WomenLift Health

GLOBAL SUMMARY STAKEHOLDER ANALYSIS

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INTRODUCTION LETTER

Dear Colleagues,

Over the last four years, WomenLift Health has worked directly with mid- and senior-level women working in global health to build leadership skills and develop peer networks to change the face of leadership in the sector. As WomenLift has increased our footprint with the number of fellowship participants in our signature Leadership Journey program and expanded into new geographies, we have upheld our values of being a data-driven, learning organization whose program designs are driven by local voices.

To this end, we have recently completed a series of stakeholder analyses in the countries and regions where we already operate—North America, India, and East Africa—as well as in Europe and Nigeria, where we soon plan to expand. In each geography, we have partnered with local research organizations to interview relevant stakeholders about what they see as the greatest barriers and enablers to women's leadership to develop an understanding of the unique context in each country/region. We use this data, along with ongoing feedback we collect from our participants and partners, to ensure our programing aligns with the distinct needs in each place and responds to shifts in the context as needed.

As we conducted these assessments, interviewees frequently expressed interest in the findings—especially given the dearth of available data about women's leadership, specifically in the global health sector. Thus, we are pleased to share our findings in the interest of transparency and with the hope it can encourage others to contribute to this global movement. We found the similarities and differences across the countries to be fascinating and hope you will too.

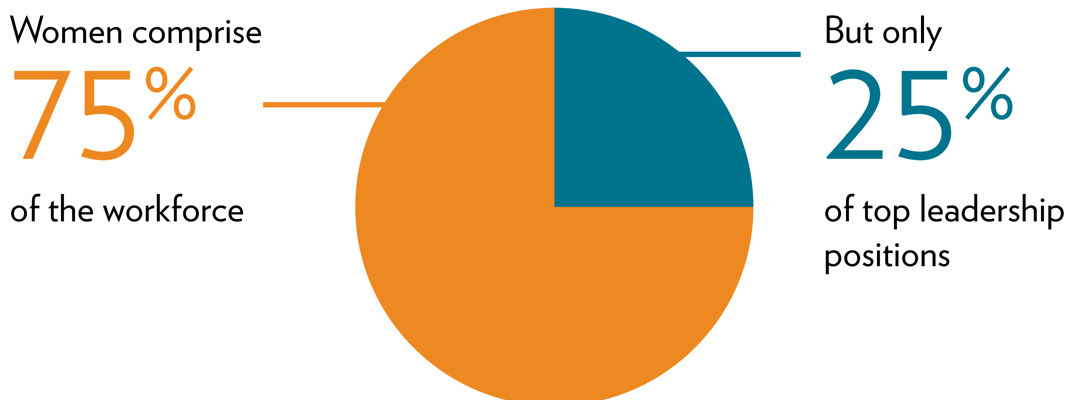
Sincerely,
Amie Batson

SUMMARY

The **World Bank's 2023 Women, Business and the Law Report notes** that,

> "last year, despite multiple overlapping global crises, most parts of the world strengthened legal gender equity across all areas measured.

Nevertheless, the most recent **United Nations' Development Programme's (UNDP) Gender Social Norms** Report reveals no improvement in biases against women in a decade, even across differences in region, income, level of development, and culture. **UNDP** has also found that 40 percent of people worldwide still believe men make better business executives than women. The effects of these biases are evident in the global health sector, where women comprise 75 percent of the workforce but only 25 percent of top leadership positions, according to the **World Health Organization.** Additional research conducted on behalf of WomenLift Health explores some of the ways this bias shows up across regions it currently or plans to work in and discusses the unique barriers and enablers of women's career development in this industry.



STAKEHOLDER ANALYSIS

As part of WomenLift's commitment to data-driven approaches, a two-pronged formative evaluation is conducted to inform each individual Leadership Journey—a yearlong leadership development fellowship for mid- and senior-level women working in the global health sector. The program first conducts a "Discovery" process, eliciting feedback directly from mid-career women to inform the design of the Leadership Journey.

A subsequent Stakeholder Analysis targets more senior leaders at influential public health institutions to understand the landscape women are working within—both at the organizational level and the national public health system.

This larger systems view informs both the Leadership Journey and WomenLift's larger advocacy agenda.

WomenLift partnered with research firms in each focal country/region to develop an understanding of the local context and design a process that accurately captured the nuances from those interviewed. The Stakeholder Analysis reports include results for India, Nigeria, Kenya, Rwanda, Uganda, United States/Canada, and Europe. Nigeria and Europe had not previously completed Discovery, so these two studies include both exercises.

The primary research questions (RQ) for the Stakeholder Analysis were:

RQ1: What are the barriers and opportunities around women's leadership in public/global health to address in the program design?

RQ2: What are current efforts that foster women's leadership, diversity, and inclusion within organizations?

RQ3: What are the various ways organizations and the WomenLift program may work together?

The study also sought to identify the influential institutions in each of the geographies within WomenLift works, begin to establish relationships with them, and understand opportunities for potential partnerships.

OVERALL METHODOLOGY

The Stakeholder Analysis began by identifying the most influential organizations in public health within each country. The research teams prioritized organizations and individual senior- or executive-level leaders within these organizations to interview on the topic of women's leadership in public health within their respective countries and organizations. The teams also conducted literature reviews to contextualize the interview findings. The Nigeria team used a focus group discussion to further elaborate on some common themes that arose through the interviews.

FINDINGS

CROSS-CUTTING BARRIERS

There was an overwhelming sense from those interviewed, across all countries, that progress has been made over the last few decades. Almost all countries have legal frameworks in place to protect women in terms of sexual harassment, job protection, and pay equity, among others. Every country, with the notable exception of the United States, had national level maternity/parental leave policies to assist working parents. However, despite the prevalence of legal protections against gender-based discrimination, women in all the countries studied face discrepancies in pay and representation in senior leadership positions relative to their male peers.
In all focal countries, the persistence of traditional gender stereotypes is a barrier to career advancement. Women are still largely considered the default caretakers in their home lives, which creates real and perceived limitations to their ability to prioritize their professional responsibilities and achieve work-life balance. Examples of sexism in the workplace provided by respondents ranged from subtle to overt, but most often included not having their ideas heard in meetings and being passed over for opportunities, either because they are considered less competent than men or less able to undertake greater responsibilities due to home life demands, especially during childrearing years.
Those who take time off during these years, even as part of nationally mandated parental leave, often face steep career penalties when they return.

Another ubiquitous consequence of gender stereotypes is "imposter syndrome," a form of internalized sexism that limits women from pursuing their own career aspirations. A widespread dearth of senior women mentors and role models also inhibits women's ambitions in most countries reviewed, contributing to a limited pipeline of willing, eligible women leaders. Relatedly, the persistence of "old boys' clubs," especially in the historically male-dominated health sector, often keeps even the most dedicated women outside of top positions, which tend to be very limited and demanding, regardless of their family commitments. In North America and Europe, these phenomena are even more acute for women of color, and similar dynamics occur in India and Kenya for women from minority groups.

CROSS-CUTTING OPPORTUNITIES

The most cited opportunity to increase women's leadership across geographies was to increase male allyship. There was universal agreement about the important role men play in supporting women's professional success, both formally and informally—namely by listening to women, mentoring them, advocating for them, and promoting them. Most respondents interviewed for the Stakeholder Analysis saw the greatest opportunities to increase women's leadership by targeting institutional-level reforms. For example, there were mentions across countries about the need for equitable policies for hiring, salary negotiation, and promotions, or in some cases, better operationalization of the policies that are in place. Many others called for an expansion of policies or other forms of support for working parents, like flexible schedules, telework, and provision of/subsidized childcare.

In all focal countries, respondents saw continuing needs for talent development programs, whether they be formal mentorship, training, coaching, or other creative ways to develop both leadership and technical skills. Several pointed out that leadership development must begin early, before they reach the mid-career point; in Rwanda, Nigeria, and India, respondents also called for increased educational opportunities for young girls nationwide, targeting the pipeline of future leaders from a young age.

GLOBAL MOVEMENTS TO PROMOTE WOMEN'S LEADERSHIP AND DEI

Nearly all countries reviewed have had a recent expansion of laws intending to promote gender equality.
For example, the United States (at the state level), Canada, the European Union, India, and Nigeria have all increased available parental leave—often for both parents—in recent years. Though these policies do not aim to boost women's leadership directly, they are enablers for working mothers to continue participating in the workforce. Likewise, most people view the normalization of flexible hours and telework resulting from the COVID-19 pandemic as helpful for retaining working parents in the workforce. However, various women in North America noted that it is too early to tell if there will be unintentional, adverse consequences of these policies due to the increased risk of proximity bias.

International movements like #MeToo and Black Lives Matter have also influenced institutions around the world to adopt measures that curtail gender, racial, and other forms of discrimination in the workplace, particularly in the Global North. Organizations from nearly every country interviewed mentioned having recently implemented or updated diversity, equity, and inclusion (DEI) policies. These policies often target recruitment processes in an effort to diversify staff and make the workplace more accessible to different types of people, though the nature and comprehensiveness of these policies vary considerably by country and organization.

OPPORTUNITIES FOR COLLABORATION

Organizations across geographies saw different possibilities to work with WomenLift to increase women's leadership in the global health sector.

In North America, Europe, and India, most respondents were keen to share the Leadership Journey opportunity with their networks and nominate potential fellows. Organizations in North America and Europe expressed interest in receiving trainings from WomenLift, whereas organizations in India, Nigeria, Uganda, Kenya, and Rwanda expressed interest in co-creating or collaboratively facilitating trainings.

Organizations in Rwanda, Nigeria, Kenya, and North America also saw opportunities for advocating either in national or sector-wide levels for reforms that may ultimately benefit women's representation in global health leadership.

RECOMMENDATIONS FOR WOMENLIFT HEALTH

Respondents in Nigeria, Europe, Uganda, Kenya, and Rwanda encouraged WomenLift to work with existing organizations and initiatives to continue developing women's leadership capacity, especially from a young age.

Respondents in India, Nigeria, and the United States recommended that WomenLift focus on efforts to strengthen male allyship in those countries.

Organizations in India, Europe, Kenya, and North America suggested that WomenLift target institutional-level reforms, e.g., promoting DEI policies and practices and adopting benefits that provide better support for caretakers.

Recommendations specific to each geography are included in the country-specific report and summary.

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