



**WGH** | WOMEN IN  
GLOBAL HEALTH

# Women in Global Health

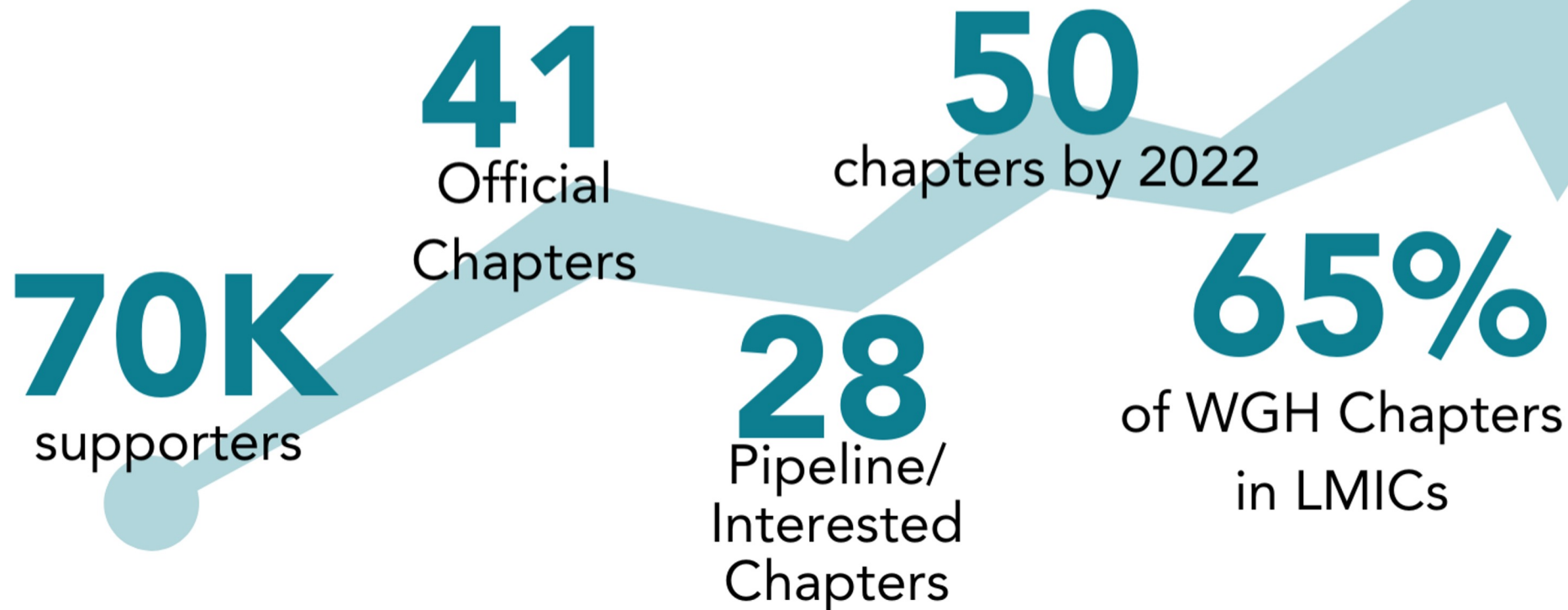
## Challenging Power & Privilege for Gender Equity in Health

Dr. Roopa Dhatt, Executive Director, Women in Global Health  
Norway  
8 September 2022

# WHO IS WOMEN IN GLOBAL HEALTH?

**Tagline:** Challenging power and privilege for gender equity in health

**About Us:** As a registered 501c3, we are the largest network of women and allies working to challenge power and privilege for gender equity in health. Since our founding in 2015, WGH has grown to include:



# WGH Does Things Differently

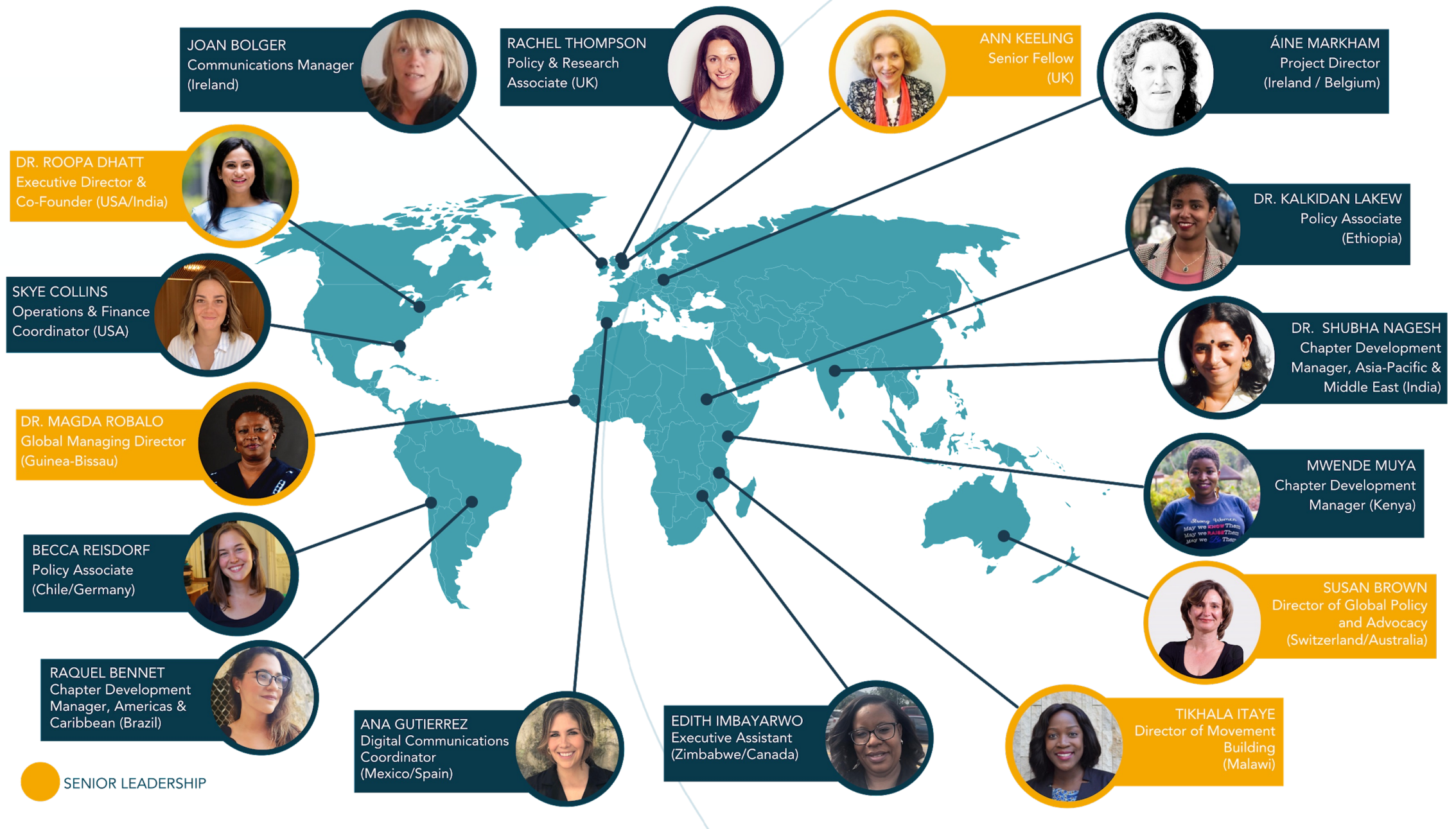
WGH brings a **power and privilege lens**, which provides a tailored approach to impact those hardest to reach and puts the last women first.

WGH can reach those **traditionally left out of the global dialogue**, driving true social change at all levels, among all genders.

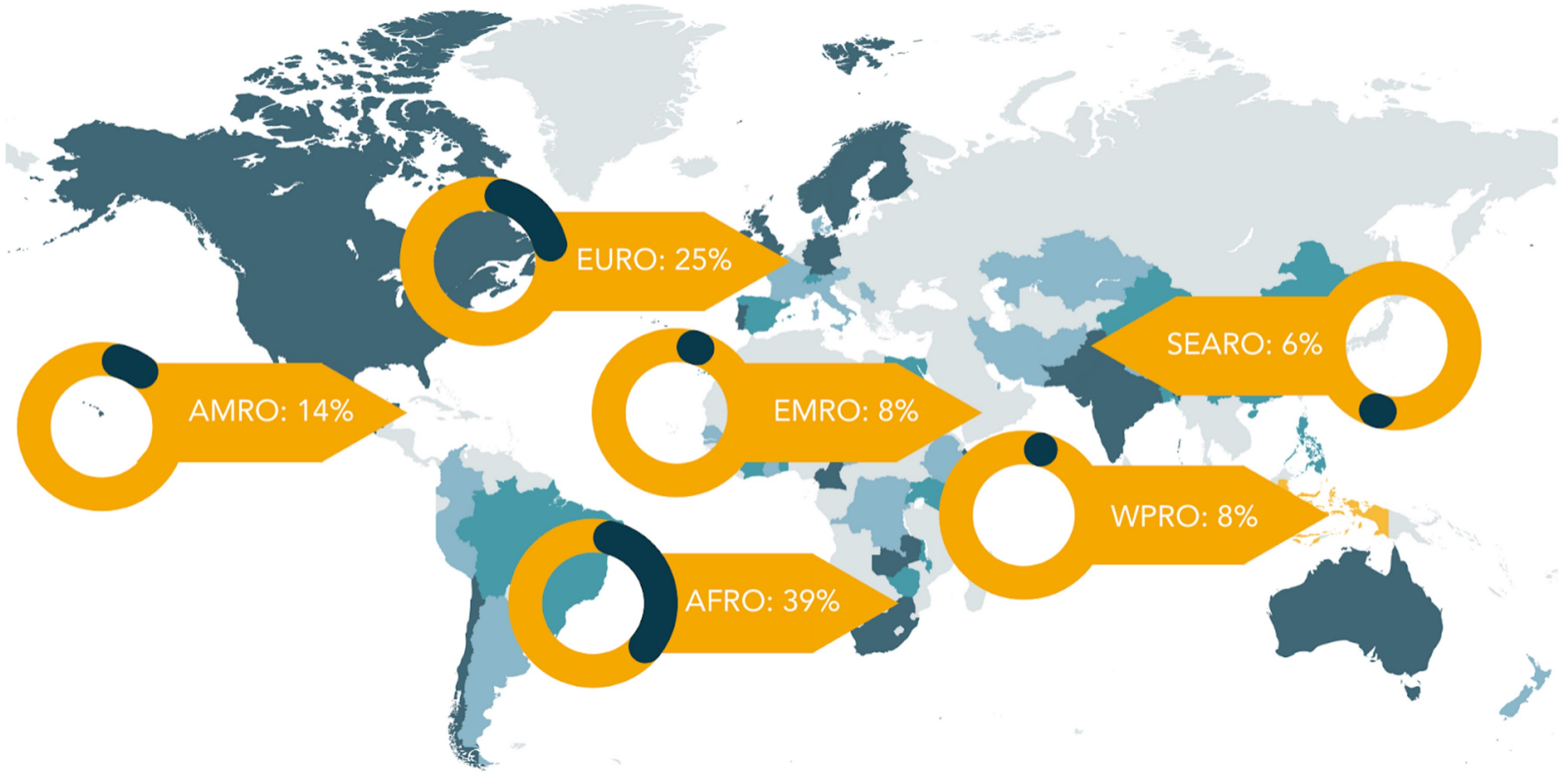
We work at global, regional and national levels through our network to drive change through evidence, policy and mobilization.



WGH Pakistan launch, August 2019



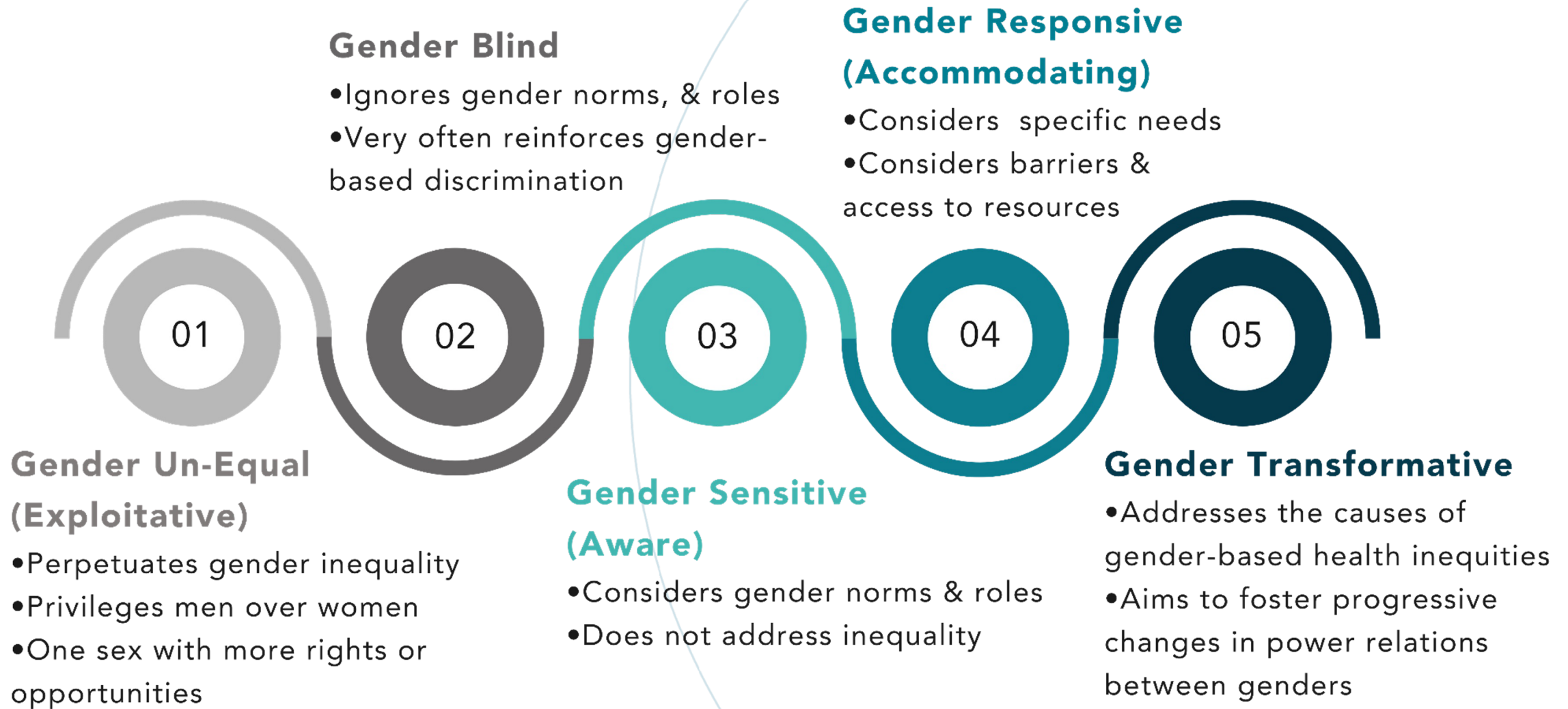
# Chapter Distribution



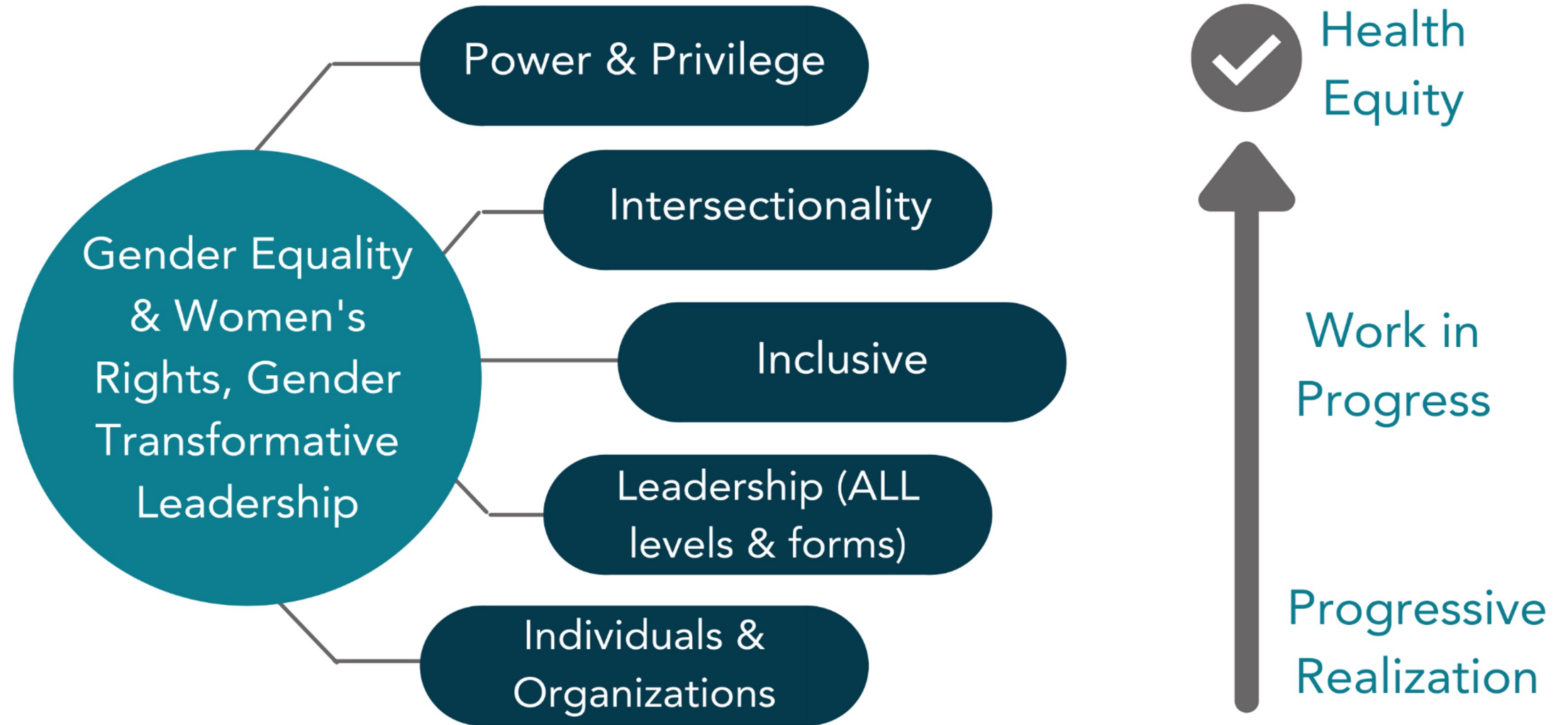
# GENDER-TRANSFORMATIVE LEADERSHIP



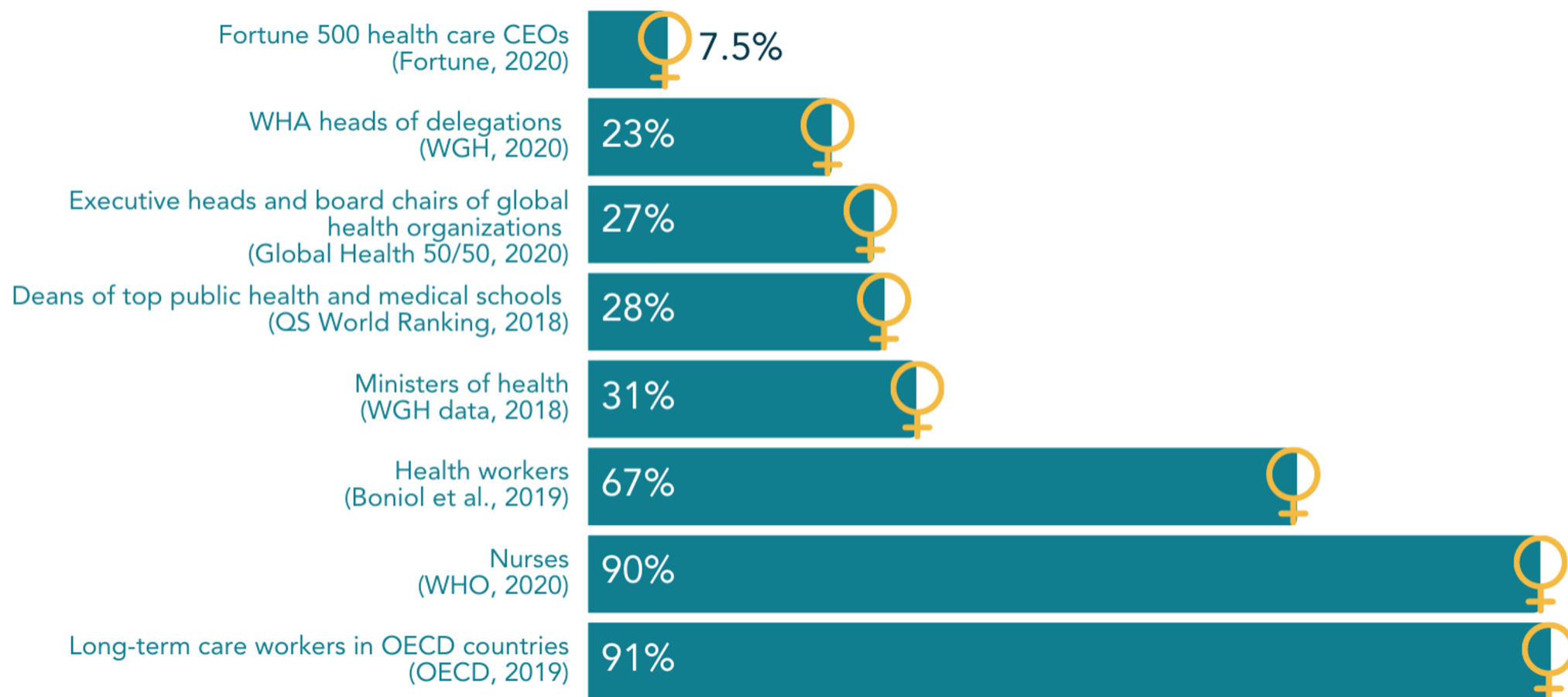
# Gender Transformative Approach



# Gender Transformative Leadership



# Global Health Leadership Pyramid





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Women contribute an estimated  
**\$3 TRILLION**    
to health annually

of which almost

**1/2** 

is unrecognized & unpaid.

# Women in Decision Making in COVID-19

**85%** of national COVID-19 task forces are comprised of majority of men

**3.5%** of task forces had gender parity



Source: Symptoms of a Broken System: The Gender Gaps in COVID-19 Decision-Making, BMJ Global Health

"This lack of representation is one symptom of a broken system where governance is not inclusive."

An urgent health workforce  
problem has just gone critical





Artwork by Dr. A Dhaliwal

# The pandemic exacerbates global health worker shortages

- **Pre pandemic global shortage** approximately 15 million health and care worker shortage to achieve universal health coverage.
- **Pandemic – losing health workers** from death, long COVID, burnout. Women health workers hardest hit by infection, increased unpaid work and exhaustion.
- **Pandemic is far from over.** Low vaccination rates in low income countries, health workers not protected.
- Low income countries fear **unmanaged migration** health workers to high income countries, threatens vulnerable health systems and universal health coverage.
- **Critical address gender inequities in health and care workforce** to retain women and attract women into new jobs – **health can be exemplar sector.**

# The problem: gender inequity in health and care workforce harms women AND health systems



Women 70% health and care workers (90% nurses), but hold only 25% senior roles – loss of talent, expertise, morale



Lower status roles often held by racial/ethnic minority, lower class/caste and migrant women – intersectionality multiplies disadvantage



Women are underrepresented in pandemic decision making – 85% national COVID-19 task forces majority male membership



Women are paid less: - 24% gender pay gap in health globally - over 6 million women health workers grossly underpaid/ unpaid



Women are clustered into lower status, lower paid roles in health e.g nursing not surgery



Violence and sexual harassment of women health and care workers 'treated as normal'. Increased in the pandemic

# GENDER EQUAL HEALTH AND CARE WORKFORCE INITIATIVE



#GenderEqualHCW



**GOUVERNEMENT**

*Liberté  
Égalité  
Fraternité*



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# Four Pillars of the GEHCWI

GEHCWI aims to drive action in the health and care sector under four pillars:



Increasing the proportion of women in health and care **leadership** roles



Recognizing the value of unpaid health and care work and the importance of **equal pay** in the health and social care sectors



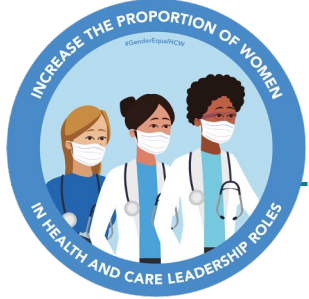
**Protecting** women in health and care against sexual harassment and violence at work



Ensuring **safe and decent working conditions** for all health workers, everywhere

# Gender Equal Health and Care Workforce Initiative 2021

## Sample Commitments



Set targets to reach gender parity in leadership

Champion gender equity in leadership and incorporate in performance indicators



Publish Gender Pay Gap

Move women in unpaid health system roles onto the formal payroll



Ratify & implement Convention ILO190

Implement and monitor best practice policies & processes against sexual harassment



Prioritise health workers for COVID-19 vaccination

Source PPE designed to fit women

# How will the GEHCWI achieve change?

## Deliver existing commitments

Engaging Member States to deliver on commitments made in this area, including in the Beijing Platform for Action; the Sustainable Development Goals; the Political Declaration on Universal Health Coverage and the Working for Health Five Year Action Plan 2017 – 2021.

## Garner new specific, measurable commitments

Inviting Member States, international organizations, foundations, NGOs and other significant global health organizations to make specific, measurable commitments under one or more of the four GEHCWI pillars to reduce gender inequity in the health and care workforce.

## Raise commitments at global political fora

Raising the commitments and recommendations from the June 2021 GEHCWI High Level Meeting at global political fora, including the G7, the United Nations General Assembly and the G20.

## WE THANK GOVERNMENTS THAT PLEDGED TO UPHOLD THEIR COMMITMENTS UNDER THE GENDER EQUAL HEALTH AND CARE WORKFORCE INITIATIVE

Commonwealth of Australia	Republic of Argentina	Republic of Fiji	The Republic of Guinea-Bissau United Mexican States United States of America
Democratic Republic of the Congo	Republic of Cape Verde	Republic of Liberia	
French Republic	Republic of Chile	Republic of Malawi	
Government of Ethiopia	Republic of Costa Rica	The Islamic Republic of Pakistan	

## WE THANK INTERNATIONAL ORGANIZATIONS THAT PLEDGED TO UPHOLD THEIR COMMITMENTS UNDER THE GENDER EQUAL HEALTH AND CARE WORKFORCE INITIATIVE





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Safe, decent, and equal work for women in the health and care workforce underpins strong health systems and global health security and will realize.....

# THE TRIPLE GENDER DIVIDEND:

-  **HEALTH DIVIDEND:** equal opportunities and decent work will attract and retain female health workers, helping to fill the 18 million global health worker gap.
-  **GENDER DIVIDEND:** investing in women to enter leadership and formal sector jobs in health will increase gender equality as women gain more income and decision making power.
-  **DEVELOPMENT DIVIDEND:** new jobs created in health will fuel economic growth and strengthen health systems and outcomes, all contributing to UHC and the SDGs by the 2030 end date.



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#GenderEqualHCW

# Examples from Women in Global Health's recent work



# #PayWomen in Global Health Campaign



At least **6 million**  
women work unpaid and  
underpaid in core health  
systems roles.

Subsidizing global health with  
their unpaid labour

#PAYWOMEN



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Health Policy Plus Project | Souleymane Bathieno/HP+

# #PAYWOMEN

## EXECUTIVE SUMMARY

**EXECUTIVE SUMMARY**

**SUBSIDIZING GLOBAL HEALTH:  
WOMEN'S UNPAID WORK IN  
HEALTH SYSTEMS**

April 2022



Women in Global Health Series: Gender Equity and the Health and Care Workforce



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## 01. WHY PPE IS A GENDER ISSUE

**P**PE was a gender issue before COVID-19. This report focuses on the health and care workforce during COVID-19, but women have faced challenges wearing PPE designed for men in all sectors. A 2017 research by the UK Trades Union Congress confirmed that it is commonplace for companies to procure men's PPE for women but in smaller sizes. "Wearing equipment designed for men can be fatal: women are 73% more likely than men to be killed in a car accident because crash test dummies are based on male body measurements," where COVID-

in most countries where COVID-19 infections among HCWs have been reported, disaggregated by sex, women were the majority of HCWs infected. At the start of the pandemic, infection rates of COVID-19 among healthy persons were significantly higher among women than men (75.5% vs 24.5% in Spain; with Italy seeing a similar ratio of women to 37% men.<sup>8</sup>

While some of the shortages and poor PPE for example, shortages and poor PPE affect HCWs of all genders, we are focusing on women because they make up 70% of global health workforce, and 90% of nurses.<sup>6</sup> Therefore, a medical PPE is not fit for women, is not fit for the majority of the health care workforce who have been on the frontline of the pandemic.

[illegible]

frontline HCWs, 90% of whom were women, to enable them to work long shifts with COVID-19 patients without removing their PPE.<sup>4</sup>

Our research finds that although HCVs, it does universal issue for women HCVs, it does not manifest equally. HCVs in high income countries have generally had access to PPE, while many HCVs in low-income countries still do not. The COVID-19 pandemic has exposed inequalities in health systems both within and between countries. Within all health systems, because of the lower status roles they hold, our data finds women have often been less able to access PPE than their male counterparts. There is also evidence that women from racial

There is also evidence that women from racial and ethnic minorities have been less protected, highlighting the intersectionality of gender inequalities in the health and care workforce.<sup>1</sup> PPE designed for women and minority races is often scarce, and internalized by women, as an 'unavoidable' economic burden for health systems. Women should not have to experience non-male, non-whiteness as their problem and a downside of their job, while believing that there is 'little to be done' about the situation.

“As the pandemic has unfolded, it has become apparent that PPE does not protect all workers.”

"As the pandemic has unfolded, it has become apparent that PPE does not protect all workers equally. This is because – quite often – these specifications are drawn up on the basis of the male body, which all too often is taken as the reference for the human population as a whole."<sup>7</sup>

# PAY WOMEN EVENTS

**SUBSIDIZING GLOBAL HEALTH**

7 APRIL 2022 | 8:00-9:30 EST | 14:00-15:30 CET



<b>Linda Etim</b> Deputy Assistant Administrator for Africa, USAID	<b>Desta Lakew</b> Group Partnerships & External Affairs Director, Amref Health Africa	<b>Dr. Magda Robalo</b> Global Managing Director Women in Global Health	<b>Dr. Svea Closser</b> Associate Professor, Johns Hopkins Bloomberg School of PH	<b>Sandra Massiah</b> Sub-regional Secretary for the Caribbean, PSI	<b>Bhanupriya Rao</b> Founder, Behanbox India	<b>Ann Keeling</b> Senior Fellow Women in Global Health	<b>Euniter Adoyo</b> Community Health Worker Lwala Community Alliance
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 #WHWEEK #PAYWOMEN  WGH | WOMEN IN GLOBAL HEALTH

We held **10** related events  
between 2021 and 2022, soft  
launching the #PayWomen report  
cohosting with strategic partners,  
and featuring government and  
international organizations'  
perspectives, as well as the voices  
of health and care workers.

**OF NO VALUE? WOMEN'S UNPAID WORK**

INTERACTIVE DIALOGUE | FRIDAY, 18 MARCH 2022 | 13:00-14:00 EST | 18:00-19:00 CET



<b>Dr. Nadine Gasman</b> President, National Women's Institute of Mexico	<b>Dame Marilyn Waring</b> Council Member, WHO Council on the Economics of Health for All	<b>Dr. Magda Robalo</b> Global Managing Director, Women in Global Health	<b>Dr. Madeleine Ballard</b> Executive Director, Community Health Impact Coalition	<b>Dr. Beverley Essue</b> Associate Professor of Global Health, University of Toronto	<b>Ms. Margaret Odera</b> Health Workers Advocate, IntraHealth International, Mathare, Kenya
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#Economy4Health   WGH | WOMEN IN GLOBAL HEALTH  Community Health Impact Coalition #CSW66

# KEY FINDINGS

- 1 Calculating the number of women working unpaid and underpaid in health is complex
- 2 There are diverse forms of remuneration and incentives but none give economic security
- 3 Unpaid work tasks differ, as does time commitment
- 4 Women take unpaid health roles for a mix of reasons
- 5 Unpaid work may have some benefits for women but generally it undermines their economic rights and potential
- 6 Health systems are weakened by depending on women's unpaid work
- 7 The pandemic increased the burden on unpaid women workers in health but raised awareness of their work



# Women's Leadership in Global Health Governance at the WHO

GLOBAL VIEWS | GLOBAL HEALTH

## Opinion: We must get women into the 'control room' in global health

By **Dr. Roopa Dhatt, Myrna Doumit, Dr. Magda Robalo** // 02 February 2022

Global Health

Social/Inclusive Development

Institutional Development

WHO



*A World Health Organization executive board session in Geneva in 2016. Photo by: Denis Balibouse / Reuters*

# It's time for a gender equal WHO EB

## Women members as % of WHO's Executive Board (final count)\*

WHO EB145  
2019



WHO EB146  
2020



WHO EB147  
2020



WHO EB148  
2021



WHO EB150  
2022



#WomeninGH

#EB150

# CALL TO ACTION:

## To ensure gender parity on WHO's Executive Board and World Health Assembly delegations.



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#GWL | VOICES  
FOR CHANGE & INCLUSION



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February 7, 2022

Dr Patrick Amoth

Chair of the Executive Board of the World Health Organization

& Sra. Carla Moretti

Vice Chair of the Executive Board of the World Health Organization

cc the 33 other members of the Executive Board

**RE: ENSURING GENDER PARITY ON THE WHO'S EXECUTIVE BOARD**

Your Excellency,

Last week the World Health Organization's (WHO) 150th Executive Board (EB150) met as the world entered the third year of a global pandemic which continues to devastate lives, communities and economies. Health has never been higher on the global agenda, making the role of the WHO's EB pivotal in global health decision-making. For this reason, it is critical that the composition of the Board is fair and equitable, reflecting the diverse voices and views of all people in the decisions it makes since they impact everybody's health. The design of the EB builds in geographical diversity but it does not build in equity for women - only 6% of last week's EB150 members were women and women's representation has been falling over time.

Women comprise 70% of health and care workers globally and 90% of nurses. For the last two years of the pandemic women have held the overwhelming majority of patient facing roles, risking their own health and safety to shoulder the burden of soaring patient numbers. Women have been the social shock absorbers in this health emergency, taking on extra shifts in hospitals and additional hours of unpaid care for family and community members. Yet only 2 women (from Argentina and Slovenia) out of 34 EB150 members represented the health interests of nearly 4 billion women and girls across the globe at the EB150 meeting.

Before the pandemic women held only 25% of senior leadership positions in global health. In a profession where women are the experts in the health systems they largely deliver, that number was unacceptably low. It was, however, at least moving in the right direction. Prior to the COVID-19 pandemic, women's representation on the WHO EB had risen to 32% in January 2020. But by 2021, one year into the pandemic, the percentage of women at the EB table had fallen to 18% and then it fell further to 6% in 2022. That mirrored the marginalization of women in pandemic leadership at national level, with 85% of national COVID-19 task forces having majority male membership and only 3.5% having equal numbers of women and men. It is of serious concern that expert and qualified women have been so marginalized in health leadership during the greatest global health emergency in contemporary history.

Various items on the agenda of EB150 last week highlighted the potentially positive impact of gender parity in leadership in WHO on better health and governance. Too few women in leadership was identified by WHO staff as a reason why complaints of sexual exploitation, abuse and harassment were not taken seriously, according to the Independent Oversight and Advisory Committee (IOAC) report presented to the EB150 meeting. The marginalization of women in leadership in health systems is also cited as a contributory factor to the low morale of women health and care workers, who have often felt expendable rather than essential during the pandemic. There are reports from many countries that a 'Great Resignation' of health workers is underway, particularly among women health workers who are exhausted and burnt out after two years on the pandemic frontlines. Some estimates show that 1 in 5 health workers, especially nurses, are planning to leave the profession. Before the pandemic there was a global shortage of trained health workers, with an additional 18 million needed to achieve Universal Health Coverage by 2030. There are no health systems without the women who largely deliver them and this 'Great Resignation' requires all Member States to address gender equity urgently in the health sector.

LETTER TO WHO | 1



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# MEMBER STATES ARE MAKING DECISIONS NOW ON WHO WILL DECIDE OUR FUTURE GLOBAL PANDEMIC RESPONSE!

CALL ON THE **WHO EB** TO:

1. Strengthen **women's participation** in decision-making.
2. Be **gender responsive** in the pandemic prevention, preparedness and response.



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#GWL | VOICES  
FOR CHANGE & INCLUSION

\*Resolutions: WHA49/199, C/98, WHA73/2020, REC/17

# COVID 50/50



# About COVID 50/50

In early 2020, after the COVID-19 pandemic devastated the world, WGH took immediate action by launching the COVID 50/50 campaign which featured several events and initiatives under its umbrella to promote WGH's 5 Asks for Global Health Security. This included:

- Women in Global Health Security Summit
- Women, Power, & Leadership Action Lab Series
- #BuildBackBetter Digital Innovation & AI Challenge
- REPORT: Global Health Security Depends on Women
- Operation 50/50 Roster



# WGH'S 5 ASKS FOR GLOBAL HEALTH SECURITY

- 1 Include women in global health security decision making structures and public discourse
- 2 Provide health workers, most of whom are women, with safe and decent working conditions
- 3 Recognize the value of women's unpaid care work by including it in the formal labor market and redistributing unpaid family care equally
- 4 Adopt a gender-transformative approach to health security data collection/analysis and response management.
- 5 Fund women's movements to unleash capacity to address critical gender issues

# Women in Global Health Security Summit

The WGH Security Summit partnered with Foreign Policy and the Wagner Foundation to put on a day-long summit with high-level speakers from around the world and garnered commitments from over 40 organizations and governments.

**1,400+** total live attendees

**9,385+** views from around the world



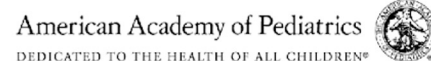
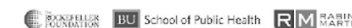
“The response will change when you bring women to the fore with policies.” - Sahle-Work Zewde, President of Ethiopia”

**50+** speakers participated in the summit, **90%** were women, and **40%** from LMICs, with **6+** professions represented.

## WE THANK GOVERNMENTS THAT PLEDGED TO UPHOLD THEIR COMMITMENT TO SDG5 IN THE CONTEXT OF COVID-19



## WE THANK ORGANIZATION PARTNERS THAT COMMITTED TO WORK TOWARDS GENDER-RESPONSIVE HEALTH SECURITY IN THE CONTEXT OF COVID-19





# Q&A



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# JOIN THE MOVEMENT



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



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Contact us: [membership@womeningh.org](mailto:membership@womeningh.org)

