Working paper on Gender & Equity in the Health and Social Care Workforce

Consultative Draft Report (Work in progress)

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Foreword
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Acronyms
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<th>Acronym</th>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<td>GEH</td>
<td>Gender Equity Hub</td>
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<td>GHWN</td>
<td>Global Health Workforce Network</td>
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Executive Summary

The importance of promoting a gender equality and human rights based approach to global health and social workforce programmes and policies has been established as a key policy agenda of policy makers and international development partners in light of the Sustainable Development Goals (SDGs). The purpose of this literature review is to synthesize the literature on gender and equity within the global health and social care workforce. This literature review focuses on trends in global health workforce participation, leadership, gender pay gap, and occupational segregation.

Chapter one provides an overview of the Gender Equity Hub, which is one of the thematic hubs of the Global Health Workforce Network, and is co-chaired by the World Health Organization (WHO) and Women in Global Health. It also provides a snapshot of the current state of evidence and the rationale for doing gender analysis within the global health and social care workforce.

Chapter two highlights key objectives and detailed methodology used to conduct the literature review.

Chapter 3 highlights the gender gap in leadership despite women being the majority of the health workforce globally and the barriers they face in achieving positions of leadership.

Chapter 4 highlights the gender pay gap which is defined as the differences in incomes between men and women across different health professions. Some of these studies are drawn from other sectors and highlight the factors that contribute to gender wage inequalities.

Chapter 5 highlights decent work as work without discrimination, bias or harassment which includes gender-based biases and sexual harassment.

Chapter 6 provides an overview of occupational segregation in global health and how the majority of women are clustered in primary health care, nursing and midwifery, leading to a phenomenon known as the ‘feminization of healthcare professions’.

Chapter 7 highlights the rationale for achieving gender equality within the health and social care workforce as a key to building stronger and resilient health systems.

Chapter 8 highlights the strengths and limitations of the literature review highlighting areas of future research work.

Chapter 9 provides policy recommendations and a call for action to address the gender inequities within the global health and social care workforce.
Chapter 1: Introduction

Background

With 7 out of ten health and social care workers being women and unpaid care work representing half of women’s annual $3 trillion contribution to global health, resilient health systems and universal health coverage (UHC) cannot progress without consideration of gender-related trends and dynamics in the health and social care workforce [1]. Yet systemic challenges, gender biases and inequities persist for women in the health and social care workforce around the world. These significant challenges result in system inefficiencies that are attributed to bottlenecks in health worker educational pipelines, recruitment bottlenecks, attrition, and worker distribution imbalances across formal and informal health workforces.

**Gender** is a social construction reflecting the distribution of power between individuals, and is influenced by history, laws, policies and politics, by economic, cultural, community and family norms that shape the behaviors, 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, place and through the life-course.

*Gender interacts with, but is distinct from, the binary categories (male, female) of biological sex. Gender also intersects with, and is shaped by, other axes of inequality—e.g. age, education, economic position and power, race and ethnicity.*

*When a person’s gender identity does not correspond with their assigned sex, they may identify as transgender [2, 3].*

With the growing population around the world, there is growing demand for health care. The growing need for affordable and accessible health care services has increased the complexity of challenges we face in terms of the changing patterns of disease, natural disasters and climate change. To make the situation worse, there is a global shortage in the health and social workforce with non-uniform distribution in terms of geographical locations (e.g. urban and rural settings) and areas of specializations (e.g. primary care vs. surgical care). Thus, health systems around the world are facing a dilemma: growing demand and a shortage in supply that calls for a global action to address the problem.

Developing countries especially in Sub-Saharan Africa are faced with a critical shortage of skilled health personnel. Out of the six regions of the WHO, the African region, has the lowest doctor-patient ration of 2.5/100,000 as compared to USA with 20.4/10,000 and European regions with 33.3/10,000 population[4]. Japan is also facing a “medical crisis” with closure of health care facilities due to shortages of medical personnel [5, 6]. A recent report published by the Association of American Medical Colleges concluded that the USA will face a shortage of 40,800 to 104,900
physicians by 2030. For primary care the shortage will be around 8,700 to 43,100 and shortages in non-primary care specialties will be around 33,500 to 61,800 physicians [7].

While human resource planning and policy in the health sector have previously been gender blind in relation to health care production and delivery[8] and health workforce planning[9], more recent global health and workforce strategies are recognizing the critical importance of addressing the gender challenges of the health and social workforce as key to achieving the SDG target of Universal Health Coverage (UHC) by 2030, and maximizing women’s economic empowerment and participation.

**Gender Blind** refers to the failure to recognize that the roles and responsibilities of men/boys and women/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. [10]

SDG 5 makes a universal commitment to: “Achieve gender equality and empower all women and girls”[11]. Addressing gender biases and inequities in the health and social workforce is not only essential to achieving SDG 5, but also to achieving SDG 3 (health and well-being), SDG 4 (quality education) and SDG 8 (decent work and inclusive economic growth). SDG 4 (quality education) for girls in particular, will be the essential foundation for all other SDGs.

**Gender equality in the health workforce** describes a condition where 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; implies that workplaces are structured to integrate family and work to reflect the value of caregiving for men and women [12].

**Gender equity** is the process of being fair to men and women. 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 a means. Equality is the result. [13]

The WHO Global Strategy on Human Resources for Health (HRH) Workforce 2030, was developed to advance progress towards the SDGs and UHC by ensuring equitable access to health workers and it calls for the alignment of gender, employment, education and health with national human resource development and health system strengthening strategies [14]. The WHO Global Strategy on HRH estimates a global shortfall of almost 18 million health workers by 2030, primarily affecting low- and lower-middle income countries. This projected global deficit, coupled with rising demand to create approximately 40 million to 67 million new health and social 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.

The UN High-Level Commission on Health Employment and Economic Growth, recognizing that the health sector can greatly contribute to gender equality by being one of the biggest and fastest growing employment sectors for women [15], made the following Recommendation on gender equality and rights: “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 [16].”

The WHO partnered with the International Labour Organization (ILO) and the Organization for Economic Co-operation and Development (OECD) to support the implementation of the UN Commission Recommendations. The ILO-OECD-WHO Working for Health Five-Year Action Plan identified the (1) development of gender-transformative global policy guidance and (2) 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 [17]:

**Deliverable 2.1:** Gender-transformative global policy guidance developed and regional and national initiatives accelerated to analyze and overcome gender biases and inequalities in education and the health labour market across the health and social workforce, for example:
1) increasing opportunities for formal education,
2) transforming unpaid care and informal work into decent jobs,
3) equal pay for work of equal value,
4) decent working conditions and occupational safety and health,
5) promoting employment free from harassment, discrimination and violence,
6) equal representation in management and leadership positions,
7) social protection/child care, and elderly care)

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

*Gender-transformative approaches are programs and interventions that create opportunities for men and women to challenge gender norms, promote positions of political and social influence for women in communities, and address gender inequities between person of different genders [18].*

**About the WHO GHWN Gender Equity Hub**

Facilitating the development of evidence-based gender–transformative global guidance and their implementation requires a collective and concerted effort. The WHO established the Global Health Workforce Network (GHWN) and Gender Equity in the Health and Social Workforce Hub
or the ‘Gender Equity Hub’ (GEH) with it, at the 4th Global Forum on Human Resources for Health held in November 2017. GEH brings together key stakeholders to collaboratively achieve the deliverables of the Working for Health Five-Year Action Plan. The purpose of the Gender Equity Hub is to accelerate large-scale gender transformative progress to address gender inequities and biases in the health and social workforce in order to achieve the SDGs. The Gender Equity Hub works in tandem with GWHN’s other thematic hubs focused on topics identified to be crucial for progressing the WHO’s Global Strategy on HRH and the Working for Health program.

The Gender Equity Hub is co-chaired by the WHO and Women in Global (WGH). WGH is an organization built on a global movement that brings together all genders and backgrounds to achieve gender equality in global health leadership. The GEH hub brings together members from a range of global health stakeholders including intergovernmental/multilateral agencies, civil society organizations, academic and research institutions, think tanks, UN member states, foundations, private sector and individual experts.

The work of the GEH is focused on the priority areas of equal representation in management and leadership positions, equal pay for work of equal value, and promoting employment free from harassment, discrimination and violence.

Activities of the hub span the following:

1. Mapping: to map global evidence on good practice
2. Data and Evidence: to evaluate current data and evidence, and identify gaps for future research and development
3. Policy Tools: to capture and develop policy briefs
4. Dissemination: to disseminate evidence, policy tools, advocacy kits, accountability scorecards, and guidance to other GHWN hubs
5. Implementation: to facilitate implementation of policy guidance through policy labs, business solutions, and public-private sector engagement

Why do gender analysis on health and social care 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, the impact of health expenditure discrimination on the female population, among others [8]. However, the evidence base is relatively thin on the gender dimensions of the health care production side and human resources for health. Where available, research on this area rarely extends beyond sex-disaggregation into critical aspects of gender power relations in health systems and their
implications for aspects such as working practices, career patterns, and occupational choices [8, 19].

Gender analysis on the health and social care workforce is important for health systems research. For research to instill social and policy change for better health, it ought to aim “to transform institutions, structures, systems, and norms that are discriminatory” [20]. 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 taking into account the effects of past discrimination, recognizes that rights, entitlements, opportunities and access are not equally distributed throughout the society, and the need to sometimes treat people differently to achieve equal results.

**Intersectionality** is a feministic 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 not only defined by gender but by other identity factors such as race, class, age, religion and sexual orientation to name a few – all of which are determined, shaped by, and imbedded in social systems of power. Intersectional paradigms view race, class, etc. as mutually constructed systems of power that require special measures to reach women who face multiple forms of discrimination [21].

**Substantive Equality** is a principle that takes into account the effects of past discrimination, recognizes that rights, entitlements, opportunities and access are not equally distributed throughout the society, and the need to sometimes treat people differently to achieve equal results. Allows for differential treatment to the level playing field for women, particularly where structures of dominance and subordination are embedded in the baseline of opportunity [21].

Investing in evidence on gender aspects of the human resources for health is needed to progress the implementation of global recommendations and guide global health policy makers and institutions in developing gender-transformative policy. The Global Health 50/50 Report (2018) evaluated the gender-responsiveness of the world’s most influential global health organizations by looking at two dimensions: gender-responsive programmes and policies and gender equality at the workplace. The report finds that, among 140 global organizations, only 40% mention gender in their programme and strategy documents and not enough is being done to support gender equality in the workplace. [2]

With global health policy responsiveness to gender lagging behind, more evidence is needed now more than ever to support the development of evidence-based, gender-responsive health policies across global health systems and institutions.
Chapter 2: Objectives and Methodology

2.1 Objectives

The main objectives of this literature review are:

I. To identify the available data and evidence from the literature (published and gray) on addressing gender equities in the health and social care workforce.

II. To examine case studies, policies, tools, strategies and their impact on addressing health and social care workforce gender equity and occupational segregation issues.

III. To map programmes, initiatives, stakeholders, campaigns and inter-sectoral opportunities across the public and private sectors of relevance to addressing gender inequities and biases in the health and social care workforce.

IV. To synthesize lessons learned from the evidence, programmes, initiatives and campaigns and how they can be applied to the health and social care sector.

2.2 Methodology

A comprehensive review of peer-reviewed articles, policy briefs and programme interventions was undertaken to evaluate gender and equity research within the health and social care workforce globally. The process included the following:

1. A global call for submissions on good practices and best practices was conducted by the Gender Equity Hub from December 2017 to January 2018. All articles, policy briefs, programs and other interventions received were analyzed. A total of 25 submissions were received through this call, which included peer-reviewed publications, program interventions as well as policy briefs. All of these submissions were decided to be included in the review.

2. Following the completion of the call for submissions, the Gender Equity Hub members provided further readings and articles to guide the literature review. A total of 98 articles were received after removing duplications.

3. A comprehensive and robust literature review was conducted utilizing a keyword search using electronic databases: PubMed and Google Scholar. Keywords used to perform the search include: gender, bias, discrimination, inequalities, harassment, violence, stereotyping, gender wage gaps, occupational segregation, gender parity, women’s leadership in global health, health and social care workforce. AND and OR Boolean operators were used to search the databases. A total of 40 articles were found after removing duplications from step 1 and step 2.
4. For the 138 articles retrieved through step 2 and step 3, paper titles and abstracts were examined using following inclusion criteria: 1) studies published in peer-reviewed journals, 2) published in the year 2000 and beyond, 3) English-language publications, 4) articles for which full-text was available or accessible to us, 5) studies evaluating gender and equity dimension in the workforce, and articles pertaining to health and social care workforce were prioritized. A total of 114 articles included our criteria and were selected to be included in the review.

5. A total of 138 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 138 articles.

7. We intend to search the subsequent reference lists to pull out further articles that fit our inclusion criteria and those that may have been missed in steps 1 to 4. This has not been done for this consultative draft, however, will be conducted in round 2 of the review.
Chapter 3: Leadership & Governance

3.1 Leadership and governance in the Global Health and Social Care Workforce

Across health and the health workforce, women are underrepresented in the upper levels of management, leadership and governance. 31% of the ministries of health are led by women [22]. In examining health leadership, Dhatt et al, found that at the 68th World Health Assembly only 23% of Member States had a woman in the role of chief delegate [23]. Some of this relates to the fact that women are also underrepresented in the senior levels within Ministry of Health (MoH) in some countries, for example in the Cambodian MoH women only held 20% of senior roles [23].

The majority of the reviews of leadership in the health and social care workforces has been focused on women’s leadership in medicine. However, a study in 2006 also found that despite increasing numbers of women in pharmacy, they are still underrepresented in leadership roles [24]. Ramakrishnan et al, looking beyond the United States, found that regardless of the rates of representation of women in a medical field in a country, across the board they are underrepresented in more prestigious specialties, and in leadership particularly [25]. Within anesthesiology women’s leadership is lower than other medical professions [26]. Looking at the leadership in the World Federation of Societies of Anaesthesiologists (ASFA), showed a striking lack of representation across boards (5:1, men:women), councils (15:5) and committee chairs (9:1) [27]. In academic medicine, Downs et al, found that in the top 50 US medical schools only 24% of the directors were women [28]. While Ash et al, 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, this was confirmed even after other factors were accounting for including number of publications and degrees [29].

3.2 Factors that contribute to leadership and governance gaps in the Global Health and Social Care Workforce

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:

1. Issues around initiating a family, leave and balancing gendered expectations of women related to child-rearing. Ramakrishnan et al, found that these barriers existed even in countries where there were progressive leave policies [25].

2. Overall gender norms and expectations of women negatively impacted their advancement to leadership [21, 30]. In Cambodia, gender norms impacted how men and women engaged in the health sector, and were exacerbated by issues around access to education, family responsibilities and risk to female security [30]. Dhatt et al noted that gender norms impacted women’s progression to leadership at three intersecting levels, including the individual, household and community and within health systems [23].
Zambia and Uganda, gender norms and the understanding of key leadership traits negatively impacted the advancement of women, and organizational processes leading to leadership, i.e. hiring, promotion, as leadership itself were gendered [21].

3. Bullying and sexual harassment also negatively impacted women’s advancement to leadership positions [30, 31].

4. Leadership gaps were also the result of vertical occupational segregation, which were the result of gender stereotypes, biases and notions [21].

5. Finally, 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 its reliance on a hierarchal system that disregards the modern needs of people to balance career expectations without non-career expectations [32].

3.3 Recommendations

1. The institutionalization of women’s leadership, particularly the institutionalization of gender-responsive leadership [23]. For example, the utilization of the ILO labour standards, which govern equal opportunity and non-discrimination, which should be operationalized in human resource for health policies [21].

2. It was also noted that to achieve recommendation one, there is also the need to garner political will and to gender mainstream within health workforce policy [30].

3. Mentorship was highlighted as a key component of supporting women’s advancement [28, 30, 31, 33, 34]. Javadi, et al recommended pairing young women with leaders, and that early social support enabled women leaders to develop confidence and credibility [35]. Reichenbach et al, particularly recommended, a more focused mentoring and support system throughout the entire process [34]. However, a study which undertook interviews with women Chief Executive Officers of healthcare organizations found that mentorship was helpful in their advancement, but not critical [33]. Two examples of mentorship programs are found below in the text box.

4. Multiple sources also recommended the direct targeting of gender bias within the workplace [30, 31, 34]. In particular, it was recommended that leaders regardless of gender should undertake values clarification on gender norms to understand its impacts on leadership and advancement [34].

5. Targeted leadership training grants and research-enabling grants [28] are also recommended as ways to go beyond classic mentorship models.

6. Setting targets and quotas for female candidates were suggested as a means to ensure female representation [30, 36].
Examples of promoting women’s leadership

**Program 1**

An intensive research mentoring program targeted at young women in research institutions in Africa noted a 100% retention rate, and the placement of all fellows in their first choice during the national service scheme matching [37].

**Program 2**

The Employment for Women in Health Initiative in Liberia has focused on providing leadership development for women health workers in its post-Ebola health systems restructuring, but it is too soon to measure the results [38].
Chapter 4: Gender Pay Gap

The Gender pay gap is an everyday reality affecting women globally. Gender pay gap is defined as the differences in median earnings between men and women. Gender inequalities and discrimination in terms of gender pay gap in the workforce are dissected greatly by global economists and have spurred many research initiatives. However, 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 developed countries [39]. Research gaps remain in our understanding of the factors contributing to the gender pay gaps in low and middle income countries.

Historically, women have earned less than their male counterparts. Variations in wages between men and women vary between industries and professions, as well as non-employment factors such as race and ethnicity. In the USA, the healthcare industry is both amongst the industries with the largest pay gap [39] and also one that exhibits the largest differences in wage between professions [39]. In United States, women earn 80 cents for every dollar earned by a man [40], the gap is even wider for women of color, with Africa-American women earning 62 cents and Latinas earning 54 cents for every dollar earned by a man [41]. Across the 28 member states in the European Union, women on average earned 16.4 percent lower pay than men [42]. On average, the gender pay gap around the world is around 23% [43].

4.1 The Gender Pay Gap in the Global Health and Social Care Workforce

The gender pay gap varies across different occupations within healthcare. One study from Australia found the average gender wage gap to be 16.7 percent [44]. Even in industries where women are playing a larger role such as dentistry, women continue to earn less than their male colleagues [45, 46]. Similarly, in the USA the number of women pharmacists has seen an increase, but the gender pay gap persisted [24]. Amongst academic pharmacists, the gender wage gap was also present even when accounting for qualifications and years in service. In the USA, the number of women taking up anesthesiology is increasing but still female anesthesiologists earn 25% less than their male counterparts compared with a 17% gap for all physicians [47-49]. One study conducted in medical faculties in the USA concluded that women were less likely to become full professors as compared to men and earned lower wages even after controlling for observable factors [29, 50]. Physicians were found to earn $16,819 more than newly trained female physicians, a gap that had increased five times in the 9 year period [51, 52].

In Australia, Vecchio et al. concluded that being a woman was a major explanatory factor for the wage gap within healthcare [44]. Elsewhere research highlighting the gender gap between male and female physicians attributed much of the difference to gender differences in specialty choice and hours worked. However, recent studies suggest that the gender gaps in physician salaries persist even after controlling for specialty, practice type, and hours worked. (seabury 2012) On one hand there are studies that show the gap in wages to converge after controlling for these
observable factors such as specialty, numbers of hours worked; while other studies demonstrate the disparity in physician starting salaries persist. Due to limitations in these studies, it is difficult to draw a conclusion in light of these mixed findings.

4.2 Factors that contribute to gender wage gaps

i. A growing trend in wage differentials is due to unexplained factors. This means that studies have concluded that even after controlling for observable factors such as specialty choice, work hours, or other characteristics, a large portion of the gender pay gap remains unexplained. [44, 51, 53, 54]

ii. Subtle and unconscious bias has implications on women’s careers, hiring rates, salaries and promotions. These unseen and unfair barriers women face in the health care labor market need to be addressed. [39, 55]

iii. Occupational segregation and sorting of men and women in specific type of jobs emerges as a key contributing factor to gender pay gaps. Women are concentrated in primary health care, low-grade and low-paying jobs, public sector and employed part-time. [39, 56, 57]

iv. The differences between men and women’s human capital endowments, job characteristics and family responsibilities impact the gender gap [58].

v. Wage gaps are consistent across different occupations. Men are likely to work longer hours than women and the gap widens as the occupation gets higher paid. [58]

vi. The wage gap widens with higher level of education, with men receiving higher returns to schooling. [44, 59-61]

vii. The gender wage gap widens with seniority [62]. This phenomenon was found to be true for both physician and non-physician groups of women [29].

viii. Women are more likely to pay a higher penalty for being married and having children especially at low-paying jobs. Married men and those with dependent children on the other hand were found to earn higher as compared to single men. [58, 61, 63]

ix. When you control for important factors such as age, education, experience, industry, occupation, specialty choice, practice setting, work hours, or other characteristics the pay gap still exists [51, 64]. 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 nonmedical final degree, and school [29].
The fact that there are gender wage gaps in health care is very alarming as it implies that women despite being majority of the global health and social care workforce, are still unable to gain respect and job status that are equal in caliber to their male counterparts. Thus the gender pay gap remains a huge global health concern, as building stronger and resilient health systems would require women to participate in the workforce with their full potential, which will not be possible until pay inequities are addressed.

4.3 Why addressing the gender pay gap in the global health and social care workforce is important?

Addressing gender equality and the elimination of discriminatory practices in the workforce are closely linked. The presence of subtle, unconscious biases can influence women’s careers, salaries and hiring. Recognizing these close links, the United Nations, including the International Labor Organization (ILO) has identified gender pay equity as a basic human right and have passed conventions to improve women’s pay. Within the health and social care workforce, it is important to address the gender pay gap for a multitude of reasons, including:

i. The gender wage gap is directly linked to poverty as it has implications for lifelong financial strength. Poverty effects women at disproportionately higher rates as compared to men [65], and eliminating the gender wage gap could half poverty levels for women [66].

ii. Women face greater pressure to leave paid job opportunities when couples are struggling to fulfill family obligations [67-69]There is greater aspiration of egalitarian relationships among younger generation, but gender wage gaps undermine these goals [70]. To overcome this pressure, women are delaying marriage and motherhood until their early thirties, or forgoing it altogether [71].

iii. Earning lower pay means lower pensions and lesser income from Social Security for retired women as compared to retired men. Similarly, it means women qualify for lower disability and life insurance benefits.

iv. Wage differences lead to lower morale and motivation to work longer hours or cause women to quit the workforce altogether. With the majority of the health and social care workforce being women, this has serious implications as women compared to men are more likely to opt for working shorter hours, taking part-time jobs and devoting less time to patient care. With the growing shortage of global health and social care workers, addressing gender pay gaps needs serious efforts from policy makers to improve the labor supply and meet health care needs of an aging populations.
Despite advances in policies and reductions in gender pay gap over the years; the difference persists which calls for global action to address the problem. In a recent survey on equal pay conducted in the USA; it was found that almost one third of the Americans were not even aware that the gap existed and men were twice as likely to think it didn’t exist as compared to women [72]. In another study, 80% men thought their salaries to be comparable to those of women as compared to 41% women who felt their incomes were comparable to those of men [50]. Thus, there is a need to increase awareness of the problem in order to address it.

4.4 Limitations of Current Research

With over 50 percent of the gender pay gap attributed to unexplained factors, there is huge gap in our understanding and research. The current literature has many limitations:

i. There is lack of pay data that is gender-disaggregated and spans over multiple time periods. The gap in adequate datasets limits the research analysis to be cross-sectional. Longitudinal studies that analyze data over different time periods could help explain the gender wage differentials as well as identify factors contributing to the gender wage gaps.

ii. Research highlights that unpaid overtime helps explain the gender wage gap. Further studies should incorporate this factor in their analysis. According to International Labor Organization there is a missing link between gender inequalities in unpaid care work and the analysis of gender gaps in labor outcomes such as participation of the sexes in the workforce, salaries and quality of job which need to be further studied and evaluated.

iii. There is a need to shift the narrative and research focus away from traditional or mainstream approaches that examine the deficits in female characteristics, behavior and job preferences towards more transformative approaches that investigate the root cause of gender inequalities embedded in systems of discrimination, bias, norms, institutional systems as well as pay policies.

iv. There is a need to understand the unexplained factors that contribute to the gender pay gap. This requires deeper understanding of structures, pay policies and systems. Further, findings need to be packaged for targeted stakeholders, such as make policymakers, providing them with an understanding of the factors that help explain the salary differences among men and women, why and how to address them.
4.5 Recommendations

i. **Changing norms and attitudes towards recognition of women’s contribution to healthcare**

The narrative of addressing health care worker shortages needs to shift focus away from demand side considerations such as making employees attractive to employers to developing responsive health care organizations that address issues of work-life balance, working hours, workloads and wage gaps. This requires policy makers and health managers to recognize and reward the contribution of women as health workers, primary carers and unsung heroines of health in achieving better health outcomes for their communities, families, and children and ultimately contributing to the economic development of their communities.

ii. **Capacity building and education programs for policy makers**

There is lack of awareness and understanding of the gender differences in wage gaps among policy makers, decision makers and health managers. Developing the capacity of these key stakeholders to understand systems and structures that create gender differences in pay would enable them to deploy policies that enable change.

iii. **Instituting gender transformative policies within health and social care workforce**

There is a need to address gender inequities within the global health workforce. Starting from hiring processes, gender-blind screening of resumes could help eliminate some of the biases and discrimination while selecting candidates for interviews. Another policy to remove the differences in pay between men and women is comparing compa-ratios for both men and women health and social workers. Compa-ratios are used to assess the competitiveness of employee’s pay and are position specific ratios. If women’s compa-ratio are below the average, it is an indicator that they are likely getting inequitable pay within the organization.
Chapter 5: Decent Work

5.1 Decent Work in the Global Health and Social Care Workforce

The Sustainable Development Goal (SDG) 8 defines the agenda for decent work and economic growth for both men and women 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 principles of equal opportunities for both men and women, free of discrimination, bias or harassment. This is an important goal that is a crosscutting theme across other forms of inequalities including occupational segregation and wage gap. In the context of this paper, decent work includes work free from discrimination, bias and sexual harassment within health and social care workforce. Addressing discrimination and bias within global health and social care workforce is an important step towards achieving gender equality, and building stronger and more resilient health systems on the principles of human rights.

**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, overt or covert, and associated with negative consequences for the person who experiences it [12].

**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 [12].

The gender and power relationships that exist within and outside of health system, create differences in exposure and vulnerabilities among men and women which leads to reproduction of inequalities within the health system [73]. Work place violence and discrimination is also linked to the social norms that create gender hierarchies and imbalances, starting from home to society at large. Women face a disproportionate burden of violence and discrimination across all sectors, but the female-dominated occupations such as health and social care services are at greater risks [74, 75].

One study concluded that gender discrimination and inequality are key barriers to entry, re-entry and retention of female health workers [76]. Another study conducted in Rwanda found that around 39% of the health workers faced at least one form of workplace violence, such as verbal abuse, bullying and sexual harassment, in the 12-month period prior to study. Female health workers being disproportionately affected [77]. Another study from Nepal found 42% of the health workers in the study 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 [78]. Women are also found to be more prone to face discrimination while working in
the private sector as compared to the public sector [79]. Women health and social care workers working in conflict-affected countries or remote settings are highly vulnerable to violence [80]. A study from Cambodia found that women in conflict affected areas face risk to their personal safety, and loss of family contact [81]. In Pakistan, polio workers have faced death threats and attacks resulting in loss of health and social workers [82] and has stalled progress on eliminating polio from the country. Women’s childbearing and family obligations also prevents them for undertaking health trainings, scholarships or prevent them from school enrollment [76] often because training is not set up to accommodate the needs of workers with care responsibilities. Caregiver discrimination also results in fee demotion for pregnant students, who are often left behind in their curriculum or practicum practicals [76].

Literature suggests that gender discrimination and gender inequality within organizations are linked to low morale, low self-esteem, lower productivity for the workers and affects mental and physical health [12, 78, 79, 83]. This creates health system inefficiencies that clog the pipeline of qualified and skilled health workers, creates bottlenecks in recruitment strategies, lead to absenteeism, attrition and maldistribution of the health workforce [12].

**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 [12].

There is stigma in reporting cases in the health and social care professions which has created misperception that sexual harassment cases are rare in medical profession. But, health care systems are no exception to sexual harassment incidents and #metoo movement. Nurses and community health workers have largely been prone to sexual harassment despite the work environment consisting of predominantly women. Even the with the perceived power help by women physicians; they are not safe. 30% of the physicians in the study reported having faced a personal incident of sexual violence [84].

**Sexual Harassment** refers to unwelcome sexual advances or request for sexual favors whether verbal, physical, or visual. These behaviors are illegal if they submissions to such behaviors are made a condition for employment, a decision affecting the individual or has the purpose to interfere with an individual’s performance [85].

**Workplace violence** includes physical assault, verbal abuse, sexual or racial harassment, bullying or mobbing [12].

There are many forms of gender discrimination which includes [12, 57]:

i. Direct discrimination e.g. excluding women from decision making

ii. Indirect discrimination e.g. exclusion of informal or home health workers from protective labor laws.
iii. Sexual harassment
iv. Discrimination based on sex or gender e.g. marital status, family or caregiver responsibilities.
v. Gender stereotyping which limit women to inferior roles or types of jobs available to them
vi. Vertical and horizontal occupational segregation
vii. Wage discrimination
viii. Benefits and working conditions

5.2 Limitations of Current research

Studies that evaluate discrimination as an aspect of gender are very challenging. In many research studies, discrimination remains implicit. For example, one study conducted in Tanzania found gender skewness, a part of which was due to occupational segregation. Similarly studies that have evaluated a link between occupational segregation and gender wage gap have not explicitly stated the association. A part of this gap in our understanding is due to little clarity and consensus about the terms which makes these incidents filtered through the eyes of beholder. The lack of data disaggregated by sex and gender within global health further elevates the problem. This has resulted in limited attention to study gender discrimination within the health and social care workforce.

5.3 Recommendations

i. Establishing grievance and sexual harassment policies

Instituting policies to address grievances and sexual harassment within health care organizations would help overcome the stigma and encourage victims to file complaints.

ii. Policies that take into account women’s child rearing and family obligations

These include maternity and paternal leave policies, providing spaces at workplace where women can breastfeed their children, providing day care facilities and offering flexible working hours to young mothers.

iii. Affirmative action policies

Creating gender awareness among health workers and policymakers. This would involve conducting workshops and trainings on sexual harassment and gender sensitization tools to enable policymakers and health managers to address issues of discrimination and violence.
Chapter 6: Occupational Segregation

6.1 Occupational Segregation in the Global Health and Social Care Workforce

Occupational segregation refers to the distribution of workers across and within occupations. This distribution is made often on the basis of demographic characteristics and more specifically on gender and race. There are two types of occupational segregation: horizontal segregation which is the difference in number of people of each gender present across occupations [86] e.g. greater number of women concentrated in low-paying, part-time and unpaid care work as compared to men; whereas vertical segregation refers to domination of one gender in the highest echelons of the organization e.g. men dominating in leadership positions as compared to women. Occupational segregation has been found to be a leading cause of the gender pay gap [39].

Gender segregation of occupations, which sort women in caring and nurturing and men in technical or managerial jobs is an established source of inequality. This gender segregation in the health workforce has implications for the development of strong and resilient health systems that are capable of tackling the health needs worldwide [77]. The number of female enrollment in medical schools has increased over the years. A recent data from United States by Association of American Medical Colleges showed that women outnumbered men in medical colleges for the first time in history [87]. Since 2015, female enrollment increased by 4% while male enrollment decreased by 6.7% which indicates that the future of medicine and global health is women. However, an increase in enrollment at medical schools does not necessarily ensure supply of healthcare professionals to meet the population need. For example, women continue to be under represented in the fields of surgery and surgical sub-specialties, a trend that is not only found within United States, but also in Canada, United Kingdom and the Netherlands [88, 89].

Women account for one-third of all physicians within United States, in Scandinavia women make up 45-56% of the doctors and 70% of physicians in Russia [45]. Within the field of dentistry, percentage of female dentists is likely to increase to 28 percent by 2030 [90]. Feminization of certain medical specialties [91] has been an established phenomenon globally with studies showing that women prefer the fields of pediatrics, obstetrics and gynecology [92-95] and are highly concentrated in primary care, nursing and midwifery, making these sectors within global health defined by gender. The other specialties found to be associated with the female gender include pediatric surgery, pediatrics, oncology, and dermatology [96]. Women obstetricians has grown substantially, however the availability of women breast surgeons and urologists remains very low.

Moreover, sex inequality within the medical workforce remains a topical area of debate, particularly for surgical specialties, as only one third of female doctors select surgery as compared to men [89]. The increasing proportion of men pursuing internal medicine and hospital specialties versus the increasing proportion of women pursuing family practice and obstetrics and gynecology has largely resulted in the gender-based segregation of men and women in
healthcare within United States [97]. With huge gender gaps in wages and leadership positions in health care, understanding patterns of occupational segregation in health care is important [98-100].

While there is plethora of literature investigating why men and women medical students pursue different specialties, most of these studies have been conducted in the United States or United Kingdom. This limits our understanding of the factors that explain why more and more women are being excluded from different health care specialties. Some studies suggest that women are actively rejecting surgical specialties [101, 102].

Global health policymakers and decision makers need to understand the factors that lead to sorting 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. [103] Global health systems need to learn and adapt from these strategies to address shortage in pipeline of health care workers.

6.2 Factors that contribute to occupational segregation

From the literature review the emerging factors that contribute to occupational segregation include:

i. The paucity of role models and successful women in surgical specialty is most often cited reason discouraging female medical students from taking up this profession, with as much as 5.6% to 35% female trainees found to be affected by this factor. [104, 105]

ii. One study found demographic characteristics and personal values to be associated with gender differences in specialty choice [97].

iii. Control of lifestyle and work-life balance were identified as being related to women’s specialty preference and choice [93, 106, 107] Lifestyle has also been reported by men as a deterrent to enter surgical care [108].

iv. women discriminating against women may perpetuate the cycle of gender disparity especially within surgical care [88].

v. Women’s greater burden of household work and responsibility for family, maternity leave, child care and time for breast feeding has been the most common explanation of occupational segregation [97, 109]. Burton et al. noted that in Canada, women work fewer hours, see a lower amount of patients, have a higher probability of leaving medicine sooner, and join a greater proportion of professional organizations in comparison to men [110].
vi. Women may be discouraged to take surgery as a specialty due to the discriminatory attitudes while training rotations in General Surgery [96, 111].

vii. Long training hours and lack of flexibility in scheduling rotations leave little time for women for family obligations or childrearing responsibilities. This could discourage them from undertaking from male dominating specialties such as surgery. [112, 113]

viii. Social policy such as parental leave, maternity leave, subsidized child care also influence the choice of careers opted by men and women [114] and ways in which they organize personal lives [109].

ix. Gender differences in specialty choice can partly be explained as a function of socialization [115], but also by structural operating barriers or closure mechanisms within specific fields [116, 117].

x. It was reported that female students seemed to have a more idealistic approach than male students, and were less often influenced by the prospect of a good income or prestige [92].

xi. Experiences at medical school also have shown to be associated with choice of medical specialty [118].

xii. Men continue to dominate surgical sciences [119, 120]. It is likely that this preference is due to social stereotype that exists in the medical environment, which promotes a type of “male surgeons’ club” [121].

xiii. Women’s disproportionate, inequitable HIV/AIDS caregiving burden lies gender inequality and the traditional gender roles and stereotypes that come into play in men’s and women’s responses to the epidemic.

xiv. The tendency to choose a particular medical specialty differs across countries [122]. Recent studies show that factors contributing to include personal preferences [123], the academic exposure of the student [124], motivational factors [125], the specialty’s working conditions [126], and socio-demographic factors [127].

6.3 Limitations of Current research

Most of the studies conducted in the areas of medical careers and gender are dominated in western countries more specifically from United States and United Kingdom. The results of these studies are not generalizable as the contexts and cultures are very different between global north and global south.
6.4 Recommendations

i. **Change in attitudes toward female in surgery to address gender discrimination**

Research shows that positive interaction by surgeons with medical students positively influences and develops interest among young doctors in pursuing surgical care. This would also help female surgeons to gain respect and recognition which would lead to higher morale and motivation. [128, 129] Moreover educating administrative, clerical, and nursing staff especially women staff working with women surgeons, could dramatically and positively impact discrimination in the surgical workplace [108]. Unless the working environment in health care systematically changes, the shortage of doctors in these specialties is not expected to be solved [93].

ii. **Mentorship and career counselling**

Mentorship and early exposure play a positive role in women’s decisions to enter surgery, and a greater proportion of successful women in surgical departments should allow more female students to recognize surgery as a viable option. Of note, three women in our survey reported being positively supported based on their gender. Additionally, exploring how institutions can best help male physicians and trainees to mentor female trainees is worthwhile in order to truly equalize the surgical environment [108]. Individual medical schools with workforce objectives may address these trends by offering counseling to undecided students early in medical school [97].

iii. **Gender transformative recruitment strategies**

Studies suggest that targeting and encouraging women to take up surgery before and during the medical school works in encouraging women to choose male-dominated specialties [88, 89]. Offering equal opportunities to both men and women can also help address shortage of workforce [96].
Chapter 7: Why gender equality in the global health workforce matters?
To be completed by final version

Chapter 8: Strengths & Limitations
To be completed for final version
Chapter 9: Policy implications and recommendations

i. Adopting integrated approaches to tackling structural factors of gender inequity

Focusing on three main areas of gender equality to transform the gender and power relations within the health workforce to create more gender-equitable organizational cultures. These approaches entail addressing issues of violence in the workplace, providing equal opportunities for men and women to achieve positions of leadership and enhancing skills and capabilities of the health workforce. This also involves recognizing and valuing the different interest and skills of men and women in global health workforce spread across developed as well as resource-poor countries.

ii. Widening the evidence on community, mid-level, informal and frontline workers

Most of the research aggregated focused on physicians, with some studying the nursing, midwifery, pharmacy and academic workforce. However, evidence on community, mid-level, informal and frontline workers is relatively thin. While this could be attributed to the wider availability of and access to data (such as registration) of some professions, evidence is needed to understand gender equity challenges in this critical workforce, both formal and informal.

iii. Gaining a richer understanding of barriers and facilitators to gender equity

Current research on gender equity in the health and social care workforce tends to be based on, primarily, quantitative analysis of data (e.g. registration data, surveys). While sex-disaggregation data does shed light on the realities of gender equity such as the wage gap for example, quantitative research alone does not provide insight into the barriers and facilitators identified through the real-life experiences of women in the workforce. Further rich qualitative research is needed in the area of gender equity in the health and social care workforce to ensure policy changes are attuned to the contextual realities of gender challenges.

iv. Factoring in, with gender, other determinants of inequities

The review highlighted the emphasis on taking on an intersectionality approach by researchers and experts in the field. However, practical examples of incorporating an intersectionality lens in research on gender equity in the health and social care workforce are lacking. While there has been an increase in the number of frameworks for conducting research on gender equity, more research that factors in determinants of inequity (e.g. race, social class), in addition to gender, is needed.

v. Examining the link between gender transformative policy in academia and improvements in the practicing workforce

A high proportion of the literature identified for this review examines gender inequities among the academic health workforce. The link between gender-transformative policies at the academic level and their positive impact on gender
equities in the practice health workforce has also been discussed, with the argument that addressing the gender dimensions in academia - affecting both students and faculty - will improve the distribution, extent and skill mix of the health workforce. For examples, the issue of occupational segregation often starts at enrollment. However, more evidence examining this link and its impact on gender-based outcomes in the practice workforce is needed to influence policy at the academic institutional level.
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