WOMEN'S LEADERSHIP IN THE HEALTH WORKFORCE

At the 73rd United Nations General Assembly, a group of advocates, thinkers, and policy makers convened to identify concrete actions that could be taken to make measurable progres on barriers to advancing women's leadership in the health workforce.

Throughout the past year, there has been increasing attention paid to the disparity between the vast numbers of women operating in the global health workforce and their representation in leadership positions. While women make up a large majority of the health workforce, their representation at management and director levels remain woefully low and certain specialties are coded as gendered (ex. anesthesiologists or pediatrics). There has been evidence from other sectors that an increase in the number of men in a given industry or position increases its pay & prestige, so it's an easy jump to wonder if a vast majority of frontline health worker positions were held by men, whether they would be better paid, given clear mobilized career pathways, and be considered altruistic volunteers as many women in these positions are now.

The following highlights some of the discussion and responses and look forward to seeing the discussion move forward in the coming months.

What steps can we take to address unpaid care delivered by health workers? What other changes are needed and feasible to address gender pay gap issues (e.g. creation of #MyWagesToo campaign)? What are the barriers to salary transparency and how can we break down those barriers?

What do we consider to be care work in the first place? In order to advocate around this issue, there needs to be consensus on what is included. One immediate way to address unpaid care work would be for workplaces or governments to provide child and/or elder care, enabling health (and other sector) workers to concentrate on their jobs and be unburdened by additional unpaid work. Lack of documentation is a huge barrier to achieving salary transparency. Often, payment is not formally executed, making it clear to have data-driven evidence of the gender pay gap within the health workforce. Beyond just getting health workers paid -- is being paid for labor rendered sufficient if the work conditions around that labor do not meet the definition of decent work? Does being paid justify being overworked? Some of these things can be addressed by strengthening professional asociations and coalitions, but we need to standardize competencies for all health worker cadres.

What policies have demonstrated success in achieving gender parity at leadership levels? Are there programs that have achieved parity, or close to it, that have not used quotas or other mandates that could be replicated?

There is evidence from implementation of gender quotas in politics that after two "generations", the image of women leaders was so normalized that gender quotas were no longer necessary which may suggest that they could work as a foundation for short term corrective measures. Take advantage of older women's leadership: the focus is often on developing and empowering young women, neglecting the needs and ambitions of older women. This works both ways -- younger women need to see older women in leadership positions to serve as role models, so attention is needed across age ranges. These more concrete steps are needed in addition to an overall shift of how we view women in the workplace.

Connect comprehensive sexuality education to the need to change gender power dynamics

What policy changes are needed to create a workplace free from harassment - at national/regional/local levels? Is the creation of reporting mechanisms effective? Are the policies or programs that have demonstrated success in prevention?

Discussions about sexual harassment can make some participants feel attacked, so it is important to approach workplace programs with non-confrontational language and with concepts that are relevant to the setting. In addition to ensuring that reporting mechanisms exist (for both the harasser and those that protect them), reporting mechanisms need to be tailored to the context - health workers also need a way to deal with harassment from patients. For health workers in many low-resource settings, it is especially important to ensure access to safe housing and accomodation to enable work in an unfamiliar community. Harassment and sexual violence prevention needs to start day one in schools with comprehensive education on consent, bodily autonomy, and appropriate language.

What actions could we take to ensure enough investment in health workforce and health employment in the right places to maximize the health & economic impact for women?

Engage private and public investments for health professional education

Many participants agreed that mandating that health workers be compensated would be an instantaneous economic impact for women around the world, but that kind of investment needs to be met with increased resources for supporting health workers so they are not overburdened and overworked. Occupational sex segregation is an issue for the health workforce both vertically and horizontally -- health is overall paid less by virture of its being a "women's" job, while specific positions within the health workforce (ex. nurses, midwives) are often undervalued by those positions being comprised mostly of women. Beyond gendered positions and industries, health is not considered to be profitable, so the economic case needs to be made at all levels of government and policy decision-making.

NEXT STEPS

- **Support the Global Health Workforce Network Gender Hub activities.**
- **Collaborate with and strengthen professional health workforce associations.**
- **Create mechanisms for documentation of barriers to women's leadership in the health workforce.**
- **Send us any ideas for advocacy and partnership!**