occupy only 25% of leadership roles. Men hold the majority of leadership roles in health at all levels, from global to community.
- The current gender gaps in leadership are predominantly a result of power imbalances, gender stereotyping, discrimination and structures that create pathways for one gender to excel while others remain segregated in subordinated roles.
- Lack of gender balance in health leadership means global health loses female talent, perspectives and knowledge. The women who deliver global health do not have an equal say in its design and delivery.
- Women's limited opportunity to enter leadership roles is compounded by the intersection with other factors such as race, religion, caste, class and ethnicity, which can further disadvantage women with more than one marginalized identity (for example, a low-caste woman).
- There is evidence that women in leadership positions in health expand the agenda, giving greater priority to rights – such as sexual and reproductive health and rights – that apply to all genders but, where absent, can have the most negative impacts on women's health.
- The persistent absence of female talent from leadership positions is likely to prove a significant barrier to the rapid scaling up of the global health and social care workforce needed to achieve the SDGs, including universal health coverage.

6.2 Leadership and gender: background

Leadership is the fourth theme prioritized by the GEH. The current gender gaps in leadership are predominantly a result of power imbalances, gender stereotyping, discrimination and structures that create pathways for one gender to excel while others remain segregated in subordinated roles. Gender gaps in leadership are pervasive in all sectors, including health. Women make up only 5% of the Fortune 500 CEOs *(172)*; 24% of parliamentary seats *(173)*; and 39% of the total labour force *(43)*. With the SDGs restating gender equality as a global priority, addressing gender gaps in leadership is key.

6.3 Leadership and governance in the global health and workforce

Leadership comes in many forms and it matters at all levels of global health. Women are leaders in their communities providing health at the front line, they are the first responders in outbreaks and disasters, and they are predominantly the caregivers in their homes and family. However, due to power structures within workplaces, women remain underrepresented in top positions.

Women's representation in top policy-making positions remains low in global health agencies, with women holding around 25% of the most influential leadership and governance roles. As shown in Figure 6.1, an evaluation of 140 global health organizations found that decision-making power remains largely in the hands of men, with 69% of organizations and 80% of organization boards led by men *(82)*. Moreover, beyond gender parity, women have less visibility, less recognition and less influence than men. This shapes the health agenda and resources at all levels – even at the community level. Anecdotal examples of the contribution made by community health workers is important in capturing the impact women are having on the health of their communities, but most have little or no opportunity for promotion to more influential leadership roles. This applies across health professions. Most recently, nurses and midwives, in response to leadership disempowerment, have launched the Nursing Now 2020 campaign, with one key goal being to have nurses or midwives in leadership roles and on governing boards at all levels in health *(174)*.

The gender gap in health leadership goes beyond the numbers. Deep-rooted power structures, including patriarchal and gender bias, creates a preferential opportunity for men to be leaders in the mostly

Figure 6.1 Who leads global health organizations?

	Women	Men
Executive Directors	31%	69%
Board Chairs	20%	80%

Source: Global Health 5050: https://globalhealth5050.org/gh5050-summary-findings-on-leadership-and-parity/.

powerful, influential roles in society. In the health sector, especially given the historical structure of hospitals and health systems based on hierarchy and patriarchy, the power relations create an environment that enables men and disempowers women, limiting their ability to reach their maximum potential as leaders. A contextual analysis of women in the health workforce shows there are unique barriers women face based on gender. They are less invested in and supported in their roles, as they operate in environments that are not enabling for all genders *(2)*.

In the health sector, especially given the historical structure of hospitals and health systems based on hierarchy and patriarchy, the power relations create an environment that enables men and disempowers women, limiting their ability to reach their maximum potential as leaders.

One study identified those positions that embody power, influence and leadership as the "final male bastions" and noted that women are less likely to be in positions of power and authority, have the opportunity to advance, be rewarded for the work they do, and find themselves in strong support networks *(175)*. These positions of power and leadership roles in global health can take on many forms, from the executive team of a United Nations agency to the head of a community nongovernmental organization or to the head of a local health clinic. While leadership is often linked to the most senior and well paid positions, one can be a leader at all levels, including in underpaid or underrecognized roles in health.

Across the health workforce, women are underrepresented in the upper levels of management, leadership and governance. Only 31% of ministries of health are led by women *(176, 177)*. At the high end is the Africa Region with 38%, with South-East Asia at the low end with 18% of ministries of health led by women *(177)* (Figure 6.2).

In examining health leadership, Women in Global Health found on average 25% of Member State chief delegates, to the World Health Assembly, were women, increasing over time, since 2005, as seen in Figure 6.3. *(101)*. Percentages of women 2016-2016 were 26%, 31% and 29% respectively. In many cases this mirrors the underrepresentation of women in the senior levels of ministries of health. For example, women held only 20% of senior roles in the Ministry of Health in Cambodia *(178)*. However, there is an opportunity to transform the health leadership to be more representative of the largely women-led health workforce (Figure 6.4).

The majority of the reviews of leadership in the health workforce have previously focused on women's leadership in medicine. Emerging literature has started exploring trends in other sectors, for example, the work undertaken by the Nursing Now campaign. Similarly, another study in 2006 found that despite increasing numbers of women in pharmacy, they are still underrepresented in leadership roles *(136)*. Research is expanding beyond the United States; for example, one study found that women are underrepresented in prestigious specialisms and leadership roles regardless of the rate at which women are entering the health sector in a country *(45)*. Within anaesthesiology women's leadership is lower than in other medical professions in the United States *(179)*. Looking at the leadership in the World Federation of Societies of Anaesthesiologists, a striking

Figure 6.2 Percentage of Member State ministries of health headed by women, by WHO

Source: Women in Global Health, 2018

Figure 6.3 Women's representation as chief delegates at World Health Assembly, 2005–2015

Source: Women in Global Health, 2018

Figure 6.4 Global health leadership pyramid

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

= 10%

Fortune 500 Healthcare CEOs (1) 3.7%

Heads of global health organizations & boards of global health organizations (2) 25%

Ministers of Health (3) 31%

World Health Assembly heads of Delegations (4) 27%

Deans of top Public Health & Medical Schools (5) 28%

Health and Social Workforce (6) 70%

Long-Term Care Workforce (7) 90%

1. Fortune 500 list for healthcare sector, Fortune, 2018
2. Global Health 50/50 Report, Global Health 50/50, 2018
3. World Health Organization Member States, Womean in Global Health (data) unpublished), 2018
4. Work Health Organization's World Health Assembly List of Delegates and Other Participants, Women in Global Health (data unpublished), 2018
5. QS World Ranking 2018: Top 25 Global Universities for Public Health and Medicine, 2018
6. Improving employment and Working conditions in health services, international Labour Organization, 2017
7. Improving employment and Working conditions in health services, international Labour Organization, 2017

WGH

Source: Women in Global Health, 2018

lack of representation can be observed across boards (5:1, men: women), councils (15:5) and committee chairs (9:1) *(180).* There are gender gaps in academic medicine as well, for example, in the top 50 American medical schools only 24% of the directors were women *(181)*. A gender analysis of Kenya's health training institutions found that women made up 76% of the nursing profession, but men held 62% of the faculty positions *(182).* One study found that men with 15 to 19 years of experience were 17% more likely to hold full professorships when compared to women with the same years of experience, even after adjusting for other factors such as number of publications and degrees *(160).*

6.4 Why addressing gender gaps in leadership matters

Addressing gender gaps in leadership sets the agenda for equal representation of genders at all levels of the organization as well as across different sectors of health. It leads to a more empowered workforce, improved motivation, reduced attrition, improved quality of care, and better understanding of health systems, which feeds into designing more suitable solutions *(183).*

Addressing gender gaps in leadership leads to a more empowered workforce, improved motivation, reduced attrition, improved quality of care, and better understanding of health systems, which feeds into designing more suitable solutions.

There is a need for the diversification of leadership in the health workforce. Across sectors women are seen to exhibit transformational leadership qualities, including those that focus on motivating others, supporting the advance of the whole team while attending to individual needs, and creating excitement about the future, more frequently than men. With these foundational qualities, studies have confirmed that overall women were seen as more effective leaders *(184).* Within the health sector, there is some evidence to indicate the same. Several studies in India indicated that women leaders in health have resulted in positive benefits such as the reduction of neonatal mortality, increased expenditure on health facilities, antenatal care and immunizations, and prioritization of issues traditionally related to women *(181).* Evidence also shows that providing nurses with the opportunity to lead and shape health services leads to improvements in health outcomes and supports innovation, recruitment and retention *(185).*

6.5 Factors contributing to leadership gaps in the global health workforce

The lack of women in leadership is often said to result from a "glass ceiling", but recent literature aptly identifies that the lack of women in leadership is more the result of a labyrinth, a twisting and turning series of barriers that are both visible and invisible, rather than a sudden and clear limit that prevents women from reaching the final upper level of leadership *(186)*. There are a multitude of barriers faced by women in advancing in leadership. These barriers exist at the individual, interpersonal, institutional, and community levels, and up

to the public policy level. The global health and social workforce has a problem which is not limited to a "glass ceiling effect". Rather, the whole pipeline is leaking women all the way up to the top. *(187)*.

The lack of women in leadership is more the result of a labyrinth, a twisting and turning series of barriers that are both visible and invisible, rather than a sudden and clear limit that prevents women from reaching the final upper level of leadership.

It is important to note that gender is only one dimension of the labyrinth that women in the health workforce must negotiate on their way to leadership. There are multiple ways to understand marginalization within health systems leadership. For example, a unitary approach focuses on one primary marker of difference as sufficient for explaining a social problem, in isolation from other markers (for example, gender as separate from race) *(188)*; a multiple approach considers more than one explanatory factor but does so in an additive manner (for example, gender plus race equals greater disadvantage) *(188)*; and an intersectionality approach explicitly focuses on the relationships between factors and mutually constructed processes that lead to social differences. Inequities are never the result of single, distinct factors; rather, they are the outcome of intersections of different social locations, power relations and experiences *(189)*. Gender as one aspect of an individual's identity plays a major role in a person's experience of the world, including professional development and career advancement. However, not acknowledging the dynamic interconnectedness of gender with other social identities, especially when considering women who do not fulfil the "white woman from the West" benchmark, is a pitfall that hinders adoption of solutions that benefit all women. And this benchmark is the typical image used to portray most women in leadership positions.

The majority of the reviews and studies found similar barriers to women advancing within their professions and reaching leadership positions across geographies and occupations. They include the following.

- Overall gender norms and expectations of men and women negatively impact women's advancement to leadership *(115, 190)*. Traditional gender norms do not portray women as leaders, and leadership qualities are associated traditionally with masculine traits. Women are perceived as having more communal traits, leading to a double bind if they exhibit leadership traits perceived as traditionally masculine *(184)*. In Uganda and Zambia, gender norms and the understanding of key leadership traits negatively impacted the advancement of women and skewed the organizational processes leading to leadership – such as hiring and promotion – as leadership itself was gendered *(190)*. Leadership stereotyping is only one way in which gender norms impact women's advancement in the health workforce. One study noted that gender norms influenced women's progression to leadership at three intersecting levels – individual, household and community – as shown in Box 6.1 *(178)*.

- Bullying and sexual harassment have negatively impacted women's advancement to leadership positions *(191, 194)*. Adverse systemic consequences include "impediment of health workers' advancement, increased stress and decreased morale and productivity", and a "limited pool of health workers to deal with today's health challenges" *(5)*. The story of Dr Caroline Tan, an Australian neurosurgeon, personifies the impacts of sexual harassment and assault on women's career advancement in health care. Dr Tan, who won a tribunal case against a fellow surgeon, faced targeted attacks by the perpetrator to undermine her credibility, a delay in the award of her fellowship by the Royal Australian College of Surgeons, and difficulty in securing a position, despite high examination scores and excellent references *(195)*.

- The interrelationship between horizontal occupational segregation and the occupational leadership hierarchy within the health workforce has influenced women's career advancement and the way women leaders are represented. In Jordan, a study found that two thirds of men in the health workforce were doctors, whereas almost 80% of nurses were women, while men held 90% of managerial positions *(196)*. It was noted that in South and Central Asia, nursing was seen as a low-status profession and nurses were directly managed by doctors who served in the main decision-making roles *(186)*. Nurses were seen as "extra hands" for doctors, and were presented with few or no opportunities for career advancement and leadership *(186)*. The Review Board of the All-Party Parliamentary Group on Global Health in the United Kingdom found "overwhelming evidence" that nurses in leadership were not being engaged adequately in policy-making or decision-making at all levels, from local to global *(186)*.

- Women often report that lack of recognition and respect is a detriment to their career advancement and entry into leadership roles. One study found that women received only 1 in 10 awards in health and medicine *(197)*, while another study found that female

Box 6.1 Individual, household and community dimensions of gender stereotyping

INDIVIDUAL

In Cambodia, it was shown that gender norms affected how men and women engaged in the health sector, and in turn their progression to leadership *(115).*

HOUSEHOLD

Regardless of organizational policies, women were held back by gendered time use. In Cambodia, women's advancement was impacted by family responsibilities *(115).* In Japan, women in medicine saw a "motherhood penalty" with reduced hours worked, and several years of unemployment during early child-rearing, with consequences for their access to leadership *(45).* Even in Scandinavia, where policies and cultural attitudes promote work–life integration, women were more likely to switch from specialties and leadership tracks after childbirth to positions that provided more flexibility with childrearing *(45).* A study of women doctors in the United Kingdom attributed the lack of women's leadership roles to the rigidity of career paths leading to leadership within medicine, and reliance on a hierarchical system that disregards the modern needs of people to balance career expectations with other responsibilities outside work *(191).*

COMMUNITY

In a review of the post-conflict health system in Cambodia, women had reduced clinical time due to community expectations of gender roles. For example, women reported being unable to work night shifts due to disapproval from the community *(115).* In Zimbabwe, men were more likely to be selected for very remote and rural areas, where they were able to gain invaluable career experiences. These experiences supported men's career advancement over women through increased promotions, and participation in international trainings and workshops *(192).* In Afghanistan, women were able to gain increased access to resources at the community level as community health workers, due to gendered social norms, but men were more likely to hold leadership positions and in turn control resource allocation *(193).*

managers felt that their voices were not as respected as those of their male colleagues, and also faced additional discrimination due to younger age or perceived lower technical skills *(198).* In Pakistan, where the requirement for lady health workers to travel to people's houses and to work with men clashed with cultural norms, lady health workers reported lack of respect and devaluation of their work *(199).*

- These studies also highlight the need for a deeper analysis of the detrimental impact that gender inequality in health workforce leadership is likely to have on health outcomes.

Removing gender gaps in leadership roles makes good business sense. It leads to the creation of a workforce pipeline that supplies educated, trained and skilled health workers using 100% of the talent pool.

SECTION 3. CONCLUSIONS

Chapter 7. Conclusions: policy context, findings, and next steps

This chapter brings together the findings of the GEH literature review, draws conclusions, and outlines next steps. All these will influence gender equity in the health workforce. Since countries have different starting points in terms of health systems, resource levels, health worker supply, gender equality and socioeconomic context, there can be no universal blueprint for addressing gender equality in the health workforce. All policy measures will need to be contextualized to suit the local situation, with all genders in the local health workforce having a voice in the decision-making process.

The findings of this report and the Gender at Work framework *(200)* will form the foundation for the next phase of gender policy work by the GEH, with the aim of supporting country-level implementation and measurement of context- and evidence-based policy solutions.

7.1 Policy context

The Sustainable Development Goals (SDGs), the overarching goal to reach universal health coverage, the Global Strategy on Human Resources for Health, and the joint WHO, ILO and OECD Working for Health five-year action plan (Box 7.1) together create a strong platform for addressing the gender inequality that causes inefficiencies in the health workforce. They also set a timetable, since the commitments of the five-year action plan are to be delivered by 2021, and the SDGs, universal health coverage and Global Strategy on Human Resources for Health have a timeline of 2030.

There is no health without the people who deliver health care. With growing global demand for health care and a projected health worker shortage, there is an urgent need to scale up the numbers of new health worker jobs in high-, middle- and low-income countries. Since women form the majority of health and social care workers, the Working for Health five-year action plan 2017–2021 recognizes the importance and urgency of addressing gender inequity in the health workforce. The deliverables of the plan include gender-transformative policy development and implementation capacity to overcome gender inequities and form the foundation for the work of the GEH, including this report.

Box 7.1 Working for Health: five-year action plan for health employment and inclusive economic growth 2017–2021 (WHO, ILO, OECD)

RECOMMENDATION 2

Maximize women's economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.

DELIVERABLES

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).

2.2 Gender-transformative policy development and implementation capacity to overcome gender biases and inequalities in education and the health labour market supported.

7.2 Findings of the GEH literature review

The findings of the GEH literature review are divided into two parts:

1. findings from each of the four focus areas covered by the report;

2. overarching findings and conclusions generated from the exercise.

The following subsections highlight what the literature review found – or did not find – in the sources that were reviewed.

7.2.1 Key findings of the GEH literature review on the four focus themes

Key findings from the four focus areas of the GEH literature review are summarized in Figure 7.1. Each theme is explored in depth in a separate chapter of this report.

7.2.2 Overarching findings from the GEH literature review

Of the eight overarching findings (summarized in Figure 7.2), five highlight serious deficiencies in data and research, which limit compilation of a comprehensive global picture upon which to base policy.

First, the majority of the 170 studies identified and reviewed in this report come from the global North and report findings from the global North, many of which are not transferable to settings with different cultures and resource levels. There are major gaps in data and research from all regions, but the most serious gaps on gender and equity in the health workforce are in low- and middle-income countries. This is of particular concern since the most rapid and radical progress is needed in low- and middle-income countries to reach the SDGs, attain universal health coverage and achieve the health for all targets by 2030.

Figure 7.1 Key finding in four focus areas of GEH literature review

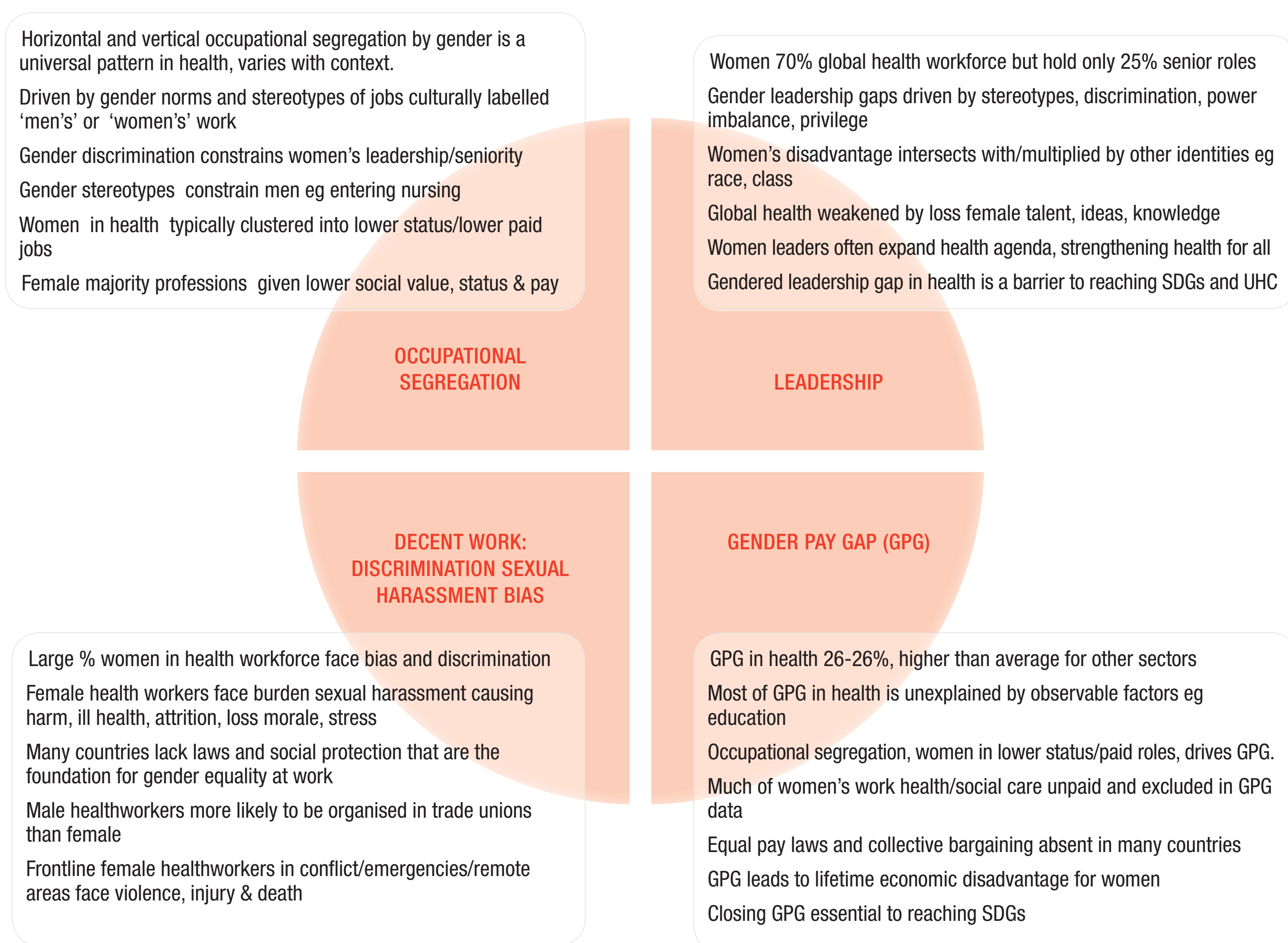


Figure 7.2 Key overarching findings of GEH literature review

OCCUPATIONAL SEGREGATION

LEADERSHIP

DECENT WORK: DISCRIMINATION SEXUAL HARASSMENT BIAS

GENDER PAY GAP (GPG)

Overarching Findings from literature review:

- 170 studies in this review, most from global North
- Major gaps in data and research from low- and middle-income countries (LMICs) on gender and equity dimensions health workforce
- Major gaps in implementation research on impact of policy change or gender transformative approaches in different cultural settings
- Major gaps in data in all areas, particularly sexual harassment and data comparable across countries on the gender pay gap
- Studies limited in methodological approaches. Very few adopt an intersectionality lens or use mixed methods approaches
- Occupational segregation, vertical and horizontal, is major driver and consequence of gender inequality
- Critical role of women in health (70% health workforce) is often overlooked, so priority not given to addressing gender/equity in workforce
- Gender inequality in health and social care workforce will limit delivery of UHC & health for all

In addition, widespread gaps in the data and literature were found from countries of all income levels on implementation, application of gender-transformative policy measures and what works to change the health system weaknesses and deficiencies caused by gender inequality. This will be an important focus for the work of the GEH going forward.

Major gaps and lack of comparable data were also found in countries from all regions. Examples include sexual harassment and gender pay gap data. Despite the prominence the #MeToo movement has given to the issue of sexual harassment in the last year, a disturbing 59 countries still lack legislation prohibiting sexual harassment in the workplace. The #MeToo movement has prompted women in health in some countries to speak about their experience of sexual harassment and abuse at work. Although, from confidential reports, sexual harassment of female health workers by co-workers, patients and members of the community appear to be widespread, with consequent harm both for women affected and for health systems, systematic collection of data and research studies are not common. A supportive legal framework and data collection are the starting points for identifying patterns of and trends in sexual harassment, abuse and violence suffered by female health workers and putting in place preventive measures and support for survivors.

Similarly, with the gender pay gap, data collection is uneven and not always comparable across countries, while several studies conclude that much of the gender pay gap is “unexplained” by observable factors. Clearly, research is needed to explain the “unexplained” and identify solutions to inequities in pay, which have serious lifelong impacts for women’s income, autonomy and well-being.

Finally, in the list of deficiencies in the data and literature, studies identified for the review were limited in methodological approaches. Although in many countries female health workers are clustered into different sectors of health and social care by social identities such as race, ethnicity, class, and migrant status, very few studies take an intersectional approach to highlight how gender disadvantage in employment can be compounded by other social identities. Some countries are now investigating pay gaps based on disability and race, in addition to gender. It is critical to take an intersectional approach to understand how multiple identities interact with gender in the health workforce to compound inequity.

Three further overarching conclusions from this review also need emphasis. The first is the near universal and pronounced occupational segregation of women and men within the health workforce. This report emphasizes that the fast-growing health and social care sectors are important employers of women and critical drivers of economic growth. But although women hold around 70% of jobs in the health workforce, they remain largely segregated within it, both vertically and horizontally. Vertical segregation, with men holding the majority of higher-status, higher-paid roles, is a pattern found in most countries. It is particularly acute in the health and social care sector, resulting in an estimated gender pay gap higher than the average for other sectors of the economy. It is a paradox that even in female-majority health professions, such as nursing, the small minority of male employees often have a “glass escalator” to the top, reaching leadership positions faster than their female colleagues. Women in the health workforce are disadvantaged by being clustered into lower-status and lower-paid (often unpaid) roles, and are further disadvantaged by horizontal

occupational segregation resulting from gender norms and stereotypes that brand some jobs in health more suitable for women (nursing) or men (surgery). Women are then triply disadvantaged by social gender norms that attach lower social value to majority female professions and thereby devalue the status and pay of those professions.

Occupational segregation in the health sector is driven by gender inequality and, in turn, is the foundation for other gender inequalities identified in this report. Occupational segregation in the health workforce drives the gender pay gap and also makes lower-status female health workers, often on insecure contracts and less unionized than men, more vulnerable to sexual harassment, abuse and violence.

There is nothing inevitable about occupational segregation by gender in the health workforce. Education and employment patterns in many countries have changed rapidly over the last 25 years with far more women entering medicine and, in some countries, now forming the majority of medical students. Countries vary, for example, in the percentage of men in nursing. Occupational segregation in health is not fixed over time or across countries and policy measures can be taken to change it. In its next phase of work, the GEH will identify good practice examples to see what lessons can be learned and transferred.

A second and related point is that, despite women being the majority of the global health workforce, their role as drivers of health is often unacknowledged. Trends in applications for medical training show that health as a profession continues to attract women and is likely to remain a major employer of women. The lack of acknowledgement of women's role, however, contributes to a lack of priority given to addressing gender inequality in the health workforce. This has to change fast, with gender-transformative policies and measures put in place if global targets such as universal health coverage are to be achieved.

Critical and also largely unacknowledged is the burden of unpaid health and social care work typically done by women and girls caring for sick and disabled family and community members. Women also perform (unpaid) voluntary roles in health promotion and service delivery. This review has focused on findings from the formal labour market and a priority going forward will be to gather evidence on the unpaid health and social care work that forms an insecure foundation for the global health pyramid. Women's unpaid work must be recorded and valued, with measures put in place to enable women and girls engaged in unpaid work to access education, training and the formal labour market, where their work would be counted and paid.

Finally, a key conclusion of this report is that gender inequality in the health and social workforce weakens health systems and health delivery. However, an alternative, far more positive future scenario is possible. Addressing gender inequalities in global health and investing in decent work for the female health and social workforce will have a wider social and economic multiplier – a "triple gender dividend" – comprising the following.

- Health dividend. The millions of new jobs in health and social care needed to meet growing demand, respond to demographic changes and deliver universal health coverage by 2030 will be filled.

- Gender equality dividend. Investment in women and the education of girls to enter formal, paid work will increase gender equality and women's empowerment as women gain income, education and autonomy. In turn, this is likely to improve family education, nutrition, women and children's health, and other aspects of development.

- Development dividend. New jobs will be created, fuelling economic growth.

This triple gender dividend will improve the health and lives of people everywhere. The health and social care worker shortage is global, and addressing gender inequality in the health workforce is everybody's business.

7.3 Next steps

This literature review is the foundation for the next phase of the work of the Global Health Workforce Network GEH, which will use these findings, together with an analysis of best practices from within and beyond the health and social sector, to inform gender-transformative policy and action.

To advance this work, the GEH will develop advocacy and policy toolkits to target key stakeholders, including WHO Member States, to integrate gender-transformative health and social workforce policies into their national health workforce plans.

The GEH will also bring together various actors at the national level to design and evaluate gender-transformative health workforce policy interventions, with the aim of supporting implementation and measurement of context- and evidence-based policy options. This will provide a platform for policy-makers to collaborate with key governmental partners and external experts.

Finally, the GEH will convene a review in 2019, midway through the Working for Health five-year action plan 2017–2021, supporting WHO, ILO and OECD to assess progress on the two action plan deliverables on gender equality and, on the basis of that review, recommend steps to ensure the achievement of these deliverables by 2021.

Glossary

Bias is an inclination or prejudice for or against one person or group, especially in a way considered to be unfair, that often results in discrimination *(5)*.

Decent work is defined by the ILO as "the aspirations of people in their working lives. It involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men" *(201)*.

Discrimination in employment and occupation includes practices that place individuals in a subordinate or disadvantaged position in the workplace or labour market because of characteristics (race, religion, sex, political opinion, national extraction, social origin, or other attribute) that bear no relation to the persons' competencies or the inherent requirements of the job *(5)*.

Feminization is the movement of women into traditionally male-dominated occupations *(202)*.

Gender is a social construction reflecting the distribution of power between women and men, girls and boys and gender-diverse persons. This distribution of power is influenced by history, laws, policies and politics, and by economic, cultural, community and family norms that shape the behaviours, expectations, identities and attributes considered appropriate for all people – women and men, girls and boys, and gender-diverse people. How an individual expresses their gender identity varies across context, time, and place, and throughout their life-course. Gender interacts with, but is distinct from, the binary categories (male, female) of biological sex. When a person's gender identity does not correspond with their assigned sex, they may identify as transgender *(2)*. Gender also intersects with, and is shaped by, other axes of inequality – age, education, economic position and power, race, and ethnicity.

Gender blind refers to the failure to recognize that the roles and responsibilities of men and boys, and women and girls, are assigned to them in specific social, cultural, economic, and political contexts and backgrounds. Projects, programmes, policies and attitudes that are gender blind do not take into account these different roles and diverse needs. They maintain the status quo and will not help transform the unequal structure of gender relations *(203)*.

Gender discrimination describes any distinction, exclusion, or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights. It can be direct or indirect, or overt or covert, and is associated with negative consequences for the person who experiences it *(5)*.

Gender equality in the health workforce describes a condition whereby men and women can enter the health occupation of their choice, develop the requisite skills and knowledge, be fairly paid, enjoy fair and safe working environments, and advance in a career without reference to gender. It implies that workplaces are structured to integrate family and work and to reflect the value of caregiving for men and women *(204)*.

Gender equity is the process of being fair to all genders. To ensure fairness, measures must often be put in place to compensate for the historical and social disadvantages that prevent women and men from operating on a level playing field. Equity is the process by which equality can be achieved as an outcome *(205)*.

Gender pay gap encompasses differences in men's and women's average earnings, which refer to (a) remuneration in cash or in kind paid to an employee for the work done, together with remuneration for time not worked; (b) net earnings from self-employment; or (c) total earnings from both employment and self-employment *(125)*.

Gender-transformative policies and programming include policies and programmes that seek to transform gender relations to promote equality and achieve programme objectives. This approach attempts to promote gender equality by (a) fostering critical examination of inequalities and gender roles, norms, and dynamics; (b) recognizing and strengthening positive norms that support equality and an enabling environment; (c) promoting the relative position of women, girls, and marginalized groups; and (d) transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities *(206)*.

Health workforce is defined by WHO as "all people engaged in actions whose primary intent is to enhance health", including those engaged in direct care roles (such as physicians, nurses, midwives, pharmacists, and dentists), leaders, policy-makers, researchers, management and support staff (such as ambulance drivers and accountants). This review focuses on direct care providers *(207)*.

Horizontal segregation refers to differences in types of occupations and sectors in which men and women are concentrated. Greater numbers of women, for example, are concentrated in low-paying, part-time and unpaid care or domestic work as compared to men *(19)*.

Intersectionality is a feminist theory and analytical tool for understanding and responding to the ways in which gender intersects with other identities to create new oppressions. The experiences of marginalization and privilege are defined not only by gender but also by other identity factors such as race, class, age, religion and sexual orientation, all of which are determined, shaped by, and embedded in social systems of power. Intersectional paradigms view such characteristics as race and class as mutually constructed systems of power that require special measures to reach women who face multiple forms of discrimination *(191)*.

Non-binary, also referred to as genderqueer, is a category for gender identities that do not conform to the gender binary of masculine or feminine. Non-binary people may express a combination of masculinity and femininity, or neither, in their gender expression. Those who incorporate aspects of both male and female may identify as "androgynous", "mixed gender" or "pangender", while those who move between genders in a fluid way may identify as "bigender", "gender fluid" or "pangender". Some people who move between two or more than two genders identify as "trigender" or "pangender". Some people identify with an additional gender, known as "third gender", "other gender" or sometimes "pangender". Note that "pangender" is a flexible term. People with no gender identify as "agender", "gender neutral", "non-gendered", "genderless", "neuter", or "neutrois" *(208)*.

Occupational downgrading is a phenomenon "where women choose employment below their skills level and accept poorer working conditions" *(29)*.

Occupational segregation is the distribution of workers across and within occupations *(24)*.

Occupational gender segregation is the difference in the types of jobs men and women enter *(19)*.

Sexual harassment refers to unwelcome sexual advances or requests for sexual favours, whether verbal, physical, or visual. These behaviours are illegal if the submission to such behaviours is made a condition for employment or a decision affecting the individual, or has the purpose of interfering with an individual's performance *(209)*.

Substantive equality is a principle that considers the effects of past discrimination, recognizes that rights, entitlements, opportunities and access are not equally distributed throughout society, and accepts the need to sometimes treat people differently to achieve equal results. It allows for differential treatment to level the playing field for women, particularly where structures of dominance and subordination are embedded in the baseline of opportunity *(191)*.

Tokenism refers to a phenomenon whereby an organization includes a representative from a minority or disadvantaged social group in an activity or position only in order to give an appearance of fairness and inclusion. It may be said to occur in the workplace when one group represents less than 15% of an organization. The members of that group may be subject to predictable forms of discrimination *(210)*.

Toxic masculinity refers to stereotypical masculine behaviours associated with the male gender. It includes the social expectation for men to act in a dominant or "alpha male" manner. These expectations restrict men and boys from expressing their emotions or being affectionate, and limit their emotional range to such negative expressions as anger *(211)*. Toxic masculinity also leads men and boys to engage in higher-risk behaviours such as use of alcohol or tobacco, violence, and aggressive driving *(212)*. This is also related to the concept (introduced by R.W. Connell) of "hegemonic masculinity" – an attitude that legitimizes men's dominance over women and other gender identities that are perceived to be feminine in a given society *(213)*.

Unpaid care work refers to all unpaid services provided within a household for its members, including care of persons, housework and voluntary community work *(29)*. These activities are considered work because theoretically one could pay a third person to perform them. "Unpaid" indicates that the individual performing the activity is not remunerated. "Care" refers to the activity that provides what is necessary for the health, well-being, maintenance, and protection of someone or something. "Work" refers to an activity that involves mental or physical effort and is costly in terms of time resources *(29)*. This includes services provided by community health workers that are unpaid or on a voluntary basis.

Vertical segregation refers to the concentration of men and women in different positions of power, leadership and decision-making, for example, men dominating leadership positions and political life compared to women *(19)*.

Women's rights. The Beijing Platform for Action, in paragraph 2 of its mission statement, states: "The Platform for Action reaffirms the fundamental principle … that the human rights of women and of the girl child are an inalienable, integral and indivisible part of universal human rights. As an agenda for action, the Platform seeks to promote and protect the full enjoyment of all human rights and the fundamental freedoms of all women throughout their life cycle" *(214)*.

Workplace violence includes physical assault, verbal abuse, sexual or racial harassment, bullying or mobbing *(5)*.

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Annex 1. Membership of the Gender Equity Hub in the Global Health Workforce Network

Co-Chairs:

Women in Global Health
World Health Organization

Organizational members:

Canadian Institute for Health Information
Canadian Health Human Resources Network
Chemonics/HRH2030
DAI Global, LLC
The George Institute for Global Health
Global Association of Student and Novice Nurses (GASNN)
Frontline Health Workers' Coalition (FHWC)
International Pharmaceutical Federation (FIP)
International Federation of Medical Students' Associations (IFMSA)
IntraHealth International
Jhpiego
The Net Community
Public Services International (PSI)
Research in Gender Ethics (RinGs)
Save the Children
Wemos
Women Deliver

Annex 2. Literature matrix

GENDER EQULTY EVIDENCE MAPPING EXTRACTION TOOL

SR#	Submission
Lessons Learned	
Policy/Implications (how will the study/initiative findings or outcomes be used in the	
Limitations	
Strengths	
Key Results/Findings	
Methods of Analysis	
Input Variable(s)	
Output Variable	
Research Design A) Qualitative B) Quantitative C) Mixed Methods	
Interventions	
Study Participants A) Students in education and training B) Graduations and early	
Context	
Reasearch/Program Objectives	
Research Area A) Leadership B) Gender C) Decent work/harassment/violence	
Study Title	
Year Published	
2. Co-authors	
1. Lead author	
Type of submission	
Insert your name as a reviwer	

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