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EDITORIALS

How serious are global health leaders about gender equality?

Not at all serious, according to a new report

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In the past year unprecedented public attention has been given to gender based discrimination and inequalities, and demands for a fairer world for women. Closing the gender parity gap, however, seems a distant reality across multiple dimensions—economic participation, political empowerment, and health.[1]

But it is not only a women's issue. Gender based inequalities can disadvantage women, men, and those with diverse genders.[2] Gender norms prevalent throughout society affect health behaviours, care seeking practices, health systems responses, and health outcomes.

That women's and men's positions in society affect their life chances and their access to health promoting resources is well established.[3] In most countries, men die younger while women have a higher risk of morbidities linked to their reproductive roles, a lower status in society, and gender norms that impair their agency and bargaining position in sexual relationships. Men's poor health is also affected by gender norms around masculinity, exposing them to risk environments and harmful products, including alcohol and tobacco, which are promoted by commercial interests.[4] People who do not conform to gender binaries remain stigmatised and, in many institutional and policy contexts, invisible.

Attaining equality of genders, therefore, benefits everyone. Yet, this "common sense" has not filtered through to inform institutional priorities and governance in global health and development. The inaugural report of the Global Health 50/50 Initiative, released on international women's day, is a stark reminder of this.

The report examines the gender responsiveness of the world's most influential global health organisations, considering how gender is understood, represented, and applied in their workplace policy and programmes. Building on previous analysis of 18 global health public- private partnerships,[5] the report examines 140 institutions that play a prominent role in financing, governing, and delivering global health. These include UN organisations, philanthropic organisations, private corporations and consulting firms, and civil society organisations. Their commitment to gender equality in the programme policies they support is scrutinised, as well as their workplace.

Among the report's findings are that only half of the organisations examined make an explicit commitment to gender equality, and fewer than one third define gender in a comprehensive way that accounts for social construction of norms, roles, and unequal power relations. Comprehensive understanding of gender is the first step towards adopting a gender perspective in global health programming and priority setting. Many organisations, however, continue to regard gender as synonymous with women's health.

A closer look at how commitments to gender equality are reflected in their own governance and programmes reveals a bleaker scenario. Around 80% of the institutions in the report do not have either women chairs or gender parity in their boards of governance, and only 30% are headed by women, indicating that decision making is still dominated by men. Monitoring gender commitments in health programmes, at a minimum, requires routine reporting on programmatic data disaggregated by sex. However, only one third of organisations report sex specific data, while trans health data was reported by only one.

The overall message is clear. Most organisations surveyed were profoundly unresponsive to gender inequality, with far reaching implications for population health globally. Barring a few, these organisations are neither transparent nor accountable for these failings.

This timely report should be a tipping point in the struggle for accountability and action on gender inequality in global health, but critical questions remain.

Firstly, to what extent is the enthusiasm and concern among researchers shared by political leaders, policy makers, and funders? As Helen Clark notes,[6] institutional inertia and path dependency explain global health actors' unwillingness to align their funding priorities with shifting disease burdens and epidemiology. This has resulted in overwhelming attention given to three infectious diseases (HIV, tuberculosis, and malaria) and maternal health, at the expense of other priorities,

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such as neglected tropical diseases and non-communicable diseases, and a myopic view of women as mothers.

Secondly, how does tackling gender equality in global health sit within a broader political and economic restructuring of global health governance? We know that decision making occurs in a fragmented policy arena, with a prominence of non-state actors and commercial interests. These multiple actors and their vertical orientations have led to pressing gender equity concerns and a shift away from a focus on the economic, political, social, and commercial determinants of health. [7 8] This shift should prompt closer attention to the unintended gendered effects of global health programmes.

Evidence from low and middle income countries suggests that development and microfinancing projects have destabilised gender relations in communities and households, leading to greater violence and food insecurity among women.[9 10] Furthermore, a crisis of neoliberal (free market based) capitalism and development has intensified gender inequalities in many countries, pushing women into either unpaid or informal and precarious forms of labour.[11] The actions of these global institutions—especially corporations that profit from exploiting gender representations and behaviours—demand deeper analysis.

A further challenge lies in moving beyond gender binaries and tackling inequalities in gender with all its fluidity and complexity. While having more women in decision making positions is important, we need more substantive representation of women and transgender people from low and middle income countries, and recognition of institutional biases and blindness to issues of diversity.

We also need stronger accountability mechanisms to remove the layers of disadvantage and discrimination that structure our lives in workplaces and at home. Transformative change must be radical, inclusive, and ensure that action for gender equality is not confined to global elites and does not simply reproduce existing power imbalances.

The Global 50/50 report offers a strong impetus for action—an opportunity for the global health community to revisit priorities, seek explanations for gender disparity, and for global health organisations to demonstrate a firm commitment to change.

I have read and understood BMJ's policy on declaration of interests and declare the following interests: none.

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