**GENDER EQUALITY**

# FLYING BLIND IN A TIME OF CRISIS

2021 Global Health 50/50 Report

GENDER EQUALITY:

# FLYING BLIND IN A TIME OF CRISIS

A review of the equality and gender-related policies and practices of 201 global organisations active in health and health policy

2021 Global Health 50/50 Report

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All care is taken to ensure the accuracy of the data reported. However, if you believe that an error has been made, please contact: info@globalhealth5050.org.

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**Making it Work**
*Washington State, USA. 2020.*

NASHCO Photography

Hotel housekeeper Liza Cruz, age 42, poses for a portrait at her home in Auburn, Washington, USA. Since the start of the pandemic, she has been taking care of her elderly parents, helping her high school-aged daughter with her digital learning, and desperately calling around to ask for deferment on the bills coming in. Afraid she will lose her home, she recently returned to work. She struggles to balance each of her working roles.

# A WORD FROM

Kumsal Bayazit, CEO of Elsevier

For all leaders, 2020 has indeed been a year of 'Flying Blind' with unprecedented health, safety, and productivity challenges to navigate within our organisations. It has also been a year of personal growth. I have been humbled and inspired by the resilience of our colleagues and how they have maintained their commitment to advancing inclusion and gender equity both within our own organisation and the research and health communities that we serve.

Elsevier is one of the largest publishers of scientific research, including leading health journals such as *The Lancet* and *Cell* amongst a portfolio of 2,600 journals. As the first woman CEO in Elsevier's 140-year history, I am acutely aware of our responsibility to drive inclusion and diversity.

The Global Health 50/50 report is a unique and essential accountability mechanism in this challenging time. The Collective behind the report calls on organisations across the global health space to examine our gender-related policies and practices, including to 'measure what we treasure'. At Elsevier, we believe that data-led insights are key to transparency and progress. Without which, we will continue to 'fly blind', whether we are examining employee pay equity, editorial board diversity or understanding how COVID-19 is affecting research output among women scientists.

> **"The Global Health 50/50 report is a unique and essential accountability mechanism in this challenging time."**

This year's report reveals that although organisations are improving the way they talk about gender equality, very little has changed practically since the first report in 2018, including who holds power in senior leadership positions. Real progress is only possible if we actively drive change. This includes the basics such as establishing new flexible working policies and building on pandemic-learning to greatly reduce travel requirements. At Elsevier, we have expanded parental and family leave and now have stringent policies to deal with sexual harassment and discrimination. We are regularly assessing and rapidly addressing any pay gaps based on gender or race.

We have also made building an inclusive culture a key strategic priority for Elsevier. Together with my leadership team, we implemented unconscious bias and psychological safety training. We now use an inclusion index and a psychological safety score to measure progress and have revamped our recruitment processes to attract more diverse candidates.

But what about the communities we serve? Our 2020 report, "The researcher journey through a gender lens" examined sex-disaggregated data across 15 countries and the EU to reveal systemic issues holding women back: low support for women's research careers and leadership bids, lower



**KUMSAL BAYAZIT**

CEO of Elsevier

research output, grants, citations, patents and a leaky pipeline. In response, my colleague, Dr. Richard Horton, the Editor-in-Chief of *The Lancet*, and I launched Elsevier's Inclusion & Diversity Advisory Board bringing together leaders from across the international research and healthcare community. Our focus goes beyond gender to include race, ethnicity and geography. We have created targeted interventions to balance editorial boards across our journals, ensure equitable participation in research for authors and reviewers, support career progression in research and healthcare and develop editorial guidelines to embed sex and gender analyses in research.

I am a big admirer of the late Ruth Bader Ginsburg, who said *"real change, enduring change, happens one step at a time"*. We all know that lasting change is often a result of many small, incremental steps in the same direction. Over time, these intentional steps build a groundswell of progress. The GH5050 report shows that, over the past four years, these incremental changes are taking place. But it also underscores how far we have to go, and how much more we have to do to overcome systems of inequality.

Therefore, I encourage leaders of all global organisations active in health to use the GH5050 report and take bold, appropriate and long overdue steps with evidence-based decisions. I believe strongly that for organisations to move the needle on gender equality, and indeed all dimensions of diversity, requires advocacy at the most senior levels, supported by policies, measurement and accountability. I commend GH5050 for their pathfinding work to establish an independent accountability mechanism to support our actions. My fervent hope is that we can catalyse our collective efforts to create a fair system of opportunities and progression for all people working in health and research around the world.

# A WORD FROM

From its inception, GH5050 has invited distinguished women exercising feminist leadership to write the Forewords to our annual flagship reports. We are indebted to Amina Mohammed, Prime Minister Jacinda Ardern, President Michelle Bachelet and Kumsal Bayazit who have situated our findings in a wider context and inspired us in new directions.

In 2021 we wanted to invite both a woman and a man to pen the forewords, to reaffirm the shared responsibility for gender equality. And so, Global Health 50/50 invited a number of men leaders to write this foreword.

We were unsuccessful.

As a collective, we are disappointed. We know that gender equality is everyone's responsibility and that the benefits are realised across all of society. Nonetheless, the work to push for gender equality, and specifically to keep Global Heath 50/50 running, is largely undertaken by women.

We hope that by sharing this anecdote, men in the global health sector will share their vision and actions with us. We want to hear from men about how they are informing, inspiring and inciting action on gender equality. Please send your contributions at info@globalhealth5050.org and we will publish a selection on our website.

**Untitled**
*South Africa. 2020.*

Micha Serraf

A fisherman displays his catch during Stage 5 Lockdown, South Africa's strictest lockdown. Forming part of a broader project on the lives of front-line workers during the COVID-19 pandemic, the fisherman stood out to Micha who explains 'Whilst having a masked conversation with this person, he took off his mask for a second to shout to his colleague about the fact that I was an artist "too". In our conversation, this person described a dream that he once had of becoming a "famous fashion designer" but "because life is what life is, I accepted that I must become the man everybody needed."' The person in this portrait is so hidden by their profession, circumstances and performance of masculinity that it is impossible to see the glamorous designer they see in themselves. To "become the man" is a becoming we must always challenge.

# A WORD FROM

### the GH5050 Collective

Gender equality is fundamental to everyone's health, dignity and livelihoods – especially in a time of crisis. It is a matter of social justice and human rights; principles that lie at the heart of global health. That we should have to call out health organisations for failing to take gender equality seriously during a pandemic is deeply frustrating. Urgency cannot serve as an excuse.

When we established Global Health 50/50 (GH5050) with a vision of better health and equal opportunities for all people of all genders, everywhere, we were not naive. We know that gender inequality is deeply entrenched and that social change takes time. Yet, we have been shocked and angered at the scale of the failure to provide effective, equitable and gendered responses to COVID-19.

In some areas reviewed by 'Flying blind in a time of crisis', we can celebrate progress. We are encouraged by the marked increase in the number of organisations and individuals using the findings of the GH5050 Gender and Health Index to drive change in organisational priorities and policies. Commitment to gender equality has grown quickly since GH5050 began publishing on it in 2018. And more and more organisations are embedding gender-transformative action in their strategies to advance the health of all people.

Yet we are concerned that lofty rhetoric is too often being used as a substitute for action. Determined and concrete measures to dismantle gender inequality inside organisations and to apply a gender lens in health programmes remain too scarce.

In 2020, global health missed an opportunity of historic proportions to take a gendered approach to a gendered crisis. As data from this report reveals, organisations active in global health have been battling the pandemic with their eyes closed to the role gender plays—embedded in individuals and institutions—in influencing both policy-making and people's exposure, behaviours and health outcomes. COVID-19 exposes that lives are lost and inequities deepened as a result of flying gender-blind across the health sector.

But with our frustration comes a renewed urgency to push harder for change, and we in GH5050 are galvanised to harness this power and drive forward.

Right now, social movements on all continents are profoundly challenging structural and systemic inequalities. People are rising up to demand an end to inequality and to claim their rights. We, in our push for gender equality, feel united with these broader struggles for social, economic and climate justice.

Last year, we reviewed power, privilege and priorities in organisations and highlighted the historic roots of inequity and inequality inherent across global health. We are disappointed to find that the latest cohort of nearly 100 CEOs and Board Chairs appointed in the past year is no more diverse than existing leaders. Compared to their predecessors, women made slight gains in representation, but so too did nationals of high-income countries. Systems of inequality are being sustained within the global health workforce. There is far too little support for equitable career opportunities and a slow pace of change in fair working practices. This is from a sector that claims to embrace gender equality. We believe that organisations active in global health should be leaders in acknowledging power and privilege imbalances, confronting intersectional inequities, and shaping diverse, inclusive workplaces – and we know they can.

> *Gender inequality is not inevitable; it is made by people and reinforced in systems and organisations, including global health. And it can be unmade within those same systems.*

We find hope in the numerous initiatives, organisations and people working to bring about change. Data and evidence from GH5050 and our partners is being used strategically to embed gender equality and diversity into work structures and programme delivery. We welcome this collaboration from organisations across the world.

We are also grateful to our Advisory Council and partners in organisations that contributed to data collection and validation for this report. Without your support, none of this would be possible.

To date, our focus has been on the global operations of organisations active in health. This was a strategic decision. We urge global organisations to get their own houses in order if they are to be credible gender and equality champions in countries. Essential impact, though, lies in ensuring that country-level health policies and programmes are gender-responsive. As such, GH5050 is excited to embark on a new phase of country-level work starting in Nepal, in partnership with the Nepal-based Center for Research on Environment, Health and Population Activities.

Gender inequality is not inevitable; it is made by people and reinforced in systems and organisations, including global health. And it can be unmade within those same systems.

Gender equality is a precondition to achieving our shared ambitions of the Sustainable Development Goals by 2030 and delivering Health for All. Let us all take ownership of the demand for gender equality. Let us replace rhetoric with concrete action. Let us demand that leaders at all levels use this report to drive accountability and positive change for everyone's dignity, health and livelihoods. After a calamitous year, we know positive change is possible; but it is up to all of us, individually and collectively, to take action and create opportunities for all.

> *'It is in collectivities that we find reservoirs of hope and optimism.'*

**Angela Y. Davis, Freedom Is a Constant Struggle**

# EXECUTIVE SUMMARY

The 2021 Global Health 50/50 report, "Gender equality: Flying blind in a time of crisis," reviews the gender-related policies and practices of 201 global organisations active in global health.

Against the backdrop of a calamitous 2020, the report finds notable areas of progress and hope. The new data and research show that organisational commitment to gender equality is surging, and that organisations are becoming more transparent about their policies on shaping diverse, inclusive and equitable working environments for people.

The latest data also suggest, however, that rhetoric is often used as a substitute for action. The report reveals that the vast majority of programmatic activity to prevent and address the health impacts of COVID-19 largely ignores the role of gender. Evidence gathered by the GH5050 collective of researchers, strategists and practitioners shows that gender influences everything from who gets tested for COVID-19 to risk of severe disease and death. Yet, in a male-default world, the report finds that gender as a driver of everyone's health, including that of men and boys, remains under-appreciated, under-counted and under-addressed. The result is gender-blind pandemic responses that are less effective than they should be, with grave consequences for the health of people around the world.

The year 2020 marked the 25th anniversary of the Beijing Declaration and Platform for Action, a global blueprint for gender equality and women's rights. This year, however, sees the appointment of yet another cohort of mostly male global health leaders, predominantly from high-income countries, with the mandate to exert influence over the health and wellbeing of people worldwide. Despite substantial rhetoric, the data reveals little progress towards gender equality and diversity in leadership across the health sector and a widening gender pay gap.

In the face of multiple global crises, a global health system dominated by individuals and institutions in high-income countries forgoes essential talent, knowledge and expertise, with serious implications for pandemic preparedness, progress on Universal Health Coverage and meeting the health-related targets of the Sustainable Development Goals.

## Key findings

The 2021 report assesses organisations on 14 variables across four dimensions. 45 high-scoring organisations are recognised in the report. The Gender and Health Index presents detailed results for each organisation. High-level findings include:

**1. Words matter: Most organisations active in global health state that gender equality matters to their work**

- **Stated commitment to gender equality has grown steadily since 2018.** Today, 79% (159/201) of organisations in the sample commit to gender equality.
- **Organisations that state what they mean by 'gender' are on the rise, but still only 40% of organisations de ine gender in their public communications**. While progress has been made since 2018, the majority of organisations are not seizing the narrative power of defining gender in their policies and strategies.

**2. Policies fall short: Despite strong rhetoric, only 60% of organisations have transparent gender equality policies and even fewer have diversity and inclusion policies**

- **Progress on transparency of workplace gender equality policies has stalled.** Gender equality policies were accessible for six out of ten organisations - the same proportion as in 2020. Progress on public facing transparency, recorded over previous years, has stalled.
- **More organisations are making public reference to diversity and inclusion.** Diversity and inclusion policies - beyond those on gender diversity - were accessible for half of the surveyed organisations. Reference to diversity and inclusion increased by 10% over the past year.
- **A small fraction of organisations have transparent board diversity and inclusion policies.** Governing boards are among the most influential decision-makers in global health. Commitment and measures to promote diversity and representation in these bodies are on the rise, yet 80% appear to still lack specific policy measures to advance diversity.
- **Transparency of anti-sexual harassment policies and family-friendly policies is low but growing.** The availability of both anti-sexual harassment and family-friendly workplace policies increased by 10% over the past two years. Still, policies were accessible for fewer than half of organisations surveyed.

**3. Power imbalances pervade: Male privilege in global health still circulates**

- **The global health sector ought to lead on equity and justice, but instead male privilege pervades.** One-quarter of CEO and Board Chair positions changed hands in 2020, offering an opportunity to appoint a more diverse cohort of leaders amidst a proliferation of commitments to diversity and inclusion. Data show, however, that men continued to hold 70% of leadership positions and nationals of high-income countries held 84% – marking no change over the previous year, despite the appointment of nearly 100 new leaders.
- **It's a slow crawl towards parity in senior management and governing bodies.** One-third of organisations had parity (45-54% women) in their governing bodies or senior management. The proportion of organisations with senior management composed of at least 1/3 women increased by 14% since 2018, reaching 70% in 2021.
- **Fewer women at the top - and paid less too.** CEO salaries at the 34 US-based NGOs in the sample were found to be consistently higher for men. On average, women CEOs were paid $308,000, while men CEOs were paid $415,000 – a gender gap of $106,000 per year.

**4. COVID-19 programmes fly gender-blind: The majority of COVID-19 health programming activities do not recognise how gender affects people's health**

- **More organisations are adopting gender-responsive language on their core programmes.** 39% of organisations position the work they do in relation to transforming gender norms and gendered systems and structures that stand in the way of better health outcomes, an increase of 10% over the previous year.
- **Yet over 80% of COVID-19 health programming activities are gender-blind.** While organisations increasingly adopt gender-responsive language in relation to their core programmes, such approaches were not applied to COVID-19 programmes. Support across a range of WHO-recommended areas for pandemic responses – including vaccine development, prevention, access to treatment and care, health workforce protection, and surveillance – was found to be largely gender-blind.

## Moving forward

GH5050 has seen a marked increase in organisations engaging with GH5050 findings to implement change in their organisations and the communities they serve. The data in "Flying blind in a time of crisis" can equip leaders at all levels – from communities to workforces to boards – to take concrete action, drive change and hold those in power accountable. To support this effort, the report offers a series of analyses, stories of progress, and resources.

The health and well-being of the people both employed and served by organisations active in global health cannot afford another year of missed opportunities. Drawing on the findings across four years of data presented in successive reports, evidence-informed, rights-based action on five interrelated fronts is urgently needed.

- **Turn the dial from gender-blind to gender-transformative**. Gender-transformative approaches recognise that gender drives health inequities and aim to transform harmful gender norms, systems and structures and foster gender equality. They are not only the just and fair thing to do, but also increase the effectiveness and impact of interventions to improve everyone's health. Organisations need to examine how they can take an increasingly strategic approach to shifting power dynamics and tackling oppressive gender norms to advance the health of everyone.

- **Measure what you treasure**. Data disaggregation is fundamental to the full implementation of the Sustainable Development Goals and fulfilling the ambition of leaving no one behind and delivering Health for All. Organisations need to to report on and recalibrate programmes based on data that is disaggregated by sex but also by other intersecting social stratifiers, including race, class, geography, age and (dis)ability.

- **Set a timer for the fair distribution of power**. Leadership that reflects the global community is more likely to bring relevant and diverse perspectives, expertise and lived experience to the challenges of global health. Organisations must challenge inequalities in power and privilege in leadership and management, including through the establishment of time-bound targets, specific policy measures and accountability mechanisms that will lead to equitable representation.

- **Publish what you promise.** Organisations should put their gender and diversity policies, related targets and progress reports in the public domain to inform their staff, facilitate public scrutiny and ensure accountability for progress. Staff should seize their right to collective bargaining practices in order to mobilise and organise pressure for change.

- **Connect and take action**. The world today faces multiple, interconnected crises. Global health actors should unite around a feminist vision where all people are valued and entitled to voice and agency in order to equitably share in the distribution of power, knowledge and resources. People working in organisations active in global health should join forces across movements for gender, social and climate justice, and hold each other accountable, including through mechanisms like GH5050, to accelerate progress for the health and well-being of people and planet.

# FLYING BLIND IN A TIME OF CRISIS:

Summary of findings

## 01  Are organisations committed to redistributing power?

### Most organisations active in global health state that gender equality matters to their work

Nearly 80% of organisations declare a commitment to gender equality, compared to 75% in 2020 and 55% in 2018. Still, one in five organisations have made no public commitment to gender equality. Commitment is lowest among funders and the private sector: one-third of these organisations make no public commitment to gender equality.

**Figure 1. Commitment to gender equality**

- 11%
- 10%
- 21%
- 58%

- ■ Commit to gender equality for the benefit of all
- ▨ Commit to gender equality, with focus on empowering women and girls
- ■ Focus on women and girls but no reference to gender equality
- ■ No reference to gender or women and girls
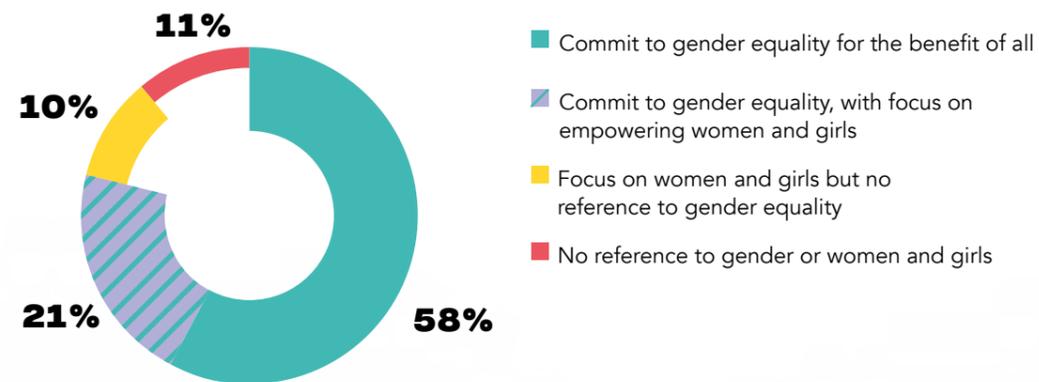
**Figure 2. Commitment to gender equality is growing**
Among the 139 organisations reviewed consistently from 2018 to 2021:

| 55% | 70% | 76% | 79% |
| 2018 | 2019 | 2020 | 2021 |
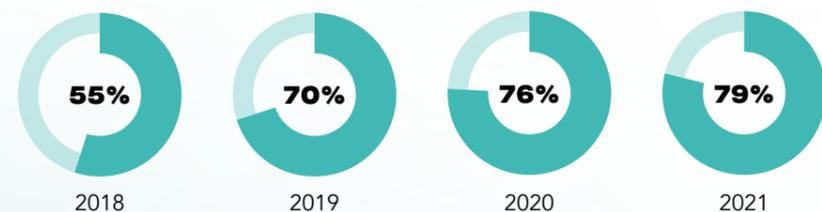
## What do you mean by 'gender'?: Too few organisations define gender

During times of profound social change, language matters more than ever. Uniting around a shared definition of gender as a social construct is the first step to embedding an appreciation of the societal, relational nature of gender and the power imbalances inherent in gender inequality. Such an understanding of gender enables organisations to tackle inequalities and deliver transformational change.

Yet the majority of organisations fail to seize the narrative power of defining gender in their policies and strategies.

### 39% Proportion of organisations that define gender as a social construct

**Figure 3. Among the 139 organisations reviewed from 2018 to 2021, gender definitions are on the rise:**

| 31% | 40% |
| 2018 | 2021 |
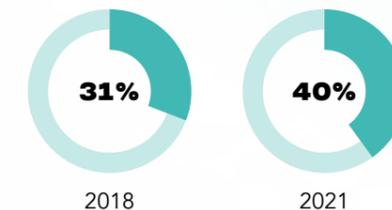
## 02  How equitable are global health workplaces? Policies to promote equity and tackle power imbalances in the workplace

### Progress on transparency of workplace gender equality policies comes to a halt

The global health sector ought to lead on equity and justice, but instead male privilege pervades, contributing to gender inequalities in career progression. The pace of progress in the availability of workplace gender equality policies appears to have stalled in the past year.

# 61% of organisations have publicly available workplace policies with specific measures to promote gender equality. This marks no change over 2020.

## More organisations are making public reference to diversity and inclusion

51% of organisations* have publicly-available policies to advance diversity and inclusion—beyond gender diversity—in their workforce. While lower than the availability of gender equality policies, a notable increase was found in policies that reference diversity and inclusion.

### Figure 4. Workplace diversity and inclusion policies in the public domain



- 15%
- 6%
- 52%
- 27%

- Policies with specific measures in place
- Commit to promoting diversity and inclusion, but no actions
- Minimal commit to non-discrimination
- No reference to non-discrimination or diversity and inclusion

| | 2020 | 2021 | CHANGE |
|---|---|---|---|
| Policies with specific measures | 45% | 51% | 6% |
| Commit to promoting | 23% | 28% | 5% |
| Minimal commit | 8% | 6% | -2% |
| No reference | 24% | 15% | -9% |
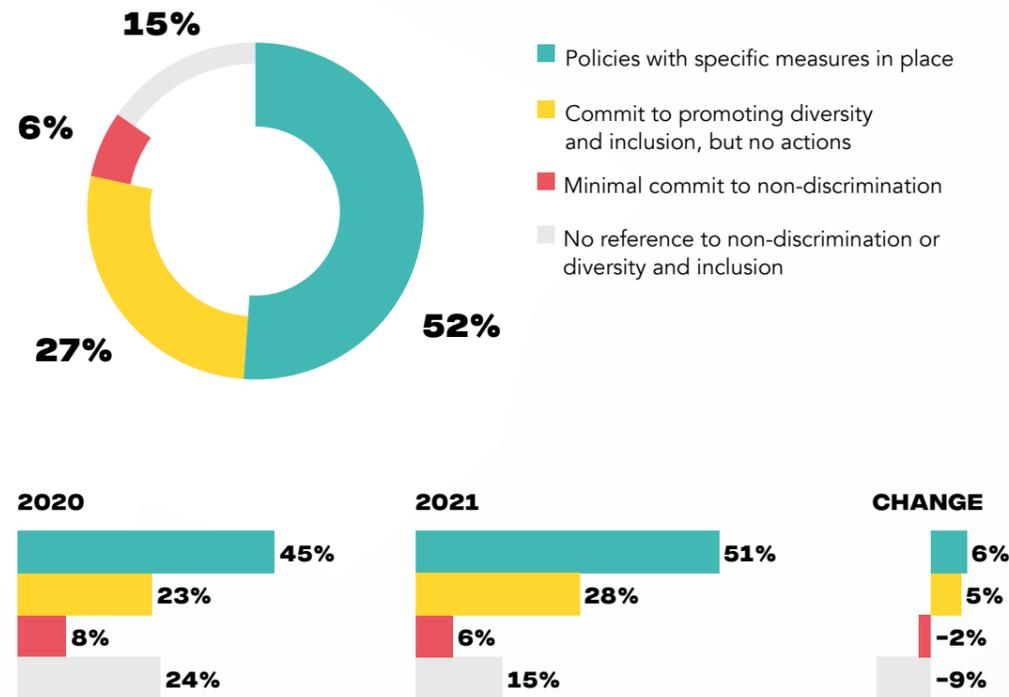
*Not including independent organisations with 10 or fewer staff (n=10)

## A small fraction of organisations have transparent board diversity and inclusion policies

Public pressure is mounting in the demand for board diversity. Commitment and measures to promote diversity appear to be on the rise, yet are still remarkably low. Eighty percent of governing bodies appear to lack specific policy measures to ensure diversity in representation and participation.

### Figure 5. Board diversity and inclusion policies
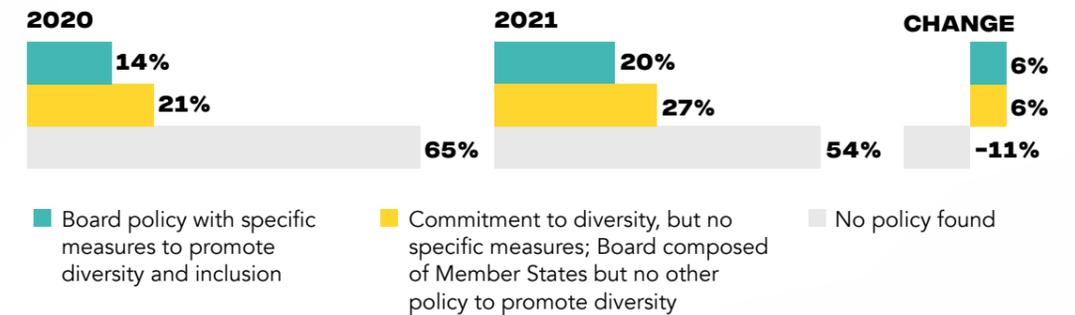
| | 2020 | 2021 | CHANGE |
|---|---|---|---|
| Board policy with specific measures | 14% | 20% | 6% |
| Commitment to diversity, no specific measures | 21% | 27% | 6% |
| No policy found | 65% | 54% | -11% |

- Board policy with specific measures to promote diversity and inclusion
- Commitment to diversity, but no specific measures; Board composed of Member States but no other policy to promote diversity
- No policy found

## Transparency of anti-sexual harassment policies and family-friendly policies is low but growing

Since 2019, when GH5050 last reviewed such policies, more organisations have placed their anti-sexual harassment and family-friendly workplace policies in the public domain. However, in the case of sexual harassment policies, improved transparency has not led to strengthened policy content.

Anti-sexual harassment policies : **44%** (2021) up from **34%** (2019)

Parental leave policies (publicly available): **36%** (2021) up from **26%** (2019)

## Gender and geography of leadership in global health

## Male privilege in global health pervades

Demands to topple power and privilege imbalances and bring forth greater diversity in leadership reached new heights in 2020. Public statements were issued from leaders recognising systemic inequalities and vowing to take action. New diversity and inclusion commitments proliferated. Yet, one year on, the sector barely budged.

Nearly one-quarter of CEOs and Board Chair positions changed hands over the past year. This opportunity to redistribute power was missed:

| Leadership in 2020 | Leadership in 2021 |
| --- | --- |
| 70% Men | 70% Men |
| 83% Nationals of high-income countries | 84% Nationals of high-income countries |
| 92% Educated in high-income countries | 94% Educated in high-income countries |

### Figure 6. Slow crawl towards diverse and inclusive leadership

Across the 139 organisations reviewed consistently from 2018 to 2021:



**CEOs**

29% — Women 2018
31% — Women 2021

**Board Chairs:**

20% — Women 2018
26% — Women 2021
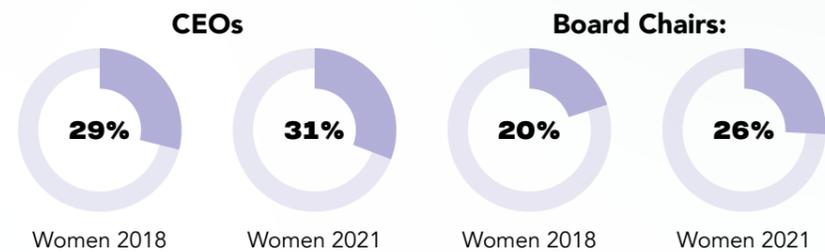
## Some progress is made towards parity in senior management and governing bodies

The number of women and men in positions of authority provides a strong measure of equity in career advancement, decision-making and power.

Roughly one-third of organisations have reached parity (45-54% women) in their governing bodies or senior management.

### Figure 7. Gender parity and disparity in senior management and governing bodies



**SMT parity** | | **Board parity**
36% | Parity | 29%
47% | More men than Women | 61%
17% | More Women than Men | 10%

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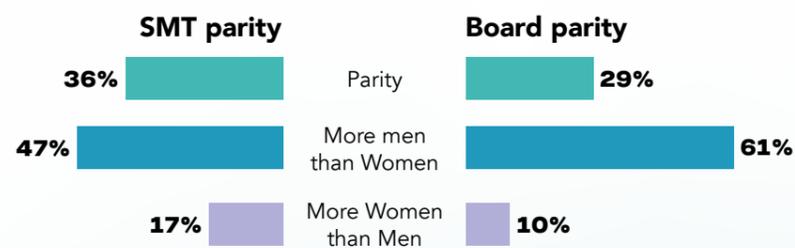
Global health is making progress towards parity:

Organisations with at least one-third women in senior management: **70%**, up from **56%** in 2018.

Governing bodies with at least one-third women: **58%**, up from **47%** in 2018.

## 03 Are organisations taking a gender-responsive approach to improving health?

### More organisations adopt gender-transformative language in describing their core work to advance health

Gender—the social construction of position and power—plays a crucial role in the distribution of ill-health across all populations and influences the success of health interventions. A growing number of organisations position their work in relation to transforming gender norms that stand in the way of better health outcomes. One in six organisations however are found to programme in a gender-blind way.

### Figure 8. Gender-responsiveness of organisational approaches (applying the WHO Scale)



| 2020 | | 2021 |
| --- | --- | --- |
| 29% | Gender-transformative | 39% |
| 32% | Gender-specific | 32% |
| 19% | Gender-sensitive | 14% |
| 20% | Gender-blind | 16% |
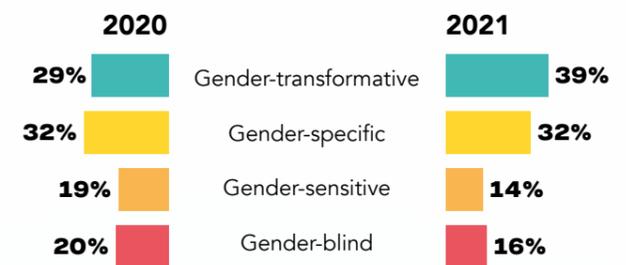
### Growing talk on gender as a driver of health outcomes is not translated into gender-responsive COVID-19 activities

Evidence from past pandemics suggests that responses that take gender and intersecting vulnerabilities into account can improve health outcomes for everyone. Yet, organisations' activities to address the health impacts of COVID-19 were found to be largely gender-blind.

GH5050 reviewed information published by organisations on their engagement in the COVID-19 response, recording which organisations were active in one or more of five WHO-recommended pandemic response areas and assessing the gender-responsiveness of those activities.

**Figure 9. Gender-responsiveness of 349 COVID-19 health programming activities reported by 140 organisations, by response area**



| | Gender-blind | Gender-sensitive | Gender-specific |
|---|---|---|---|
| Vaccine, diagnostics, treatment R&D (n=67) | 88% | 5% | 7% |
| Promoting positive health behaviours (n=99) | 75% | 4% | 21% |
| Access to health services (n=70) | 84% | 6% | 10% |
| Protection of healthcare workers (n=80) | 90% | 4% | 6% |
| Support to national surveillance (n=33) | 61% | 39% | |

■ Gender-blind　■ Gender-sensitive　■ Gender-specific
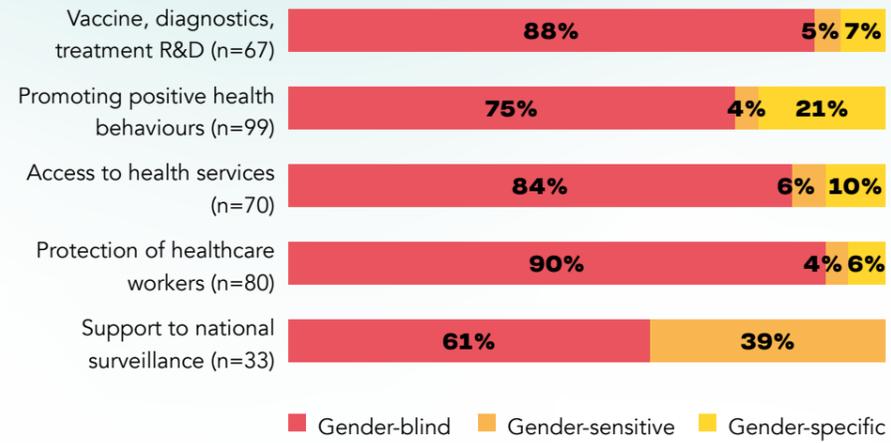
**Figure 10. Nine out of ten gender-responsive COVID-19 health activities focus primarily on women and girls**



Vaccine, diagnostics, treatment R&D (n=8)

Promoting positive health behaviours (n=25)

Access to health services (n=11)

Protection of healthcare workers (n=8)

■ Gender-responsive activity, with primary focus on women and girls　　■ Gender-responsive activity, with focus on women, men and/or transgender populations
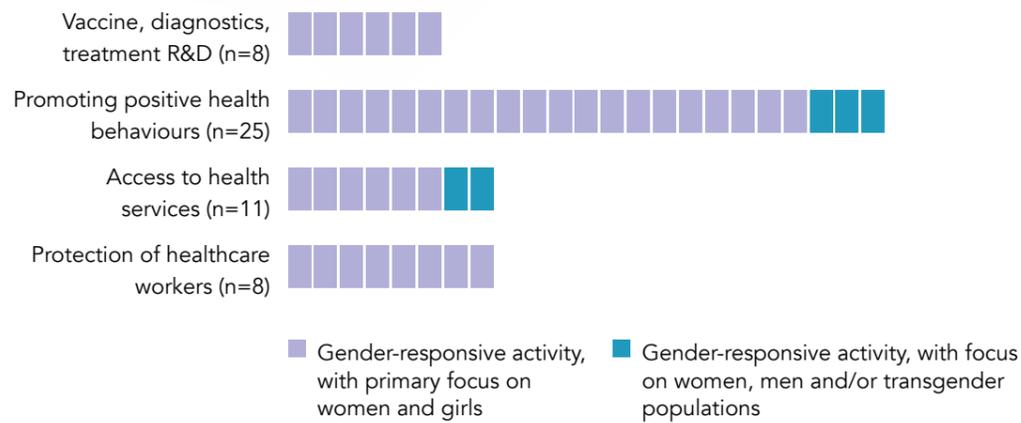
## Progress 2018-2021

Notable improvements have been observed on some variables since the first GH5050 report. Growing policy commitments to equality and to gender-responsive approaches to advancing health mark an important step forward. Yet it is far from clear that lofty policy promises are being buttressed with action and accountability mechanisms—and an earnest intention of translating talk into organisational change and more equitable outcomes for people.

**Status quo (limited change)** | **Notable progress**



Workplace gender equality plans — 24%

Committing to gender equality — 24%

Senior management with at least 1/3 women represented — 15%

Governing bodies with at least 1/3 women represented — 11%

9% — Defining gender

6% — Female Board Chairs

2% — Female CEOs
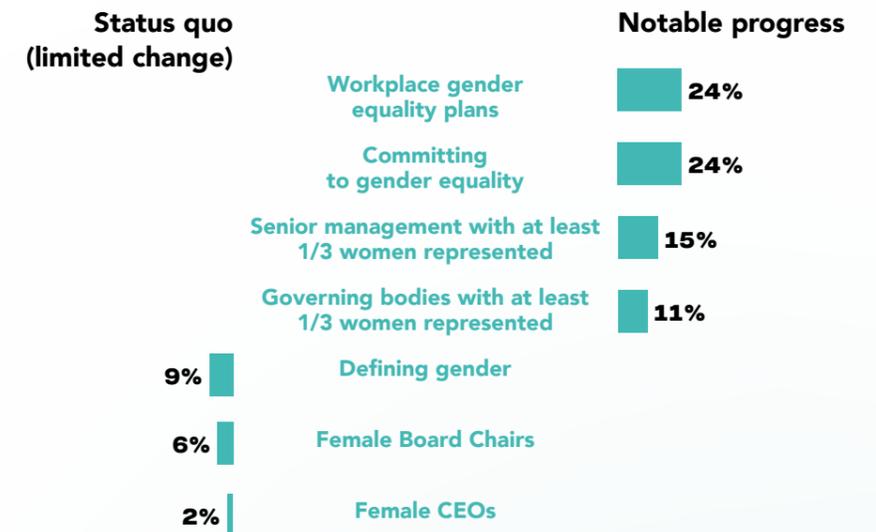
# NEW LEADERSHIP,

a missed opportunity for greater diversity

From 2020-2021, nearly 100 CEOs and Board Chairs were newly appointed by the 201 organisations reviewed.

Among the new leaders, women gained a few seats, while the representation of nationals of high-income countries also increased.

|  | Outgoing leaders | Incoming leaders |
|---|---|---|
| Men | 70% | 66% |
| Nationals of high-income countries | 74% | 76% |
| Educated in high-income countries | 85% | 88% |

**Figure 11. Nationalities and genders of 94 CEOs and Board Chairs newly appointed, 2020/2021**



NORTH AMERICA

EUROPE

ASIA

MIDDLE EAST & NORTH AFRICA

SUB-SAHARAN AFRICA

LATIN AMERICA & THE CARIBBEAN

OCEANIA

Leader Gender

■ Men ■ Women
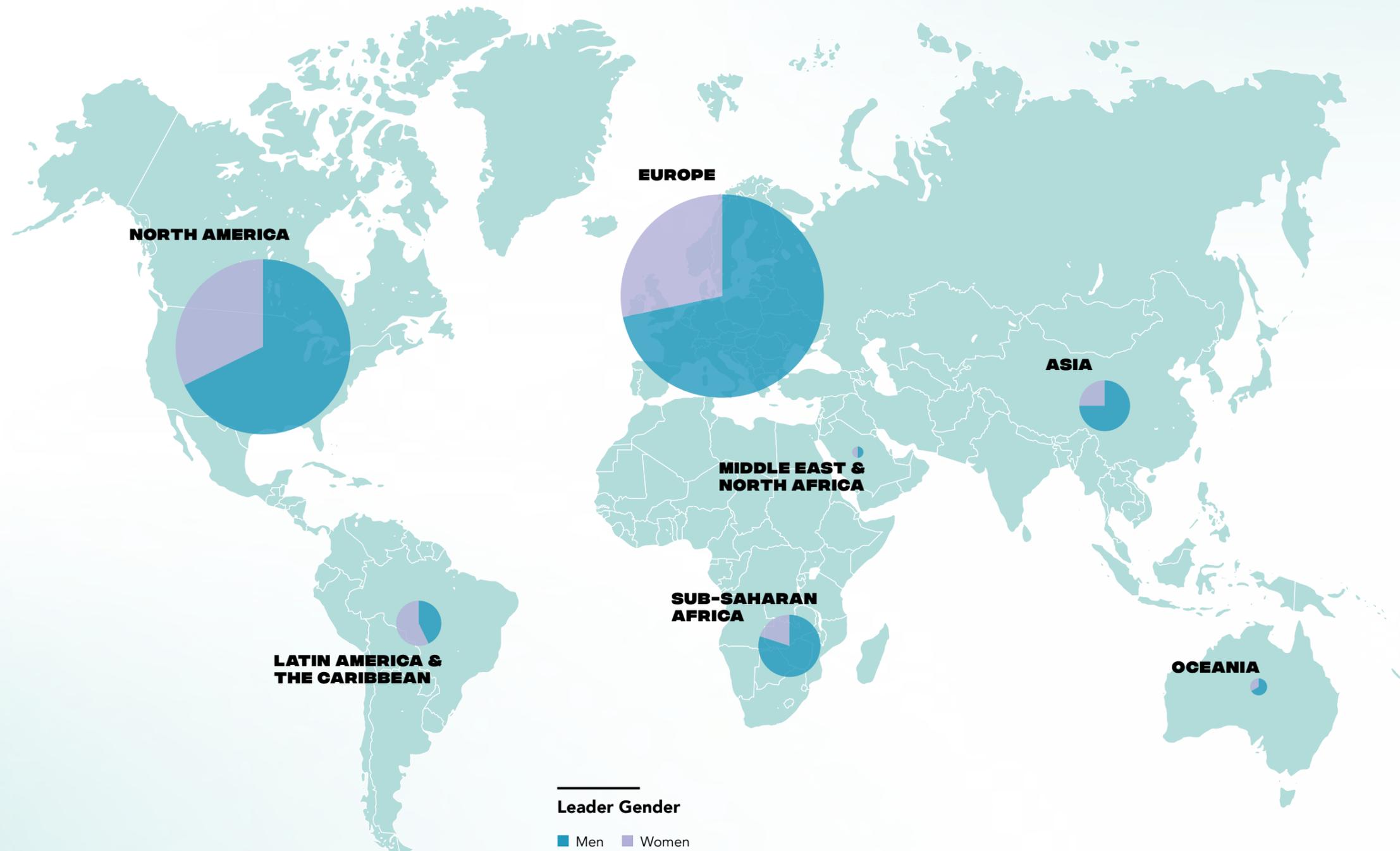
**Precaution**
*Obake village, Nigeria. 2020.*

Ismail Odetola

Bolatito emerges through the morning mist at Obake village on the mountain of Erin in Osun state, Nigeria. She is clad in a heavy shawl and concealed behind a brightly coloured mask. Bolatito is a passionate social responsibility officer who has volunteered with NGOs across Nigeria and Europe. However, in this time of pandemic, her underlying health issues - which include endometriosis, peptic ulcer disease, chronic migraines, hand seizures and depleted immunity - render her vulnerable.

# ABOUT THIS REPORT

The fourth Global Health 50/50 report reviews the gender-related policies and practices of 201 organisations. These are global organisations (operational in more than three countries), that aim to promote health and/or influence global health policy. The sample covers organisations from 10 sectors, headquartered in 37 countries which, together, employ over 4.5 million people.

Every year, Global Health 50/50 shines a light on whether and how organisations are playing their part to address two interlinked dimensions of inequality: inequality of opportunity in career pathways inside organisations and inequality in who benefits from the global health system.

Four years of robust evidence summarised in the Gender and Health Index provides an increasingly clear picture of where progress is being made and where it is not, and how organisations are using these findings to drive change. Comparisons in annual performance are reported for organisations and variables that have been consistently reviewed from 2018 to 2020 (139 organisations, across seven variables[1]).

**Section 1** presents findings on organisations' stated commitment to gender equality, and whether such commitments are supported by clear definitions of the concept of gender.

**Section 2** extends GH5050's annual workplace policy analysis by reviewing the availability and comprehensiveness of anti-sexual harassment, family-friendly, and flexible working policies. Having reported on these elements in the 2019 report, this report compares performance over the last two years. The section further reviews progress towards tackling power and privilege imbalances in decision-making bodies and at the leadership level, and assesses data on the gender pay gap.

**Section 3** examines the gender-responsiveness of global health approaches, including actions taken by the 201 organisations to contribute to the public health response to COVID-19. It presents findings on whether organisations applied a gender lens to their engagement in addressing the health needs of everyone - women and men, including transgender people, and people with non-binary identities.

Recommendations for action and a range of practical resources are offered at the end of each section. **Section 4** presents a number of considerations to heads and staff of organisations on how to use the report's findings to spark dialogue, analysis and action for more equitable, gender-responsive organisations.

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1. Public commitment to gender equality; Definition of gender; Workplace gender equality policy; Gender composition of decision-making bodies; Gender of leaders; Gender-responsive programmatic approaches, and; Reporting sex-disaggregated data

The data in this report reflects the participation and contributions of over 100 organisations, who took the time to submit documentation, verify findings, and engage with Global Health 50/50. Their participation in bringing about a more transparent, gender equal and gender responsive global health system is deeply appreciated.

Full details of the GH5050 methodology can be found on page 140.

To explore the interactive Gender and Health Index and the individual results of hundreds of organisations over the past four years, visit: GlobalHealth5050.org/data.

## REPORTS

**2018** **The Global Health 50/50 Report**
The inaugural GH5050 report presented data on 140 organisations across 7 core variables.

**2019** **Equality Works**
The 2019 report reviewed 198 organisations across the 7 core variables alongside an in-depth look at gender in the workplace, including sexual harassment policies, family-friendly and flexible working policies and gender pay gaps (find the related How-To Guides here).

**2020** **Power, Privilege and Priorities**
The 2020 report reviewed 200 organisations and complements the 7 core variables with a diversity lens, alongside an in-depth look at the priorities of the global health ecosystem.

**2021** **Flying blind in a time of crisis**
The 2021 report reviewed 201 organisations, including an examination of organisations' engagement in the public health response to COVID-19 and measurement of progress since 2019 on key policies to promote equity and dignity in the workplace.

**Figure 12. Organisational validation of GH5050 data, by sector**
% organisations that validated data published in the 2021 report



| UN system | Public-private partnerships | NGOs & non-profits | Research and surveillance | Bilaterals and global multilaterals | Private sector | Consultancy | Philanthropic and funders | Faith based | Regional organisations | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| 82% | 76% | 66% | 45% | 43% | 41% | 40% | 36% | 10% | 0% | 50% |
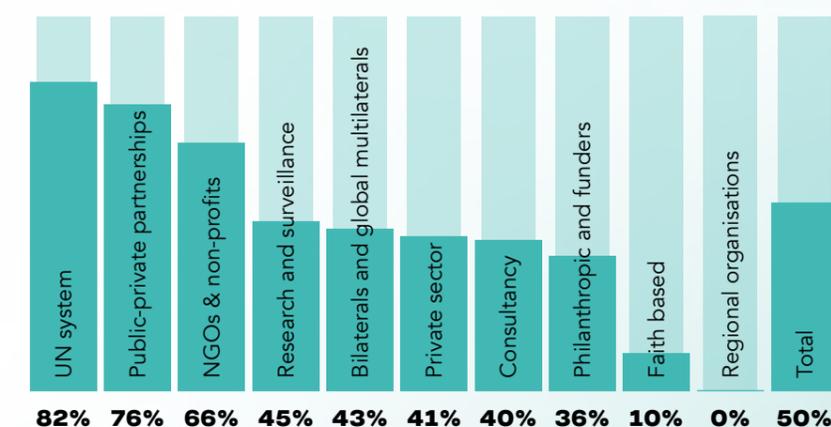
# HIGH SCORING ORGANISATIONS

GH5050 identified 45 high scorers in 2021, including 12 very high-scoring organisations and 33 high-scoring organisations. High performers per sector have also been recognised. Scoring is based on performance across the four dimensions of the 2021 analysis (Sections 1-3).

## 12 Very high scorers

- EngenderHealth
- GAVI, the Vaccine Alliance
- Global Fund to Fight AIDS, Tuberculosis & Malaria
- International Planned Parenthood Federation (IPPF)
- Population Services International (PSI)
- Save the Children
- Scaling Up Nutrition
- Stop TB Partnership
- Swedish International Development Cooperation Agency (Sida)
- UN Women
- Unitaid
- United Nations Development Programme (UNDP)

## 33 High scorers

AbbVie •

Abt Associates •

Africa Population and Health Research Centre (APHRC)

CARE International

Dalberg •

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

Drugs for Neglected Diseases Initiative (DNDi) •

Food and Agricultural Organization of the United Nations (FAO)

Foundation for Innovative New Diagnostics (FIND) •

Global Alliance for Improved Nutrition (GAIN)

Global Financing Facility (GFF) •

Health Action International

Jhpiego

Joint United Nations Programme on HIV and AIDS (UNAIDS)

Medicines Patent Pool (MPP)

Mercy Corps •

National Institutes of Health (NIH) •

Palladium Group •

Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)

PATH •

Plan International

Population Reference Bureau (PRB) •

Reproductive Health Supplies Coalition

Sanofi Espoir Foundation

Sonke Gender Justice •

UNHCR

UNICEF

Unilever •

United Nations Office on Drugs and Crime (UNODC)

United Nations Population Fund (UNFPA)

World Bank Group •

World Food Programme

World Health Organization (WHO) •

## Highest performers by sector[2]

### BILATERALS AND GLOBAL MULTILATERALS
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

Swedish International Development Cooperation Agency (Sida)

Unitaid

World Bank Group •

### CONSULTANCY
Dalberg •

Palladium Group •

### FAITH BASED
Islamic Relief Worldwide • • •

### NGOs & NON-PROFITS
CARE International

EngenderHealth

International Planned Parenthood Federation (IPPF)

Population Services International (PSI)

Reproductive Health Supplies Coalition

Save the Children

Sonke Gender Justice •

### PHILANTHROPIC AND FUNDERS
Global Financing Facility (GFF) •

Sanofi Espoir Foundation

### PRIVATE SECTOR
AbbVie •

Abt Associates •

Unilever •

### PUBLIC-PRIVATE PARTNERSHIPS
GAVI, the Vaccine Alliance

Global Fund to Fight AIDS, Tuberculosis & Malari

Scaling Up Nutrition

Stop TB Partnership

### REGIONAL ORGANISATIONS
United Nations Economic Commission for Africa (UNECA)

### RESEARCH AND SURVEILLANCE
Africa Population and Health Research Centre (APHRC)

National Institutes of Health (NIH) •

• While an organisation is found to perform well overall, a red dot indicates that there are one or more areas, as reported in the Gender and Health Index, where organisational performance is low.

# THIS IS GENDER

## Global Health 50/50 Photo Contest

Global Health 50/50 hosts the annual *This is Gender* global photography competition. *This is Gender* invites photographers to contribute to expanding the imagery associated with the concept of gender by exploring the diverse ways in which gender norms are lived, reinforced and subverted by people around the world.

This year, GH5050 was honoured to receive over 1000 submissions to the competition. The images were captured in at least 65 different countries around the world.

In collaboration with the photographers, we are pleased to present the winning cover image and several shortlisted images, which we invite you to discover throughout the report.

We hope your encounter with these images encourages you to consider the representational politics and visual ethics at play in global images of gender. We believe that images that carry a wider diversity of stories, both from behind and in front of the camera, may help to lift the veil of gender-blindness in global health.

Explore many more images at https://globalhealth5050.org/this-is-gender-2021/.

We are grateful to the Global Health Innovative Technology Fund for their generous support to This is Gender.

### WE ARE GRATEFUL TO OUR PANEL OF JUDGES:

**Azu Nwagbogu**

Founder and Director of African Artists' Foundation, a non-profit organisation based in Lagos, Nigeria.

**Esra'a Al Shafei**

Human rights activist and founder of Majal.org, a network of digital platforms that amplify under-reported and marginalized voices.

**Jessica Horn**

Founding member, African Feminist Forum and Commissioner on the Lancet Commission on Gender and Global Health

**Suhair Khan**

Strategic Projects at Google and Founder/Director of Open/Ended, a new online platform for activism in design

# GENDER-TRANSFORMATIVE

Addresses the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men.

# GENDER-BLIND

Ignores gender norms, roles and relations and very often reinforces gender-based discrimination. By ignoring differences in opportunities and resource allocation for women and men, such policies are often assumed to be "fair" as they claim to treat everyone the same.

Source: WHO, Gender mainstreaming for health managers: a practical approach, 2011

# SECTION 1.



## FINDINGS IN-DEPTH: COMMITMENT TO REDISTRIBUTE POWER

**Anyone can fly**
*Horipur, Kushtia, Bangladesh. 2019.*

Jibon Malaker

A man and woman travel by train in Bangladesh. Contained within the blackness of their box-like window frame, they travel differently. The man faces forward unaware of the unfolding landscape, perhaps content with the forward progression and speed of the journey. The woman leans her arm on the frame and peers out of the window. Above her a bird takes flight. Steeped in the symbolism of restriction versus freedom, the image echoes Moroccan feminist Fatima Mernissi's notion, "A woman could be totally powerless, and still give meaning to her life by dreaming about flight."

# STATED COMMITMENT TO GENDER EQUALITY

GH5050 reviews organisations' visions, missions and core strategy documents in the public domain to determine whether an organisation states a commitment to gender equality.

## Findings

Public commitment to gender equality appears to be strong and growing: 79% (159/201) of organisations in the sample have committed to gender equality. The proportion of organisations that commit to gender equality has grown steadily since 2018. However, one in five organisations in the 2021 sample have yet to publicly state their commitment to gender equality, including one-third of funders and private sector companies.

Organisations are increasingly embracing a more inclusive and comprehensive concept of gender equality; one that focuses not only on the empowerment of women and girls but one in which all people, regardless of their gender, will benefit from tackling restrictive gender norms and shaping a more just society. The number of organisations that explicitly include transgender and non-binary people in their commitments to gender equality has doubled in two years, from 16 in 2019 to 33 this year. This represents however just 16% of the sample.

**Where does GH5050 find commitments to gender equality?**
• On organisations' websites, in relation to their programmatic priorities or workforce principles
• When organisations sign up to the UN Global Compact, a voluntary initiative based on CEO commitments to implement universal sustainability principles and to take steps to support the SDGs, and make explicit mention of support to SDG 5 on Gender Equality and the Empowerment of Women
• When organisations become signatories of the Women's Empowerment Principles, established by the UN Global Compact and UN Women.

**Figure 13. Commitment to gender equality**



Commit to gender equality for the benefit of all

Commit to gender equality, with focus on empowering women and girls

Focus on women and girls but no reference to gender equality

No reference to gender or women and girls
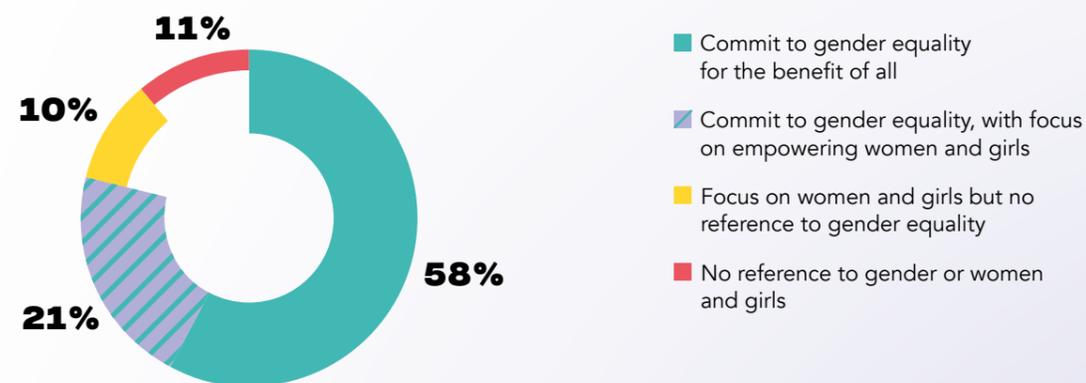
**Figure 14. Commitment to gender equality, by sector**



| UN system (n=11) | PPPs (n=17) | Bi & multilaterals (n=14) | Consultancies (n=10) | Regional bodies (n=8) | Research & surveillance (n=11) | Faith-based (n=10) | NGOs (n=64) | Private sector (n=42) | Funders (n=14) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 94% | 93% | 90% | 87% | 82% | 80% | 77% | 67% | 64% |
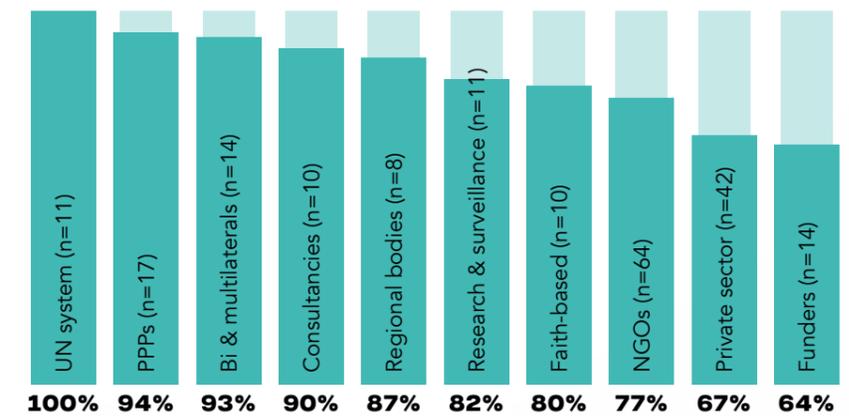
**Figure 15. Commitment to gender equality, on the rise**
Among the 139 organisations reviewed consistently from 2018 to 2021:



55%  2018   70%  2019   76%  2020   79%  2021
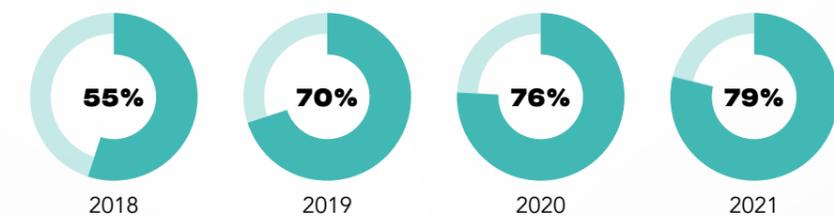
**EXAMPLES OF NEW AND UPDATED COMMITMENTS TO GENDER EQUALITY**

Amidst the global shock to food systems wrought by the COVID-19 pandemic, **GAIN** refreshed its organisational strategy, which includes "strengthened focus on negotiating and, when possible, transforming the gender power imbalances we encounter in the course of our work."

The **International Vaccine Institute (IVI)** introduced a new webpage on gender equality in 2020, which recognises gender equality as a precondition of a healthy society and as a fundamental human right.

IVI lays out a number of ways in which it is mainstreaming gender in its approach to vaccine development and delivery, with the global goal of "increasing access to vaccines and health services for all girls, women, boys, men, and persons with non-binary gender identities".

Spurred on by the Global Health 50/50 analysis, the **Sanofi Espoir Foundation** has developed a gender statement which recognises gender inequality, alongside other inequalities, as a key determinant of health, and commits to advance gender equality in its own governance, through its health programmes, and in its partnerships.

# DEFINITION OF GENDER

Definitions matter. They shape how we think as we move through the world on a daily basis, and they inform the decisions we make. Gender and the distribution of power in gender relations affect all interactions and decisions, from the household level up to the operations of transnational organisations. Gender relations are frequently unjust and unequal as a result of entrenched power relations. Until this is articulated clearly in organisations' definitions of gender, efforts to address gender equality will continue to pay lip service.

Understanding gender as a social construction (rather than a biological trait, for example) allows us to see the ways in which gendered power relations permeate most parts of life, and begin to address the distribution of power across and within societies, institutions and organisations.

## Findings

39% of organisations (79/201) define gender in a way that is consistent with WHO's global definition (see glossary).

The proportion of organisations that define gender in line with global definitions on their websites or in their strategy documents has increased since 2018, from 31% to 40% in 2021.

**Figure 16. Defining gender in line with global norms**



- Do not define gender or any gender-related terms
- Define gender as a social construct, in line with global norms
- Define gender-related terms
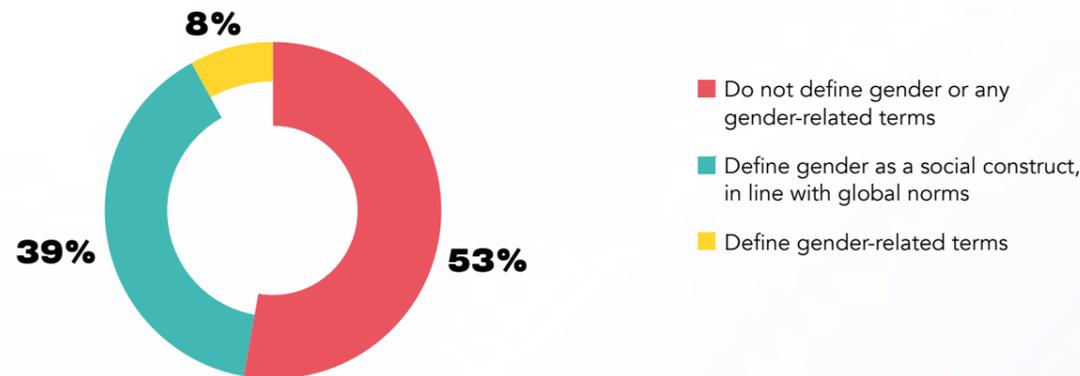
**Figure 17. Percent of organisations defining gender consistent with global definition, by sector**



| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| UN system (n=11) | PPPs (n=17) | Bi & multilaterals (n=14) | Regional bodies (n=8) | Research & surveillance (n=11) | NGOs (n=64) | Funders (n=14) | Consultancies (n=10) | Faith-based (n=10) | Private sector (n=42) |
| 82% | 76% | 64% | 50% | 45% | 44% | 21% | 20% | 20% | 9% |
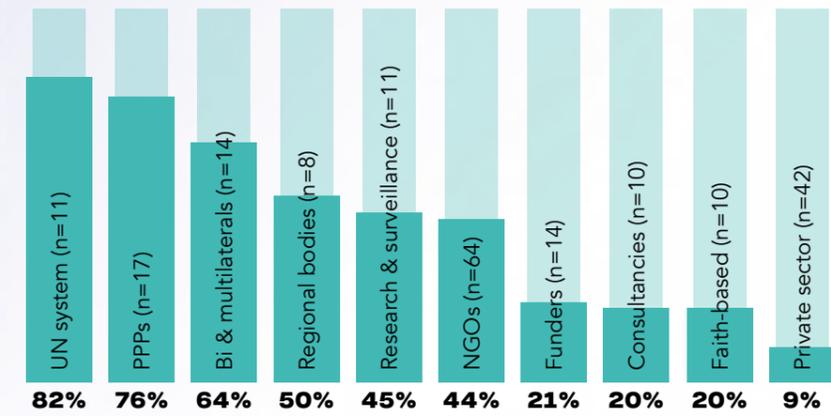
### EXAMPLES OF ORGANISATIONS' DEFINITIONS OF GENDER

In 2020, **Drugs for Neglected Diseases initiative (DNDi)** launched a new public webpage dedicated to sharing its commitments, plans and progress towards Equality, Diversity and Inclusion, and defines gender alongside a number of gender-related terms.

The **International Planned Parenthood Federation**, drawing from an EngenderHealth and UNFPA toolkit, defines gender as "a fluid concept that is present through all social life. It is not biological or natural but is constructed from the images, messages and expectations we see around us. Expectations and informal rules about what it means to be a man or woman (also called 'gender norms') can vary over time and according to context. Expectations about women's roles have seen the greatest change in modern history. The fact that gender norms can be changed means that it is possible to overcome gender inequality. Genders include men, boys, women, girls and transgender people."

**Darwin: LGBT in Honduras**
*Honduras. 2017.*

Francesca Volpi

Darwin and friends flick through a photo album at their home in Honduras. The photographer first met Darwin outside a morgue on the day Darwin's brother Marco's body was discovered wrapped in plastic in an alley. Marco, like Darwin, was a sex worker and lived within a severely marginalised and discriminated LGBTQ+ community, a community disproportionally targeted in the hyper-masculinised violence epidemic. His body had signs of torture and choking. No one has been arrested in connection with his murder.

## GLOBAL HEALTH: REINFORCING OR RESISTING THE GENDER BINARY?

Transgender people and people with non-binary gender identities continue to fight stigma and discrimination globally—including within the workplace—and often in the face of health, social, legal, educational and political systems that overtly aim to reinforce a gender binary. The impact of widespread discrimination and marginalisation can be seen in lack of access to appropriate health care services, as well as careers blighted by exclusion and harassment.

**Reinforcing the binary:**
GH5050 findings show that only 26 out of 201 (13%) organisations publish definitions that recognise the non-binary nature of gender. In addition, only 21 out of 200 organisations have programmatic strategies that refer to transgender health; this is just 10% of the sample.

**Resisting the binary:**
Overcoming binary definitions of gender to embrace an inclusive appreciation of gender is necessary to achieve equality. Global health organisations, committed to social justice and gender equality, should be leading the way.

*"We view patriarchy as creating and sustaining power inequalities by men collectively over women (including cis and trans women), as well as gender-nonconforming individuals, and by some groups of men over other marginalized men, and as a social force that keeps all individuals from having the connected, fulfilled, and peaceful lives they deserve. We view gender power and gender norms as constructed in relationships among individuals and reinforced by societies and structures, and we strive to work in ways that overcome the gender binary and achieve equality."*
**Promundo**,
https://promundoglobal.org/about/we-believe/

*"Gender diversity, gender inclusivity, an inclusive understanding of gender, and a non-binary understanding of gender all mean inclusion of all genders, not just male and female. However, in most cases a binary understanding of gender (male and female) forms the basis for legislation and dominant social orders. Self-determination of gender identity is a basic human right under international law."*
**Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ),**
https://www.giz.de/en/downloads/giz-2019-en-gender-strategy.pdf

# RESOURCES FOR COMMITTING TO REDISTRIBUTE POWER

Commitment to gender equality is on the rise, with substantial year-on-year increases. The concept of gender however remains undefined by a majority of organisations. Commitment and definition belong together: definition provides specificity to commitments that can otherwise be misinterpreted or misunderstood.

Given the contested understanding of gender in many societies, and 25 years after the global conferences of Beijing and Cairo, clarity in organisational commitments to gender equality and clarity of concept is long overdue.

The following resources provide helpful places to start when considering how to institutionalise commitments to gender equality and inclusive language to use in doing so. GH5050 has not verified the accuracy of information in these links, but we list them as a source of further information:

Women's Empowerment Principles - guidance on how to promote gender equality in the workplace

UN Global Compact - see commitments made by companies under Sustainable Development Goal 5: Gender Equality

UN Women GenderTerm - gender-inclusive language guide

" *As a young person paving my career in global health, it's promising to see how much of the sector is committed to gender equality and diversity, in their own organisations and in the programmes and policies they implement. But we must continue to do better. GH5050 has empowered all of us working in this arena to understand our shortcomings. It has inspired us to demand and act* "

## ZAHRA ZEINALI

Member of the Global Health 50/50 Collective

# SECTION 2.



## FINDINGS IN-DEPTH: IMBALANCES OF POWER AND PRIVILEGE IN THE WORKPLACE

**Health Centre in a Remote Island**
*Sunderban, West Bengal, India. 2020.*

Arpan Basu Chowdhury

A healthcare worker gives an injection against tetanus to a pregnant woman at her clinic on the remote island of Sunderban, India. Reaching across the hospital bed to maintain social distancing measures, the health worker's face is concealed by the swathes of silken yellow fabric fashioned into a face mask. The makeshift PPE is a visual reminder of the struggles healthcare workers face in rural settings. Here, boats are the only form of transportation and supply deliveries are irregular. As one of only three nurses on the island charged with serving the diverse health needs of the 20,000 strong population, innovation is essential.

# POLICIES TO ADVANCE EQUITY AND TACKLE IMBALANCES OF POWER AND PRIVILEGE IN THE WORKPLACE

## Workplace equity demands policies, action and accountability

Organisational policies matter. They are the building blocks that not only provide rules, norms, standards and guidelines for organisational culture and 'ways of working', they are also the means through which organisations can be held to account. An enabling environment should not rely solely on the discretion of individual managers. Policies formalize standards and processes and their implementation can be tracked, monitored and reported.

Policies, however, are 'words on paper.' Implementation requires strategies, plans and specific measurable actions to tackle imbalances based on power and privilege in career pathways. Importantly, implementation also requires resources, both human and financial.

## Neutral is not enough: Correcting for historical and structural disadvantages

The majority of organisations under review operate in countries with legal frameworks that protect workers against discrimination, including equal employment opportunity laws and equal pay laws. Yet while such laws are essential, they are insufficient to level the playing field when individual bias and institutional discrimination that disadvantage women continue to reinforce existing systems of power.

For organisations which have entrenched power asymmetries, addressing equality needs to go further still and delve into the past, interrogating historical injustices, identifying how they are perpetuated through existing power structures, and taking action. For example, this could mean putting specific measures in place to support the careers of historically underrepresented groups. The movements to decolonise and achieve gender equality in global health provide examples of why redressing past injustices through positive action is a vital step.

## Equity in all policies: Towards a comprehensive set of transparent policies to advance gender equality, diversity and inclusion

A working environment that embraces equality of opportunity and is inclusive of all staff relies both on committed leadership and empowered staff, supported by a comprehensive set of policies that aim to address the complex and structural nature of inequality.

Workplace policies and workplace culture are influenced by more than leadership. The presence of active trade unions or other mechanisms for collective bargaining and representing employees' rights also play a crucial role in ensuring that workplace policies are fair and equitable, and that organisations are held to account for the policy promises they make.

Key policies guide action on attracting, retaining, motivating and respecting staff who reflect the diversity of humanity. Such policies range from diversity and inclusion strategies, flexible working arrangements and family-friendly policies, to supporting a work environment free from discrimination, harassment and abuse of authority.

We encourage transparency of workplace equality policies. We also recognise that given the contested, sometimes violent, nature of debates surrounding gender in some places, a small number of organisations take the deliberate decision to keep their gender-related policies internal as a means to protect the organisation and its staff.

## Findings: How transparent are organisations in their policy commitments to gender equality, diversity and inclusion?

GH5050 assessed the availability and comprehensiveness of a set of key policy areas that contribute to shaping an equitable, inclusive and respectful workplace. These include:

- Gender equality policy/plans
- Diversity and inclusion policy/plans
- Board diversity and inclusion policy
- Anti-sexual harassment policy
- Parental leave policy
- Support to parents returning to work
- Flexible working arrangements

The assessment showed that one-quarter of the organisations with more than 10 staff (46/191) put no information on these policy areas in the public domain. Six organisations have all seven policies in the public domain: Accenture, BP, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Drugs for Neglected Diseases Initiative (DNDi), Partnership for Maternal, Newborn and Child Health (PMNCH), Scaling Up Nutrition.

*46 organisations put no information on these policy areas in the public domain. Six organisations have all seven policies in the public domain.*

Small and medium-sized organisations have fewer publicly-available workplace policies compared to larger organisations. Half (26/56) of organisations with 11-249 staff did not publish any of the policies under review. Among larger organisations (250+ staff), 14% did not publicly publish any of the policies, and 60% published at least 3 policies.

**Figure 18. Transparency by size: % of organisations\* with multiple publicly available workplace policies**

| | 0 policies | 1-2 policies | 3-4 policies | 5-7 policies |
|---|---|---|---|---|
| 11-49 staff (32) | 47% | 16% | 12% | 25% |
| 50-249 staff (24) | 46% | 20% | 16% | 16% |
| 250-999 staff (30) | 27% | 33% | 13% | 27% |
| 1000+ staff (100) | 12% | 25% | 27% | 36% |
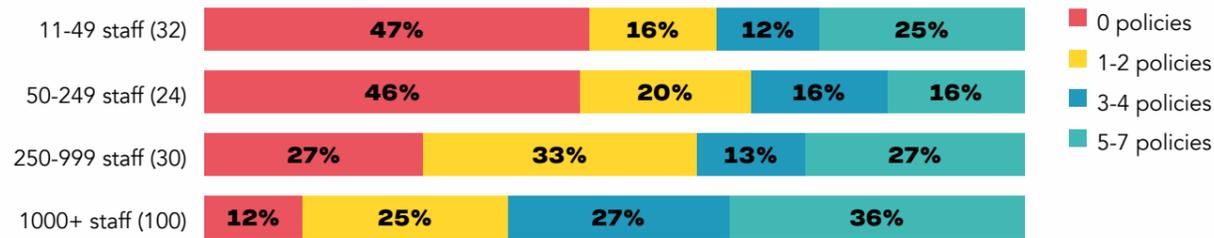
\*Where the size of the organisation could be verified.

Most bilateral agencies, multilaterals and UN system agencies, all of which tend to be larger organisations, had at least three workplace policies available. Two-thirds of private sector organisations and public-private partnerships also had at least three policies available. Across the remaining sectors, most organisations had two or fewer workplace policies publicly available, including faith-based organisations, regional bodies, NGOs, consultancies, funders and research and surveillance organisations.

**Figure 19. Transparency by sector: % of organisations with multiple publicly available workplace policies**

| | 0 policies | 1-2 policies | 3-4 policies | 5-7 policies |
|---|---|---|---|---|
| UN system (n=11) | | | 9% | 91% |
| Bi & multilaterals (n=14) | | | 7% 36% | 57% |
| PPPs (n=17) | 23% | 12% | 17% | 48% |
| Private sector (n=40) | 19% | 14% | 31% | 36% |
| Consultancies (n=10) | 10% | 50% | 10% | 30% |
| Funders (n=14) | 29% | 29% | 14% | 28% |
| Research & surveillance (n=10) | 9% | 46% | 18% | 27% |
| NGOs (n=57) | 44% | 30% | 19% | 7% |
| Regional bodies (n=8) | 75% | | 13% 12% | |
| Faith-based (n=10) | 50% | 50% | | |

# WORKPLACE GENDER EQUALITY POLICIES

The aim of gender equality in the workplace is to achieve broadly equal outcomes for women and men. Achieving gender equality is important for workplaces not only because it is 'fair' and 'the right thing to do,' but because it is also linked to increased organisational performance, enhanced ability of companies to attract talent and retain employees, and enhanced organisational reputation.

GH5050 assessed which organisations are translating their commitments to gender equality into practice through action-oriented, publicly available workplace policies. It identifies which organisations go beyond minimum legal requirements and implement affirmative policies and programmes with specific measures to actively advance and correct for historical inequalities.

Examples of specific measures may include: Gender-responsive recruitment and hiring processes; mentoring, training and leadership programmes; targets for women's participation at senior levels; gender analysis and action in staff performance reviews and staff surveys; regular reviews of organisational efforts towards gender equality; reporting back to all staff.
GH5050 does not assess the performance of small organisations—those with 10 or fewer staff—for this variable (unless they are hosted by a larger organisation), or for the existence of a diversity and inclusion workplace policy. We would not expect organisations (nor did we find any) of this size to develop gender, diversity and/or inclusion plans. However we continue to encourage them to, at a minimum, make a public commitment to gender equality, diversity and inclusion.

## Findings

61% (117/191) of organisations reviewed have publicly available workplace gender equality policies or plans which contain explicit targets, programmes or measures to achieve equality. This marks no change over 2020, which found that 60% (114/190) of organisations had such policies in place.

**The Man's Woman.**
*Ogun, Nigeria. 2020.*

Francis "Beloved" Ogunyemi

A woman shaves her husband's head in their home in Ogun, Nigeria. Like many living in lockdown, unable to venture to local salons or barbers for a trim, the couple must navigate the new roles and responsibilities the pandemic has forced upon them.

**Figure 20. Workplace policies to promote gender equality**



- Gender equality policies/plans with specific measures
- Commit to gender equality but no measures
- Compliant with law
- No policy or commitment found
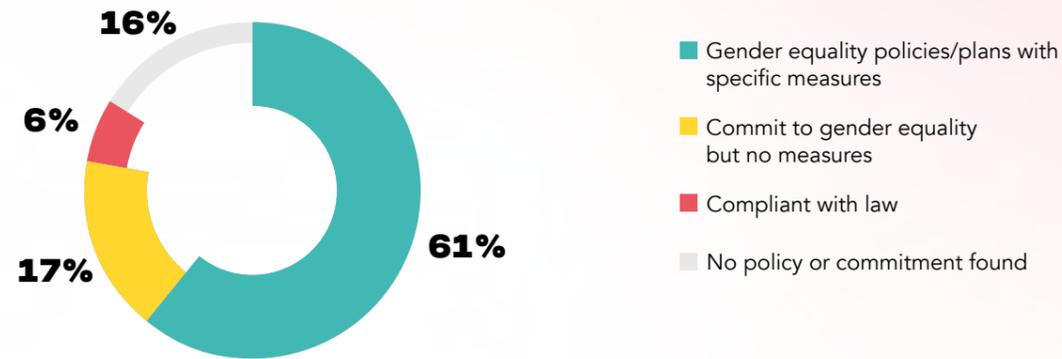
The pace of progress appears to have stalled. Whether this is a result of organisations not publishing internal plans or not developing them altogether is unclear.

An increase, from 10% in 2020 to 17% in 2021, was measured in broad commitments to gender equality in the workplace. At the same time, some reversals in progress were found. Commitments to advancing gender equality in the workplace that were found last year for several organisations could not be located this year. In some cases, commitments made in previous annual reports to advance gender equality were not reinforced or reported on this year.

Further, while a majority of organisations have gender equality measures in place, few policies and plans define the accountability structure to assign responsibility, clarify expectations, and measure progress towards realising gender equality across the workforce.

**Figure 21. Organisations with publicly available workplace gender equality policies with specific measures (%), by sector**



| UN system (n=11) | Research & surveillance (n=10) | Consultancies (n=10) | Bi & multilaterals (n=14) | Private sector (n=40) | PPPs (n=17) | Funders (n=14) | NGOs (n=57) | Regional bodies (n=8) | Faith-based (n=10) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 80% | 80% | 79% | 77% | 71% | 57% | 42% | 25% | 20% |
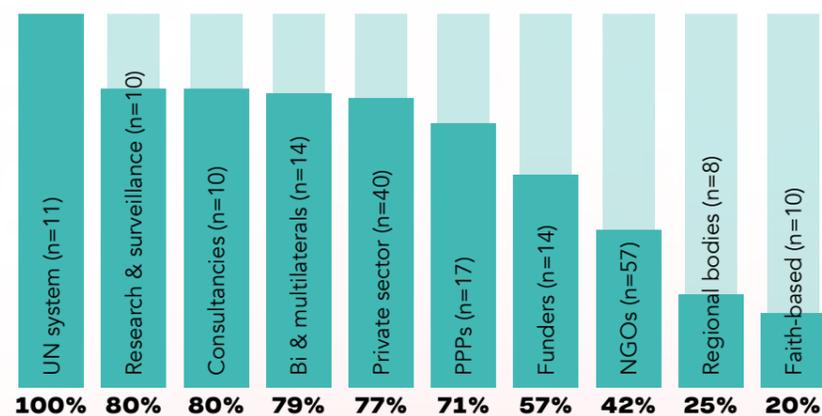
**Figure 22. Progress stalls in past year in growth in publicly available workplace gender equality policies**

Among the 132 organisations (11+ staff) reviewed consistently from 2018 to 2021:



| 46% | 56% | 70% | 70% |
|---|---|---|---|
| 2018 | 2019 | 2020 | 2021 |
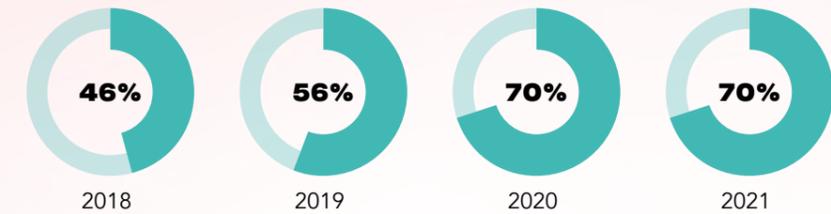
***Access the policies*** To access all publicly available gender equality policies and plans reviewed this year, go to: https://globalhealth5050.org/2021-policy-links/

## WORKPLACE DIVERSITY AND INCLUSION POLICIES

Advancing diversity and inclusion requires clear policies, deliberate focus, sustained action, and accountability. GH5050 assessed which organisations (with 10 or more employees) had publicly available policies that committed to advancing diversity and inclusion in the workplace—alongside and beyond gender equality—and had specific measures in place to guide and monitor progress.

## Findings

Policies to advance diversity and inclusion—beyond gender—in their workforce were identified for 51% (98/191) of organisations. The proportion of organisations making reference to diversity and inclusion increased from 68% to 79% in the past one year.

Several organisations incorporated recognition of the role of structural inequalities and injustice in contributing to the underrepresentation of certain groups, particularly at senior levels. With such recognition, the most comprehensive policies then move beyond commitments to non-discrimination and towards anti-discrimination practices that aim to actively redistribute opportunity.

> *"Systemic racism is built into the fabric of many American institutions in addition to policing and structures of power. The healthcare system disproportionately fails Black and Brown communities; they are disproportionately being infected and killed by COVID-19. As a global health organization, we know that inequity, discrimination, racism and violence directed at any community are all social determinants of poor health. They result in deadly circumstances, whether in the 50 formerly colonized countries where we work or here in the US. We've committed to doing what is different and difficult for change in those countries. We commit to doing it here for our employees as well."*
>
> **Population Services International,**
> https://www.psi.org/2020/06/a-statement-of-psi-solidarity/

**Figure 23. Increase in availability of workplace diversity and inclusion policies, 2020-2021**



**2020**
- 45%
- 23%
- 8%
- 24%

**2021**
- 51%
- 28%
- 6%
- 15%

**CHANGE**
- 6%
- 5%
- -2%
- -9%

- ■ Policies with specific measures in place
- ■ Commit to promoting diversity and inclusion, but no actions
- ■ Minimal commit to non-discrimination
- ■ No reference to non-discrimination or diversity and inclusion
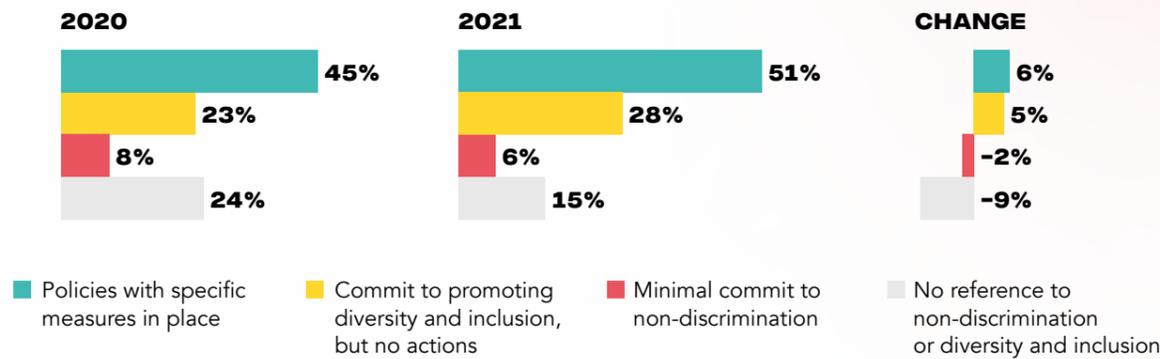
**Figure 24. Workplace diversity and inclusion policies, by sector**



UN system (n=11) — 100%
Consultancies (n=10) — 90%
Private sector (n=40) — 70%
Bi & multilaterals (n=14) — 64%
Research & surveillance (n=10) — 60%
Funders (n=14) — 50%
PPPs (n=17) — 47%
NGOs (n=57) — 33%
Regional bodies (n=8) — 12%
Faith-based (n=10) — 0%
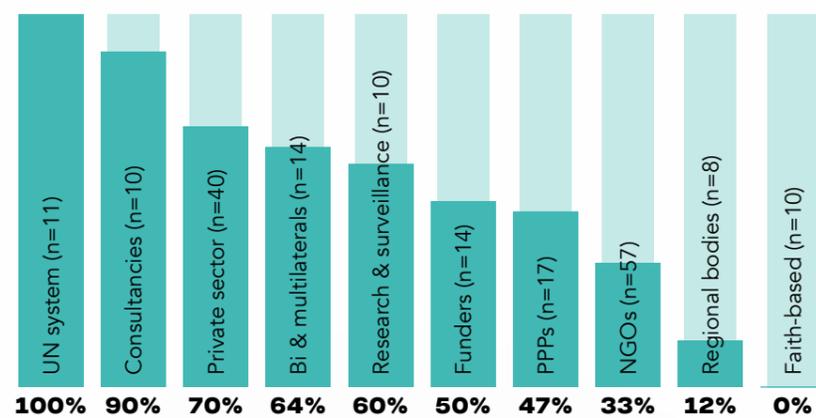
**PRIVATE SECTOR LEADS ON DIVERSITY AND INCLUSION POLICIES.**

Both the private-for-profit sector and the consultancies perform well across workplace gender and D&I policies, particularly when compared to other sectors such as NGOs or faith-based organisations. (It should be noted, however, that strong policies do not necessarily correlate to more equitable outcomes, see page 78 on gender composition of decision-making bodies). Building on the principles of SDG 17 (revitalising the partnership for sustainable development), this may provide an opportunity to expand the kind of support that the private sector can share with organisations in other sectors through its partnerships, including technical assistance to strengthen internal workplace policies of organisations that are currently lagging.

**Examples of measures organisations are taking to advance on their commitments to diverse and inclusive workplaces:**

- Targets for leadership teams and governing bodies to comprise no more than two-thirds of one gender; targets to improve ethnic diversity in leadership positions.
- Monitoring the gender and diversity composition of human resources at all levels (governance, management, staff, volunteers), and analysing in light of potential barriers to equal opportunities, diversity and inclusion related to power and decision making.
- Producing resources and FAQs for LGBTQ+ staff working overseas, including on issues of safety, security and support networks.
- Producing transgender inclusion guidelines and allyship for all staff, including rationale of adding pronouns to email signatures.
- Institutionalisation of D&I capacity in the form of offices, senior staff with specialised expertise, and ombudspersons.
- Formation of staff D&I committees and resource groups, with mandates that range from monitoring recruitment and selection processes, to facilitating and accelerating the personal development and professional advancement of underrepresented groups.
- Mandatory inclusion training, which is helping to increase awareness and understanding of inclusion and diversity, highlighting what exclusion and bias is and how to prevent it.
- Explicit inclusion of part-time workers in diversity and inclusion plans as well as ensuring their access to leave benefits, professional training, and furlough programmes.
- Annual D&I transparency reporting on progress towards defined metrics, including composition and compensation by race, gender and other characteristics.
- Undertaking third-party, independent gender and D&I audits.

The _Gender and Diversity Strategy_ of the International Federation of the Red Cross aims to guide change across the organisation. It calls for a transformation of its traditional power structures, institutional cultures and behaviour. Measures and targets include: ensuring that leadership teams and governing bodies comprise of no more than two-thirds of one gender; analysing organisational gender and diversity issues; strengthening capacity in gender and diversity mainstreaming; incorporating a gender and diversity analysis in all operations, and; promoting diversity and equality in the communications and representation of the IFRC Secretariat.

_Access the policies_ To access all publicly available diversity and inclusion policies and plans that were reviewed this year, go to: https://globalhealth5050.org/2021-policy-links/

## BOARD DIVERSITY AND INCLUSION POLICIES

Globally, demands for gender equality and broader diversity on boards are loud and growing, bolstered by evidence that diverse and inclusive boards are more innovative and effective. Boards of directors are arguably the most influential decision-makers in global health. They often nominate an organisation's leadership. They help to determine goals and strategy. Yet continued lack of diversity in boards means that they are missing the perspectives of key stakeholders, including the communities they are meant to serve.

GH5050 reviewed which organisations had policy statements online on advancing diversity and inclusion and/or representation of affected groups in their governing bodies.

## Findings

20% (39/199) of organisations that appear to have governing bodies have policies available in the public domain that indicate how they seek to advance diversity and representation in those bodies. This marks a moderate increase since 2020.

The proportion of organisations that commit to diversity and representation in their governing body increased from 35% to 46% in 2021.

### Figure 25. Board D&I policies, 2020-2021



| 2020 | 2021 | CHANGE |
|---|---|---|
| 14% | 20% | 6% |
| 21% | 27% | 6% |
| 65% | 54% | -11% |

■ Board policy with specific measures to promote diversity and inclusion

■ Commitment to diversity, but no specific measures; Board composed of Member States but no other policy to promote diversity

□ No policy found
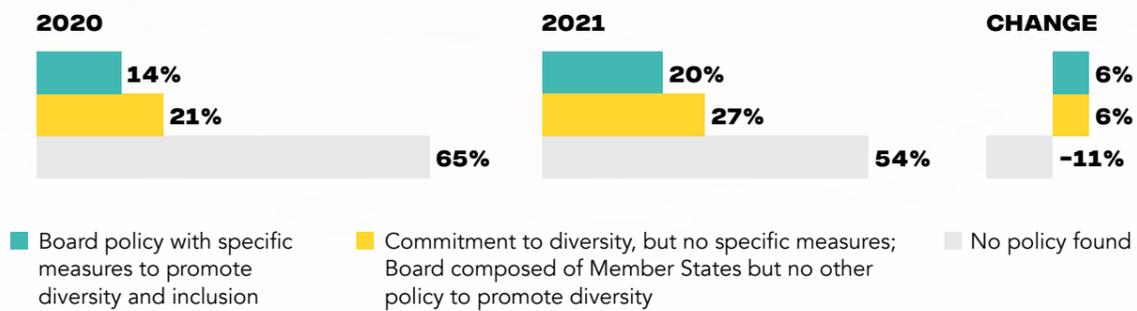
**Growing commitment: Proportion of organisations committed to diversity and representation in their governing body increased by 11% in one year.**

*We want to ensure that we achieve a 40% ratio of Black, Indigenous, and People of Color on our Board. Currently 39% of our Board identifies as Black, Indigenous, or People of Color.*

*We also are committed to a Board that is gender balanced, with 50% identifying as women, in keeping with our identity as an organization centering its work on women and girls (currently we are at 46% identifying as women).*

**Care USA,**
https://www.care.org/about-us/equity-and-inclusion/

The composition of a number of organisations' governing boards is determined by country affiliation, rather than individual appointees, which means that organisations themselves have no direct authority over who sits on the board. This is the case for the UN system and several regional political bodies. Many of these organisations however still support and encourage Member States to pursue gender parity in delegations, including by tracking and reporting gender representation, e.g. by the International Labor Organisation, UNAIDS and World Food Programme.

*Decision of the 2018 ILO Governing Body:*

*"The Governing Body: (a) urged all groups to aspire to achieve gender parity among their accredited delegates, advisers and observers to the Conference and Regional Meetings; (b) requested the Director-General, after every Conference as well as Regional Meeting, to continue to bring the issue to the attention of Members and groups that had not reached the minimum target of 30 percent of women's participation with the goal of gender parity, and to periodically report to the Governing Body on obstacles encountered, as well as measures taken by tripartite constituents to achieve gender parity."*

### Figure 26. Organisations with board diversity policies available (%), by sector



| PPPs (n=17) | Private sector (n=42) | Bi & multilaterals (n=13) | Research / surv. (N=11) | UN system (n=11) | NGOs (n=64) | Philanthropic and funders (n=14) | Consultancies (n=9) | Faith-based (n=10) | Regional orgs (n=8) |
|---|---|---|---|---|---|---|---|---|---|
| 47% | 24% | 23% | 18% | 18% | 17% | 14% | 11% | 0% | 0% |
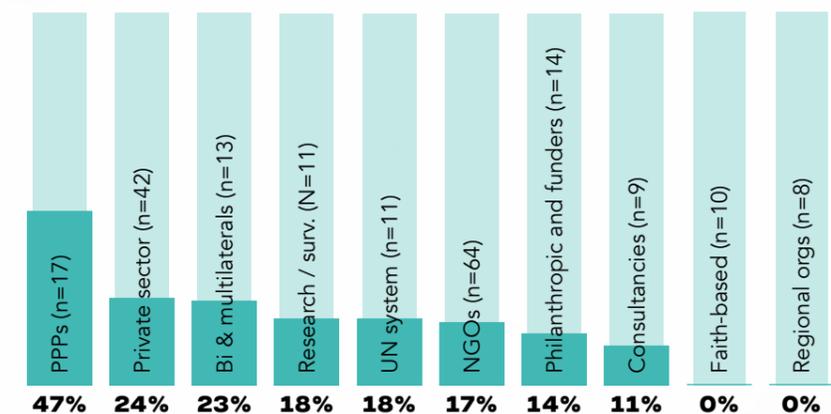
**CROSS-SECTOR LEARNING THROUGH PARTNERSHIP.**

The PPPs, most of which were established in the early 2000s, are the sector most likely to have board diversity policies. This may reflect debate over the legitimacy of private sector involvement in these partnerships at the time of their establishment and how to share decision-making while controlling for conflicts of interest. This debate resulted in structured board compositions intended to ensure balanced power and a more robust board policy environment than in other sectors. This provides another opportunity for cross-learning within and across the global health ecosystem.

*Access the policies* To access all publicly available governing board diversity policies and plans that were reviewed this year, go to: https://globalhealth5050.org/2021-policy-links/

# ANTI-SEXUAL HARASSMENT POLICIES

Global health continues to be beset by problems of sexual harassment and abuse of power in work environments. While Global Health 50/50 focuses on anti-sexual harassment policies, policies on safeguarding and combatting all forms of bullying, harassment and discrimination are essential to a safe, equitable and respectful workplace.

## Findings

A comprehensive policy is a fundamental tool to prevent and address sexual harassment and to contribute to the creation of a work environment that is based on dignity and respect. Drawing on good practice as well as existing global norms (including the UN model policy), a range of public and private sector guidelines and peer-reviewed publications, GH5050 identified four elements of a comprehensive sexual harassment policy (see Box).

**Box 1. GH5050 four best practice elements of a comprehensive sexual harassment policy**

**COMMITMENT & DEFINITION**
Does the policy: state the organisation's zero-tolerance approach to sexual harassment; sufficiently define sexual harassment, and/or provide clear examples of sexual harassment?

**TRAINING**
Does the policy guarantee mandatory training for all staff?

**CONFIDENTIALITY & NON-RETALIATION**
Does the policy: guarantee confidentiality of the investigation; and non-retaliation for complainants?

**REPORTING & ACCOUNTABILITY**
Does the policy describe: the formal and informal reporting processes; the sanctions that will apply to those who commit sexual harassment outlined; how complaints will be investigated provided; and whether the results of investigations reported back to all staff?

40% (81/201) of organisations publish their sexual harassment policies online. An additional 31 organisations shared their internal policies and gave permission to code them.

Of the 112 policies reviewed, 71 organisations (63%) were considered to perform adequately by including at least two of the four essential best practices in their policies, including 24 (21%) that included all four elements of best practice.

A large proportion of policies have some elements of best practice content in terms of: 1) descriptions of reporting and investigation processes (80%); 2) protections regarding confidentiality and retaliation (78%); and 3) state a zero-tolerance approach alongside defining and providing examples of sexual harassment (69%). However, only half (50%) stipulate mandatory training on sexual harassment for staff. For examples of organisational policy language on each of these elements, see page 69 of the 2019 Global Health 50/50 Report.

**Figure 27. Sexual harassment policies with best practice elements (of 112 reviewed)**



| 69% | 78% | 50% | 80% |
| --- | --- | --- | --- |
| Commitment | Confidentiality & non-retaliation | Training | Reporting & accountability |
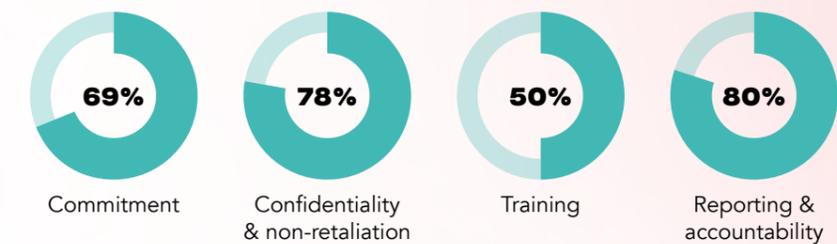
Transparency of sexual harassment policies has improved since 2019, when Global Health 50/50 first reviewed them. Among the 179 organisations reviewed in 2019 and 2021, 18 more have published their sexual harassment policies online.

Transparency uptick: 18 organisations made their anti-sexual harassment policies newly available to the public since 2019

*"The bottom line is that sexual harassment and assault are criminal offenses. No one should be exempt from being held to an organization's commitment to protecting the rights of its employees. Performance should not be brought into the discussion. It's irrelevant – high performers can be fired for this."*

**Accenture,**
https://www.accenture.com/us-en/blogs/blogs-zero-tolerance

The Inter-Agency Misconduct Disclosure Scheme was launched in 2019 to prevent perpetrators of sexual abuse from moving around the aid sector undetected. The scheme facilitates the systematic bilateral sharing of misconduct data between recruiting organisations and previous employers.

The scheme counted more than 60 participating organisations as of January 2021, including Care, Caritas, International Federation of Red Cross and Red Crescent Societies, Islamic Relief Worldwide, Oxfam, Plan International, Save the Children, and World Vision.

**Box 2. 37 organisations that score "best practice" across all four elements of a comprehensive sexual harassment policy (24 of these policies are in the public domain°)**

Abt Associates
Africa Population and Health Research Centre°
Aga Khan Foundation
Alliance for Health Policy and Systems Research°
Amref Health Africa°
Becton, Dickinson and Company°
Catholic Relief Services°
Cordaid°
Drugs for Neglected Diseases Initiative°
Food and Agricultural Organization of the United Nations°
Ford Foundation°
GAVI, the Vaccine Alliance
Global Alliance for Improved Nutrition°
Global Fund to Fight AIDS, Tuberculosis & Malaria
International Vaccine Institute
International Women's Health Coalition
Ipas

Management Sciences for Health°
McCann Health
Medicines Patent Pool°
Mercy Corps°
National Institutes of Health°
Palladium Group
Partnership for Maternal, Newborn and Child Health°
Population Services International°
Promundo
RBM Partnership to End Malaria°
Scaling Up Nutrition°
Sonke Gender Justice°
Stop TB Partnership
TB Alliance
Teck Resources
Unitaid°
United Nations Development Programme°
United Nations Office on Drugs and Crime°
World Bank Group°
World Health Organization°

*Access the policies* To access all publicly available sexual harassment policies and plans that were reviewed this year, go to: https://globalhealth5050.org/2021-policy-links/

*Access the data* To access detailed results on the policies reviewed, go to: https://globalhealth5050.org/2021-detailed-findings/

# PARENTAL LEAVE POLICIES

Equitable paid parental leave policies are critical to fostering gender transformative norms of family responsibility, promoting women's equality in career opportunities, compensating women for their reproductive labour, and closing the gender pay gap. Such entitlements further contribute to better recruitment results, higher employee morale and increased productivity, and benefit the health and wellbeing of families.

The extent to which leave policies deliver their potential benefits, including for career opportunities and progression, depends on the entitlements they provide. These include: the duration of leave; the wage replacement rate; whether leave, including shared leave, is made available to individual parents or is transferable; whether there is support available to new parents returning to work and at subsequent stages in the life of the child; the nature of leave when caring for dependents who are not children, and; support for flexible working arrangements for all staff.

The International Labor Organization's Maternity Protection Convention states that all countries, regardless of income, should guarantee women a minimum of 14 weeks of paid maternity leave. The World Health Organization, however, recommends at least 6 months (26 weeks) of breastfeeding, which is challenging for working mothers without adequate paid leave policies or lactation support in the workplace.

Despite calls for equality and universality, leave policies are frequently applied unequally or written in language that discriminates against or excludes some staff. For example, lengthy leave entitlements provided to women in the absence of similar entitlements for men can reinforce unequal parenting norms and harm women's careers over the long-term. Disparate leave policies, when parental leave benefits for fathers are inferior to those for mothers, have on occasion been found in violation of equal employment opportunity laws.

Leave entitlements may also vary by the means of becoming a parent (childbirth or adoption). Additionally, leave entitlements for parents who are in same-sex relationships may not be recognised in the language used in some policies and therefore excluded from entitlements.

In response, we find that many national and workplace policies are moving away from gender-specific and unequal maternity and paternity leave, in favour of gender-neutral, equal and/or shared policies.

**Box 3. Some definitions**

Definitions and statutory conditions of leave vary widely between countries in terms of length, entitlement and rates of remuneration. In this report we have, as far as possible, applied the following definitions to the analysis of organisational policies.

**Maternity leave** Leave generally available to mothers, designed to protect the health of the new mother and child, taken before, during and immediately after childbirth or adoption.

**Paternity leave** Leave generally available to fathers, usually taken shortly after the birth/ adoption of the child.

**Primary and secondary carers** Some countries use the terminology of 'primary carer' and 'secondary carer' (or 'partner') in place of 'mother' and 'father'. The primary carer is the person performing the majority of care for a newborn or newly adopted child. This can be a parent of any gender or someone who is not a biological or adoptive parent of the child (including a same-sex partner, co-parent or relative of either parent). The secondary carer is a carer of the child or a spouse or partner of the primary carer.

**Parental leave** Leave available equally to mothers and fathers, either as: (i) a non-transferable individual right (i.e. both parents have an entitlement to an equal amount of leave); or (ii) an individual right that can be transferred to the other parent; or (iii) a family right that parents can divide between themselves as they choose (shared parental leave). May be available to both partners in same-sex relationships in some countries.

**Flexible working** A way of working that suits an employee's needs. Different modes of flexible working exist, including: job-sharing, working from home and telecommuting, part-time working, compressed hours, flexitime, annualised hours, staggered hours and phased retirement. In some countries there is a legal right to request flexible working arrangements and organisations are required to provide a "sound" reason for any denial of flexible working requests.

**Support to returning parents** Alongside entitlements of returning to a previous post (or equivalent) after a period of leave (maternity/paternity/parental), some organisations offer support to returning parents, such as: opportunities for flexible working (see above); provision of private spaces/time for lactation; shipping breastmilk when travelling on business; on-site childcare and/or financial support for childcare options. Some organisations also offer specific programmes including career coaching, expert advice and dedicated personnel to support back-to-work transitions.

## Findings

GH5050 assessed the number of paid weeks of leave available to primary and secondary caregivers as well as options for parental and shared parental leave. It also reviewed whether the organisation offers support to parents returning to work, such as flexible transitions back to work, reduced or part-time working hours, facilities for breastfeeding mothers, and/or childcare support.

33% (67/201) of organisations publish detailed information regarding their parental leave policies online. A further 46 shared their internal policies directly with GH5050.

Transparency of parental leave policies has improved since 2019, when GH5050 first reviewed them, with 57% of organisations making policies available for review overall in 2021 versus 39% in 2019. It is noted that some organisations with multiple country offices refrain from publishing parental leave policies as they may not be standardised across the organisation.

*Transparency uptick: 17 organisations made their parental leave policies newly publicly available since 2019*

The 113 policies reviewed vary widely, in part as a response to the standards set by national and sub-national legislation in the countries where the organisations are located. Among the 113 policies reviewed, guaranteed paid leave for primary and secondary caregivers ranges from zero to 68 weeks.

Organisations headquartered in Sweden, Norway and Japan were found to offer the longest leave benefits to both parents. While organisations in the US by and large offer the fewest number of paid weeks, they are almost uniformly offering the same benefits to both parents (gender neutral), with some additional paid leave for birth mothers covered by short-term disability insurance.

Ninety-six (96) organisations indicated in their policies, or informed GH5050, of the support they offered to new parents in returning to work. Alongside entitlements of returning to a previous post (or equivalent) after a period of leave, some organisations offer support to returning parents in the form of, for example, opportunities for flexible working, provision of private spaces/time for lactation, shipping breastmilk when travelling on business, on-site childcare and/or financial support for childcare options. Some organisations also offer specific programmes including career coaching, expert advice, and dedicated personnel and resources to support back-to-work transitions.

**Figure 28. Types of support to new parents returning to work, out of total organisations that offer support (n=96)**



19%    46%    47%    38%    21%    5%

▨ Coaching and counselling, including: return to work programmes; mentoring; work/life balance counselling; family resource groups

■ Flexible working for new parents

■ Breastfeeding facilities

■ Reduced travel or accommodations for travelling with children

■ Child care facilities and stipends

■ Breastfeeding break time
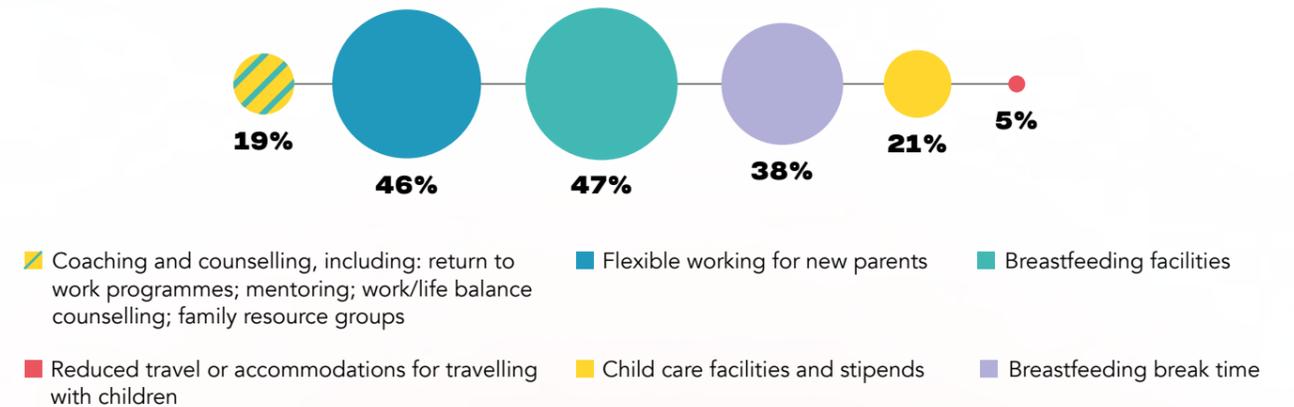
Abt Associates monitors and reports on the proportion of women and men staff who return to work following parental leave and who are still with the company 12 months later.

PATH "is committed to supporting employee family responsibilities by offering parental leave policies, additional leave options for new parents, flexible work and resources for parents through our employee assistance provider."

*Access the data* To access details on parental leave policies reviewed, go to: https://globalhealth5050.org/2021-detailed-findings/

**Figure 29. Paid primary, secondary and parental leave entitlements (weeks) in publicly-available policies**



### Primary carer & Parental leave / Secondary carer & Parental leave (left chart)

| Organisation |
|---|
| Abt Associates (1) |
| BP (1) |
| International Center for Research on Women (1) |
| Becton, Dickinson and Company (1) |
| Ipas (1) |
| Jhpiego (1) |
| Bristol-Myers Squibb (1) |
| ExxonMobil (1) |
| World Vision |
| ACHEST |
| Gilead (2) |
| Intel (1) |
| National Institutes of Health (1) |
| USAID (1) |
| Médecins Sans Frontières |
| Medtronic (1) |
| Novartis |
| Novo Nordisk |
| AB InBev |
| Accenture (1) |
| Alliance for Health Policy and Systems Research |
| DNDi |
| European Centre for Disease Prevention and Control |
| European Commission |
| GAVI, the Vaccine Alliance |
| ILO |
| Medicines for Malaria Venture |
| PMNCH |
| RBM Partnership to End Malaria |
| Safaricom |
| Scaling Up Nutrition |
| UNDP |
| UNECA |

Weeks axis: 80 60 40 20 0 | 0 20 40 60 80
Weeks

### Primary carer & Parental leave / Secondary carer & Parental leave (right chart)

| Organisation |
|---|
| UNHCR |
| Unilever |
| UNODC |
| World Food Programme |
| World Health Organization |
| Johnson & Johnson (1) |
| AbbVie (1) |
| Eli Lilly and Company (1) |
| Nestle |
| Sanofi Espoir Foundation |
| PwC (2) |
| Bloomberg Philanthropies (1) |
| icddr,b |
| UN Women |
| UNAIDS |
| UNFPA |
| UNICEF |
| Global Alliance for Improved Nutrition |
| Global Road Safety Partnership |
| Reckitt Benckiser Group |
| FCDO, UK (2) |
| Save the Children (2) |
| Agence Française de Développement |
| Ministry of Foreign Affairs, Netherlands |
| Ministry of Foreign Affairs, Italy |
| Global Affairs Canada (4) |
| AVERT (2) |
| Deloitte (2) |
| IFRC |
| GIZ, Germany (3) |
| JICA, Japan (5) |
| Norwegian Agency for Development Cooperation (7) |
| SIDA, Sweden (6) |

Weeks axis: 80 60 40 20 0 | 0 20 40 60 80
Weeks

**Primary carer & Parental leave**
- Primary carer - weeks of leave at 100% pay
- Primary carer - paid* weeks of leave
- Primary carer - unpaid weeks of leave
- Parental leave - weeks of leave at 100% pay
- Parental leave - paid* weeks of leave
- Parental leave - unpaid weeks of leave

**Secondary carer & Parental leave**
- Secondary carer - weeks of leave at 100% pay
- Secondary carer - paid* weeks of leave
- Secondary carer - unpaid weeks of leave
- Parental leave - weeks of leave at 100% pay
- Parental leave - paid* weeks of leave
- Parental leave - unpaid weeks of leave
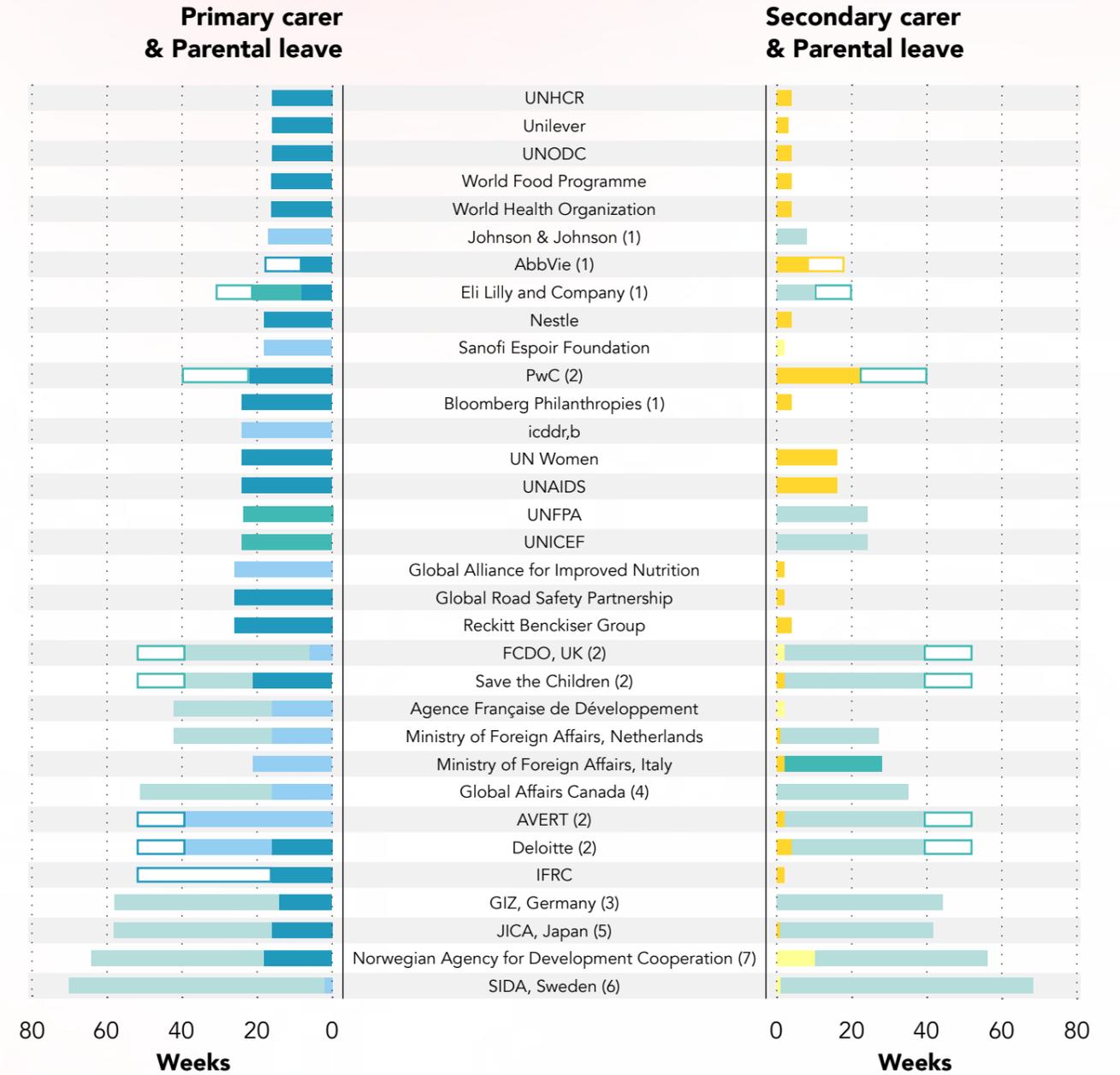
1 Depending on the employer's policy, birth mothers in the US can also access short term disability (STD) for partial wage coverage for 6-8 weeks. Most if not all of the organisations in our sample offer STD benefits. Policies do not always specify where STD is already included in the number of weeks of paid leave available to birth mothers.
2 Employed mothers have the right to transfer all maternity leave to the father, except for the two weeks of obligatory leave, i.e. up to 50 weeks. This period of leave is termed 'Shared Parental leave' (SPL).
3 In Germany, parental leave is available up to three years after childbirth for each parent, of which 24 months can be taken up until the child's eighth birthday.
4 Parental leave in Canada is shared.
5 Parental leave in Japan is shared.
6 Parental leave in Sweden is shared.
7 Parental leave in Norway is shared.
* Paid at less than 100% wages; Pay dependent on length of service; Paid but level of pay not indicated in policy

# FLEXIBLE WORKING ARRANGEMENTS

As has been made starkly visible in the course of the COVID-19 pandemic, major caring responsibilities (including attending to elderly or sick or disabled relatives) are not equally or equitably divided across society. The major burden of home-care and home-schooling responsibilities, for example, have fallen on women. For many, employee control over how many hours they work and when, has become essential. Even apart from the impact of the pandemic, younger generations are entering the workforce with expectations of greater flexibility, autonomy and work/life balance than their predecessors.

Research shows that, with sufficient support from leadership and supervisors, flexible working arrangements (such as condensed working hours, teleworking, flexible hours, term-time working, etc) can be powerful tools to enhance staff inclusion.

## Findings

As workplaces have evolved over the past two years, reference to flexible working as a benefit has grown quickly. This growth appears to be independent of the requirement for many employees to work remotely in 2020/2021 due to COVID-19 lockdowns.

53% of organisations (107/201) report, either on their website or directly to GH5050, flexible working arrangements are available to employees. This is compared to 30% in 2019.

This figure does not take into account the situation in countries where flexible working is governed by national law. In the UK, for example, all employees have the right to request flexible working. Our finding represents those organisations where GH5050 was able to find mention of flexible working on the organisation's website or policy.

*53% of organisations report flexible working arrangements are available to employees - compared to 30% in 2019.*

Some organisations reported that while flexible arrangements were available to staff in some offices, particularly in the US and Europe, these were not in practice across all country offices, in part due to local laws and culture. However, others reported that, building on lessons learned during office closures and restrictions under COVID-19, organisations intended to maintain flexible working arrangements that had been put in place, including in countries where flexible working was not yet the norm.

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**TYPES OF FLEXIBLE WORKING, AS DEFINED BY THE UK GOVERNMENT**
https://www.gov.uk/flexible-working

**Job sharing**
Two people do one job and split the hours.

**Working from home**
It might be possible to do some or all of the work from home or anywhere else other than the normal place of work.

**Part time**
Working less than full-time hours (usually by working fewer days).

**Compressed hours**
Working full-time hours but over fewer days.

**Flexitime**
The employee chooses when to start and end work (within agreed limits) but works certain 'core hours', for example 10am to 4pm every day.

**Annualised hours**
The employee has to work a certain number of hours over the year but they have some flexibility about when they work. There are sometimes 'core hours' which the employee regularly works each week, and they work the rest of their hours flexibly or when there's extra demand at work.

**Staggered hours**
The employee has different start, finish and break times from other workers.

**Phased retirement**
Default retirement age has been phased out and older workers can choose when they want to retire. This means they can reduce their hours and work part time.

# A LOOK AT COVID-19 AT WORK: HOW IS THE GLOBAL HEALTH SECTOR RESPONDING?

The COVID-19 pandemic has had profound effects on employment and the workplace. As of January 2021, 93% of the world's workers were living in countries with some form of workplace closure measures and the equivalent of 255 million full-time jobs were estimated to have been lost over the previous year.[3] Women, low-skilled workers and young people have been disproportionately impacted by job loss,[4] while women have also shouldered the majority of increased care responsibilities in the home.[5]

In the course of a global pandemic which has resulted in vast and inequitable impacts on people's lives and livelihoods, organisations have an even greater responsibility to ensure that employees are being treated fairly, discrimination is eliminated, and everyone's rights in the workforce are promoted and realised.

Global Health 50/50 put out a call to the 201 organisations included in this report for information on workplace interventions put in place to support staff in response to COVID-19. In response, 76 organisations shared hundreds of policies, communications, plans and other resources. Among them, 79% shared internal policies or correspondence with staff, and 21% shared a mix of publicly available and internal information. Information was also extracted from the websites of a further four organisations.

Organisations can act to mitigate the impact of the COVID-19 pandemic on the livelihoods, careers, health and wellbeing of their staff in a number of ways. Through its research, GH5050 identified four key areas where action can be taken. Examples of organisational action, drawn from the wealth of documents submitted, are provided under each area below. The information provided is not comprehensive and the actions that organisations have taken have not been evaluated. Nonetheless, these examples are presented as sources of information for organisations seeking to mitigate the impacts of the COVID-19 pandemic on the people they employ.

**Box 4. Various measures adopted by the 76 organisations in the sample**

### EQUALITY, DIVERSITY AND INCLUSION[6][7]

- Virtual women's networks for staff members
- Enhanced or revised child care benefits including removing monthly limits on back-up child care provisions and reducing restrictions on parental benefits
- Flexibility with reduced hours to allow employees to juggle work and child care without deductions in leave or pay
- Expanded flexible working including allowing employers to work from home, work from abroad, and adopt different schedules to accommodate child care needs
- Additional leave with full pay for temporary personal or family needs relating to COVID-19 such as quarantine or illness
- Limiting furloughs to staff unable to work from home
- Flexible return-to-office policies that acknowledge caregiving responsibilities
- Commitment to maintaining elements of flexible work arrangements after workplaces reopen

### OCCUPATIONAL HEALTH, SAFETY AND WELLBEING[8][9]

- Updated mental health and wellness resources and workshops
- Free-of-charge mental health support and counselling services including via Employee Assistance Programs
- Enhanced healthcare benefits
- Exercise classes and fitness challenges

- Informal policies encouraging respect for employee's personal time outside of working hours
- Instituting 'no-meeting days' to aid staff wellness
- Organisation-wide paid days-off
- Equipment stipends for staff working from home

### HARASSMENT, BULLYING AND VIOLENCE[10][11]

- Ensuring harassment and bullying policies extend to misconduct occurring outside of the workplace including virtually
- Online training on bullying and harassment policies that emphasise their applicability in times of remote working
- Information on domestic violence support services available in different countries
- Domestic abuse guidelines and training for managers
- On-demand domestic violence support services including via Employee Assistance Programs.

### MONITORING AND EVALUATION[12][13][14]

- Staff surveys on organisation's response to the pandemic including policies on returning to the office and remote working and wellbeing support needs
- Staff listening sessions on equity issues
- Continued equal pay monitoring for gender and ethnicity
- Conducting adverse impact analyses of workforce reductions to ensure decisions were made equitably.

**Queen Nicki Rangoon**
*Yangon, Myanmar. 2020.*

Chiara Luxardo

Queen Nicki Rangoon, 24 years old, poses
for a portrait in her bedroom in Yangon,
Myanmar. Lounging on a green sofa, her eyes
meet the viewer's. In Myanmar, homosexuality
is punishable by up 20 years in jail under
Section 377, a British colonial era law that
outlaws homosexuality. In the past, widespread
discrimination and prejudice made Nicki
afraid to walk the streets and from living as
her authentic self. But as things have slowly
changed, Nicki proudly fights for her right
to equal job opportunities and to be legally
recognised.

# WHO HOLDS POWER?: GENDER AND GEOGRAPHY OF GLOBAL LEADERSHIP IN HEALTH

The demographics of who holds positions of authority provides a strong measure of the progress organisations are making in fostering equity in career advancement, decision-making and power. As such, it is a reflection of the performance of the sector across other areas of this report.

In many ways, the professional world operates at the end of a long pipeline littered with obstacles for many people. But organisations can decide whether to passively reinforce or actively seek to correct historical disadvantage and inequality—both to meet their obligation of contributing to a more equitable world and to shape more inclusive, effective workplaces.

In order to capture the intersection of gender with other characteristics, GH5050 gathers publicly available demographic information on the CEOs and Board Chairs of the 201 organisations in the sample. This information includes: nationality, highest educational degree attained, university where that degree was attained and approximate age. These proxy measures provide insights into who holds power and privilege in global health.

## GENDER PARITY IN DECISION-MAKING BODIES

While organisations are increasingly committed to gender equality and putting policies in place, the impact of these good intentions is only slowly being translated into the redistribution of opportunities and outcomes for people.

## Findings

Results show positive movement towards equal representation of women and men in senior management. The proportion of organisations achieving parity (45-54% women) increased by 8% in one year, from 28% in 2020 to 36% in 2021. In contrast, governing bodies that reached parity increased by 3% (to 29%) over the previous year.

Eleven organisations had no women in senior management and ten organisations had no men.

**Figure 30. Decision-making bodies still disproportionately male**



| Senior management | | Governing bodies | |
|---|---|---|---|
| 36% | Parity | 29% | |
| 47% | More Men than Women | 61% | |
| 17% | More Women than Men | 10% | |
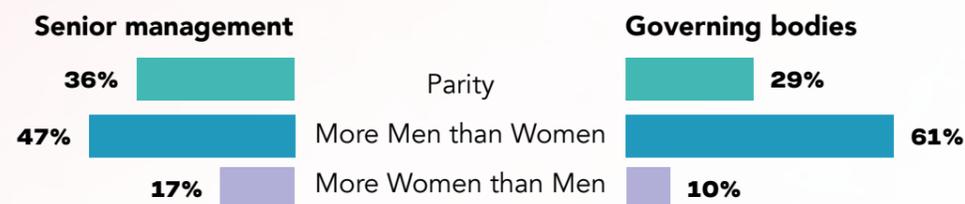
**Figure 31. Gender parity in decision-making bodies, % of organisations by sector**



Legend:
- 56-100% women represented
- 45-55% women represented; or difference of one; parity
- 35-44% women represented
- 0-34% women represented
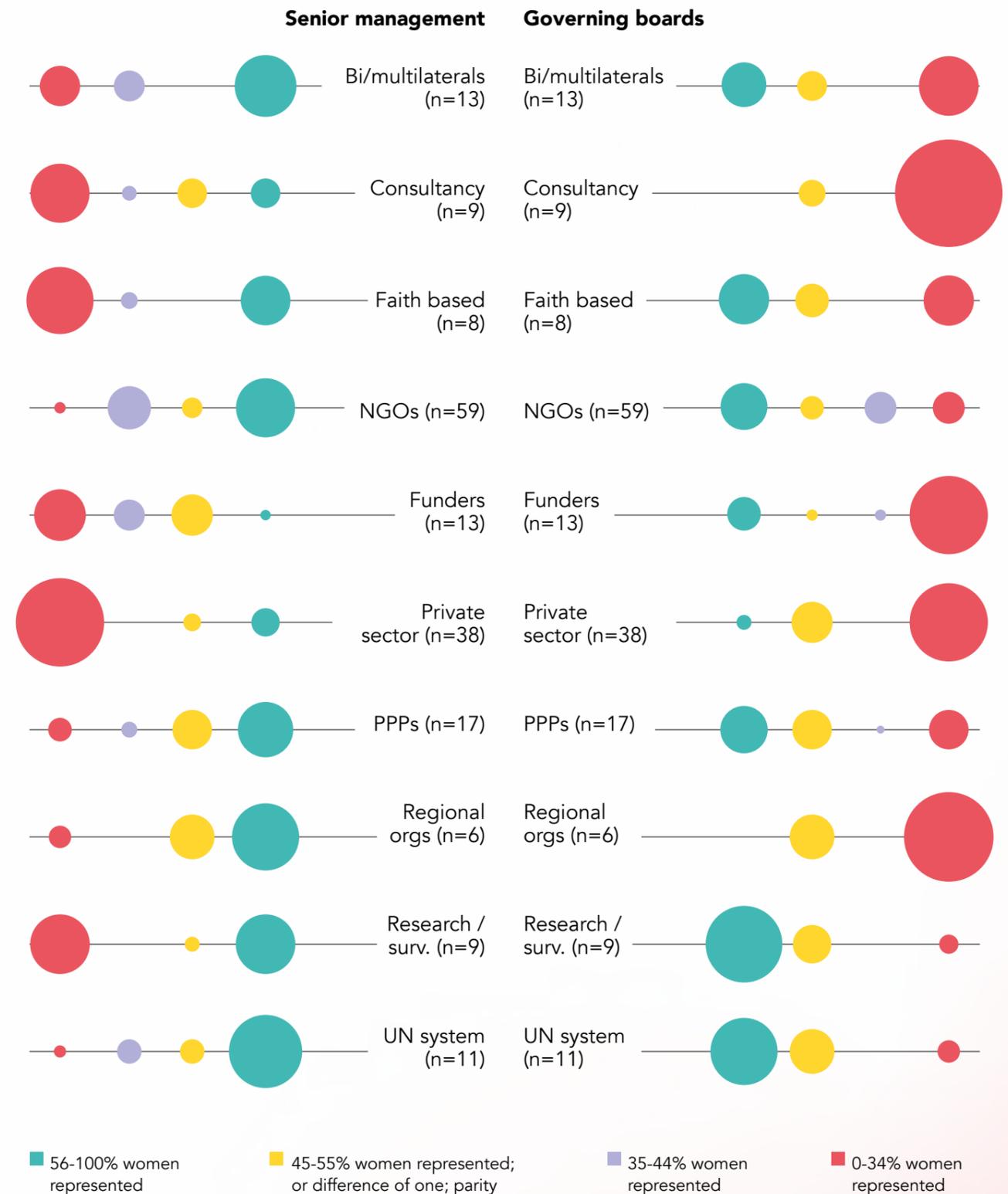
**Figure 32. Progress towards parity, 2018-2021**

Among the 139 organisations consistently reviewed:



Senior management    Governing boards

■ 56-100% women represented

■ 45-55% women represented; or difference of one; parity

■ 35-44% women represented

■ 0-34% women represented
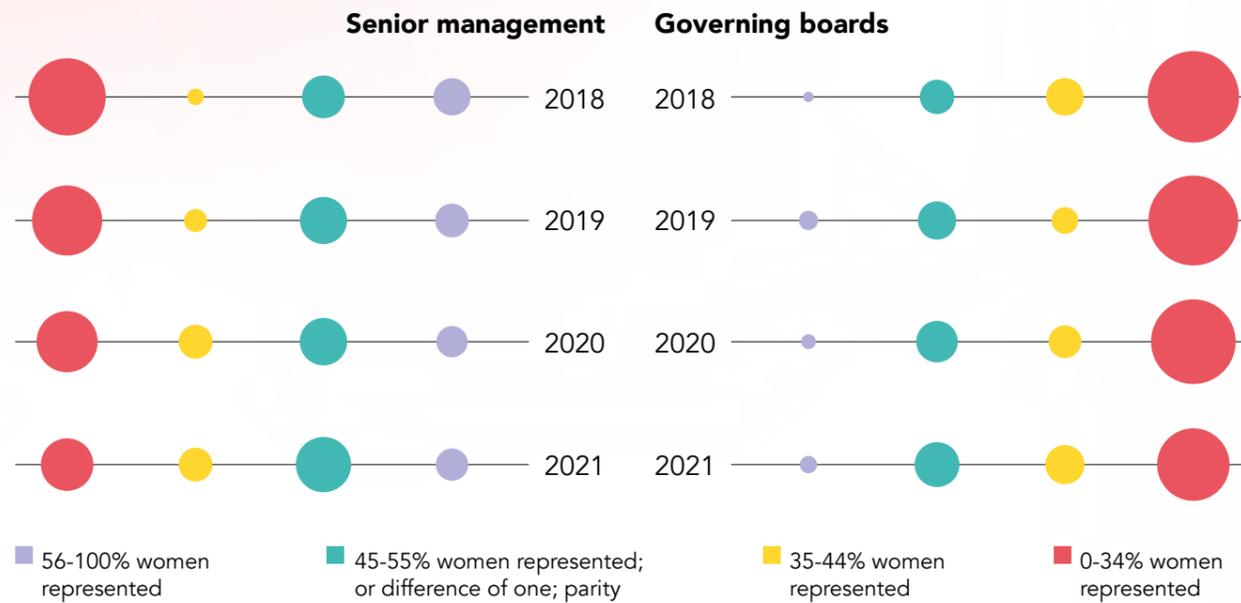
*Senior management and governing boards in the sample are composed of more than 4500 people. 40% are women. Women's representation drops by 10% one level up: 30% of CEOs and Board Chairs are women.*

Reflection from the International Planned Parenthood Federation on gender parity in senior management:

**A higher proportion of women in senior leadership is deliberate, informed and critical**

We believe that to achieve parity one day, today, global health organisations should have more women than men in positions of leadership. This is because women make up the majority of the workforce in many of our organisations and the majority of our service users. Most importantly, we must promote women at the top with determination because the gap everywhere is so large.

Our gender equality policy recognises that progress requires transformative actions to promote women's rights and empowerment, including addressing gender gaps, unequal policies and discrimination that have historically disadvantaged women and girls.

IPPF is committed to promoting feminist leadership at all levels of the organisation, which is critical for role modelling and for addressing inequalities that impact underserved individuals and communities. This leadership is reflected in our diverse board of trustees, which is inclusive of women and young people across geographies, genders, sexualities and abilities.

*Making connections:[15]*

*Woman CEOs are 5x more likely to lead organisations with gender parity in senior management, compared to organisations led by men.*

*Women CEOs are 2x more likely to lead smaller organisations (under 250 staff) than larger organisations.*

*Smaller organisations (under 250 staff) are 8x more likely to have gender parity in senior management than larger organisations.*

## GENDER AND GEOGRAPHY OF CEOS AND BOARD CHAIRS

For the last four years, the proportion of organisations headed by women has barely changed. This is despite notable progress towards parity in senior management. In 2021, 71% of CEOs in the sample were men, and 69% of Board Chairs were men.

**Figure 33. Gender of CEOs and Board Chairs**



71% (142/200) of executive heads are men

69% (129/187) of board chairs are men.
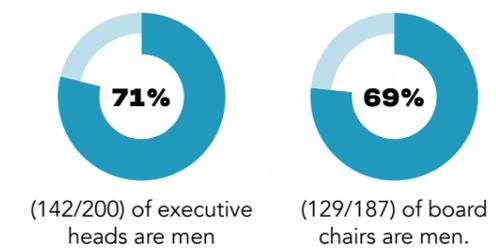
Among the sample of 139 organisations consistently reviewed since 2018, the proportion of male CEOs remains relatively unchanged, from 70% in 2018 to 69% in 2021. More boards are chaired by women in 2021 than in 2018, but women are still far outnumbered by men. 28% of Board Chairs were women, compared to 20% in 2018.

*Among the 139 organisations consistently reviewed:*

*In 2018, 41 organisations had a woman CEO*

*In 2021, 43 organisations had a woman CEO*

16% of CEOs and Board Chairs are nationals of low- and middle-income countries (LMICs), compared to 17% in 2020. These same countries are home to 83% of the global population. 28% of leaders are nationals of countries outside of Europe and North America.

15.  Statistically significant. No interpretation of causation.

## Figure 34. Gender of CEOs, by sector % men



| Sector | Women | Men |
|---|---|---|
| UN system (n=11) | 45% | 55% |
| NGOs (n=64) | 42% | 58% |
| PPPs (n=17) | 35% | 65% |
| Regional orgs (n=9) | 33% | 67% |
| Funders (n=14) | 29% | 71% |
| Research / surv. (n=11) | 27% | 73% |
| Bi/multilaterals (n=14) | 21% | 79% |
| Faith based (n=8) | 13% | 87% |
| Private sector (n=43) | 12% | 88% |
| Consultancy (n=9) | 11% | 89% |

## Gender of Board Chairs, by sector % men



| Sector | Women | Men |
|---|---|---|
| Research / surv. (n=8) | 63% | 37% |
| Bi/multilaterals (n=8) | 50% | 50% |
| NGOs (n=68) | 44% | 56% |
| PPPs (n=16) | 44% | 56% |
| Faith based (n=9) | 33% | 66% |
| Funders (n=13) | 31% | 69% |
| UN system (n=12) | 25% | 75% |
| Consultancy (n=8) | 13% | 87% |
| Private sector (n=41) | 2% | 98% |
| Regional orgs (n=4) | 0% | 100% |

*The 70-80-90 'glass border' persists:
70% of leaders in the sample are men,
84% hail from high-income countries and
94% attained their highest education in high-income countries.*

## Figure 35. Nationality and gender of 387 CEOs and Board Chairs



Europe
**25% MEN
9% WOMEN**

North America
**26% MEN
12% WOMEN**

Asia
**6% MEN
1% WOMEN**

Middle East &
North Africa
**1% MEN
1% WOMEN**

Latin America &
the Caribbean
**1% MEN
2% WOMEN**

Sub-Saharan Africa
**6% MEN
3% WOMEN**

Oceania
**2% MEN
1% WOMEN**

Dual nationality
**3% MEN
1% WOMEN**
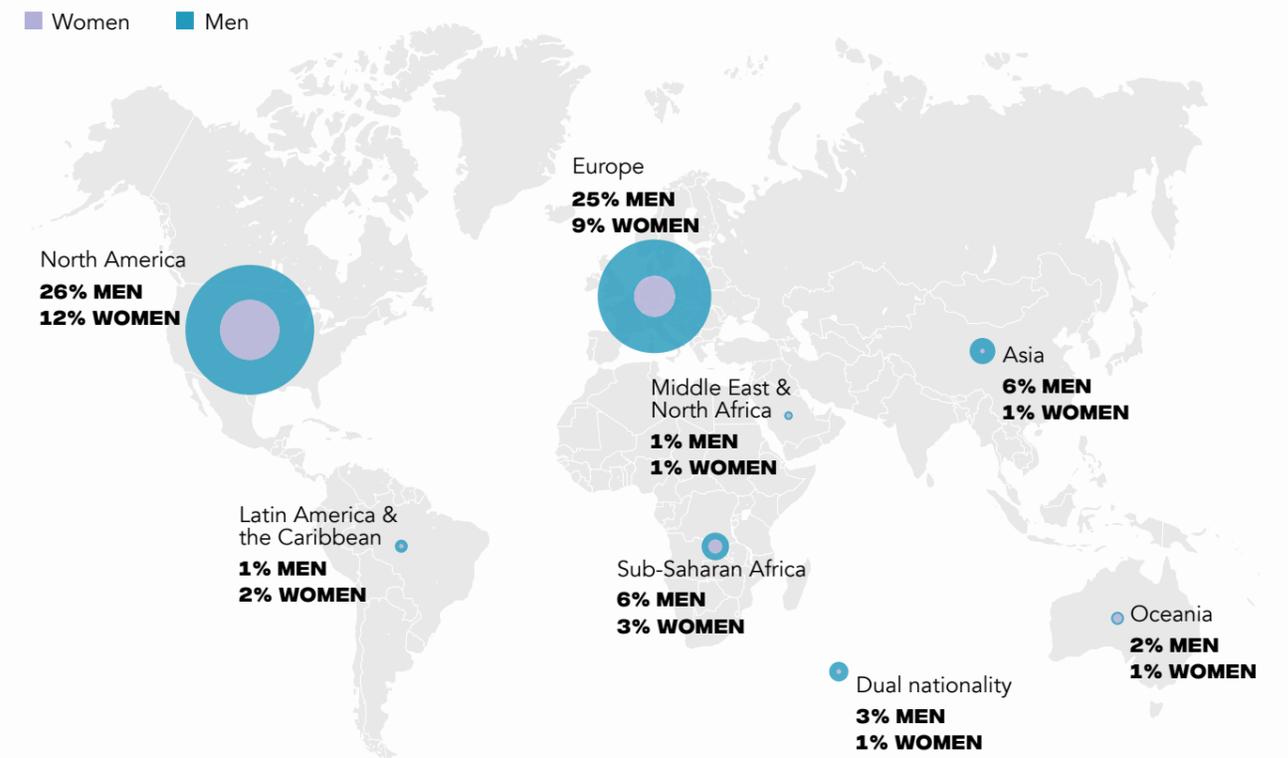
## Figure 36. Demographics of 387 CEOs and Board Chairs



**Among 271 men leaders:**

84% are nationals of high-income countries (HICs)

10% are nationals of low- and middle-income countries (LMICs) and completed their highest education in HICs

6% are nationals of LMICs and completed their highest education in LMICs

**Among 116 women leaders:**

83% are nationals of high-income countries (HICs)

12% are nationals of low- and middle-income countries (LMICs) and completed their highest education in HICs

5% are nationals of LMICs and completed their highest education in LMICs

1 is a national of an HIC who completed her highest education in an LMIC

**Just 5% of all leaders are women from low- and middle-income countries.**

## GIVEN TIME, WILL DIVERSITY IMPROVE? SPOTLIGHT ON NEW LEADERS IN 2020:

Demands to topple power and privilege imbalances and bring forth greater diversity in leadership reached new heights in 2020. Public statements were issued from leaders recognising systemic inequalities and vowing to take action. New diversity and inclusion commitments proliferated. Yet, when confronted with an opportunity to put action to words, the sector barely budged.

In the past year, more than 1 in 5 organisations (43/201) had a new CEO. Such turnover presents an opportunity to redress gender imbalances at the top. Such opportunity however was only partially seized: 70% of outgoing CEOs were men -- as were 66% of new appointees.

A total of 94 new CEOs and Board Chairs were appointed over the last year. In positions vacated by women, 54% of new appointees were women. However, in positions vacated by men, 74% of their successors were male. Overall, among the 94 new CEOs and Board Chairs appointed, women gained six positions.

If demographic trends among new cohorts of leaders continue, many in the sector will not see parity in their lifetime. Yet if 52% of new leaders appointed each year were women, parity could be achieved by 2030.

*If 52% of new leaders appointed each year were women, gender parity at the top could be achieved by 2030.*

## Comparing CEOs and Board Chairs in 2020 and 2021

**CEOs, 2020**   **CEOs, 2021**   **Board Chairs 2020**   **Board Chairs 2021**



- ■ Men
- ■ Women
- ■ Net gain of women leaders

**87 leadership positions were vacated in 2020, and filled with 94 new appointments. Among these, women gained a net of six seats.**
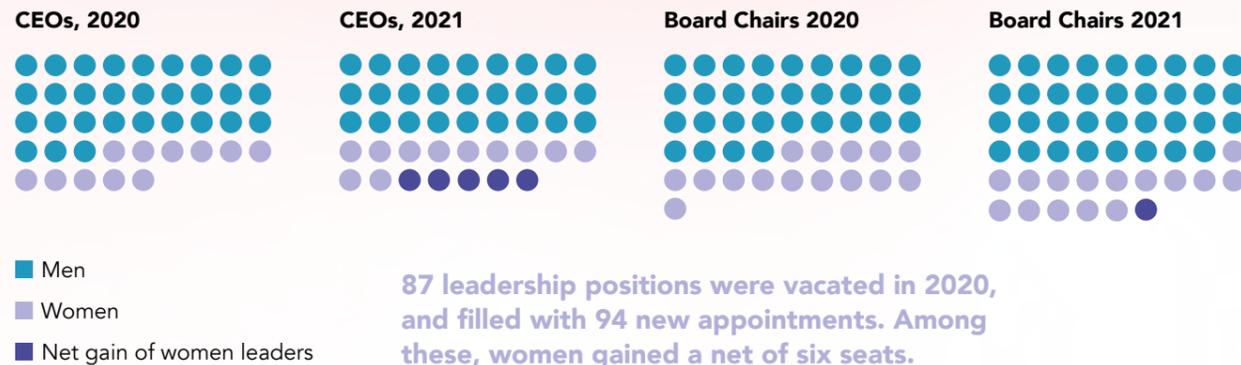
In 2020, GH5050 reported that among all CEOs and Board Chairs:



**70%** were men

**83%** were nationals of high-income countries

**92%** were educated in high-income countries
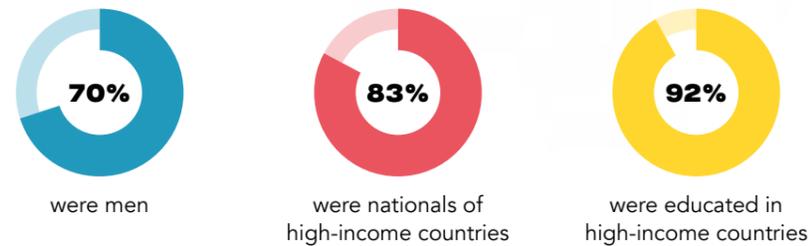
In 2021, GH5050 finds, among all CEOs and Board Chairs:



**70%** are men

**84%** are nationals of high-income countries

**94%** were educated in high-income countries
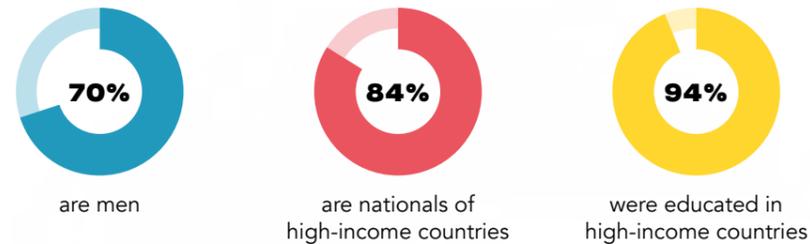
## GENDER PAY GAP

The gender pay gap provides a stark measure of power and privilege by comparing the average hourly pay of men and women. Typically, the gap reflects the gendered distribution of employees across the levels of an organisation—if an organisation has more men in senior positions and more women in lower-paid posts, it will have a wider gender pay gap.

A gender pay gap report is not the same as an equal pay audit—the latter is designed to capture any (often illegal) instances of paying men and women differently for the same work.

Following a year of unprecedented disruption to working lives, major increases in the burden of unpaid care, and evidence from countries around the world that women have suffered job loss, financial hardship and increased poverty at higher rates than men, measuring the gender pay gap takes on a new level of urgency.

## Findings

One-quarter of the sample (51 organisations) publicly report gender pay gap data on their workforce. Among these, 45 organisations are required under national law to submit gender pay gap reports, including 44 under UK law and one under French law.[16] There was little increase in the proportion of organisations reporting their gender pay gap in 2021 (27%) compared to 2019 (25%). An additional two organisations informed GH5050 that they regularly conduct gender pay gap analyses and make adjustments in light of findings, but do not publish the results.

Six organisations voluntarily calculate and publish their gender pay gap data in the absence of statutory requirements: **Care International, EngenderHealth, IPPF, International Rescue Committee, Medicines for Malaria Venture and Palladium Group.**

An additional 15 organisations informed GH5050 that they have recently conducted an equal pay audit to identify whether women and men are being paid differently for comparable jobs.

### NICE, BUT NOT NECESSARY: UK REQUIREMENT TO REPORT GENDER PAY GAP REPORTING SUSPENDED DURING COVID-19

Enforcement of gender pay gap reporting requirements in the UK was suspended on 24 March 2020, 6 days before the reporting deadline for public organisations, and 10 days before private companies were required to report their annual figures. The Government Equalities Office defended the decision as a reprieve for HR departments tasked with keeping employees and their businesses safe in the early months of the COVID-19 pandemic.

Many however criticised the decision, particularly in light of the high number of women who had already been furloughed or worked reduced hours due to caring responsibilities by that time. Proponents of continued gender pay gap reporting argued that evidence of reversals of progress towards gender equality should have been met with more rather than less transparency.

Among our sample of 52 UK-based organisations required to report under normal circumstances, seven opted out last year.

At the time of writing, it appears that the requirement of private businesses to report on their pay gap in early April 2021 will be reinstated.

Source: https://www.fawcettsociety.org.uk/news/fawcett-leads-calls-to-reinstate-gender-pay-gap-reporting

Given that the vast majority of available gender pay gap data is published by UK-based organisations, our analysis focuses on this data. Data in this report is drawn from a snapshot of income information from 2018 and 2019, which is the latest available from the official UK Government website.

Among the 44 organisations required to report under UK law,[17] GH5050 found a significant gender pay gap with a range from -39% (in favour of women) to +36% (in favour of men), and on average, a median pay gap of 11.2%. In other words, across organisations reporting, all male employees capture on average 11.2% more salary than all women employees.

In 39 of the 44 (87%) organisations, median pay for men is higher than for women. Median pay is higher for women than men in three organisations (AB inBev, Reckitt Benckiser, Unilever), and roughly the same in two organisations (+/-2%; GlaxoSmithKlein, Medecins Sans Frontieres).

Among the 39 organisations for which data was available in 2019 (2017 data) and 2021 (2019 and 2018 data), the median gender pay gap grew from 12.9% to 13.7%, in men's favour. The median proportion of women in the top quartile increased slightly, from 36% to 39%.

**Among the 39 organisations reviewed in 2019 and 2021, the median gender pay gap grew from 12.9% to 13.7%, in men's favour.**

**Access the data** To access details on gender pay gap data reported here, go to: https://globalhealth5050.org/2021-detailed-findings/

*If we want gender equality, do we worry about having a negative pay gap? Should we be aiming for no gap – 50/50 representation at all levels? At this point, I believe that for an organization that focuses on sexual and reproductive health and rights and gender equality, in a global health and development sector that overall sees women underrepresented in leadership roles, having more women in leadership roles at EngenderHealth is appropriate. Additionally, there are traditional (men being paid more) pay gaps at the national level in every country where we work; if we have a negative pay gap, we are helping pull a broader community toward balance. However, we conducted this analysis so we could learn, both about our staffing structures and about how to think about gender equality in our staffing. We remain eager to discuss and debate this issue both internally and externally.*

## TRACI L. BAIRD

CEO, EngenderHealth, link

17. UK-based organisations are required to report data using a standardised methodology for the following variables: (1) mean and median pay gap in hourly wages of men and women; (2) mean and median bonus pay gap among men and women; (3) proportion of men and women occupying pay quartiles; and (4) percentage of men and women receiving bonuses. UK guidelines include both employed workers and some self-employed people in the calculations.

**Figure 37. Gender pay gap (median difference) of organisations required to report under UK law**



% Difference in hourly pay (Median) — Women paid more / Men paid more

% Difference in bonus pay (Median) — Women paid more / Men paid more

Organisations (top to bottom):
AB InBev UK Limited, Reckitt Benckiser Group, Unilever, GlaxoSmithKline UK, Médecins Sans Frontières (UK), Heineken UK Limited, Nestle UK Ltd, Organa Pharma (formerly Merck Sharp), Sanofi UK, Kuehne + Nagel Limited, Becton, Dickinson UK Limited, Bristol-Myers Squibb Pharmaceuticals Limited, DSM Nutritional Products (UK) Limited, PricewaterhouseCoopers, Islamic Relief Worldwide, Salvation Army Trustee Company, Department for International Development (DFID), Coca-Cola European Partners Great Britain Limited, Novartis, Accenture (UK) Limited, Oxfam, Plan International, Eli Lilly and Company Limited, Deloitte LLP, McCann Health Medical Communications Limited, Medtronic Limited, World Vision, McKinsey & Company, Inc UK, Save the Children International, Wellcome Trust, ExxonMobil Chemical Limited, AbbVie, KPMG UK Limited, BP PLC, Mott MacDonald Limited, Novo Nordisk Limited, Johnson & Johnson Limited, General Electric Energy UK Limited, Philips Electronics UK Limited, Pfizer Limited, GSM Association, Gilead Sciences Europe Ltd., MSI Reproductive Choices, Intel Corporation UK Limited

AB InBev UK Limited bonus: -160%

*EngenderHealth calculates and reports its gender pay gap among global staff as well as in country offices as part of its commitment to advance diversity, equity and inclusion across the entire organisation.*

## An intersectional approach to reporting the pay gap

Inequities in pay outcomes operate not only to disadvantage women, but also other people in the workplace. Some organisations in our sample are leading the way in commitments to fair and equitable pay by going beyond gender to monitor and report pay gaps between other demographics of the workforce, including by characteristics such as ethnicity, race and ability.

*"Wellcome's ethnicity pay gap calculates average rates paid to all our employees from black, Asian and minority ethnic (BAME) backgrounds compared with average rates paid to all our employees from white (non-BAME) backgrounds. [...] At Wellcome, we see our ethnicity pay gap as one important measure of how much more we have to do to become an inclusive place to work."[18]*

*Wellcome Trust, Ethnicity pay gap reporting 2019*

### ORGANISATIONS OF ALL PAY STRUCTURES AND SIZES SHOULD CALCULATE THEIR GENDER PAY GAP

Many organisations determine pay levels based on a predetermined pay scale. While such a scale makes within-band pay inequalities unlikely, organisations with set pay scales may still have large gender pay gaps if women and men are unequally represented at different pay bands.

Conducting a gender pay gap for such organisations, such as United Nations agencies, and for all workers, including those working part-time and consultants, should be considered an essential monitoring tool to unearth inequalities across the entire workforce.

## Inequity at the top: within-band inequity contributes to the gender pay gap

To provide a snapshot of whether the gender of the Chief Executive Officer (CEO) is associated with rates of pay, Global Health 50/50 gathered publicly available financial reporting (from the US Internal Revenue Service) for the non-governmental organisations (NGOs) based in the USA and included in our sample. Financial data were available for a total of 34 NGOs, 20 of which are led by men and 14 by women.

Rates of pay ranged between $150,000 and $965,000 per annum. Salaries were consistently higher for male CEOs, on average by **$106,000** per year, compared to female CEOs across all sizes of organisation (which ranged from $600,000 to over $1 billion in annual revenue). Additionally, the average total revenue of organisations led by men was over three times that of organisations led by women.

Even when controlling for organisations' revenue, a substantial gap of **$45,000** between male and female CEOs' salaries remain. This is larger than GH5050's findings in 2019 when the calculated gap was $41,000.

*$45,000 gap:*

*Women CEOs are annually paid $45,000 less than men CEOs, on average and when controlling for organisations' revenue.*

**Figure 38. Gender gap in CEO salaries across 34 US-based NGOs**
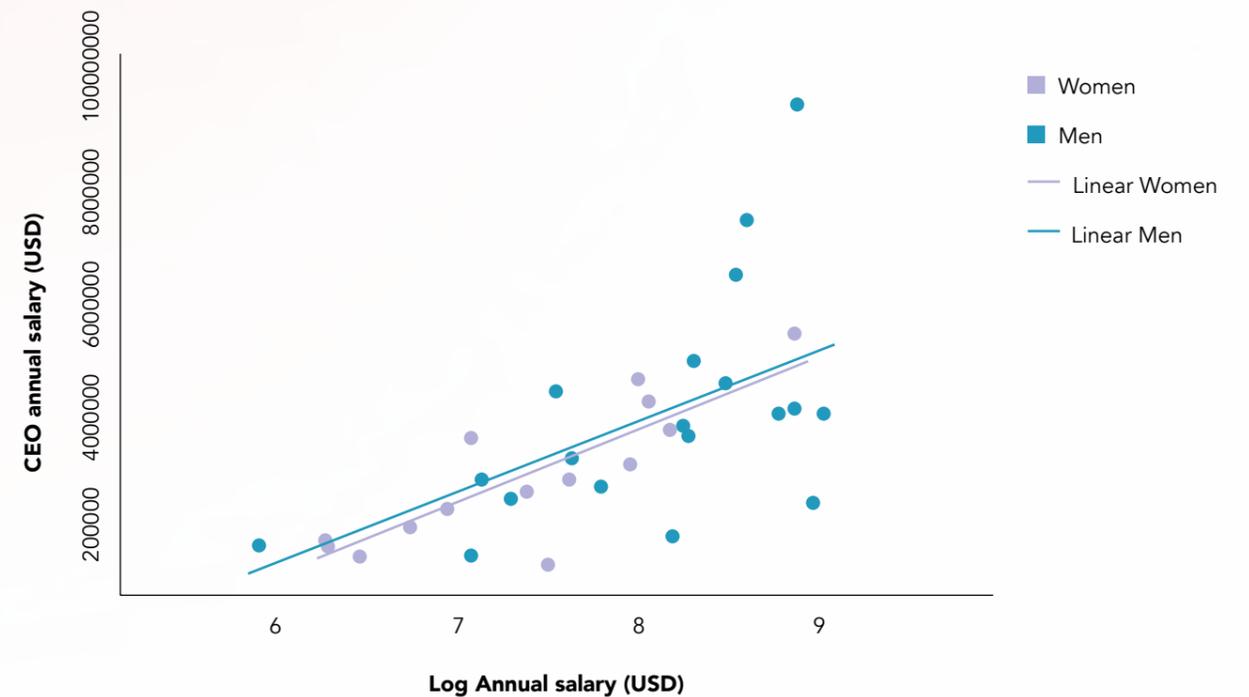
# RESOURCES FOR TACKLING POWER AND PRIVILEGE IMBALANCES IN THE WORKPLACE

This section has focused on identifying and evaluating organisational policies and the characteristics of leadership as these can contribute to workplaces which are equitable, fair, representative and respectful. There are a multitude of resources to guide employees, leaders and organisations in developing policies which promote and realise everyone's rights in the workplace. A selection of such resources are presented below for guidance across a range of policy areas, including from organisations in the GH5050 sample.

The following resources offer information and guidance for organisations on implementing workplace measures on equity, diversity and inclusion and/or updating policies and practices in response to the COVID-19 pandemic. GH5050 has not verified the accuracy of information in these links, but we list them as a source of further information:

**Family-friendly policies:**

International Network on Leave Policies & Research - Country Reports - Reports on maternity, paternity, parental leave and leave to care for sick dependents available by country

International Network on Leave Policies & Research - Defining policies - Definitions of maternity leave, paternity leave, parental leave and leave to care for children who are ill

International Labour Organisation - Maternity and Paternity at Work - Review of national law and practice on maternity and paternity at work across the world

Global Health 50/50 - How to Develop Family Friendly Workplace Policies - Guide for organisations developing parental leave, flexible working and family-friendly workplace policies

**Sexual harassment:**

UN System Model Policy on Sexual Harassment - Includes key components of a sexual harassment policy and definitions of terminology
UN Women-ILO- Handbook: Addressing violence and harassment against women in the world of work

Global Health 50/50 - How to Develop a Comprehensive Sexual Harassment Policy

**Diversity and Inclusion:**

Corporate Equality Index 2021 - includes recommended policies and measures for LGBTQ-inclusive workplaces

Stonewall - Best practices, toolkits and resources - collection of resources for organisations creating an LGBT+ inclusive workplace

UK Government - Race in the workplace - the McGregor Smith Review - independent review and recommendations on behalf of UK Government

National Council of Nonprofits - Why Diversity, Equity and Inclusion matter for Non-Profits

ILO - Promoting Equality and Addressing Discrimination - guidance on disability inclusive appraoches at work

**Gender parity and diversity within leadership:**

World Bank - Women Business and the Law - Measures gender inequalities in the law in over 170 that impact women's employment

World Economic Forum - Global Gender Gap Report 2020 - Index of gender parity in over 150 countries

BoardSource - Diversity, Inclusion and EquityBoardsource - Diversity, Inclusion and Equity - resources for inclusive, diverse and equitable boards - resources for diverse, inclusive and equitable boards

UN Women - Global norms and standards: Leadership and political participation - Overview of internationally agreed norms and standards relating to women's leadership and political participation

2020 Bloomberg Gender-Equality Index - Tracks gender equality performance of public companies

**Gender pay gap:**

Eurostat Gender Pay Gap Statistics - Gender pay gap data by country across the EU
UK House of commons Gender Pay Gap Briefing Paper - Statistics and analysis of the gender pay gap in the UK

Global Health 50/50 - How to: Measure and Address the Gender Pay Gap in Global Health - Guide for organisations seeking to address their gender pay gap

ACAS Managing Gender Pay Gap Reporting - Guide for UK employers on how to report on and address the gender pay gap

**COVID-19 and Equality, Diversity & Inclusion at work:**

ILO - An employers' guide on working from home in response to the outbreak of COVID-19

International Finance Corporation, World Bank Group - COVID-19 and Gender-Based Violence: Workplace Risks and Responses

Equality and Human Rights Commission - Coronavirus (COVID-19) guidance for employers - guidance for UK employers on preventing discrimination during the pandemic

UNICEF-ILO-UN Women - Family-friendly policies and other good workplace practices in the context of COVID-19

International Finance Corporation, World Bank Group - Childcare in the COVID-19 Era: A Guide for Employers

Unison - Bargaining for workplace practices during the easing of Covid-19 lockdown - guidance on ensuring an inclusive approach to returning to the workplace

Acas - Coronavirus and mental health at work Coronavirus and mental health - guidance and advice for employees

Acas - Managing mental health in the workplace - online training and events on mental health in the workplace guidance from ACAS

"Leaders must re-imagine benchmarks to advance equality. They should be proactive in creating pipelines to train and mentor women of color and from low- and middle-income countries. In my own experience as an early-career woman of color, I have appreciated the support of privileged mentors who have advocated on my behalf when I have faced discrimination. The power of allyship cannot be underestimated. At the same time, leaders from prestigious universities and high-income countries need to get comfortable listening and creating space to be challenged."

## JAYA GUPTA

Member of the Global Health 50/50 Collective

# SECTION 3.



## FINDINGS IN-DEPTH: TAKING A GENDER-RESPONSIVE APPROACH TO IMPROVING HEALTH

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**Fake fur and real scars**
*Vermont, Australia. 2020.*

Su Cassiano

Liam gazes towards the camera, his fur coat slipping off his shoulder to reveal a torso patterned with scars. He's been crying. He used to self-harm when using drugs. Mapped in the scars is Liam's struggle with the pressures of a rigid masculinity, and the visual trace of his complex relationship with his father. Liam's dad, an Australian veteran of the Vietnam war, suffers from post-traumatic stress disorder. Growing up in 'bloke' culture, where feelings are deemed weaknesses and pain can be endured, Liam craved paternal affection and recognition. Liam was never hugged by his dad, but he inherited his trauma.

# GENDER-RESPONSIVENESS OF GLOBAL HEALTH PROGRAMMES

Much of the global health sector agrees that gender norms play a crucial role in perpetuating disparities in the distribution of the burden of ill-health across and within populations, and gender influences how organisations address the problem(s). Some organisations in our sample are among the global pioneers in analysing, understanding and working to transform the power dynamics and structures that reinforce gender-related inequalities in health outcomes. We would therefore expect that the policies and programmes across organisations to be fully gender-responsive. We find, however, the strategies global organisations adopt to advance health range from addressing the underlying structural (e.g. economic, legal, political, cultural) drivers of gender inequality to those that ignore gender altogether.

## Findings

Over the past year, progress has been made in the reduction of gender-blind health approaches. Simultaneously, strategies, programmes and approaches that use a gender-transformative framing have increased by 10%. Recognition of the role organisations can and should play in addressing the root causes of unequal gender norms and power relations to advance health equity appears to be on the rise.

A total of 39% of organisations (77/200) promote transformative approaches in their health strategies. 25% (19/77) of these organisations focus on women and girls as the primary beneficiaries, while the majority address gender norms as drivers of health for women and men, girls and boys.

An additional 46% (92/200) of organisations were found to be gender-sensitive or -specific. Gender-sensitive approaches (28 organisations; 14%) recognise gender norms, but do not propose remedial actions to address gender inequities in health outcomes. Gender-specific approaches (64 organisations; 32%) take gender norms into account, usually by targeting a specific group of women or men to meet certain needs. These organisations stop short, however, of addressing the underlying causes of inequities and fostering progressive changes in the gendered power relationships between people. As such, they are not considered gender-transformative.

16% (31/200) of organisations reviewed were entirely gender-blind, but no organisations were gender unequal.

Of the 169 total organisations (85%) with strategies found to be gender-responsive to some degree, nearly half (81) were primarily focused on empowering, enabling and meeting the needs of women and girls. None focused on primarily meeting the health needs of men. Just over half (88) were found to be gender-responsive to meet the needs of both women and men, and 21 specifically mentioned the health needs of transgender populations.

**Figure 39. Change in gender-responsive health approaches, 2020-2021 (applying the WHO Gender-Responsiveness Scale) (N=199)[19]**

**Gender-transformative**
Addresses the causes of gender-based health inequities. Includes strategies to foster progressive changes in power relationships between women and men.

**Gender-specific**
Considers how gender norms affect access to resources. Intentionally targets women or men to meet specific needs. Makes it easier for women and men to fulfil their gender roles.

**Gender-sensitive**
Acknowledges gender norms, roles and relations , but no remedial action is developed.

**Gender-blind**
Ignores differences in opportunities and resource allocation for women and men;



|  | Gender-transformative | Gender-specific | Gender-sensitive | Gender-blind |
|---|---|---|---|---|
| 2020 | 29% | 32% | 19% | 20% |
| 2021 | 39% | 32% | 14% | 16% |

**Figure 40. Organisational approaches to address underlying gender-related drivers of ill-health (%), by sector**
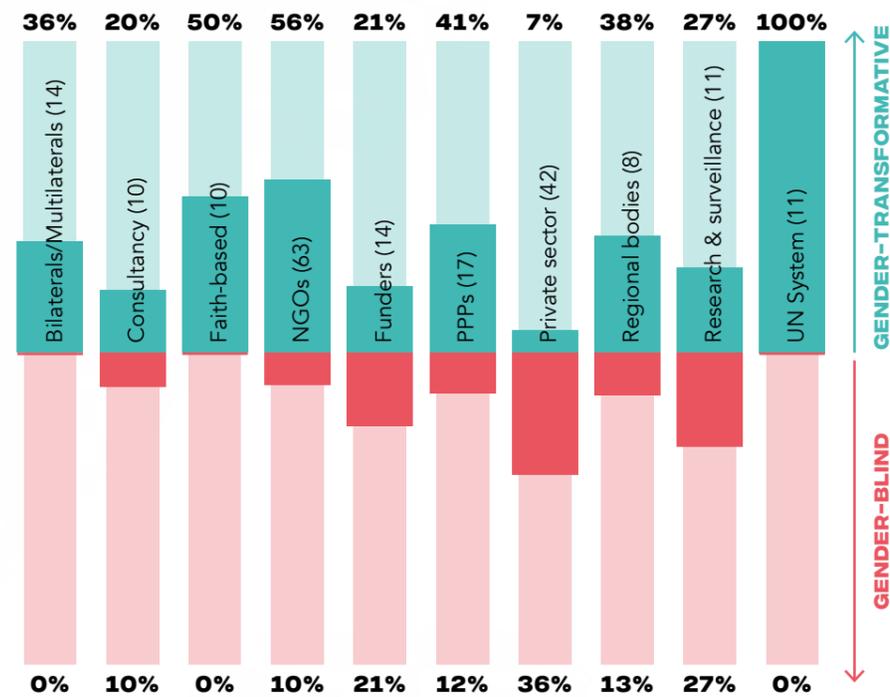


**Making connections:**

*Organisations that were found to promote gender-transformative approaches in their health strategies were 3x more likely to report sex-disaggregated data.*

**EXAMPLES OF GENDER-TRANSFORMATIVE LANGUAGE FROM ORGANISATIONS**

"Changing 'business as usual' is vital in order to reach men with HIV-related services while advancing gender transformative and responsive programmes... Urgent action is needed on two fronts. The first is challenging the harmful gender and social norms that discourage men from seeking health services… that increase the likelihood of HIV transmission to women and girls. Second is ensuring that health system policies, programmes, and service delivery adequately address the HIV-related needs of men in all their diversity. All interventions need to

be coupled with broader approaches to realise gender equality – including women's and girl's empowerment and challenging structural patriarchal barriers."

**Sonke Gender Justice,**
Sexual and Reproductive Health & Rights

"All SUN Movement actors need to reorient their work, to translate their gender equality and empowerment commitments into action and results at the country level. Our goal is a world free from malnutrition – transforming gender inequalities and power structures is critical to achieving this goal.

**Scaling Up Nutrition,**
A Call to Action

# SEX-DISAGGREGATED MONITORING AND EVALUATION DATA

This past year the term 'sex-disaggregated data' may, for the first time, have become part of common parlance. The COVID-19 pandemic has driven an influx of interest in the role sex and gender as drivers of health outcomes. COVID-19 is not an exception; across all areas of health, differences in exposure and outcomes are driven by sex and gender. Sex-disaggregated data, combined with gender analysis, contributes to identifying health disparities, shaping programmes to address them and measuring whether such programmes are reaching different populations equitably. Sex-disaggregation (along with age-disaggregation) of data should be ubiquitous within health programmes: it is a means to hold organisations to account for their commitments not only to equity but also to the delivery of effective interventions.

## Findings

39% of organisations were found to be providing data on their programmatic delivery broken down by sex. A further 28% of organisations report on the proportion of beneficiaries who are women and girls. For 34% of organisations, no sex-dissggregation of data was found

*Among the 139 organisations reviewed consistently from 2018 to 2021, reporting of sex-disaggregated data has barely budged, shifting from 35% in 2018 to 36% in 2021.*

**Figure 41. Organisations that sex-disaggregate their programmatic data**



- Fully disaggregate data in reporting
- Report percentage of women and girls
- Commit to report sex-disaggregated data, but do not report it
- No disaggregation or commitment

**Figure 42. Organisations that sex-disaggregate programmatic data, by sector**



| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| UN System (11) | Regional bodies (8) | Research & surveillance (11) | Bilaterals/Multilaterals (14) | PPPs (17) | NGOs (63) | Consultancy (10) | Funders (14) | Faith-based (10) | Private sector (42) |
| 100% | 62% | 54% | 50% | 47% | 44% | 40% | 21% | 10% | 9% |
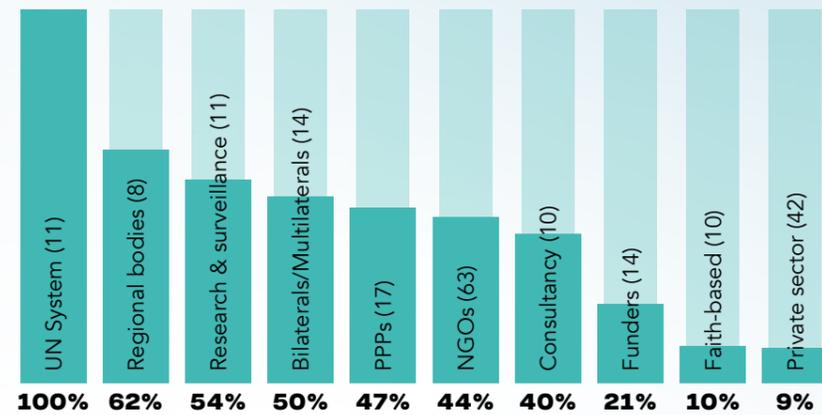
*Lives have been saved because of sex-disaggregating data. COVID-19 should encourage more organisations, governments and individuals to prioritise this data, as the pandemic could not have provided a more forceful example of why we need sex-disaggregated data. Humans are not unisex, so it doesn't make sense to treat data that way.*

# CAROLINE CRIADO-PEREZ

Watch the full video here

# RESOURCES FOR TAKING A GENDER-RESPONSIVE APPROACH TO IMPROVING HEALTH

Alongside other social constructs, gender plays a key role in determining health and well-being across the lifecourse. Being fully 'gender-transformative' therefore requires that organisations recognise and address the root causes of gender-based health inequities.

The following resources from the global literature offer guidance on implementing gender-responsive health interventions, including in response to COVID-19. GH5050 has not verified the accuracy of information in these links, but we list them as a source of further information:

WHO - Gender Responsive Assessment Scale - Criteria for assessing the gender-responsiveness of programmes and policies

Institute for Health Metrics and Evaluation - Global Burden of Disease tool - Database of causes of deaths and DALYs globally including by population

Sida - Gender Analysis - Principles & Elements - Guidance for conducting gender analysis

Engender Health - Engaging Men in Sexual and Reproductive Health and Rights, including Family Planning - why using a gender lens matters - Guide for designing and implementing gender-responsive programs

Inclusive Data Charter commits signatories to strengthen data disaggregation and publishes action plans of signatory countries and organisations to meet their commitments.

**COVID-19:**

Bill and Melinda Gates Foundation - Gender Equality Toolbox - A Gender Lens on our COVID-19 Response - Recommendations for making gender-responsive investments in the pandemic response

WHO - Gender and COVID-19 Advocacy Brief - Guidance for countries and global actors on gender-responsive interventions to address the health, social and economic impacts of COVID-19

The Sex, Gender and COVID-19 Project Sex Disaggregated Data Tracker - Database mapping the gender disparities in COVID-19 health outcomes in over 180 countries

WHO COVID-19 Strategic Preparedness and Response Plan - Strategy for national and international public health measures to prepare for and respond to COVID-19

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**Palomas, Transsexuality and Pandemic**
*São Paulo, Brazil. 2020.*

Dan Agostini

Celina 19, and Lourena 21, live in a support house for transgender women in São Paulo and work at Praça do Jaçanã, a prostitution spot near where they live. Celina left Fortaleza for São Paulo at 16 with the dream of becoming a model. Lourena left home for the first time at 19 after family conflicts related to gender identity. Before, the two worked in events and bars, but during the pandemic they had to resort to prostitution.

# DEEP DIVE ON COVID-19, GENDER AND HEALTH:

## Examining the gender-responsiveness of organisations' activities on COVID-19

## The role of sex and gender in the COVID-19 pandemic

COVID-19 is a gendered pandemic. From issues of livelihoods to child care, gender-based violence to food security, there are differences - socially, politically, economically - in how people of different genders are experiencing and being impacted by the virus and responses to it.

Health outcomes related to COVID-19 are similarly affected by gender and sex. Biological sex (which influences hormonal, immunological and physiological systems in the body) and gender (socially constructed and influencing roles, norms, expectations, power and position for all people in society) both play an important role in how individuals and communities experience the pandemic.

Data from the GH5050 COVID-19 Sex-disaggregated Data Tracker, which collates sex-disaggregated evidence from national surveillance reports from 190+ countries, shows differences between men and women in COVID-19 health outcomes across the exposure-to-outcome pathway. Globally, men are less likely to be tested for COVID-19, more likely to be hospitalised, and more likely to die from the virus, compared to women. Data from non-binary and transgender people are regretably generally absent from national surveillance data.

> *Globally, men are less likely to be tested for COVID-19, more likely to be hospitalised, and more likely to die from the virus, compared to women.*

What explains these differences? In part, biology. Research suggests that different immune responses, linked to having XX or XY chromosomes in the body, may influence the likelihood of severe COVID-19 disease and death.[20]

But biology only tells a small part of the story: gender plays a role at all points in the COVID-19 pathway. Exposure to the virus and access to COVID-19 -related health services are affected by gender and influence COVID-19-related outcomes (see Box 5). Not all men and women experience the same environmental, social, economic and political factors that play a role in determining their health outcomes in relation to COVID-19. Inequalities related to race, class, caste, disability, sexuality and age intersect with sex and gender to create complex and overlapping vulnerabilities to the impact of COVID-19.

---

**Box 5. Examples of how gender impacts COVID-19 health outcomes**

**Exposure to COVID-19**
In some countries the high proportion of cases among men may result from gender norms around who participates in the paid labour market (meaning, for example, that women are less present in crowded factories or on public transport).

In other settings, women face increased exposure to infection, particularly in countries where they make up the majority of frontline workers in health and social care.

**Access to testing and health care**
Access to services, including intensive care units, may be limited for people without the financial resources to pay for care, meaning women may have less access in some settings. However, even in countries where healthcare is universal and free, rates of hospitalisation are often higher in men.

**Vulnerability due to pre-existing health conditions**
The chronic diseases associated with more severe COVID-19 disease  and higher death rates are frequently more common in men - and often associated with men's higher rates of exposure to unhealthy behavior and environments over their lifetimes (such as tobacco use, exposure to air pollution, and poor diets).

**Gendered data gaps**
In highly gender unequal countries, gender gaps in reported mortality rates may to some extent reflect the failure to register  women's deaths within vital registration systems.

---

## Applying a gender lens to pandemic responses

Evidence from past pandemics suggests that taking gender and intersecting vulnerabilities into account when designing and delivering interventions to address COVID-19 will improve health outcomes for everyone. Conversely, pandemic response programmes without consideration of sex and gender can leave vulnerable and marginalised groups bearing a disproportionate burden of the pandemic and thereby exacerbate existing inequities.

WHO has recommended a number of public health interventions that every country should consider in pandemic responses, as well as essential support strategies from the international community (Box 6).[21]

Gender-responsive approaches to many of these areas can improve outcomes and ensure more equitable pandemic responses. This relies on inclusive policy design, implementation and accountability processes that meaningfully engage women, civil society and gender experts.[22][23] Gender-responsive pandemic responses matter not only for immediate COVID-19 outcomes, but will contribute to building gender-responsive health systems and approaches.

**Rohingya Refugee Life In Bangladesh**
*Cox's Bazar, Bangladesh. 2020.*

Ziaul Huque

A grandfather gently brushes back his granddaughter's hair on a makeshift hammock in the Kutupalong Rohingya Refugee Camp, Cox's Bazar, Bangladesh. The joyful moment of intergenerational care and familial love contrasts starkly with the reality of their situation. Both grandfather and granddaughter were forced to flee their home in Myanmar in light of the 'ethnic cleansing campaign' carried out by Myanmar security forces. Enduring a perilous journey, both now live in a spontaneous settlement where lack of adequate shelter, water, sanitation and access to basic services leaves them both vulnerable.

**Box 6. WHO-recommended pillars of national and international pandemic responses**

**CORE PILLARS OF AN EFFECTIVE NATIONAL PANDEMIC RESPONSE**

1. Coordinate and plan
2. Engage and mobilise communities to limit exposure
3. Find, test, isolate and care for cases and quarantine contacts to control transmission
4. Provide clinical care and maintain essential health services to reduce mortality
5. Adapt strategies based on risk, capacity, and vulnerability.

**INTERNATIONAL SUPPORT TO COUNTRIES' RESPONSE TO COVID-19**

1. Coordinate and monitor country preparedness and response
2. Support epidemiological analysis and risk assessment
3. Undertake risk communication and community engagement
4. Coordinate global supply chain management
5. Provide technical expertise and health emergency workforce
6. Accelerate research, innovation, and knowledge sharing
7. Strengthen pandemic preparedness for the future

## A framework for examining organisations engagement in the health response to COVID-19

We conducted a review of the Global Health 50/50 report sample of 201 global organisations active in health in order to understand their gendered response to the COVID-19 pandemic.

We reviewed five areas derived from WHO pandemic response recommendations:

1. Research and development of vaccines, diagnostics and treatment.
2. Encouraging positive health behaviours.
3. Facilitating access to health services and systems.
4. Ensuring the protection and care of healthcare workers.
5. Supporting national and global COVID-19 surveillance.

The five areas were chosen as those: (i) that target the direct health impacts of the pandemic; (ii) where prior evidence suggests that using a gender-responsive design would improve outcomes; and (iii) which are relevant to the roles of global health organisations (not only national bodies).

We reviewed each of the 201 organisations' websites to answer three questions: (1) is the organisation working on any of these five areas? (2) how does the organisation's COVID-19 work in these areas take sex and gender into account? and (3) which population is targeted (women, men, transgender people, non-binary people, or a combination)?

Using publicly available information from organisations' websiteS, we assessed their gendered approach to COVID-19 programming activities using the WHO gender-responsiveness assessment scale (Fig. 43)[24]. For more on our methodology, see page 140.

**Figure 43. Applying the WHO gender-responsive assessment scale to COVID-19**

| WHO gender-responsive assessment scale | Examples of COVID-19 activities along the scale |
|---|---|
| **Gender-unequal**<br>Perpetuates gender inequality | A COVID-19 testing programme that makes diagnostic tests available for children via schools in a region where few girls receive education. Underprivileged children would not be reached by the intervention, perpetuating inequities in access to health services. |
| **Gender-blind**<br>Ignores gender norms, roles and relations | A programme for the procurement of PPE that distributes single-size PPE designed for a 'standard male body', failing to acknowledge the high proportion of healthcare workers that are women who require different sizes of PPE for adequate protection. |
| **Gender-sensitive**<br>Considers gender norms, roles and relations; does not address gender inequality | A vaccine development programme that includes an analysis of rates of uptake of similar vaccines in men and women and observes that vaccine hesitancy is more common among women but does not integrate measures into the programme in order to improve women's vaccine uptake. |
| **Gender-specific**<br>Considers gender norms, roles and relations; Targets and benefits specific women, men and/or transgender populations to meet their needs | A programme has monitored compliance with risk mitigation behaviours such as mask-wearing and found that men are less likely to engage in such behaviours. In response, the programme adopts communication strategies focussed on reaching men, such as in male dominated workplaces or social settings or by using marketing materials that target men. |
| **Gender-transformative**<br>Considers gender norms, roles and relations; Address the causes of gender inequality; Transforms harmful gender norms, roles and relations | A COVID-19 vaccination programme engages local communities to promote equitable decision-making within families around accessing health services in order to challenge harmful gender norms that limit women's agency as well as men's health seeking behaviour. |

# Do global health responses to COVID-19 take gender into account?

Among the 201 organisations, 70% (n=140) were found to have programmes focused on at least one of the five WHO-derived pandemic response areas (see Fig. 44). A total of 349 activities addressing COVID-19 across these five areas were identified.

**Figure 44. Proportion of organisations found to have programmes on each of the five pandemic response areas**

| 48% | 71% | 50% | 57% | 24% |
|---|---|---|---|---|
| Research and development of vaccines, drugs and therapeutics | Promoting positive health behaviours | Access to COVID-19 -related health services | Protection of healthcare workers | Supporting national surveillance efforts |
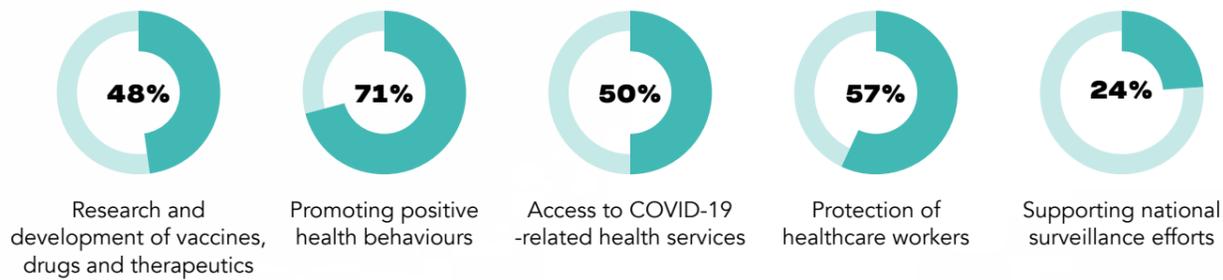
The majority of the 349 activities reviewed were found to be gender-blind - i.e. gender was not taken into account in the programme or policy reviewed - ranging from 60% to 90% across the five areas (see Fig. 45). Gender-blind approaches were seen most frequently in the following areas: 1) vaccine, therapy, and diagnostics R&D; 2) treatment of health services; and 3) protection of healthcare workers.

Just 8% (27/349) of COVID-19 activities were gender-sensitive, meaning that reference was made to the role of gender norms or inequalities in the pandemic, but no appropriate actions to address the impact of gender appeared to have been proposed or taken. 11% (38/349) of activities were gender-specific, meaning that activities were tailored to specifically reach men, women, transgender or non-binary people or a combination.

**Figure 45. How responsive? Proportion of COVID-19 activities (N=349) by level of gender-responsiveness[25]**

**Overall**



- Gender-blind
- Gender-sensitive
- Gender-specific

**By area**



- Gender-blind
- Gender-sensitive
- Gender-specific
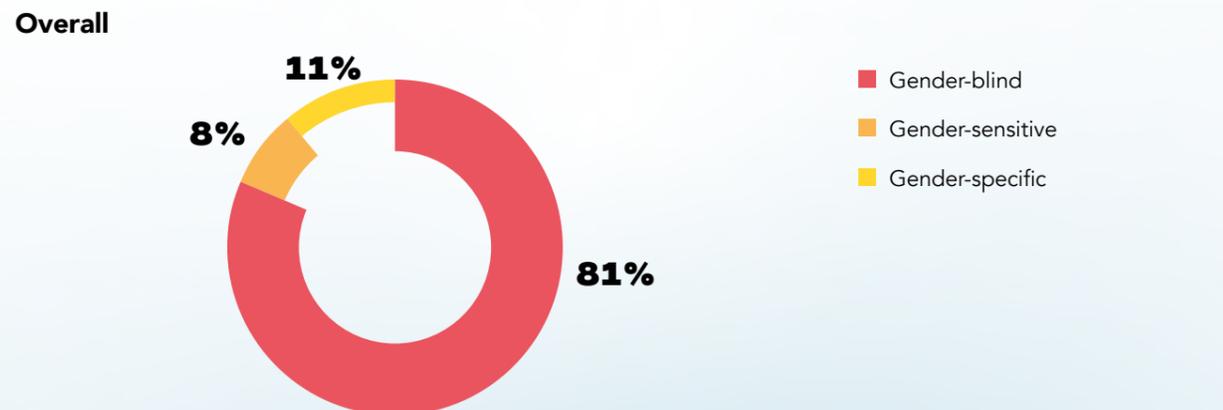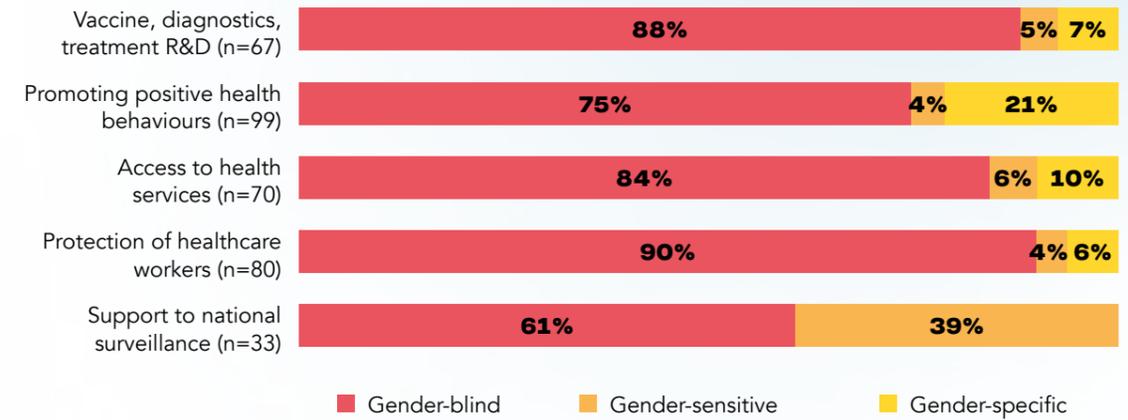
No activities were identified that were gender-transformative -- i.e. that address underlying causes of inequities and seek to foster progressive changes in gendered power relationships between people. This is in contrast to the analysis of the core, non-COVID-19 activities of the 201 organisations, which found that 39% organisations reported undertaking "gender-transformative" programming (Pg. 99).

13% (45/349) of all recorded COVID-19 activities detailed which population(s) their gender-reponsive programmes were aiming to reach (i.e., men, women, trangender and non-binary people or a combination). The majority of these activities -- 88% (40/45 ) -- focused primarily on women and girls. Just five gender-responsive activities referenced the aim of reaching both men and women, including two that also acknowledged transgender populations (see Fig. 46).

**Figure 46. Who benefits? COVID-19 activities with target populations identified (N=45)**



- Gender-responsive activity, with primary focus on women and girls
- Gender-responsive activity, with focus on women, men and/or transgender populations
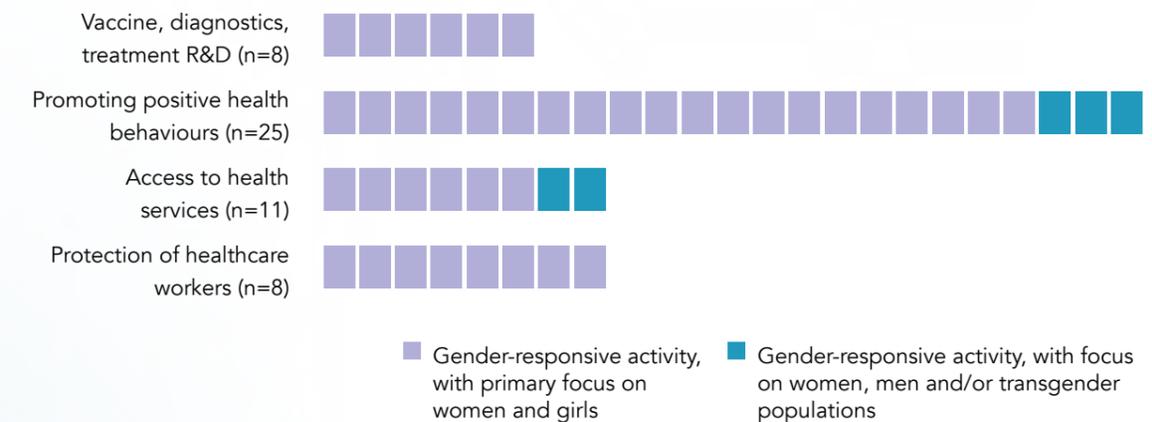
## Recommendations for gender-responsive pandemic responses

Many organisations in the sample provide only a high-level and brief overview of how they are contributing to responses to COVID-19. It may be too soon to expect detailed reporting on organisational activities, in what remains the height of the pandemic in many places. Some gender-responsive action is likely taking place around the world -- and ideally will come to light in future reporting. What this review suggests, however, is that for the vast majority of organisations, recognising the role of sex/gender in the pandemic or how it was being taken into account in programmatic activities did not appear to be sufficiently important to warrant reporting.

The few organisations that reported gender-responsive programmes focused almost exclusively on women, with few inclusive of men. This is concerning given that men are less likely to be tested for COVID-19, more likely to be hospitalised, and more likely to die as compared to women.

Comparing these findings with the stronger performance on gender-responsiveness of organisations' core programmatic activities (see Pg. 99) suggests that gender may have been deprioritised in this time of crisis.

GH5050 encourages organisations to integrate the following gender-responsive measures into their pandemic responses:

1. **Ensure that vaccine R&D accounts, at a minimum, for the role of sex in vaccine efficacy and the role of gender in rates of vaccine uptake. Monitor and evaluate the impact of sex and gender throughout vaccine roll-out.**

2. **Apply a gender lens in the design and delivery of public health interventions to ensure equitable access to information on how to mitigate risk of infection and seek testing and treatment.**

3. **Implement targeted measures to reach marginalised groups with testing, health services and registration systems to monitor the impact of COVID-19 on different populations to ensure equitable access to these services.**

4. **Commit to understanding the needs of health and social care workers and guaranteeing equitable protection and support, including quality and properly-fitting PPE and appropriate mental health support.**

5. **Carry out sex-disaggregated surveillance of and reporting on vaccinations, testing, cases, hospitalisations, ICU admissions, infections among healthcare workers, and deaths.**

## Taking a deeper look at five pandemic response areas: role of sex/gender, effectiveness of gender-responsive approaches, and illustrative examples from our review

Here we present evidence for the role that gender plays in each pandemic response area and select evidence of gender-responsive intervention effectiveness. Given the lack of current evidence from the COVID-19 pandemic, we have brought in examples from gender-responsive approaches used in the control of other infectious diseases, including in pandemics and health emergencies. We also highlight illustrative examples of gender-responsive work being done by organisations in our sample.

### RESEARCH, DEVELOPMENT AND DELIVERY OF VACCINES, DIAGNOSTICS AND TREATMENT

## Making the case

#### The issue
Sex (biology) and gender play a role in how people respond to vaccines and other pharmaceutical interventions through differences in immunological responses, drug metabolism and vaccine acceptability.

#### Evidence for the role that gender plays
Biological studies have shown that some vaccines may provoke a higher immune response in women compared to men.[26] Conversely, some 'acceptability' studies in Europe,[27] the UK[28] and the US[29] have indicated that women may be less likely than men to accept the COVID-19 vaccine. In the case of some drugs—including those used to treat influenza—men and women metabolise the drug differently,[30] while other studies have shown that gender plays a role in both drug-prescribing[31] and drug-compliance.[32] Taking gender into account when designing trials is a key consideration.

#### Evidence for Interventions taking gender into account
Gender-specific HPV vaccine programmes that target both girls and boys have been shown to have a higher public health benefit, compared to those that target girls alone[33]. A large community-based trial of HPV vaccine coverage in Finland, for example, found that high levels of coverage in young men also provided benefit to young women who had not been vaccinated—an important finding in comparison to the previously standard policy of only offering the vaccine to young women. Taking gender into account in this trial led to improved public health benefits for everyone.

## Our findings

#### Findings from our review
Sixty-seven organisations were found to be active in this area, for example in vaccine and drug research, developing diagnostics, monitoring vaccine efficacy and safety and funding countries to scale-up testing capacity. Among the 67 organisations, **12%** (8/67) were found to be doing so with some level of gender-responsiveness, while **88%** (59/67) were gender-blind.

Among the few gender-responsive interventions that were identified, their focus was primarily on researching COVID-19 in pregnant women and efforts to ensure gender-representation in vaccine and drug development. In all instances where the population targeted by the intervention was specified, the focus was on women.

**Figure 47. Proportion of R&D programmes found to be gender-responsive**



Among the 8 activities found to be gender-responsive, 6 are focused on benefiting women and girls only, and 2 do not name specific populations

9%
3%
88%

■ Gender-blind
■ Gender-responsive, for women and girls
☐ Gender-responsive, does not specify populations

88% (56/67) of organisations working in this area appear to d so gender-blind
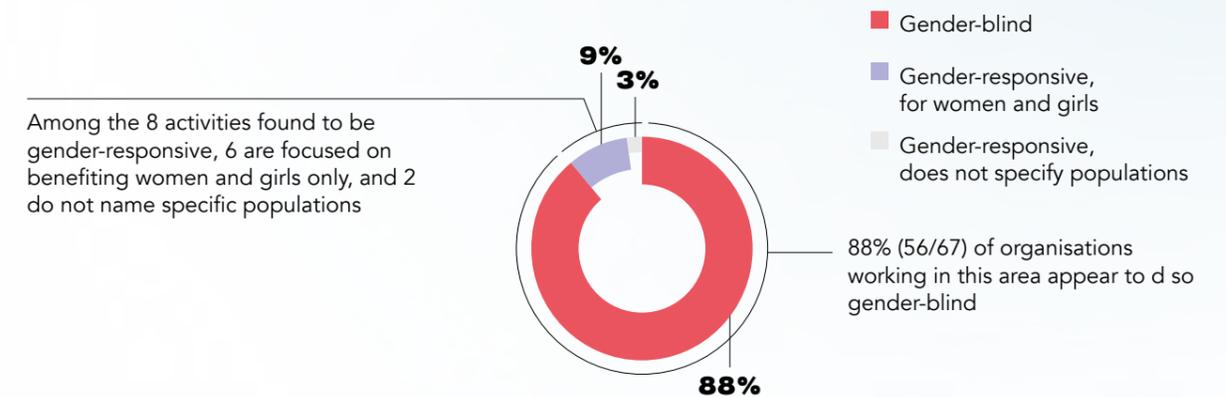
**EXAMPLE OF A GENDER-SPECIFIC APPROACH TO COVID-19 VACCINES, DIAGNOSTICS AND TREATMENT R&D**

"Abt is using an existing network of sites and protocols from CDC Pandemic Flu and Global Flu contracts to study COVID-19 in pregnant women. [...] We will identify COVID-19 (and vaccine) knowledge, attitudes, and beliefs, pregnancy/infant outcomes, and potential COVID-19 cases. The data can improve modelling of respiratory illness burden and characteristics during pregnancy."[34]

**Abt Associates**, *Emerging research into COVID-19 and pregnancy*

# PROMOTING POSITIVE HEALTH BEHAVIOURS

## Making the case

### The issue

Risk of exposure to a virus, and response to that risk, including through adopting health-protective behaviours, varies according to the context of peoples' lives. Capacity to respond to public health communications and interventions depends, among other things, on economic and social factors, trust in the State and public health services.

### Evidence for the role that gender plays

In past respiratory pandemics and epidemics, women were generally more likely than men to adopt non-pharmaceutical behaviours such as hand washing, face mask use or avoiding public transport.[35] Early evidence suggests that similar patterns are emerging in relation to COVID-19.[36] A June 2020 survey across eight high-income countries found that women were 4.9% and 5.8% more likely to adopt recommended behaviours to reduce risk of infection in the first and second waves of the pandemic respectively.[37] Some of these differences in behaviours are driven by gender. For example, men in paid employment that cannot be undertaken at home may not have the agency to avoid public transport to get to work and get paid.

### Interventions that take gender into account

Experience from previous influenza pandemics,[38] and from the HIV epidemic, have highlighted the importance of understanding and addressing the socio-economic context of people's lives, and their perspectives on risk (and benefit) as lying at the heart of effective public health communications strategies.

Gender specific engagement measures in response to HIV, including comprehensive sexuality education for boys, peer education programmes and promoting social marketing of condoms have been effective at increasing health-seeking behaviours among men with low uptake of HIV testing services.[39]

## Our findings

### Findings from our review

99 organisations reported working on promoting positive health behaviours in the COVID-19 response. Interventions included awareness-raising campaigns on infection, risks and preventive behaviours as well as distribution of hygiene equipment.

Among these activities, 25% (25/99) were gender-responsive in some way while 75% (74/99) were gender-blind.

Gender-responsive activities included conducting sex-disaggregated studies into adherence to measures to reduce infection risk, training of women community health workers on infection-prevention, and COVID-19- awareness campaigns targeted towards women using health facilities. Among the 23 gender-responsive activities that mentioned which populations they aimed to reach, 20 focused on women and girls, and 3 included men and/or transgender populations in their target audience.

**Figure 48. Proportion of activities to promote positive health behaviours found to be gender-responsive**



Gender-blind

Gender-responsive, for women and girls

Gender-responsive, does not specify populations

Gender-responsive, specifying women, men and/or transgender people

2%
3%
20%
75%

Among the 25 activities found to be gender-responsive:

- 20 are focused on women and girls only,
- 3 include men and/or transgender populations, and
- 2 do not name populations they aim to reach.

74/99 of organisations working in this area appear to do so gender-blind

### EXAMPLE OF A GENDER-SENSITIVE APPROACH TO HEALTH PROMOTION RELATING TO COVID-19

"If you are investing in accelerating detection and suppression, keep in mind that there are gender-specific behavioral barriers to prevention and testing, and quarantine-induced increases in domestic care burdens and gender-based violence (GBV). Key [a]ctions [include] [i]ntegrat[ing] messaging and focused interventions to improve men's health seeking behaviors (given their higher mortality from COVID-19) in COVID-19 testing efforts and education campaigns around personal and environmental hygiene."[40]

Bill and Melinda Gates Foundation, Guidance for gender-responsive investments in the COVID response

## FACILITATING ACCESS TO HEALTH SERVICES AND SYSTEMS

## Making the case

### The issue
Differences in admissions to hospital, including to intensive care units, and deaths recorded in vital registration systems, may reflect the impact of gender on access to services and systems. "Access" captures a range of dimensions including: accessibility; availability; acceptability; affordability; and adequacy in service design, implementation and evaluation—all of which have gendered elements to them.[41]

### Evidence for the role that gender plays
Heavy domestic, child-care and paid workload, the need for permission from male relatives to travel, and lack of access to transportation impact the accessibility of testing and treatment for women.[42] Stigma around communicable diseases is also known to have deterred women from seeking testing, while lack of women's financial autonomy can make services unaffordable.[43] Societal notions of masculinity may delay care-seeking among men.[44]

### Interventions that take gender into account
Studies have shown that the introduction of self-testing can be highly effective at increasing uptake among women and communities not traditionally reached by screening.[45] This is because it can reduce stigma, be more convenient for those with work and family commitments, and reduce costs of travel to testing centres.

## Our findings

### Findings from our review

70 organisations reported working on facilitating access to health services for people with COVID-19. Activities in this area included efforts to prepare and build capacity of national healthcare systems, provision of medical devices and protective equipment, training for healthcare workers and support for countries with procurement of medical supplies.

Among these activities, 16% (11/70) were gender-responsive in some way while 84% (59/70) were gender-blind.

Gender-responsive activities included the establishment of mobile medical clinics to reach vulnerable women in remote areas or by acknowledging the different needs of men, women and gender diverse individuals in guidelines for national healthcare systems. Among the eight gender-responsive activities that mentioned which populations they aimed to reach, six focused on women and girls only, one referenced women and men, and one referenced women and men and specified transgender populations.

**Figure 49. Proportion of activities to facilitate access to services found to be gender-responsive**



Legend:
- Gender-blind
- Gender-responsive, for women and girls
- Gender-responsive, does not specify populations
- Gender-responsive, specifying women, men and/or transgender people

3%
4%
9%
84%

Among the 11 activities found to be gender-responsive:

- 6 are focused on benefiting women and girls only,
- 2 include men and/or transgender populations, and
- 3 do not name populations they aim to reach.

(59/70) of organisations working in this area appear to do so gender-blind

### EXAMPLE OF A GENDER-SPECIFIC APPROACH TO ACCESS TO COVID-19 HEALTH SERVICES AND SYSTEMS

"Up to 60 percent of pregnancy-related deaths are preventable, highlighting inequities in health care access and quality-of-care factors that contribute to racial disparities in maternal mortality and severe morbidity. As such […] NIH has initiated large-scale studies to investigate the effects of COVID-19 on such factors as pre- and postnatal care, rate of Cesarean section delivery, and maternal health complications. […] NIH also will support research on the use of therapeutics to treat COVID-19 during pregnancy and breastfeeding"

**National Institutes of Health,**
*Investigating COVID-19 and maternal care*

## ENSURING THE PROTECTION AND CARE OF HEALTHCARE WORKERS

## Making the case

### The issue

Women are estimated to represent 70% of the global health and social care workforce,[46] and are more frequently involved in care of the sick inside the household. The safety and security of health and social care workers is paramount for themselves and the people and populations they care for, including during a pandemic.[47]

### Evidence for the role that gender plays

WHO has warned that without adequate consideration of women in the design of personal protective equipment (PPE), the protection offered for women can be compromised.[48]

The impact of working on the frontline may also be taking a heavy toll on health workers' own wellbeing: a rapid systematic review of studies into the mental health impact of the COVID-19 pandemic on healthcare workers found that women were more at risk of experiencing poor mental health outcomes than men.[49]

### Interventions that take gender into account

Experience from other sectors where PPE is commonly used, have found that 'traditional' PPE is frequently designed for the male body, and PPE for women is often not widely available. By designing PPE in collaboration with women users, other sectors, such as the construction industry, have been able to redesign equipment and make it more acceptable to women in the sector.[50]

## Our findings

### Findings from our review

Among our sample, 80 organisations were found to be working on protection and care for health workers. Activities include distributing and issuing grants for PPE and hygiene products, providing guidance and training to frontline workers on infection prevention and control and establishing psychological support services.

Among these 80 organisations, 10% (8/80) described their activities with some level of gender-responsiveness while 90% (72/80) were gender-blind. Gender-responsive language included a recognition of the disproportionate risk of infection faced by women community health volunteers and directly targeting them with PPE provisions, and recommendations for policy-makers and investors on key gender responsive actions to be adopted in programmes targeting the health workforce.

All activities that specified their target population focussed exclusively on women healthcare workers.

**Figure 50. Proportion of activities to protect healthcare workers found to be gender-responsive**



All 8 activities found to be gender-responsive focused on benefiting women.

Gender-blind

Gender-responsive, for women and girls

72/80 of organisations working in this area appear to do so gender-blind
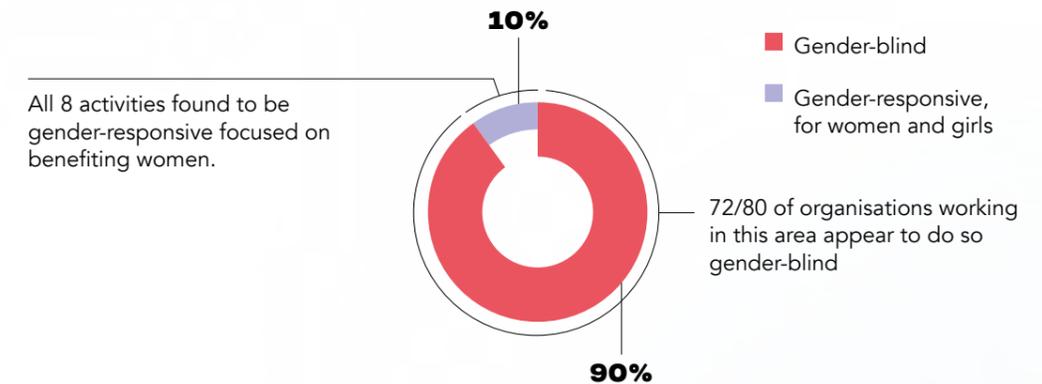
**EXAMPLE OF A GENDER-SPECIFIC RESPONSE TO PROTECTION AND CARE OF HEALTHCARE WORKERS DURING COVID-19**

"Women have borne a heavy burden as frontline healthcare workers by taking on vital caregiving roles for COVID-19 patients. [...] These women face increased risks of infection, particularly when they work long hours without being provided with adequate personal protective equipment (PPE), or work in places where serious preventive measures are not taken."

JICA commit to:
- Provide female healthcare workers and caregivers with necessary disinfectants and PPE, mental health services and psychosocial support, as well as reduce the burden of unpaid housework and domestic care work.
- Involve women in decision-making and have them represented in leadership positions within the healthcare and caregiving industry.

**Japan International Cooperation Agency**, *Supporting female frontline healthcare workers*[51]

## SUPPORTING NATIONAL AND GLOBAL COVID-19 SURVEILLANCE

## Making the case

### The issue
Without sex-disaggregated data we will have an inadequate understanding of inequalities in the distribution of disease and insufficient knowledge of whether public health interventions are reaching all parts of the population equitably. Yet the Global Health 50/50 COVID-19 data tracker shows that just 70 out of 192 countries are presently publishing sex disaggregated data on both cases and deaths. Disaggregated data reporting is in urgent need of scale-up if we are to understand and address health inequities relating to COVID-19 in all countries.

### Evidence for the role that gender plays
Sex-disaggregated data allows every organisation, country and health system to identify differences along the COVID-19 testing-to-outcome pathway, and to investigate how gender may be contributing to those differences. The World Health Organization recommends disaggregating data on testing, severity of disease, hospitalisation rates, recovery and health worker status at a minimum by sex and age, as well as by other social stratifiers such as socioeconomic status, ethnicity, sexual orientation, gender identity and refugee status.[52] Collecting data on how these identities intersect is also important to understanding who is most vulnerable to adverse health outcomes.

Moreover, while we do not yet know the extent of gender bias in registration of COVID-19 deaths, historic bias in vital registration against individuals with fewer resources suggests that there may be an under-counting of female deaths in many countries.[53]

### Interventions that take gender into account

Increasing rates of civil registration is essential for improving registration of deaths and cause of death. Physical access to civil registration sites, costs associated with birth registration and stigma towards single mothers can act as deterrents for vital registration among women. In Pakistan, for example, introducing mobile registration services staffed exclusively by women has increased accessibility for women[54] and the Majoni scheme in India, which provided conditional cash payments to girls if they received birth registration, had a measurable improvement on birth certification rates in girls.[55]

## Our findings

### Findings from our review
33 organisations were found to be supporting data collection and national surveillance of the COVID-19 pandemic. This included organisations that provide funding and technical assistance to strengthen national COVID-19 disease surveillance systems, training communities to be engaged in surveillance activities and conducting national level epidemiological studies.

Among these 33 organisations, 39% (13/33) reported or referenced sex-disaggregated data.

**Figure 51. Proportion of surveillance activities that reported sex-disaggregated data**



39%

61%

13/33 reported or referenced sex-disaggregated data

20/33 of organisations working in this area did not report sex-disaggregated data
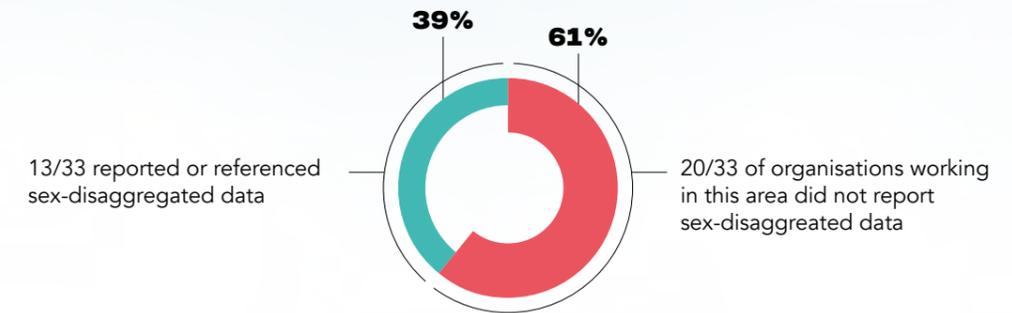
### EXAMPLE OF A GENDER-RESPONSIVE APPROACH TO COVID-19 SURVEILLANCE

The International Center for Research on Women (ICRW) and the Africa Population and Health Research Council (APHRC), in partnership with Global Health 50/50, produce the world's largest tracker of national sex-disaggregated data on COVID-19 health outcomes. Together, they examine the availability of sex-disaggregated data and collect, analyse and report on available data. They further advocate and engage government representatives and other stakeholders to strengthen commitment to the importance of analysing and reporting sex-disaggregated data to inform a more effective, equitable response to the pandemic.[56]

**APHRC, ICRW and Global Health 50/50**, *Tracking sex differences in COVID-19 health outcomes and advocating for sex-disaggregated reporting*

**Championship**
*Minsk, Belarus. 2019.*

Mikhail Kapychka

A young girl from Turkey prepares for her race at an international swimming championship, Minsk, Belarus. Gripping the belt with her teeth, she firmly holds herself in place. Her face turns upwards, her eyes evidence her resolve. She is ready to race.

# SECTION 4.

## HOW TO USE THIS REPORT TO PUSH FOR CHANGE WITHIN YOUR ORGANISATION

**For organisational leaders/directors:**

1. **Monitor and evaluate progress:** Compare your organisation's scores across the 14 variables reviewed in the 2021 report with scores received in past years to identify areas of improvement. Present the evaluation to staff and governing board and consider integrating performance across these variables into organisational performance indicators.

2. **Compare and learn from peers:** Use the Gender and Health Index to compare your organisation's performance with that of others in your sector. Use the Index to explore high-scoring policies or programmatic work from others in your sector or engaged in similar work, and consider how these examples of best-practice could apply to your own policies and programmes.

3. **Consult staff on effective responses:** Where your organisation's scores highlight a need for improvement in a domain, convene a discussion among staff on what changes should be introduced to improve performance in this area. Use the scorecards in this report, recommendations and examples of best practice included in this report to guide the discussion.

4. **Inform and discuss with your Board:** Include equality, diversity and inclusion (based on GH5050 and other organisational reviews) as a standing item for Board discussion.

5. **Explore resources:** Refer to the GH5050 assessment framework, model policies and other resources identified in the 2021 report, and our 'How To' guides to inform effective, equitable internal policies to advance equality in the workplace.

6. **Engage in targeted funding:** If you are a funder, consider opportunities to support organisations in improving performance in one or more of the 14 variables. Explore using the scorecard to set targets for grant reporting.

7. **Convene other leaders in the sector:** Systematic change will only occur when the benchmark across the sector is raised. Convene a meeting with other organisations of a similar size or doing similar work in the sector to share learnings and strategies to advance progress across, and consider setting shared targets that will help raise the standards across global health.

**For staff:**

1. **Advocate for action from leadership:** Use the assessment of your organisation in one or more of the 14 areas in this report to advocate for action among leadership in your organisation. Utilise the score criteria and examples of good practice from other organisations in this report to suggest policies and measures that should be adopted. If your organisation is lagging behind in your sector, highlight this and challenge leadership on why this is the case.

2. **Share the results with your union or staff association:** The findings of the report can be a source of evidence-informed advocacy by employee associations within each organisation.

3. **Lobby your Board:** Advocate for your organisation's Board to include discussion of equality, diversity and inclusion (based on the results of the GH5050 review as well as other reviews within the organisation) as a regular standing item order.

4. **Self-assess your organisation:** If your organisation is not among the 201 included in this report, use the self-assessment tool to review your organisation's performance across our 14 variables. Use the framework to present the areas in need of policy action to your HR department or leadership team.

5. **Initiate dialogue:** Organise a staff meeting, using our slide deck to present the report findings and kick-start discussions on why they are relevant to your organisation.

6. **Organise a gender equality working group:** If you don't have one already, create a staff working group to advance issues of gender and equality in your organisation. Use your organisation's results as a starting point for discussion.

7. **Identify potential collaborators:** Review organisations' scores along the 14 variables to identify those with strong commitments to gender equality in global health when considering potential partnerships.

8. **Use the scorecard when considering employment opportunities:** Review how a potential employer prioritises, commits to and delivers on gender equality and diversity when considering career opportunities. Do they have transparent, high-scoring workplace policies that will support your career pathway? Do they prioritise gender in their programmatic work? Our scorecard can provide a strong indication of their commitment to gender equality as an employer.

# GLOSSARY

Definitions are drawn from global normative guidance, including from WHO and UN Women.
For these and more definitions visit: https://globalhealth5050.org/glossary/

**Accountability**
Accountability refers to the ways in which individuals and communities hold themselves to their goals and actions, and acknowledge the values and groups to which they are responsible. Key principles of accountability include monitoring, review and remedial action.[57] Upholding these principles requires independent, transparent and participatory mechanisms to be in place.

**Anti-racism**
Anti-racism is defined as the work of actively opposing racism by advocating for changes in political, economic, and social life.

**Diversity**
The representation of varied identities and differences (gender, race, ethnicity, disability, sexual orientation, gender identity, national origin, tribe, caste, socioeconomic status, neurodiversity, etc.), collectively and as individuals.

**Feminism**
"... I choose to re-appropriate the term "feminism", to focus on the fact that to be "feminist" in any authentic sense of the term is to want for all people, female and male, liberation from sexist role patterns, domination, and oppression." bell hooks, Ain't I a Woman: Black Women and Feminism, 1981

**Flexible working**
A way of working that suits an employee's needs. Different modes of flexible working exist, including: job-sharing, working from home and telecommuting, part-time working, compressed hours, flexitime, annualised hours, staggered hours and phased retirement. In some countries there is a legal right to request flexible working arrangements and organisations are required to provide a "sound" reason for any denial of flexible working requests.

**Gender equality**
People of all genders, across the life-course and in all their diversity, have the same conditions and opportunities to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Gender equality does not mean that men and women, boys and girls become the same, but that their opportunities and life chances are equal and that the differences that do exist in their skills, interests, ideas, etc. will be equally valued.

**Gender equity**
More than formal equality of opportunity, gender equity refers to the different needs, preferences and interests of women, men and transgender people. This may mean that different treatment is needed to ensure equality of opportunity. Gender equity is often used interchangeably with gender equality, but the two refer to different, complementary strategies that are needed to reduce gender-based health inequities.

**Gender pay gap**
The gender pay gap is the difference in the average hourly wage of all women and men across a workforce, as monitored by the Sustainable Development Goal indicator 8.5.1. If women hold more of the less well paid posts within an organisation than men, the gender pay gap is usually bigger. The gender pay gap is not the same as unequal pay which is paying men and women differently for performing the same (or similar) work. Unequal pay is prohibited in some 64 countries.

**Gender-responsiveness**
Criteria for assessing the gender-responsiveness of policies and programmes:
1. gender unequal: reinforces or perpetuates existing gender inequalities
2. gender-blind: ignores gender norms, roles and relations
3. gender-sensitive: considers gender norms, roles and relations
4. gender-specific: targets a specific group to meet identified needs
5. gender-transformative: addresses the causes of gender-based inequities and includes ways to transform harmful gender norms, roles and relations, including addressing power in relationships.

**Health equity**
The absence of unfair, avoidable or preventable differences in health among populations or groups defined socially, economically, demographically or geographically.[58]

**Inclusion**
A culture of belonging built by actively inviting the contribution and participation of all people, and striving to create balance in the face of power differences.

### Intersectionality

Intersectionality moves beyond examining individual factors such as biology, socioeconomic status, sex, gender, and race. Instead, it focuses on therelationships and interactions between such factors, and across multiple levels of society, to determine how health is shaped across population groups and geographical contexts.[59]

### Maternity leave

Leave generally available to mothers, designed to protect the health of the new mother and child, taken before, during and immediately after childbirth or adoption.

### Parental leave

Leave available equally to mothers and fathers, either as: (i) a non-transferable individual right (i.e. both parents have an entitlement to an equal amount of leave); or (ii) an individual right that can be transferred to the other parent; or (iii) a family right that parents can divide between themselves as they choose (shared parental leave). May be available to both partners in same-sex relationships in some countries.

### Paternity leave

Leave generally available to fathers, usually taken shortly after the birth/ adoption of the child.

### Primary and secondary carers

Some countries use the terminology of 'primary carer' and 'secondary carer' (or 'partner') in place of 'mother' and 'father'. The primary carer is the person performing the majority of care for a newborn or newly adopted child. This can be a parent of any gender or someone who is not a biological or adoptive parent of the child (including a same-sex partner, co-parent or relative of either parent). The secondary carer is a carer of the child or a spouse or partner of the primary carer.

### Sexual harassment

Sexual harassment is any unwelcome conduct of a sexual nature that might reasonably be expected or be perceived to cause offense or humiliation, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment. Sexual harassment may occur in the workplace or in connection with work. While typically involving a pattern of conduct, sexual harassment may take the form of a single incident. In assessing the reasonableness of expectations or perceptions, the perspective of the person who is the target of the conduct shall be considered.

### Support to returning parents

Alongside entitlements of returning to a previous post (or equivalent) after a period of leave (maternity/paternity/parental), some organisations offer support to returning parents, such as: opportunities for flexible working (see above); provision of private spaces/time for lactation; shipping breast-milk when travelling on business; on-site childcare and/or financial support for childcare options. Some organisations also offer specific programmes including career coaching, expert advice and dedicated personnel to support back-to-work transitions.

### Transparency

Transparency is about making public rules, plans, processes and actions. It is knowing why, how, what, and how much. Transparency ensures that public officials, civil servants, executives, managers and board members act visibly and understandably, and report on their activities. Transparency enables accountability. It is the surest way of guarding against corruption, and helps increase trust in the people and institutions on which our futures depend.

# RESULTS BY SECTOR

## Organisations with publicly available workplace gender equality policies with specific measures (%), by sector

| UN system (n=11) | Research & surveillance (n=10) | Consultancies (n=10) | Bi & multilaterals (n=14) | Private sector (n=40) | PPPs (n=17) | Funders (n=14) | NGOs (n=57) | Regional bodies (n=8) | Faith-based (n=10) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 80% | 80% | 79% | 77% | 71% | 57% | 42% | 25% | 20% |

## Commitment to gender equality, by sector

| UN system (n=11) | PPPs (n=17) | Bi & multilaterals (n=14) | Consultancies (n=10) | Regional bodies (n=8) | Research & surveillance (n=11) | Faith-based (n=10) | NGOs (n=64) | Private sector (n=42) | Funders (n=14) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 94% | 93% | 90% | 87% | 82% | 80% | 77% | 67% | 64% |

## Workplace diversity and inclusion policies, by sector

| UN system (n=11) | Consultancies (n=10) | Private sector (n=40) | Bi & multilaterals (n=14) | Research & surveillance (n=10) | Funders (n=14) | PPPs (n=17) | NGOs (n=57) | Regional bodies (n=8) | Faith-based (n=10) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 90% | 70% | 64% | 60% | 50% | 47% | 33% | 12% | 0% |

## Percent of organisations defining gender consistent with global definition, by sector

| UN system (n=11) | PPPs (n=17) | Bi & multilaterals (n=14) | Regional bodies (n=8) | Research & surveillance (n=11) | NGOs (n=64) | Funders (n=14) | Consultancies (n=10) | Faith-based (n=10) | Private sector (n=42) |
|---|---|---|---|---|---|---|---|---|---|
| 82% | 76% | 64% | 50% | 45% | 44% | 21% | 20% | 20% | 9% |

## Organisations with board diversity policies available (%), by sector

| PPPs (n=17) | Private sector (n=42) | Bi & multilaterals (n=13) | Research / surv. (N=11) | UN system (n=11) | NGOs (n=64) | Philanthropic and funders (n=14) | Consultancies (n=9) | Faith-based (n=10) | Regional orgs (n=8) |
|---|---|---|---|---|---|---|---|---|---|
| 47% | 24% | 23% | 18% | 18% | 17% | 14% | 11% | 0% | 0% |

## Gender parity in decision-making bodies, % of organisations by sector



|  | Senior management | Governing boards |
|---|---|---|
| Bi/multilaterals (n=13) | | |
| Consultancy (n=9) | | |
| Faith based (n=8) | | |
| NGOs (n=59) | | |
| Funders (n=13) | | |
| Private sector (n=38) | | |
| PPPs (n=17) | | |
| Regional orgs (n=6) | | |
| Research / surv. (n=9) | | |
| UN system (n=11) | | |

- 56-100% women represented
- 45-55% women represented; or difference of one; parity
- 35-44% women represented
- 0-34% women represented

## Gender of CEOs, by sector % men

| Sector | Women | Men |
|---|---|---|
| UN system (n=11) | 45% | 55% |
| NGOs (n=64) | 42% | 58% |
| PPPs (n=17) | 35% | 65% |
| Regional orgs (n=9) | 33% | 67% |
| Funders (n=14) | 29% | 71% |
| Research / surv. (n=11) | 27% | 73% |
| Bi/multilaterals (n=14) | 21% | 79% |
| Faith based (n=8) | 13% | 87% |
| Private sector (n=43) | 12% | 88% |
| Consultancy (n=9) | 11% | 89% |

## Gender of Board Chairs, by sector % men

| Sector | Women | Men |
|---|---|---|
| Research / surv. (n=8) | 63% | 37% |
| Bi/multilaterals (n=8) | 50% | 50% |
| NGOs (n=68) | 44% | 56% |
| PPPs (n=16) | 44% | 56% |
| Faith based (n=9) | 33% | 66% |
| Funders (n=13) | 31% | 69% |
| UN system (n=12) | 25% | 75% |
| Consultancy (n=8) | 13% | 87% |
| Private sector (n=41) | 2% | 98% |
| Regional orgs (n=4) | 0% | 100% |

**Organisations that sex-disaggregate programmatic data, by sector**



| UN System (11) | Regional bodies (8) | Research & surveillance (11) | Bilaterals/Multilaterals (14) | PPPs (17) | NGOs (63) | Consultancy (10) | Funders (14) | Faith-based (10) | Private sector (42) |
|---|---|---|---|---|---|---|---|---|---|
| 100% | 62% | 54% | 50% | 47% | 44% | 40% | 21% | 10% | 9% |

**Organisational approaches to address underlying gender-related drivers of ill-health (%), by sector**



GENDER–TRANSFORMATIVE

| | 36% | 20% | 50% | 56% | 21% | 41% | 7% | 38% | 27% | 100% |
|---|---|---|---|---|---|---|---|---|---|---|
| | Bilaterals/Multilaterals (14) | Consultancy (10) | Faith-based (10) | NGOs (63) | Funders (14) | PPPs (17) | Private sector (42) | Regional bodies (8) | Research & surveillance (11) | UN System (11) |
| | 0% | 10% | 0% | 10% | 21% | 12% | 36% | 13% | 27% | 0% |

GENDER–BLIND

# METHODS

To measure concepts as contextual as diversity and equality with a standardised, simple methodology may seem a fool's errand. We recognise what has been called the 'violence' committed to nuanced concepts such as intersectionality when we attempt to reduce them to measurable indicators. Nonetheless, we are all aware that what gets measured, gets done.

**Sample and criteria for inclusion**
This report reviews 201 organisations active in global health. GH5050 defines "global organisations" as those with a presence in at least three countries. The sample includes organisations actively involved in global health and those organisations that aim to influence global health policy even if this is not their core function. Inclusion of an organisation does not signify GH5050's endorsement of its activities, nor that GH5050 considers the organisation to be contributing to advancing population level health in a positive direction. Rather, organisations under review have been identified as having demonstrated an interest in influencing global health and/or global health policy.

Over the past four years, the sample has shifted in its composition to account for 1) the thematic focus of the report each year, 2) continued efforts to identify global organisations headquartered in low- and middle-income countries, and 3) the general evolution of the global health architecture.

Ten sectors are represented in the 2021 sample:

1. Public-private partnerships (PPPs), defined as those partnerships with for-profit and public sectors represented on their governing bodies
2. UN system agencies working in the health, nutrition and labour fields
3. Bilateral and global multilateral organisations, including the 10 largest bilateral contributors of development assistance for health in the period 2005-2015
4. Funding bodies, including philanthropic organisations
5. Non-governmental and non-profit organisations, which can include industry groups registered as charitable organisations (e.g. 501(c)(3) in the US)
6. Private sector for-profit companies: Corporate participants in the Business and Health Action Group of the Global Business Council that provided a platform for the engagement of business in setting the health-related targets of the SDGs,[60] or companies that contributed to consultations on the Uruguay Road Map on noncommunicable diseases[61]
7. Consultancy firms with an interest in the health sector
8. Research and surveillance institutions
9. Faith-based organisations
10. Regional organisations

We recognise the limitations of grouping organisations by sector, particularly in light of the unique features of many in our sample that preclude distinct categorisation. We have sought to establish clear rationale for the categorisation of each organisation, at times directly with the organisation.

**Approach and methods for data collection**
GH5050 has developed a rigorous methodology that is consistent with established systematic review research methods. At least two reviewers extract each data item independently, and a third reviewer verifies the data. The reviewers discuss any discrepancies in data extraction until they reach a consensus. Data are coded according to content, using a traffic light system established in advance of data collection and refined iteratively. The codes in the GH5050 2021 report were updated from previous years, to bring further nuance and accuracy and as a result of invaluable ongoing discussions with organisations.

The data collected and analysed comes from publicly available websites and is in the public domain. Transparency and accountability are closely related and by relying on publicly available data we aim to hold organisations and stakeholders to account - including for having gender-related policies accessible to the public. Aside from human resources policies (see below), we do not ask for confidential information, information of a commercially sensitive nature or information that would identify individuals in organisations (other than the gender of the CEO, for example, which is publicly available for all included organisations).

This year's report covers human resources policies - some of which remain internal to the organisation itself and have not been published in the public domain. At the start of our data collection we requested organisations to share relevant policies with us. The policies have been coded and we have indicated, where appropriate, when these were internal rather than public policies. As per ethical approval (see below), these internal policies were stored by us on secure servers and will be destroyed from our servers after an agreed length of time.

Several variables assess the availability and contents of policies. We do not consider newsletters or blogs as evidence of policy. Further, for workplace-related policies, we do not consider the contents of job advertisements as evidence of policy, Rather, we look for evidence of actual policies or an overall commitment from the organisation. This decision is also drawn from our concern that some people may not get as far as the job ads if they don't see any commitment to equality in the main pages of the organisation itself.

Some organisations follow the workplace policies of host organisations or parent companies. In these cases, we used the same code as for the host/parent. For example, several organisations employ the workplace policies of the World Health Organization (WHO), e.g. Partnership for Maternal, Newborn and Child Health and the Alliance for Health Policy and Systems Research. Other non-workplace policy variables (e.g. gender parity in leadership, stated commitment to gender equality, etc.) are coded for each organisation individually.

For the corporate alliances and federations we looked for evidence of policies that were normatively gender equality-promoting. We did not accept evidence from members alone (e.g. IFBA has membership including Coca-Cola; we did not accept evidence of gender-responsive programmes from Coca-Cola for coding IFBA).

Data analysis and scoring for the variable on sex-disaggregated data was updated for the 2021 report. Where in the past we allocated a Green to those organisations for whom we were able to identify a single example of reporting sex-disaggregated data, in 2020 and in 2021 we reserved the Green scoring for those organisations regularly reporting sex-disaggregated data, or where we found explicit policy commitment to sex-disaggregated data. During data collection, we looked at those sites where we would reasonably expect to find disaggregation (e.g. annual reports or specific reports relating to a health issue). If data were not disaggregated, then we coded accordingly.

We used an earlier version of this methodology to review a small number of global health organisations and global PPPs in health. These reviews were published in peer-reviewed journals (The Lancet[62] and Globalization and Health[63]) prior to 2017.

### Engaging and validating results with organisations

We contact each organisation at least twice during the course of data verification. Initially we inform the CEO and head of human resources, or their equivalent, about the project and the start date of data collection, using email addresses found online. In that correspondence, we request the nomination and contact details of a focal point in the organisation who can review and validate the data once collected. Following completion of data collection, we send each organisation their preliminary results and ask them to review and provide any additional information, documentation or policies to review. In order to amend organisational scores, we request that organisations show us evidence in the public domain to support their amendment. Throughout the process of data collection, GH5050 encourages organisations to contact us to discuss queries about the process and the variables. Final results are shared with all organisations before publication.

### Ethics

The methods described above have been approved by the ethics committee of University College London, where GH5050 is housed. Consent from organisations was explicitly sought and received before internal, non-publicly available, policy documents were shared with GH5050. All confidential documents were stored on secure servers and will be destroyed after an agreed length of time.

### Strengths and limitations

As far as we know, this is the only systematic attempt to assess how gender is understood and practiced by organisations working in and/or influencing the field of global health across multiple dimensions (commitment, workplace policy content, gender and geography of leadership and gender-responsive programming). While our efforts may have omitted relevant measures and do not include all active organisations, this method provides the opportunity to measure status quo and report on organisations' progress. This method has allowed us to shine a light on the state of gender equality in global health and organisations across all sectors have begun to respond to our call. We believe that the collection of data and information for measurement and accountability is a fundamental first step to change.

## Research on the gender-responsiveness of organisations COVID-19 pandemic response activities: methods

### Scope

We focused on programmes and activities that aim to control the health impacts of COVID-19, undertaken by the 201 organisations covered in this report. While we recognise the gendered

impacts of COVID-19 across a range of social and economic areas, assessing these were beyond the scope of our review.

We performed a standardised review of publicly available information on organisations' activities, published on organisations' websites, and used the WHO Gender Responsive Assessment Scale to apply a standardised evaluation.

Our review focuses on organisational responses to COVID-19 within five pandemic control areas derived from in the WHO Strategic Preparedness and Response Plan. The five areas of focus of the review were selected on the basis that: (i) they target the direct health impacts of the pandemic; (ii) prior evidence suggests that using a gender-responsive design would improve outcomes in this area; and (iii) they are relevant to the roles of global health organisations (not only national bodies). With these criteria, five areas from the WHO recommendations were identified and included:

1. Research and development of vaccines, diagnostics and treatment
2. Reducing exposure, promoting preventive behaviour, encouraging positive health behaviours
3. Facilitating access to health services and systems
4. Ensuring the protection and care of healthcare workers
5. Supporting national and global COVID-19 surveillance.

### Sample

We identified information on interventions related to the health impacts of COVID-19 in 140 of the 201 organisations.

### Assessment

We categorised the work of the organisation into at least one of the five pandemic response areas. Many organisations undertake activities in more than one area - and we assessed each programmatic area separately. To assess the gender-responsiveness of the programmatic areas, we applied the WHO Gender Responsiveness Assessment Scale which defines a set of criteria for assessing programmes and policies, ranging from gender unequal to gender transformative.

Each organisation was reviewed by at least one researcher. A random sample of 50 organisations were reviewed by two researchers. Any discrepancies were discussed and verified by a third researcher.

### Limitations

One limitation is that the sample only includes data that is published online by organisations. We recognise that, given capacity and resource constraints faced by some organisations in recent months, some of their activities may not be reported or regularly updated, and therefore this review likely does not include all relevant activities of organisations.

Some organisations are implementing programmes addressing the secondary impacts of the COVID-19 pandemic, such as gender-based violence, disruption of health services, and food and financial security - which are gender-responsive. These fall outside of the scope of this review which focuses on primary health impacts and therefore these organisations and/or activities have not been included.

# ENDNOTES

1   Public commitment to gender equality; Definition of gender; Workplace gender equality policy; Gender composition of decision-making bodies; Gender of leaders; Gender-responsive programmatic approaches, and; Reporting sex-disaggregated data.

2   Given the fact that many workplace policies are system-wide for UN system agencies, high-performers have not been presented for this sector.

3   ILO (2021). ILO Monitor: COVID-19 and the world of work. Seventh edition https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf

4   ILO (2021). ILO Monitor: COVID-19 and the world of work. Seventh edition https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf

5   UN Women, Women Count (2020). Whose time to care? Unpaid care and domestic work during COVID-19 https://data.unwomen.org/sites/default/files/inline-files/Whose-time-to-care-brief_0.pdf

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7   International Finance Corporation, World Bank Group (2020). Childcare in the COVID-19 Era: A Guide for Employers https://www.ifc.org/wps/wcm/connect/2e12d33a-ce55-46b2-aae5-ee8304a6506a/202004-Childcare-COVID-19-Guide-for-Employers+B.pdf?MOD=AJPERES&CVID=ncQxRT9

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10  UN Women. The Shadow Pandemic: Violence against women during COVID-19 https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

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12  Equality and Human Rights Commission. Coronavirus (COVID-19) guidance for employers https://www.equalityhumanrights.com/en/advice-and-guidance/coronavirus-covid-19-guidance-employers

13  UNISON (2020). COVID-19: Black and female workers – more impacted than the rest https://southeast.unison.org.uk/news/article/2020/05/covid-19-black-female-workers-impacted-rest/

14  Women's Budget Group, London School of Economics, Queen Mary University of London and The Fawcett Society (2020) BAME women and Covid-19 – Research evidence https://wbg.org.uk/wp-content/uploads/2020/06/BAME-women-and-Covid-FINAL.pdf

15  Statistically significant. No interpretation of causation.

16  https://travail-emploi.gouv.fr/droit-du-travail/egalite-professionnelle-discrimination-et-harcelement/index-egalite-professionnelle-femmes-hommes

17  UK-based organisations are required to report data using a standardised methodology for the following variables: (1) mean and median pay gap in hourly wages of men and women; (2) mean and median bonus pay gap among men and women; (3) proportion of men and women occupying pay quartiles; and (4) percentage of men and women receiving bonuses. UK guidelines include both employed workers and some self-employed people in the calculations.

18  https://wellcome.org/sites/default/files/wellcome-ethnicity-pay-gap-report-2019.pdf

19  WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies https://www.who.int/gender/mainstreaming GMH_Participant_GenderAssessmentScale.pdf

20  Scully, E.P., Haverfield, J., Ursin, R.L. et al. (2020) Considering how biological sex impacts immune responses and COVID-19 outcomes. Nature Reviews Immunology 20, 442–447

21  WHO (2020) 2019 Novel Coronavirus (2019-nCoV) Strategic preparedness and response plan https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus

22  Crespí-Lloréns N, Hernández-Aguado I, Chilet-Rosell E. (2021). Have Policies Tackled Gender Inequalities in Health? A Scoping Review. Int J Environ Res Public Health. 18(1):327. DOI: 10.3390/ijerph18010327. PMID: 33466282; PMCID: PMC7796005

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25  WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

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# LIST OF ORGANISATIONS

To view the Gender and Health Index and explore individual organisation's performance, visit globalhealth5050.org/data.

## Bilaterals and Global Multilaterals
Agence Française de Développement (AFD)
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
European Commission
Foreign, Commonwealth & Development Office
Global Affairs Canada
Japan International Cooperation Agency (JICA)
Ministry of Foreign Affairs and International Cooperation, Italy
Ministry of Foreign Affairs of the Netherlands
Norwegian Agency for Development Cooperation (Norad)
Partners in Population and Development (PPD)
Swedish International Development Cooperation Agency (Sida)
Unitaid
United States Agency for International Development (USAID)
World Bank Group

## Consultancy firms
Accenture
Dalberg
Deloitte
John Snow, Inc
KPMG
McKinsey & Company
Mott MacDonald
Palladium Group
PwC
Rabin Martin

## Faith-Based Organisations
Africa Christian Health Association Platform (ACHAP)
American Jewish World Service (AJWS)
Caritas Internationalis
Catholic Medical Mission Board (CMMB)
Catholic Relief Services (CRS)
Islamic Relief Worldwide
Muslim Aid
Salvation Army International
World Council of Churches (WCC)
World Vision

## Non-Governmental Organisations and Non-Profits
ACTION Global Health Advocacy Partnership
Action on Smoking and Health (ASH)
Advocates for Youth
Africa Centre for Global Health and Social Transformation (ACHEST)
Africare
Alight
amfAR, Foundation for AIDS Research
Amref Health Africa
AVERT
BRAC
China Foundation for Poverty Alleviation (CFPA)
Clinton Health Access Initiative (CHAI)
Cordaid
CORE Group
CARE International
Elizabeth Glaser Pediatric AIDS Foundation
(EGPAF)
EngenderHealth
FHI 360
Framework Convention Alliance (FCA)
GBC Health
Global Health Council
Health Action International
Health Poverty Action
i+solutions
International AIDS Society (IAS)
International Center for Research on Women (ICRW)
International Diabetes Federation (IDF)
International Federation of Medical Students (IFMSA)
International Federation of Red Cross and Red Crescent Societies (IFRC)
International Planned Parenthood Federation (IPPF)
International Rescue Committee (IRC)
International Union Against Tuberculosis and Lung Disease
International Women's Health Coalition (IWHC)
Ipas
Jhpiego
Magna
Management Sciences for Health (MSH)
Médecins Sans Frontières (MSF)
Medicines Patent Pool (MPP)
Medico International
Memisa
Mercy Corps
Movendi International
MSI Reproductive Choices
NCD Alliance
Oxfam International
Partners In Health
PATH
Pathfinder International
Plan International
Population Action International
Population Council
Population Reference Bureau (PRB)
Population Services International (PSI)
Promundo
Reproductive Health Supplies Coalition
Save the Children
Sonke Gender Justice
SRHR Africa Trust
Union for International Cancer Control (UICC)
Vital Strategies
World Economic Forum
World Heart Federation
World Obesity Federation

## Philanthropies and Funders
Aga Khan Foundation (AKF)
Aliko Dangote Foundation (ADF)
Bill & Melinda Gates Foundation
Bloomberg Philanthropies
Caterpillar Foundation
Ford Foundation
Global Financing Facility (GFF)
Imam Khomeini Relief Foundation
Islamic Development Bank
Open Society Foundations
Qatar Foundation (QF)
Rockefeller Foundation
Sanofi Espoir Foundation
Wellcome Trust

## Private Sector
Abt Associates
AB InBev
AbbVie
Becton, Dickinson and Company
BP
Bristol-Myers Squibb
Coca-Cola
Consumer Brands Association
DSM
Eli Lilly and Company
ExxonMobil
General Electric
Gilead
GlaxoSmithKline (GSK)
GSMA
Heineken

Intel
International Council of Beverages
Associations (ICBA)
International Federation of Pharmaceutical
Manufacturers and Associations (IFPMA)
International Federation of Pharmaceutical
Wholesalers Foundation (IFPW)
International Food and Beverage Alliance
(IFBA)
Johnson & Johnson
Kuehne + Nagel
Laerdal
McCann Health
Medela
Medtronic
Merck
Nestle
Novartis
Novo Nordisk
Pfizer
Philips
Reckitt Benckiser Group (RB)
Safaricom
Sumitomo Chemical
Teck Resources
TOMS
US Council for International Business (USCIB)
Vestergaard Frandsen
Viatris
Unilever

**Public-Private Partnerships**
Clean Cooking Alliance
Drugs for Neglected Diseases Initiative (DNDi)
Foundation for Innovative New Diagnostics
(FIND)
GAVI, the Vaccine Alliance
Global Alliance for Improved Nutrition (GAIN)
Global Fund to Fight AIDS, Tuberculosis &
Malaria
Global Handwashing Partnership (GHP)
Global Health Innovative Technology Fund
(GHIT Fund)
Global Road Safety Partnership (GRSP)

International Vaccine Institute (IVI)
Medicines for Malaria Venture
Nutrition International
Partnership for Maternal, Newborn and Child
Health (The Partnership, PMNCH)
RBM Partnership to End Malaria
Scaling Up Nutrition
Stop TB Partnership
TB Alliance

**Regional Organisations**
African Union Commission (AUC)
Association of Southeast Asian Nations
(ASEAN)
Caribbean Public Health Agency (CARPHA)
Community of Latin American and Caribbean
States (CELAC)
Pacific Community
Southern Africa Development Community
(SADC)
United Nations Economic Commission for
Africa (UNECA)
West African Health Organization (WAHO)

**Research and Surveillance**
Africa CDC
Africa Population and Health Research
Centre (APHRC)
Alliance for Health Policy and Systems
Research (AHPSR)
Centers for Disease Control and Prevention (US)
China CDC
European Centre for Disease Prevention and
Control
Fundação Oswaldo Cruz (Fiocruz)
Health Systems Global
icddr,b
Institut Pasteur
National Institutes of Health (NIH)

**UN System**
Food and Agricultural Organization of the
United Nations (FAO)
International Labour Organization (ILO)

Joint United Nations Programme on HIV and
AIDS (UNAIDS)
UN Women
UNHCR
UNICEF
United Nations Development Programme (UNDP)

United Nations Office on Drugs and Crime
(UNODC)
United Nations Population Fund (UNFPA)
World Food Programme
World Health Organization (WHO)