WOMEN DELIVER EYE HEALTH **LET’S REFRAME WHO LEADS IT**

PHOTO: KABIR DHANJI

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REPORT

The Fred Hollows Foundation believes that achieving gender parity in eye health leadership will help reduce inequities in eye health – now we are calling for action.

The **Fred Hollows** Foundation

DR PATHOUMPHONE'S STORY

In Lao PDR, where there is approximately one eye doctor for every 100,000 patients and where less than a third of its eye doctors are female, 33-year old Dr Pathoumphone Kethdomli has been one of the lucky few who has successfully realised her dream of becoming an ophthalmologist. Thanks to a scholarship from The Fred Hollows Foundation Dr Pathoumphone was able to start her basic training as an eye doctor, finish her further studies, and gain work at the eye unit in her home town of Xayabouri.

But as the only qualified female ophthalmologist, she faced many challenges in the male dominated industry. Balancing traditional expectations at home and her professional responsibilities meant she had to sacrifice so much and spend long periods away from her family. But despite these hardships she wants to encourage more of the young generation to apply and study Ophthalmology in the hope of attaining the goal to fix avoidable blindness in Lao PDR.

"YOU HAVE GOT TO GET PEOPLE INVOLVED, YOU HAVE GOT TO MOBILISE THEM, YOU HAVE GOT TO MAKE THE HEALTHY SYSTEM PART OF THEM."
- PROFESSOR FRED HOLLOWS

PHOTO: BART VERWEIJ

CONTENTS

1 EXECUTIVE SUMMARY 2

2 INTRODUCTION TO HYPOTHESIS STATEMENT 4

- 2. Introduction to theory 4
- 2.2 Unlocking outcomes for health services design and delivery 8

3 CASE STUDIES AND EVIDENCE FROM OTHER SECTORS 10

- 3.1 Governance 11
- 3.2 Sport 12
- 3.3 Education 13
- 3.4 Apparel 14

4 CONCLUSIONS AND RECOMMENDATIONS FOR THE EYE HEALTH SECTOR 16

5 APPENDIX 19

- 5.1 Project scope 19
- 5.2 Purpose and use of outputs 19
- 5.3 List of interviewees 20

1 EXECUTIVE SUMMARY

"We believe that by achieving Gender Equity in Leadership, we can catalyse positive outcomes in eye health for everyone."

This project has explored and tested this hypothesis held by The Fred Hollows Foundation (The Foundation) around the potential of parity for women in leadership positions and what this would unlock for eye health services and outcomes.

Our work is exploratory. It draws on some academic viewpoints to establish a supporting evidence base, but it is not an academic review. It is an attempt to draw out some key lessons and experiences from other sectors and organisations. It is an invitation to think about how The Foundation and the wider eye health sector might respond to this opportunity.

PHOTO: MICHAEL AMENDOLIA

> This research and evidence-gathering gives confidence that the hypothesis holds true.

Global health is losing out on women's talent, skills, perspectives and experiences. More women leaders can influence health policy and improve the organisational and institutional environment for all health workers in the sector.

Excluding women from leadership positions in global health sees negative consequences for the success of health care services, systems and delivery. Achieving equal representation in positions of power across health and in sectors outside of health matters. It supports more diverse voices making decisions around system design, resource spend and policy change which leads to systems and services that better reflect the needs of the entire population This creates role models for the next generation of future women leaders.

The gender gap in health leadership is systemic: this is about deep-rooted, historical power structures of medicine, hospitals and health systems. Women face many visible and invisible barriers along the pipeline to leadership – not just at the final hurdle (glass ceiling).

Insights from other sectors (across Governance, Sport, Education, Apparel) have helped to identify **five key lessons** for The Foundation to consider:

1. **BE DELIBERATE**
2. **SET WOMEN UP FOR SUCCESS**
3. **CREATE AN ENABLING ENVIRONMENT**
4. **BUILD THE DATA AND EVIDENCE**
5. **FIX THE PROBLEM, NOT WOMEN**

What should the eye health sector do next?

> There are different calls to action that the sector can decide which could be about organisation, processes and/or culture.

This could mean new commitments and accountabilities to diversity, equity and inclusion. There are opportunities here for the eye health sector to address processes, practices and ways of working – from data and metrics, to internal / external (driving new conversations and partnerships within the eye health sector and more widely) communications, training and allyship initiatives.

Women face structural, intersecting barriers to change both on the path to becoming a leader and once they are in leadership positions. These are the result of generations of power and privilege. Tackling them is not an overnight job and this is beyond just one institution or organisation's capacity to change. The eye health sector will need to work collaboratively with others. This may mean new projects for data and research, external communications and partnership programs to help drive wider change.

2 INTRODUCTION TO HYPOTHESIS STATEMENT

2.1 INTRODUCTION TO THEORY

Introduction to hypothesis statement

The agreed hypothesis statement to test was: **"we believe that by achieving Gender Equity in Leadership, we can catalyse positive outcomes in eye health for everyone".**

The hypothesis statement denotes to having gender parity (at least) in leadership positions – leaders in health organisations, institutions (hospitals, clinics, etc) or agencies with the authority to influence resources and decision-making.

The hypothesis refers to the "catalytic" nature of gender equity in eye health leadership "for everyone". This means that gender parity in leadership brings about or accelerates a number of positive outcomes for all people irrespective of gender or other characteristics. Being a catalyst positions leadership as a key intervention to facilitate a wider long-term and systemic change.

Top line academic overview of theory: women in leadership positions in (eye) health

The United Nations Sustainable Development Goals (SDGs) set a vision for global sustainable development and social progress by 2030, offering a guiding framework for relevant stakeholders in the space. Achieving gender equality for women and girls is Goal 5 of the SDGs, with target 5.5 to "*ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life*".[1] The global health industry is striving to achieve Universal Health Coverage (UHC) which means all individuals and communities receive the health services they need without suffering financial hardship.[2] Leaders in the health sector play a critical role in the quality of health services delivered to progress towards UHC.

In global health, it is estimated that women contribute over USD3 trillion annually to international health systems.[3] This contribution is markedly undervalued – women in health tend to be clustered into lower status, low paid and often unpaid roles (such as "women's work" like nursing, midwifery or social care roles).[4] Women do not have equal participation in health leadership or decision-making.

A seminal 2019 report by the WHO titled *Delivered by Women, Led by Men*, with research conducted by the Gender Equity Hub (GEH) co-chaired by WHO and Women in Global Health, found that **women occupy almost 70% of the global health workforce but hold only 25% of senior roles.**[5] This is consistent across all levels of leadership, from international organisations to the community or local level.

Evidence from the 2021 Global Health 50/50 Report offers a private sector lens. There is a very "slow crawl" towards gender parity in health leadership. In 2018 health organisations had an average of 29% women CEOs or Executive Directors, which increased to 31% in 2021. This trend is worse in low- and middle-income country settings. In 2018, Boards in global health comprised only 20% women – this has increased to 26% in 2021.[6] There is senior management team (SMT) parity in only 36% of global health organisations, and Board parity in less than one third of organisations. The public sector closely mirrors this trend.

[1] See https://sdgs.un.org/goals/goal5

[2] See https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

[3] See https://www.who.int/activities/value-gender-and-equity-in-the-global-health-workforce and https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60497-4/fulltext

[4] Mousa, M, Boyle, J, Skouteris, H, Mullins, A, Currie, G, Riach, K, Teede, H. 2021. *Advancing women in healthcare leadership: A systematic review and meta-synthesis of multi-sector evidence on organisational interventions.* Available: https://www.sciencedirect.com/science/article/pii/S2589537021003643

[5] *Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce.* Geneva: World Health Organisation, 2019. (Human Resources for Health Observer Series No. 24). Available: https://apps.who.int/iris/handle/10665/311322.

[6] See https://globalhealth5050.org/2021-report/.

Women in Global Health conducted similar research on women's representation across health. This is captured in Figure 1 below:

FIGURE 1: WOMEN'S REPRESENTATION IN GLOBAL HEALTH (UPDATED IN 2021) [7]

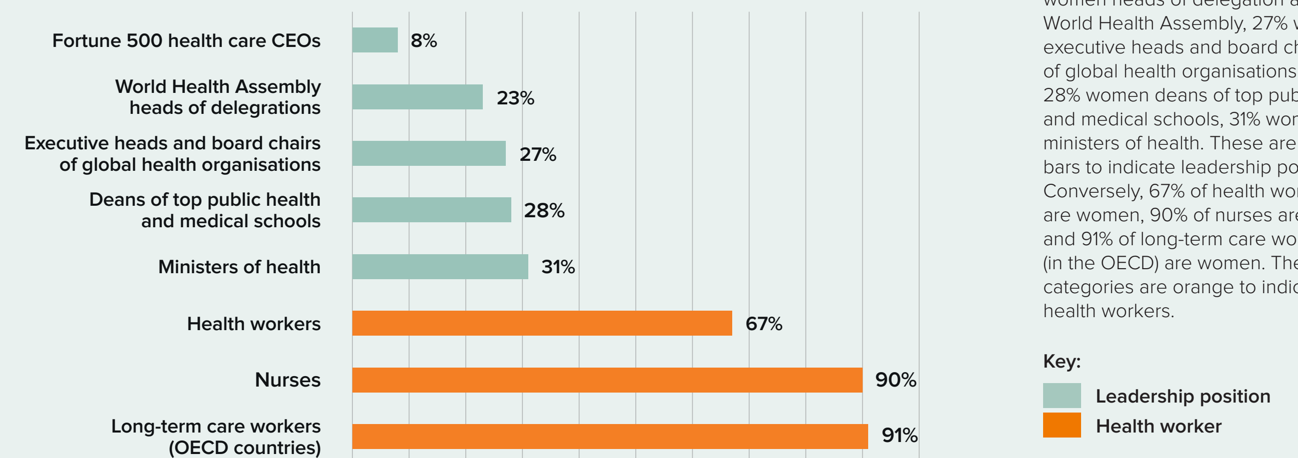


Figure 1 is a bar chart. It illustrates there are 8% women CEOs in Fortune 500 health care companies, 23% women heads of delegation at the World Health Assembly, 27% women executive heads and board chairs of global health organisations, 28% women deans of top public health and medical schools, 31% women ministers of health. These are blue bars to indicate leadership positions. Conversely, 67% of health workers are women, 90% of nurses are women and 91% of long-term care workers (in the OECD) are women. These three categories are orange to indicate health workers.

Key:
- Leadership position
- Health worker

Figure 1 illustrates the status quo of the 70:25 "pyramid" in 2021: women compromise the majority of health and care workers (orange bars) but hold few senior leadership positions across international health institutions and governing bodies (blue bars).

The number of women leading Ministries of health.[8] It is the highest area for women's leadership at 31% and varies significantly based on geography and context. In the regions of Southeast Asia, Western Pacific, and Eastern Mediterranean it is relatively low, whereas in Europe, Africa and the Pan American regions, women head more than 30% of health ministries. At the WHO itself, women account for under 10% of the 34 executive board members.[9]

PHOTO: SIN SARETH

For eye health, the International Agency for the Prevention of Blindness (IAPB) has been tracking women's leadership representation since 2020 through its annual gender equity in eye health survey.[10] The survey is limited in that it only reaches 90 organisations in eye health (but IAPB respondents grow annually). The survey presents some useful insights for eye health: in 2021, 31% of organisations surveyed had Board member parity and 32% had a female CEO. This is higher than the 2021 Global Health 50/50 finding (29%). The IAPB found that 56% of eye health organisations surveyed have parity or almost parity in SMT leadership – notably higher than outside of eye health (36%).

[7] See https://womeningh.org/.

[8] For WHO member states.

[9] See here.

[10] Drawn from the Global Health 50/50 survey design. IAPB. *2021 Snapshot: Gender equity in the eye health sector.* Available here.

PHOTO: MARK MAINA

In June 2021 following the launch of the *Delivered by Women, Led by Men* report, the WHO released a policy action paper titled *Closing the Leadership Gap: Gender Equity and Leadership in the Global Health and Care Workforce.*[11] This paper argues that women had a marked impact on the health sector's response to the global coronavirus pandemic but were not sufficiently recognised for their efforts. Many were on the frontlines working as nurses and healthcare workers which elevated their risk of contracting COVID (and potentially "long COVID").[12] Many women health workers spent an average of two additional hours of unpaid care work fulfilling childcare duties or undertaking home-schooling due to widespread lockdowns.[13]

Early evidence suggests that countries led by by female political leaders in high-income countries suffered six times fewer deaths from COVID-19 than countries led by men.[14] This is largely attributed to their swift decision-making and action to implement early lockdown measures, and their clear and frequent communication style during crisis. This is, however, dependent on the country context and the factors for success – some of these early, hard lockdowns are now being criticised for negatively affecting health systems readiness and public mental health. Research into media coverage of the pandemic showed that one woman was quoted as an expert on the pandemic in media outlets for every three male experts.[15] Another study found that 85% of national COVID-19 decision-making groups (task forces) had majority male leadership.[16]

Barriers to entry – a "glass ceiling" and a "leaking pipeline"

The gender gap in leadership extends beyond numbers to a systemic issue: **deep-rooted, historical power structures of medicine, hospitals and health systems and the "glass ceiling" effect, that creates a preferential opportunity for men to be leaders and occupy influential roles in the sector.**[17] This establishes a power dynamic that enables men and disempowers women. Still, there is no shortage of women in the age cohorts that typically feed into leadership. As the *Closing the Leadership Gap* paper notes, "*the problem is not a shortage of women entering the leadership pipeline, rather a blockage in the pipeline [which sic] stops women entering leadership in equal numbers as men.*" Women face many visible and invisible barriers along the pipeline to leadership not just at the final hurdle (glass ceiling). This is referred to as a "leaking pipeline".[18]

[11] World Health Organisation. *Closing the Leadership Gap: Gender Equity and Leadership in the Global Health and Care Workforce.* Policy Action Paper, June 2021. Available here.

[12] See further insight: OECD Policy Responses to Coronavirus. 1 April 2020. *Women at the core of the fight against COVID-19 crisis.* Briefing paper. Available here.

[13] Ibid.

[14] Bearing in mind the sample size is small – in January 2020, 12 out of 193 countries had a woman as head of government. See research findings here.

[15] Women in Global Health. September 2020. *COVID-19: Global Health Security Depends on Women. Rebalancing the unequal social contract for women.* Available: http://covid5050.org/Global-Health-Security-Depends-on-Women-WGH.pdf

[16] Sample size was 115 national task forces. See van Daalen KR, Bajnoczki C, Chowdhury M, Sada S, Khorsand P, Socha A, et al. Symptoms of a broken system: the gender gaps in COVID-19 decision-making. BNK Global Health, 2020: 5(10. Available: https://gh.bmj.com/content/5/10/e003549. Also supporting data from https://data.undp.org/gendertracker/

Key barriers that negatively impact women's advancement to leadership include:

Less investment in women's mentoring, talent and skills development to hold leadership positions (both technical trainings and soft skills).

Workplace bullying and sexual harassment that leads women to feel unprotected at work / within their work culture, which prevents them from applying for leadership positions or causes early exit from the position.[19] Women tend to face compounded disadvantages due to both their gender and their age.[20]

Perpetuating norms and gender stereotypes held by society such as men being traditionally associated with having "better" leadership qualities (masculine traits). Men are considered "better" surgeons while women are considered "better" nurses.

Gender pay gap that contributes to women becoming demotivated and more likely to consider leaving their professions early.

Lack of recognition and respect that serves as a detriment to career advancement.[21]

Discrimination, including ageism in the workplace. Evidence shows that female employees are often passed up for promotion or denied access to training because of age.[22]

Institutional factors such as certain HR policies, restrictive maternity leave or lack of family friendly policies such a flexible working.

Individual factors, such as imposter syndrome, that may manifest in feelings of self-doubt, inadequacy or fear of failure.

Interviewees shared examples of these factors at play in their work and communities:

"*Laws and policies that protect women against discrimination are vital. They offer a safe space to express their views, and also where they get support and feel support for their expressing opinions.*"

"*Social stigma is important, even at the community level. You can train your health service staff to be sensitised, but patients also need to understand these practices. For example, a woman can go into a community clinic to access something but then feel uncomfortable to be treated by a female doctor.*"

"*There is social stigma, even among educated people. For example, when a female student is pursuing advanced medicine, they face a stigma [in South Asia] – you will see a lot of female doctors choose to study gynaecology because it is considered more female. There is this belief that women cannot become good surgeons – even if women have been established as good surgeons, they tend to convey that message to other women.*"

"*At the Generation Equality forum, the gender pay issue was the biggest achievement that came out of that space, and how governments can play a role to subsidise the gaps.*"

"*A lot of men in power find it is really difficult to let go of power – we have to try to get men to realise they can't be the only ones in this room, we need them to learn to share power.*"

[17] See WHO reports *Closing the Leadership Gap (2021) and Delivered by Women, Led by Men (2019).*

[18] See https://pubmed.ncbi.nlm.nih.gov/28341310/

[19] Forty-five countries around the world have no national law against sexual harassment at work.

[20] WHO (2021). Global report on ageism. World Health Organization https://www.who.int/publications/i/item/9789240016866

[21] https://www.oecd.org/employment/retaining-talent-at-all-ages-00dbdd06-en.htm

[22] One study found that only one in 10 awards in health and medicine were given to women. See here.

It is important to assess individuals within their regional, social and public policy contexts to understand the distinct factors that impact their entry into leadership positions.[23] Action is needed at all levels to address the "leaking pipeline" and enable gender parity in leadership.

"A lot of these issues are really systematic and structural. You put a woman in leadership, but you also need to have an enabling environment so that she can enforce her policy. The biggest thing I've seen is that if they put a woman in place without any supporting mechanisms and then they see her fail. Some of the most enabling factors are to get people to understand what is gender, why this is important, what does it look like practically – both from a staff and a patient perspective."

2.2 UNLOCKING OUTCOMES FOR HEALTH SERVICES DESIGN AND DELIVERY

PHOTO: MICHAEL AMENDOLIA

Excluding women from leadership positions in global health has negative consequences for the success of health care services, systems and delivery.

Global health is losing out on women's talent, skills, perspectives and experiences. More women leaders can influence health policy and improve the organisational / institutional environment for all health workers in the sector. This can maximise the value of the predominantly female workforce in health – it is estimated that global human capital wealth will increase by 22% if equal participation in health is realised.[24]

Women leaders will increase the number of women role models and mentors for both men and women. This helps to break social gender norms of men as "natural leaders".[25] Moreover, more women leaders could result in fewer cases of sexual harassment in the workplace.[26] This reduces harm to individual health workers and health systems more broadly – as fewer (talented and skilled) women choose to leave the sector due to experiences of harassment. Studies have shown that more women leaders in C-suite teams in health produce better outcomes – more innovation, more creative solutions to intractable problems, and better financial results.[27]

Women leaders can significantly expand the global health agenda and give greater priority to issues that affect women and girls. A health system consists of all people, institutions, resources and activities whose primary purpose is to promote, restore and maintain health.[28] All these components deliver healthcare. Health system design should integrate national policies and plans with evidence-based research to consider women's experiences. This develops a health care system that can meet the needs of the community / individual and better respond to national disasters or public health crises. The recent coronavirus pandemic placed a strain on global health system and has raised conversations around health systems strengthening to the global agenda.

"One of the biggest things is getting data from lived or personal experiences, what is really happening on the ground, creates the environment to have dialogues at the international level. But the qualitative data is key – putting a face behind the numbers really helps."

[23] See https://twitter.com/womeningh/status/1402263392879099913.

[24] Mousa et al, 2021.

[25] UNDP. 2020 Human Development Perspectives. *Tackling Social Norms – A Game Changer for Gender Inequalities*. Available here.

[26] See Au, s, Tremblay, A and You, L. 2020. Times Up: Does Female Leadership Reduce Workplace Sexual Harassment? Available: https://journals.aom.org/doi/10.5465/AMBPP.2020.21007abstract

[27] See Harvard Business Review. How Women Drive Innovation and Growth. Available here.

[28] See https://www.who.int/health-topics/health-systems-governance#tab=tab_1.

Implications for eye health

Better access to services:

Those suffering preventable blindness is 55% women compared to 45% men. This is due to a number of factors, including women living longer, women and girls not being prioritised in terms of access to services especially in low- and middle-income countries, women facing higher barriers to services (such as breastfeeding, rearing young children, cultural constraints). Research has also shown that decisions in healthcare have led to conditions primarily affecting women being understudied and underfunded historically. Achieving gender parity in leadership could help increase attention to these diseases and conditions (including vision loss which disproportionately affects women) ensuring more equal access to resources.

More inclusive service design and delivery:

A lack of women leaders in eye health sees negative impacts on the health service design process, including limited considerations for data disaggregated by sex or services catered to meet women's specific requirements.

More representation and role models:

There is a lack of female leaders across leading eye health organisations including international non-governmental organisations (INGOs), multilaterals, academic institutions, publishing/ editing houses, global institutions and bodies etc. It is also important to consider diversity, geographic, cultural and ethnic representation in leadership.

PHOTO: ALDRENE TAN

3 CASE STUDIES AND EVIDENCE FROM OTHER SECTORS

PHOTO: SAM PHELPS

The hypothesis statement was tested by looking outside eye health and general health through semi-structured interviews with select external stakeholders to determine whether the "catalytic change" from leadership parity could produce similar outcomes elsewhere.

The hypothesis statement is generalised such that it can be replaced with a sector for study: "*we believe that by achieving Gender Equity in Leadership across [insert sector], we can catalyse positive outcomes in [insert sector] for everyone*".

Interview subjects were selected using the following criteria:

- Individuals or organisations with subject matter expertise on gender, leadership, or both within their sector/s
- Individuals or organisations with a specific program focus on women leadership, such as those running initiatives or workplans on the subject
- Sector experts with lived experience (as women leaders themselves, for example)
- Relevant geographic representation from the global north and global south
- A range of governance levels – international, regional, national, and even relevant community work (that was representative of national trends?
- Considerations for wider definitions of gender and intersectionality

The case studies draw on desk research and interviews. The governance sector provides an overall view of general themes that are present across all sectors. Positive outcomes are reported from research in the sport sector while the education and apparel sectors are includes as outcomes are less developed or more complex.

Interviews were based on the lived experience of women leaders and may not be fully representative of the wider sector.

[30] McKinsey and Company. October 2017. *Women Matter: Time to accelerate. Ten years of insights into gender diversity.* Available here.

3.1 GOVERNANCE

Overview

Globally, women represent half of the world's working age population, but hold only one quarter of management positions and less than one quarter of ministerial or parliamentary roles.[30] In the United Kingdom, there are just eight female CEOs on the FTSE 100 companies, and no women of colour. Women hold only 14% executive directorships and 38% of all directorship positions.[31] An estimated USD12 trillion could be added to global output by 2025 if the gender gap was closed in both the workforce and the composition of the leadership.[32]

Interviewees referenced Joan Acker's work and the intersection of four gendering processes – cultural, structural, personal and interpersonal – that create gendered organisations and gender inequality within organisations.[33] Women's positions within organisations must be assessed through these processes and holistically – this can either maintain the status quo for women or seek to disrupt or enhance it.

"*It is the structures, the interpersonal interactions, what we see in the mentoring and sponsorship, the old boys' clubs.. if you want to achieve 50/50 and you don't tackle unconscious bias and make men accountable, the numbers won't make sense. You can recruit women, but you might not get them to thrive if you don't change the culture.*"

To break the cycle of inequality within leadership structures, interviewees and research support a focus on sponsorship as an intentional intervention.[34] Sponsorship allows senior leaders to use their power and insider knowledge to advocate for capable women to move into key roles – preventing them from leaving the organisation, or even the industry, prematurely. Sponsorship spans the four gendering processes but it is most notable within culture. This means holding current leaders (men or women) to account for positive sponsorship behaviours and creating an enabling culture for women to succeed around a new understanding of opportunity and merit.

"*We find women were being mentored but they weren't receiving the opportunities to advance their careers. But focusing on sponsorship – the opening of doors, advocating, including women in projects and positioning them well to succeed – is a way to tackle the leaky pipeline.*"

Interviewees stressed the importance of keeping a holistic view of the operating environment that does not look to "fix" women. "*When you focus on women, it is quite easy to see them as the problem and then it really is a slippery slope. Numbers matter. Women are quite vulnerable up to a point because they are treated as the representative of their group – the tipping point is around 40% when the dynamics change.*"

This "tipping point" emerged as a theme across a number of sectors. Statistically, research has found that an organisation should strive for at least 33% representation of women in leadership positions, from which inclusion will grow across the organisation as an effect.[35] Colloquially, the tipping point is sometimes diluted to 30%. Surpassing the tipping point brings real changes of cultural and interpersonal interactions within organisations.

Outcomes

There is significant research on the link between female-led management teams and organisational performance of companies – across financial performance, social responsibility and higher quality customer outputs. Studies have also found that women leaders in the C-suite bring new perspectives and have changed the way companies innovate: becoming more open to change and less open to risk, and shifting organisational strategy from one centred around mergers and acquisitions (external) to one that prioritises internal research and development goals.[36]

"*What I see when women step up is they have different values, they regard different things as important and this gives diversity in decision-making. [...] But still, they are operating in this hypermasculine, hypercompetitive culture where you have to be better at "playing the game". The kinds of women that survive and thrive would still lean towards women without kids, for example.*"

Interviewees argue that to affect real, lasting change, cultural change is key.

"*The framework is a puzzle piece, when you change one thing, you have to tackle all of them. It is structural change.*"

Structural change is addressed by looking at intersecting, structural norms like power, identity, merit and education / training – and how these are defined culturally (within local context). Actions such as bringing more men into more junior roles to facilitate gender balance across the organisation and implementing quotas in leadership teams may help.

[31] The Fawcett Society. 2022. *Sex & Power* report. Available here.

[32] McKinsey and Co, Women Matter.

[33] See Joan Acker. 1990. *Hierarchies, Jobs, Bodies: A Theory of Gendered Organisations*. Available here.

[34] Women are often over-mentored and under-sponsored. See https://hbr.org/2019/08/a-lack-of-sponsorship-is-keeping-women-from-advancing-into-leadership.

[35] See https://www.forbes.com/sites/womensmedia/2014/05/29/the-female-tipping-point-in-the-boardroom/.

[36] Post, C, Lokshin, B and Boone, C. 6 April 2021. *Research: Adding Women to the C-Suite Changes how Companies Think*. Harvard Business Review. Available here.

3.2 SPORT

Overview

Women's participation in elite sport has seen a rapid rise in recent years, with expanded grassroots programs, enhanced visibility of women's events,[37] and a new generation of role models. At the Tokyo 2020 Olympics, 48% of athletes were women, up from 44% at London 2012 and 34% at Atlanta 1996.[38]

Leadership-level representation, (executive committees/commissions, boards of national governing bodies or professional clubs, coaching staff) has not yet matched this, although many sports governing bodies and boards have surpassed their 30% target. In England, for example, a study of 131 organisations found that an average of 37% of national governing bodies (NGBs) have a women leader on the board.[39] British Cycling, British Equestrian, fencing, netball and hockey are some of the NGBs that have reached parity.

This is not reflected in the private sector – the same study found only 8% of commercial clubs in England have a woman leader on the board. Sports like cricket, rugby and football perform the worst. There is only one club in the Premier League that meets the 30% target.[40]

Outcomes

It is widely recognised that gender diversity in sports leadership has positive outcomes, including bringing broader perspectives to decision-making and resource allocation, inclusive sport infrastructure design (facilities, changing rooms), role models that encourage wider participation in elite and grassroots sports.[41]

Through capacity building initiatives like the New Leaders Programme, the International Olympic Committee (IOC) has identified gender equal leadership as a key focus area in the lead up to next Olympic Games. As the IOC chair remarked, "*sport has the power to propel gender equality and girls' and women's empowerment in society at large.*"[42]

According to interviewees, the recent shift in sports governance has been supported using national targets of parity (50%) for boards in sports bodies. These governance standards support transparency and sound reporting in the sport sector – this was a tangible measure that could be linked to funding applications.

"*We see this knocking down to the club level. Now we are seeing around 35% women presidents in club committees [in tennis]. They award coaching contracts and with more female coaches, there is a trickle-down effect on raising sport participation and reducing dropout rates, creating talent paths and better support mechanisms.*"

This has supported more inclusive access for all people participating in sport. It helps to demonstrate the case for change.

"*What we are seeing is facilities that were designed by men, legacy structures to suit men, are now being addressed at a higher governance level to think about LQBTQI access, disability access.*"

Despite these targets, there is not a critical mass. Women leaders in sport require support mechanisms to succeed – from male allies, too.

"*Sport is a very competitive industry and being a woman at the top is a lonely position to be in when you don't have enough female leaders to drawn on.*"

Interviewees made suggestions for networking events among women leaders, leadership coaching and the key role of male allyship.

[37] In 2022, almost a third of the UK population watched women's sport. See https://www.womenssporttrust.com/new-research-by-the-womens-sport-trust-reveals-unprecedented-viewership-for-the-barclays-fa-wsl-2021-22-season/.

[38] International Olympic Committee, *Gender Equality & Inclusion Report*. 2021. Available here.

[39] Farrer and Co, *Women in Sport: Levelling the Playing Field*. 2019. https://www.paperturn-view.com/uk/briannawilson/farrer-co-women-in-sport?pid=NzA70913&v=1.1.

[40] See here.

[41] Farrer and Co.

[42] International Olympic Committee, *Gender Equality & Inclusion Report*. 2021.

3.3 EDUCATION

Overview

Most international efforts for gender parity in the education sector have been focused on getting girls into public school systems and improving outcomes for girls' education.[43]

Women's representation in leadership positions across education institutions and school systems is lagging given the composition of the teaching workforce.

At British universities, only one in four professors is female despite half of lecturers being women.[44] There is more parity seen at faculty member level. Across the United Kingdom, 63% of teaching staff are women but only 38% of headteacher positions are held by women. Data from UNICEF indicates that at primary public schools in Niger, Mali and Togo, 1 in 10 school leaders are women. In Niger, 40% of teachers are female but this drops to 11% at school leader level.[45] Several Latin American and Caribbean countries, including Mexico, Chile and Colombia, fare slightly better but still lag behind – female primary school teachers outnumber female school leaders by at least 20%.[46]

Women's entry to and participation in leadership positions in the education sector has been changing over the last few years. The gap is getting smaller. Interviewees feel this is most apparent in higher education, although it is cascading to primary and secondary education levels.

"*Progress has been made – for example, for the first time, we now have a Dean of Engineering who is a woman [...] Generally speaking, the higher education sector has been a vanguard in promoting gender equality. But, the issue of diversity has really taken hold of universities and gender is seen within a landscape of other issues being pursued – racial equity, diversity in terms of underserved communities. The opening up of the field of diversity means that gender equality is one element in a broader array of diversity strategies. These have prompted processes and procedures – like diversity ombudsman services.*"

These conversations extend beyond the student population and faculty leadership to diversity of curriculum, particularly for social sciences and the humanities. Interviewees argue culture is important, too – particularly behaviour in the classroom.

"*The solutions that can be implemented are around training and awareness – faculty members and heads have a role to play when they see that women [in higher education] tend to be subdued in a certain environment – they don't necessarily intervene or raise their hands as often as their male counterparts.*"

The composition of primary and secondary school heads has also changed, although the barriers to entry may differ – interviewees argue leadership choices in education are driven by demand and supply side factors.

"*Women can be held to higher academic standards. Selection committees are predominantly led by men and are looking for something similar to them or have a tendency to hire men. On the supply side, it is a question of how women don't picture themselves as leaders. There are no role models to look up to, they are bounded by this traditional image that leaders are male, this is so embedded in society. Women will then internalise these ideas that they won't succeed in the job.*"

Addressing these barriers is a complex combination of "pushing on all sides".

"*We need to rethink hiring processes and how we recruit and assess candidates as these may be gender biased. We need to get rid of ideas like "boys will be boys and girls will be chatty, boys are good at maths and girls are good at reading". We need to lead by example and move education forward.*"

Interviewees shared other systemic barriers to address, including the gender pay gap and flexible working allowances, especially for women with family or care responsibilities at home.

Interviewees contend there is also an important element of mentorship and confidence building for prospective women leaders in education.

"*Women will wait until they can do 9 out of 10 of the skills and then they apply for the job, whereas men will just apply. [...] It is switching the narrative around what you can do with confidence and value. If you think about challenging discrimination, you have to build people's confidence to expose it.*"

Networks are key, too. "*You need to have a supportive network and community to help women leaders. We found there was so much more discussion within these networks around other issues like diversity and intersectionality, the gender pay gap and how to work together on these.*"

[43] See https://www.brookings.edu/wp-content/uploads/2016/07/whatworksingirlseducation1.pdf.

[44] See here.

[45] See evidence from UNCIEF "Data Must Speak" programme, available: https://www.unicef-irc.org/research/data-must-speak.

[46] See https://openknowledge.worldbank.org/bitstream/

Outcomes

Early evidence suggests that women led primary schools may perform better than male-led schools. This is supported through UNICEF research that reports better learning outcomes for girls and boys studying under women leaders. UNICEF found eight countries with women leaders (Benin, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Madagascar, Niger, Senegal) performed better in reading, and six countries (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Madagascar, Senegal) saw improved mathematics outcomes.[47]

> "*These results are not anecdotal, they are statistics. In Madagascar, for example, it is gendered – the impact for boys is positive, for girls it is really much more positive. But we know the influence of school leaders extends beyond this to much more qualitative outcomes. Learning environments, wellbeing, motivation, teacher attrition, especially among young teachers 2-3 years in, the role of mentoring and professional development – these need to be tested.*"

Women's representation in leadership positions in education is seen to produce positive outcomes for all learners. Key programs like UNICEF's Women in Leadership Learning are looking to test this more rigorously across these factors.

3.4 APPAREL

Overview

The focus on women's leadership in the broader fashion industry can be assessed through two lenses – production and consumption. For the latter, women make 80% of fashion-related purchasing choices (either for themselves, or for their children or spouses), representing approximately USD15 trillion, but women represent only 12.5% of fashion CEO positions and hold 26% of board positions in Fortune 1000 companies.[48] Of the 61 companies with clothing lines intended for women, 75% have predominantly male corporate teams or leadership structures.

Women play an integral role in the production of apparel, or ready-made garments (RMG), especially in Asian, South Asian and some African countries. The RMG sector in these contexts has expanded with the meteoric rise of fast fashion – in Bangladesh, for example, it contributes approximately USD30 billion (2019) annually, more than 80% of export revenue.[49] In Ethiopia, the sector is forecast to grow by 86% and create 683,000 new direct jobs by 2025.[50]

> "*The RMG sector is very young, the boom started recently – in 2015. We see young workers, 80-90% women, joining the labour market. Most women are at operating level and don't have any prospects because they don't see themselves in leadership positions.*"

This growth in industry has seen the composition of female leaders (production line managers, supervisors etc.) grow slightly, but not without deliberate action.

> "*Five years ago, representation of women leaders in the sector was at 1%, now it is around 2-3%. The data is telling us that mindsets are changing, there is economic participation by women and factories are now starting to look at gender gap analysis, but this shift is very slow. The question becomes how can we move this forward so that we leave no one behind.*"

Outcomes

Fashion companies that raise gender representation in the C-suite by close to one third, stand to raise profitability by 15%.[51] Those with gender parity on boards perform better in corporate social responsibility indicators. Teams with women leaders in mid-/upper-level management have proven to be highly innovative and, on average, generate 20% more patents than teams without gender parity.[52]

The case is more complex on the production side.

> "*Changing the power dynamics in the factory does not follow one track, it is lots of barriers to address. The first is the traditional mindset and existing social norms – some women may be reluctant to take on more responsibilities in leadership positions because of their care burden, they are worried it might be difficult to manage the workload and home demands. The second is the issue of capacity and competency. The typical factory worker has a very limited scope – it is working on a production line to a defined target with no option to grow their skills beyond producing pieces. Very few factories dedicate time to training their workers – it is not in their [management] interest to stop production.*"

Interviewees indicated two pathways to change: securing buy-in from existing factory leaders (through mentorship programs, for example) and providing holistic training / capacity building for women factory workers that consider technical expertise for leadership and personal development goals.

> "*It is that base training and then asking the RMG worker what is your vision? What do you want to achieve in your career? If you want to be a supervisor, auditor, etc, what skills gaps do you have?*"

This enables women workers to make informed decisions about what leadership roles demand and whether to pursue them.

Interviewees shared both quantitative and qualitative outcomes of these programs.

> "*You see a very quick change, even after delivering a short training, in terms of knowledge, attitude, behaviour. Among factory workers who took part, there was improved communication, more self-confidence and a renewed sense of responsibility not just for their work but for their team, which is very important in the garment industry. And piloted lines saw increased line efficiency, reduction of absenteeism and reduced turnover.*"

Following the training, women factory workers were promoted to leadership positions, which brought outcomes for work culture and created a new pool of home-grown talent.

> "*The message we want to convey is that you can have women leaders at any stage of their careers if you give them the right training tools.*"

However, these programs would not have been possible without the buy-in of current (predominantly male) management, "*if the factory management does not change its mindset, nothing will change.*"

[47] See UNICEF. March 2022. Office of Research: *Increasing Women's Representation in School Leadership*. Available here.

[48] Fortune 1000 represents the 1000 largest companies in the United States of America ranked by Fortune magazine – it is a more expansive list (than Fortune 500 or 100) to consider medium sized enterprises like apparel retailers. See Pricewaterhouse Coopers (PwC). 2019. *Unravelling the fabric ceiling: tracking female leadership in the apparel industry*. Available here.

[49] International Labour Organisation (ILO), 2020. *Issue Brief: Understanding the Gender Composition Composition and Experience of Ready-Made Garment (RMG) Workers in Bangladesh*. Available here.

[50] See https://www.ilo.org/africa/technical-cooperation/WCMS_687547/lang--en/index.htm.

[51] See here.

[52] PwC, 2019.

4 CONCLUSIONS AND RECOMMENDATIONS FOR THE EYE HEALTH SECTOR

"We believe that by achieving Gender Equity in Leadership, we can catalyse positive outcomes in eye health for everyone."

This project is not an academic review. It is an attempt to start to test and evolve a starting hypothesis. This report offers an evidence base and a way of thinking about the potential areas of focus for the wider eye health sector as a next step.

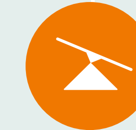
This project frames its response within a recognition that women face structural barriers to change both on the path to becoming a leader and once they are in leadership positions– including gender norms ("men are better leaders"), the double burden of care, higher performance standards, the ongoing gender pay gap, issues of workplace harassment. These barriers are intersecting and the result of generations of power and privilege.

Throughout this work and through the case studies, five lessons have been identified that shed light on the rate of change for women leaders and the outcomes they can support.

PHOTO: DILLON LEIGH

1. Be deliberate. Progress for women leaders is happening, but it is slow and not always intentional.

Over the last five years, there has been positive change to the number of women leaders. In some cases, this is surpassing statistical tipping points and moving closer to parity which has seen shifts in the cultural dynamics of organisations. In other cases, progress is organic and change in leadership is happening slower. Deliberate interventions including quotas or national targets can help to support change – but there are benefits and challenges to this approach which need further research.



OPPORTUNITY:

Wider research into the dynamics of a tipping point and what this could look like / mean for the wider eye health sector. For example this might result in recommendations for quotas or similar responses to support the sector to reach that point.

2. Set women up for success. Recognise the role that training and sponsorship plays in supporting progression.

Compared to men, women have limited access to advice and training opportunities that support their success as leaders. Across sectors, programs that provide mentor support and prioritise upskilling for prospective women leaders have proven helpful. The case studies further support deliberate sponsorship interventions that advocate for capable women to have better access to leadership opportunities.

OPPORTUNITY:

The eye health sector could consider a holistic sponsorship initiative pilot that offers training for prospective female leaders alongside executive sponsorship pairings. This pilot could provide an example / case study (within eye health and beyond) to learn from and replicate.

3. Create an enabling environment. Women leaders succeed when organisations invest in and implement progressive systems and policies.

Using an intersectional lens is important as women may face compounded disadvantage due to their gender but also other characteristics, including age. These could include considerations for the establishment of (global) networks or support systems for women leaders, having male allies and institutional responses like progressive organisational policies for flexible working, maternity / paternity care – and wider diversity, equity and inclusion initiatives. Across case studies, there was a strong argument for making gender a core part of the way the organisation thinks, plans and delivers. Many of the interviewees provided examples of the power of storytelling or lived experience and the impact that can have on organisations.

OPPORTUNITY:

The IAPB Gender Equity Work Group could look to explore and establish new types of networks for women leaders to provide advice, support, community e.g., interdisciplinary, international, cross-sectional and cross-functional, exploring potential for inclusion allies.

4. Build the data and evidence base. Be clear about the change you are trying to make. Set up the right mechanisms to measure, monitor and communicate your progress.

In most cases, outcomes from women leaders are captured anecdotally through the sharing of success stories in the media, among networks, colleagues or friends. International organisations and those working in coalitions can be more purposeful about what they set out to achieve and how they measure and report on this change. This will help to build more transparency and accountability among organisations.

OPPORTUNITY:

The IAPB Gender Equity Work Group could review insight and tools for reporting and sharing of gender equity outcomes, including growing the response rate for the Gender Equity in Eye Health survey, develop tools to track progress and define and set universal and key metrics to track change in women's representation in leadership.

5. Fix the problem, not women.

All of the research and case studies demonstrate the need to overcome structural barriers – even if a woman holds a leadership position, she won't change the system on her own. And it should not be her burden to carry – change requires shared accountabilities. There needs to be collective action across partners / actors in the international community and the key role of existing male leaders to act as allies.

OPPORTUNITY:

Organisations in the eye health sector could consider how they respond to this challenge within their own organisational culture and internal communications. Organisations might consider designing and developing their own inclusion and allyship program to empower all colleagues to think about their roles and how they act in allyship ("being an upstander", behaviour change, internal advocacy etc.).

There could be an opportunity for further external engagement and communications around this theme – for example, the IAPB Gender Equity Work Group could convene new events, debates and conversations to help change the narrative and put the focus on the system, not women.

This initial research and evidence-gathering gives confidence that the hypothesis holds true. Achieving equal representation in positions of power across health, and in sectors outside of health, matters. It supports more diverse voices making decisions around system design, resource spend and policy change. It creates role models for the next generation of future women leaders.

The gender gap in health can only be closed by addressing systemic barriers to women's leadership.

Changing policy and practice in any sector is hard. Tackling systemic barriers to equality is not an overnight job and this is beyond one institution or organisation's capacity to change. We will need to work with others to address and tackle the themes identified.

5 APPENDIX

5.1 PROJECT SCOPE

Overview

This project tests an hypothesis held by The Fred Hollows Foundation (The Foundation) around the potential of parity for women in leadership positions and what this would unlock for eye health services and outcomes.

This project is exploratory. It draws on some academic viewpoints to establish a supporting evidence base and looks to frame the problem through external case studies. This signposts themes or issue areas for the eye health sector to explore in more depth at a later stage.

Gender is one part of other social identities such as ethnicity, race, culture, class, sexual orientation, disability, religion as they apply to an individual or a group. This combination of factors – intersectionality – creates differing modes of discrimination and privilege for different women.[53] Intersectionality is critical to broaden our understanding of bias so that it is more reflective of lived experience. Notwithstanding, **this project is limited to gender only.** An intersectional lens would prove too broad and complex to test in the project timeline. It is an area that the eye health sector might choose to explore further at a later stage.

Project process

The project is based on desk research alongside targeted stakeholder engagement conducted by the consultants Firetail (target=3, actual=10).

5.2 PURPOSE AND USE OF OUTPUTS

This project will produce a developed response to the hypothesis, with a compilation of international case studies that provide an opportunity to test the hypothesis across sectors outside of health. Direct quotes from select interviewees are included throughout the report. The report will conclude by recommending some suggested steps / key questions for the eye health sector to consider and take forward.

[53] See https://theconversation.com/intersectionality-how-gender-interacts-with-other-social-identities-to-shape-bias-53724.

5.1 PROJECT SCOPE

NAME	POSITION	ORGANISATION	SECTOR	FOCUS AREA
Tikhala Itaye	Director of Global Movement Building	Women in Global Health	Health	Global
Lemona Chanda	UN Champion for Change and Bangladesh Chapter Leader	Independent/ Women in Global Health	Health	South Asia
Kidist Chala	Programme Manager, SIRAYE[54]	International Labour Organisation (ILO)	Apparel (RMG)	Ethiopia
Tigist Fisseha	Team Leader for Better Work	International Labour Organisation (ILO)	Apparel (RMG)	Ethiopia
Sophia Kifle Ayele	Trainee Officer, SIRAYE	International Labour Organisation (ILO)	Apparel (RMG)	Ethiopia
Babul Azad	Deputy Project Manager, Women Thrive in Bangladesh[55]	CARE Bangladesh	Fashion (RMG)	Bangladesh/ South Asia
Pierre Gouëdard	Education Researcher, Women in Learning Leadership (WiLL)[56]	United Nations Children's Fund (UNICEF)	Education	West and Central Africa
Jill Berry	Leadership consultant, former headteacher	WomenEd	Education	UK/ global
Jules Daulby	Co-Founder	WomenEd	Education	UK/ global
Vivienne Porritt	Co-Founder	WomenEd	Education	UK/ global
Emmanuel Kattan	Director of the Alliance Programme	Columbia University	Education	United States and Europe
Jennifer de Vries	Organisational consultant and gender strategist[57]	Independent	Governance	Global
Olivia Birkett	Head of Operations	Tennis West	Sport	Australia

[54] SIRAYE aims to promote decent work for women working in textile factories/ industrial parks in Ethiopia, with a key area being to encourage women leaders. See here.

[55] See https://www.care.org/our-work/education-and-work/dignified-work/made-by-women/.

[56] WiLL is a nascent programme that assesses the outcomes of women leaders in primary/ secondary schools across 11 African countries. See here.

[57] See http://jendevries.com/.

ACKNOWLEDGEMENTS

Firetail
Strategy for social progress

firetail.co.uk

Africa's first democratically-elected woman President, Ellen Johnson Sirleaf, led Liberia through reconciliation and recovery following a decade-long civil war and responded to the Ebola Crisis of 2014 – 2015. She has won international acclaim for the economic, social, and political achievements of her administration, and, in 2011, she was awarded a Nobel Peace Prize for her work to empower women.

PHOTO: UN WOMEN / J CARRIER

She says:

"Increasingly there is recognition that full gender equity will ensure a stronger economy, a more developed nation, a more peaceful nation. And that is why we must continue to work."

ELLEN JOHNSON SIRLEAF

The **Fred Hollows** Foundation

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