DELIVERED BY WOMEN, LED BY MEN: A GENDER AND EQUITY ANALYSIS OF THE GLOBAL HEALTH AND SOCIAL WORKFORCE

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.







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

Horizontal and vertical occupational segregation by gender is a universal pattern in health, varies with context.

Driven by gender norms and stereotypes of jobs culturally labelled 'men's' or 'women's' work

Gender discrimination constrains women's leadership/seniority
Gender stereotypes constrain men eg entering nursing

Women in health typically clustered into lower status/lower paid iobs

Female majority professions given lower social value, status & pay

OCCUPATIONAL SEGREGATION

Women 70% global health workforce but hold only 25% senior roles Gender leadership gaps driven by stereotypes, discrimination, power imbalance, privilege

Women's disadvantage intersects with/multiplied by other identities eg race, class

Global health weakened by loss female talent, ideas, knowledge
Women leaders often expand health agenda, strengthening health for all
Gendered leadership gap in health is a barrier to reaching SDGs and UHC

LEADERSHIP

DECENT WORK:
DISCRIMINATION SEXUAL
HARASSMENT BIAS

Large % women in health workforce face bias and discrimination

Female health workers face burden sexual harassment causing harm, ill health, attrition, loss morale, stress

Many countries lack laws and social protection that are the foundation for gender equality at work

Male healthworkers more likely to be organised in trade unions than female

Frontline female healthworkers in conflict/emergencies/remote areas face violence, injury & death

GENDER PAY GAP (GPG)

GPG in health 26-26%, higher than average for other sectors

Most of GPG in health is unexplained by observable factors eg

Occupational segregation, women in lower status/paid roles, drives GPG.

Much of women's work health/social care unpaid and excluded in GPG

Equal pay laws and collective bargaining absent in many countries GPG leads to lifetime economic disadvantage for women

Closing GPG essential to reaching SDGs

Figure ES.2 Overarching findings and conclusions of 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

- 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.
- 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.