

Power, privilege and priorities



GLOBAL
HEALTH
50/50
REPORT

20
20

Power, privilege and priorities

GLOBAL HEALTH 50/50
REPORT 2020

A review of the equality- and gender-related policies and practices of 200 global organisations active in health and health policy.

Cover photo:
Markevich Volha Fedarauna poses at the house.

Andrei Liankevich, winner of the 2020 Global Health 50/50 Photo Contest, This is Gender.

A widowed woman sits at her home in Belarus. Surrounded by flowers, embroidery and dolls, she dries grain on her carpeted floor. Women outlive men in every country in the world. In Belarus, there are more than twice as many women as men above the age of 74. Here Liankevich explores how new identities can flourish in the later years of a woman's life.

The Global Health 50/50 initiative is hosted by the University College London Centre for Gender and Global Health. Global Health 50/50 was co-founded by Professor Sarah Hawkes¹ and Dr Kent Buse.² It is staffed with a dedicated collective of researchers, strategists and communications experts working on a largely voluntary basis: Wafa Aftab, Imogen Bakelmun, Emily Blitz, Jesse Bump, Tiantian Chen, Mireille Evagora-Campbell, Iaria Galizia, Mikaela Hildebrand, Ruth Lawlor, Rebekah Merriman, Kristine Onarheim, Anna Purdie, Artricia Rasyid, Geordan Shannon, Ashley Sheffel, Sonja Tanaka, Nina van der Mark, Kate Williams, Zahra Zeinali and Laure-Anais Zultak. Sonja Tanaka and Anna Purdie co-ordinate and manage the GH5050 collective.

The initiative is guided by a diverse independent Advisory Council³ to whom we are deeply grateful.

Thank you to Blossom for graphic design and afh. for communications support.

This report was supported by a grant from the Wellcome Trust [210398/Z/18/Z] 'Global Health 50/50: Towards accountability for gender equality in global health.'

Suggested citation:
Global Health 50/50, 'The Global Health 50/50 Report 2020: Power, Privilege and Priorities', London, UK, 2020.

#GH5050 #PowerPrivilegePriorities
@GlobalHlth5050
www.globalhealth5050.org
info@globalhealth5050.org
media@globalhealth5050.org

¹ Director, Centre for Gender and Global Health, Institute for Global Health, University College London, UK

² Chief, Strategic Policy Directions, UNAIDS, Switzerland

³ <https://globalhealth5050.org/advisory-council/>

Contents

Foreword by Michelle Bachelet

Preface by the GH5050 Collective

15 -

SECTION 1. Overview

Facing up to a broken system: a summary of Power, Privilege and Priorities in global health	16
About this report	20
Summary of key findings	22
The global health agenda: which priorities and for whom?	29
Global health: How global? (Map)	30

SECTION 2. Our Findings

Examining the equality- and gender-related policies and practices of 200 global organisations active in health and health policy

I. Commitments to Redistribute Power	34
Public commitment to gender equality	34
Definition of gender	40
Takeaways	43
II. Policies to tackle Power and Privilege imbalances: Gender equality and diversity policies at work	44
Workplace gender equality policies	44
Workplace diversity and inclusion policies	50
Board diversity and inclusion policies	53
Takeaways	56

32 -

III. Who holds Power and enjoys Privilege?: Gender and geography of global leadership in health	58
Gender parity in senior management and governing bodies	58
Gender of CEOs and Board Chairs	61
Demographics of CEOs and Board Chairs	64
Takeaways	70
IV. Do global organisations address the gendered Power dynamics that drive inequalities in health outcomes?	74
Gender-responsiveness of global health programmes	74
Sex-disaggregated monitoring and evaluation	80
Takeaways	84
High scorers	86

88 -

SECTION 3. The global health agenda: which priorities and for whom?

Are global health organisations aligned with the health agenda established by the SDGs?	90
What is the burden of disease associated with the SDG health-related targets?	92
Are organisational priorities aligned with the distribution of the burden of disease?	93
Takeaways	97

98 -

Glossary	98
Performance by sector	100
Methods	104
List of Organisations	108

Including conversations with:

• Catherine Ohura, CEO, Global Health Innovative Technology Fund	38	• Catherine Kyobutungi, Executive Director, APHRC	78
• Samantha Stokes-Baydur, Deputy Head of Human Resources, Global Fund to Fight AIDS, Tuberculosis and Malaria	48	• Samira Asma, Assistant Director-General, for Data, Analytics and Delivery, World Health Organization	80
• Rosanna Duncan, Chief Diversity Officer, Palladium	72	• Yogan Pillay, Deputy Director-General, National Department of Health, South Africa	82

#ThisisGender Photography Contest Images:

• The Prince, Camilla Douraghy	6
• Tea Workers, Suvro Paul	14
• Untitled, Micha Serraf	32
• Buren Dalliance, Marie Muller Priqueler	37
• Dogoyaro, Nnebuife Kwubei	83
• Life partners, Digwas G Hegde	88

Explore the Gender and Health Index and individual organisational performance at globalhealth5050.org/data



The prince
Camilla Douraghy

Part of the Opium Den series, The Prince explores the construction of "The Orient" as a place of opulence and sexuality in the social imaginary. Drawing on Edward Said's seminal concept of 'orientalism', the work interrogates and challenges the gendered othering of the 'Eastern man' as submissive, voiceless, seductive and feminine in contrast to the dominant, moral and masculine West.

Camilla Douraghy is an Iranian-American photographer and philosopher.

Foreword

Inequalities in health deeply touch people's ability to pursue their life aspirations and to realise their human rights. However, the right to health is not equally realised by all. We can do better. Inequalities in health, and denials of human rights, can be a matter of life and death for women, girls and gender non-conforming individuals. Harmful gender stereotypes continue to exist and directly influence people's bodily autonomy, risks of ill health and early death. These gender norms also play a critical role in shaping health-seeking behaviours and determine who gets services and when and how they are provided.

Delivering on the right to health without discrimination will simply not be possible without addressing one of the fundamental demands of our era: gender equality.

Gender equality is no different from any other human right, and is a prerequisite for delivering on the transformative agenda of the Sustainable Development Goals (SDGs) and its promise to "leave no one behind." Respect for gender equality is a necessity and an obligation for everyone, everywhere, always. If we want to have fairness in our societies, inclusion, diversity and gender equality must be a driving force.

Global Health 50/50 has established itself as the world's leading authority on gender equality in global health. Its annual Gender and Health Index provides a comprehensive, in-depth analysis of the gender-related policies and practices of 200 global health organisations. By putting its data in the public domain, GH5050 provides a mechanism through which to hold these organisations accountable for their progress on gender equality. In so doing, GH5050 provides a unique vehicle to reinforce the operationalisation of the right to health.

This report demonstrates that the current global health system is failing to embrace gender diversity and respond to gender inequalities. I therefore join Global Health 50/50 in calling for gender-responsive health programming as a critical enabler of the right to health—and indeed all human rights—of all people and as a pathway to delivering across the SDGs.

The report forecasts that it could take more than 50 years to see gender parity at the senior levels of these organisations—another half century is too long to wait. I



“

I join Global Health 50/50 in calling for gender-responsive health programming as a critical enabler of the right to health—and indeed all human rights—of all people and as a pathway to delivering across the SDGs.

”

**Michelle
Bachelet**

*United Nations High Commissioner
for Human Rights, former President of Chile*

call on leaders of these organisations to heed the report's call to action and inject more urgency into their efforts to implement commitments made towards gender equality. It is time to truly level the playing field for all staff, transform organisational cultures, ensure equal opportunity and to model behaviour for the international community.

I am encouraged to see this year's report push the analysis to strengthen our understanding of the relationship between gender and other related systems of power and privilege such as age, nationality and educational background. The intersection of multiple forms of discrimination and inequalities has a devastating impact on opportunities and outcomes in global health and things must change.

We need to mobilise across the world—peacefully and powerfully—to advance on rights, dignity and diversity for everyone. By shining a light on equality- and gender-related practices in global health, Global Health 50/50 reminds us that the health sector needs to lead and advances a powerful incentive for change in this urgent struggle. It is imperative that global health leaders match their words and commitments with action by investing in and delivering gender-transformative health programmes.

Preface

This report reviews the equality- and gender-related policies and practices of 200 global organisations active in health and health policy. The report, and its accompanying Gender and Health Index, provides the single-most comprehensive analysis on gender equality and the distribution of power and privilege in global health. Through these vehicles, we aim to inform, inspire and incite action and accountability towards equality in the workplace and in global health policies and programmes.

Gender has a fundamental bearing on how power and privilege are distributed and maintained, and is a key determinant of everyone's health and wellbeing. Gender also acts as a gateway to revealing and understanding opportunity, expectations and achievements along a number of structural and social stratifiers, such as class, geography, ethnicity/race, age and (dis)ability.

This report steps through that gateway. It urges actors and organisations to interrogate systems of power—global, national and local, interpersonal and institutional—and how they undermine an equitable and effective global health system. It also urges an assessment of how social and political structures intersect with one another to drive vulnerability and ill-health among those with less power.

It is time to face up to the entrenched power dynamics at play in global health. We find that more than 70% of leaders in our sample are men, more than 80% are nationals of high-income countries and more than 90% were educated in high-income countries. This strikes us as a system that is neither fair nor fit-for-purpose. We believe that the health and well-being of people around the world will benefit from—and require—diverse leadership.

“

Confronting the 70-80-90 'glass border' in global health: more than 70% of leaders in our sample are men, 80% are nationals of high-income countries and 90% were educated in high-income countries

”

Activists and their allies have compelled decision makers and organisations to confront discrimination, inequity and the historical underrepresentation of some groups in the field of global health. A primary aim of this report is to catalyse faster progress in this journey by enabling a degree of enhanced accountability through rigorous evidence.

A second aim of this report is to recognise the role that gender plays in driving health outcomes in everybody—men, women, and people with non-binary gender identities. In our male-default world, gender as a driver of everyone's health, including men and boys, often remains under-appreciated and under-addressed. Our report captures the extent to which the global health system is addressing and acknowledging gender as a universal health determinant.

Our third aim is to unite the fragmented and sometimes competing global health world around a fair, relational understanding of gender. In 2020, the very concepts of gender and gender equality, and those who dare to promote it, are under attack worldwide. Given the highly politicised and contested environment in which many concerned with gender work, we recognise that some organisations are suffering financially and in other ways from their position on gender and gender equality. Now is the time for the global health ecosystem to be clear and resolute in both what gender means and that gender equality benefits everyone—in line with leaving no one behind and the right to health for all.

At Global Health 50/50, we recognise our own shortcomings in diversity and access to opportunity. Our collective is built of people who are primarily women at the start of their careers and who are in the privileged position of being able to work flexibly and not rely on this work as a primary source of income. We commit to reflecting on the biases and limitations within our own collective, and introducing more inclusive ways of identifying people who wish to work and partner with us—representing a greater variety of genders, social classes, geographies, nationalities and career stages.

To date, our focus has been the global operations of organisations active in health. This was a strategic decision. Organisations must get their own houses in order if they are to be credible gender and equality champions in countries. Real impact, however, lies in so-called grassroots mobilisation to demand that government health policies and programmes are gender-responsive—only this approach will ensure the sustainable generation of equitable health outcomes for all. As such, GH5050 intends to enter into partnerships with advocates and organisations that seek to advance evidence-informed advocacy on gender equality and diversity in health in select countries.

We close with a thank you to those people who are using the power and privileges at their disposal to push for gender equality, including our Advisory Council. We are also grateful to colleagues that challenged us to expand our lens beyond gender. May this report further fuel the collective demand for a more critical, political understanding of the field of global health, and for action to stamp out the causes of health inequities around the world.

#ThisIsGender

Global Health 50/50 Photo Contest

Global Health 50/50 hosted its first global photo contest in late 2019 on the theme of gender, intersectionality and health. The contest invited photographers of all levels to capture representations of what gender—for men, women and/or people with diverse gender identities—looks like in their communities.

GH5050 was honoured to receive nearly 400 submissions. Photographers represented at least 53 nationalities from all regions of the globe and submitted images taken in at least 67 different countries.

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 how imagery can reinforce power, privilege and priorities in global health, and the representational politics and visual ethics at play in global images of gender.

Explore many more images at globalhealth5050.org/thisisgender.

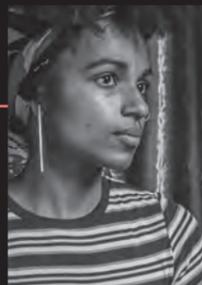
We are grateful to our panel of judges:

James Chau,
host, The China
Current; United
Nations Goodwill
Ambassador

Yagazie Emezi,
artist and
self-taught
documentary
photographer,
based in Nigeria

Sahra Mani,
award-winning
filmmaker,
university lecturer
and founder of
Afghanistan
Documentary House

Elena Fortes,
co-founder
of No Ficción and
Ambulante, Mexico's
largest documentary
film festival



HOW GH5050
UNDERSTANDS
POWER, PRIVILEGE
& PRIORITIES
AND APPLIES THEM
IN THIS REPORT

Power

The ability to influence and control material, human, intellectual and financial resources to achieve a desired outcome. Power is dynamic, played out in social, economic, and political relations between individuals and groups.

Privilege

A set of typically unearned, exclusive benefits given to people who belong to specific social groups.

Priorities

Those issues and populations towards which political and financial resources are allocated.

Section 1

Overview

The 2020 report takes an in-depth look at power, privilege and priorities in global health. Its review provides an unprecedented bird's eye view of the global health system today.



Tea Workers
(Srimangal district, Bangladesh, 2017)
Suvro Paul

Suvro's Tea Workers explores the intergenerational economic realities of life as a tea worker. At 65, Chandan earns the equivalent of \$1.16 per day. As he grows too old to work, it will be his grandson who inherits the responsibility of supporting the family. At once desperate and hopeful, Suvro encourages us to question how economic inequality intersects with masculinity to limit opportunities, health and wellbeing.

Suvro Paul is an economist and amateur photographer from Bangladesh.

Facing up to a broken system

The 2020 report takes an in-depth look at power, privilege and priorities in global health. It provides an unprecedented bird's eye view of the global health system today.

We find evidence of a system in need of urgent change. Its failings have profound consequences measured in early deaths, unnecessary disabilities and enduring injustices and inequalities. We see three major fault lines: the continued expression of historical power imbalances, inadequate progress on gender equality and diversity within organisations, and the systemic lack of attention to major burdens of disease and the role of gender in driving ill-health.

These failings are neither inevitable nor irreparable. The field of global health has long been a beacon for global solidarity and has delivered remarkable gains for people. Over recent decades, the sector has transformed itself in the face of changing risks, advances in knowledge and in response to community demand. Time and again, actors and activists in global health have achieved the seemingly impossible—from the people-powered movement to combat the harmful effects of the promotion of breast-milk substitutes on child survival, to the adoption of the Framework Convention on Tobacco Control, the first international treaty negotiated under the auspices of WHO, to the roll-out of antiretroviral treatment to 25 million people (and counting) living with HIV around the world.

The findings of this report demonstrate that the field of global health is primed to transform itself once again to effectively tackle the challenges of the SDG era. It reveals growing commitment to issues of equality and organisations' ability to make meaningful and rapid change. The number of organisations with public policies to advance gender equality in the workplace has increased by 25% in just two years. The proportion of women board chairs jumped from 20% to 26% in the same period. The proportion of organisations with at least one-third women in senior management increased by nearly 10%. An inspiring movement to shift power is strong and growing.

The data reported here however reaffirm an urgent case for more rapid change. The fault lines it reveals call for serious self-reflection, courage and action on the part of global health organisations to fully deliver on their potential:

One, power asymmetries continue to plague the global health architecture, which are rooted in a long heritage of unequal and unfair relationships, including colonialism, imperialism, post-World War II governance structures and patriarchal norms and practices. These asymmetries are most starkly evidenced by our finding that 85% of global organisations active in health and health policy are headquartered in Europe and North America. Two-thirds are headquartered in just three countries: Switzerland, UK and USA (page 30). The geographical concentration of institutional power extends to the characteristics of global health

leaders, over 80% of whom are nationals of high-income countries, and over 90% of whom completed their education in these economically rich countries (page 64).

Two, patterns of privilege drive a troubling lack of gender equality and diversity within global health organisations. Organisations are failing to achieve diversity and equality in positions of power and leadership. Over 70% of CEOs and board chairs are men, while just 5% of leaders are women from low- and middle-income countries (page 64). Gender parity will not be reached among CEOs for 40 years if current trends persist. At the level of senior management, gender parity will not be achieved for at least a half century or more (page 64). Greater diversity is a social justice imperative in itself, and is also associated with more effective organisations.

Three, global priorities have not kept pace with changing health needs and fail to adequately address gender. We find a startling mismatch between global burdens of disease and the stated priorities of global health organisations and funders. Further, we find a lack of recognition of and action on addressing gender norms (a so-called 'gender-blindness'), despite the role gender plays in driving health inequities (page 74). Failure to comprehensively address all leading health issues and apply a gender lens to policies and programmes will likely result in some people being denied their right to the highest attainable standard of health and wellbeing.

Towards a new era in global health

With only a decade left until 2030, the skewed distribution of power, privilege and priorities is undermining global efforts to reach the health-related Sustainable Development Goals. It is time to face up to the uncomfortable questions of whose interests reign in perpetuating the present governance arrangements in global health, why major burdens of ill-health remain disproportionately neglected and why too few organisations consider and address the impact of gender on their health investments and advice.

Remarkable progress has been made in improving the health of people around the world. A more representative and diverse global health system is likely to be even more effective in providing support to communities and countries to create fairer and healthier societies.

This year marks the 25th anniversary of the Fourth World Conference on Women held in Beijing, and the dawn of the Decade of Action to achieve the SDGs. At this pivotal moment, our responsibility is to fix the system to reflect our priorities of today and tomorrow, not of the past. We know it is needed and we are convinced it is possible.

Global health and the long shadow of colonialism

Exposing the patterns of the past to break their hold on the present

Advancing equality is a defining objective in global health, and a full three-quarters of the organisations reviewed in this report publicly commit to social justice and gender equality. But progress towards equality has been persistently elusive. In part, the challenge of advancing equality is that it depends on broad societal advancement. This is at odds, however, with global health's lineage of colonial medicine, which focused on single diseases and did not build the systems that broadly protect and promote public health.

A critical element of colonialism itself, colonial medicine was concerned with protecting European health, maintaining military superiority and supporting extractive industries. While colonial physicians and scientists made substantial contributions to medicine, they worked almost entirely on health issues that were unique to the colonies, which in part reflected a competition for knowledge and prestige using material unavailable elsewhere. In doing so, they established a focus on infectious diseases exclusive to the colonies—an interest that has been inherited by global health today.

Accordingly, colonial medicine emphasised malaria, yellow fever, sleeping sickness and other specific diseases, and quickly came to focus on narrow bacteriological approaches to disease control. The emphasis on controlling diseases this way reduced the need to secure

cooperation from indigenous people. In the colonial and post-colonial periods, European and American specialist interest groups have followed this pattern, using their leverage to shape a continuing concentration on diseases through, for example, public-private partnerships for drug development. Similarly, virtually all of the major pharmaceutical manufacturers either produced, or have evolved from firms that supplied medicines to sustain colonialism.

Over the same period in the late 19th and early 20th centuries, metropolitan societies developed urban sanitation, municipal water supply, public housing and other public health measures as a complement to advancing knowledge and control of specific infectious agents. These broader interventions were deployed only selectively in the colonies and never as part of an inclusive state-building process. This form of systems-building thus did not enter the heritage of what was to become global health and remains underutilised today.

Post-independence, population control was one of the key elements in the evolution of colonial medicine into international health. While priorities and approaches shifted, international health continued to take on ideas powered by colonial relationships and the economic interests of former colonial powers. International health was thus very much linked to concerns with the so-called 'population explosion' in the 'third-world' and among low-income communities domestically.ⁱ This focus was to later be situated in more people-centered concerns about reproductive health and rights, but the focus on women's reproductive health remains prevalent in global health.

Today, alternative approaches and agendas are emerging. While rich and poor countries alike signed on to Agenda 2030, there are many deep disagreements. For example, the G7 (Canada, France, Germany, Italy, Japan, UK and US) and the BRICS (Brazil, Russia, India, China and South Africa) have divergent views of global health priorities.ⁱⁱ As new regional and global health bodies are established in low- and middle-income countries, and older organisations explore alternative structures to share and shift power, calls to decolonise global health grow louder around the world.

Waldemar Mordecai Wolffe Haffkine inoculating a community against cholera in Calcutta, March 1894. Credit: Wellcome Library.



The Pasteur Institute Hospital, Kasauli, India: Indian patients grouped outside the inoculation building awaiting rabies vaccination. Photograph, ca. 1910. Credit: Wellcome Library.



From an album compiled while serving on Sleeping Sickness Commission, Uganda and Nyasaland, 1908 - 1913. Credit: Wellcome Library.



"If corrective measures to check this human flood are not taken right here and now, the resulting world-wide misery, strife, revolutions and war will make our experience in Vietnam appear minor by comparison." New York Times, 1969. Credit: Princeton University Library



ⁱ Hartman B. *Reproductive Rights and Wrongs: The Global Politics of Population Control*. South End Press, 1995, Boston; pp. 101-105.

ⁱⁱ McBride B, Hawkes S, Buse K. *Soft power and global health: the sustainable development goals (SDGs) era health agendas of the G7, G20 and BRICS*. *BMC Public Health*, 2019, 19(816).

About this report

The third Global Health 50/50 report reviews the gender-related policies and practices of 200 organisations. These are global organisations (operational in more than three countries) that aim to promote health and/or influence global health policy (see Box 1). The sample covers organisations from 10 sectors, headquartered in 33 countries across seven regions and which, together, employ an estimated 4.5 million people.

The 2020 Report assesses global organisations on their progress towards gender equality in four dimensions:

- Commitment to gender equality
- Gender equality and diversity policies at work
- Gender and geography of global health leadership
- Gender-responsiveness of health policies and programmes

This year's report brings increasingly rigorous approaches to existing variables, reflecting the evolving discourse on gender and the need to continue to raise the bar in what constitutes sufficient or good practice.

Comparisons in annual performance are reported for organisations and variables that have been consistent from 2018 to 2020 (139 organisations, across five variables). Practical examples of good practice are also presented through a number of case studies and policy excerpts.

Box 1. Why does Global Health 50/50 review private for-profit organisations?

In many societies and households, private companies play a major role in influencing people's health outcomes. In a direct way, companies employ people and produce the medicines, food and goods we consume on a daily basis. In less visible ways, the private sector influences preference, habits and values through marketing—with budgets that often dwarf that of ministries of health. They also wage well-resourced, sophisticated lobbying efforts to promote or block policies that often have considerable public health implications.

The particular for-profit sample in this report has been identified as clearly indicating an interest in influencing global health policy: the 42 companies were either corporate participants in the Business and Health Action Group of the Global Business Council,¹ which provided a platform for the engagement of business in setting the health-related targets of the SDGs, or contributed to consultations on the Uruguay Road Map on noncommunicable diseases.²

The inclusion of any organisation in this analysis neither indicates GH5050's endorsement of its activities, nor that GH5050 considers the organisation to be contributing to advancing population-level health.

Our reports

2018

The Global Health 50/50 Report

The inaugural GH5050 report presented data on 140 organisations across seven core variables

2019

Equality Works

The 2019 Report reviewed 198 organisations across the 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 reviews 200 organisations and complements the seven core variables with a diversity lens, alongside an in-depth look at the priorities of the global health ecosystem

The 2020 report extends and deepens GH5050's annual analysis by adding new variables to explore related systems of power and privilege within organisations. These variables include: workplace diversity and inclusion policies, board diversity policies and additional demographic information about executive leaders and board chairs. Additionally, we examine the stated health priorities of 150 organisations against both the health-related targets of the SDGs and the global burden of disease, and identify who and what continues to be left behind.

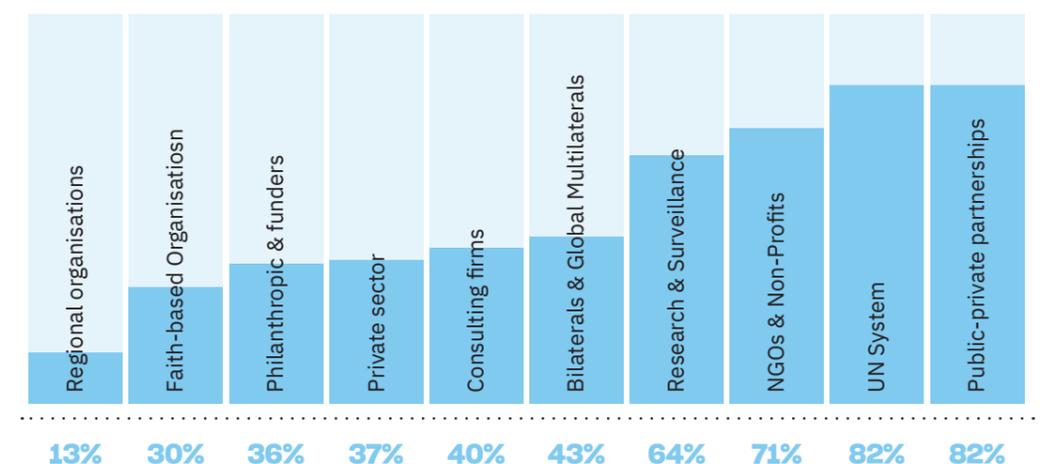
In our continued push for transparency, the report only reviews publicly available information. Data collection was conducted between October 2019 and January 2020. One hundred and ten organisations (55% of our sample) verified the accuracy of the data we collected (see Figure 1). We are grateful to all organisations who engage with us throughout the year.

Full details of the GH5050 methodology can be found on page 105.

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

Figure 1. Organisational validation of GH5050 Data, by sector

% organisations that validated data published in the 2020 Report



Power, privilege and priorities in global health: Summary

Findings from the Gender and Health Index

01

Commitment to Redistribute Power

Organisations report a fast-growing commitment to gender equality

We find a strong and growing commitment to gender equality among the 200 organisations reviewed.

Figure 2. 75% of organisations commit to gender equality

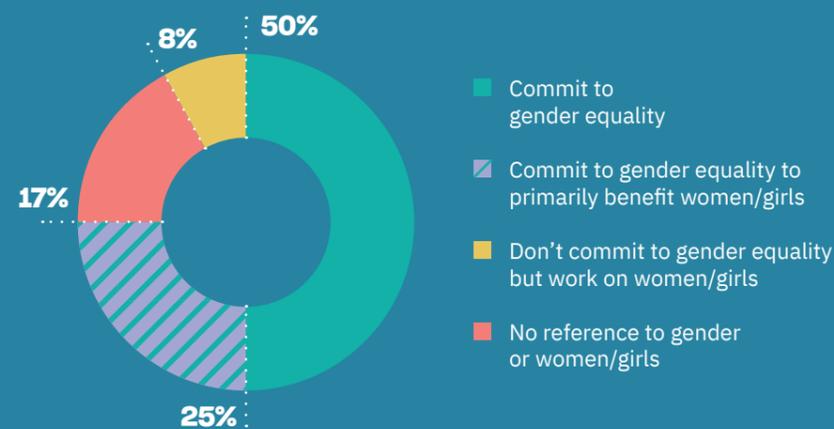


Figure 3. Commitment to gender equality on the rise

Among the 139 organisations reviewed consistently from 2018 to 2020:



[Read more on page 34.](#)

Too few organisations define gender

Defining gender in a way that is consistent with global norms is a political act, in that it confronts efforts around the world that try to manipulate the term, hijack it or erase it entirely.

Yet too many organisations are failing to seize the narrative power of defining gender as a social construct.

35% Proportion of organisations that define gender as a social construct

Since 2018, 9 of the original 139 organisations have added a definition of gender to their policies or websites.

[Read more on page 40.](#)

02

Policies to tackle Power and Privilege imbalances

60% of organisations have workplace gender equality policies

The global health sector ought to lead on justice and fairness, but instead male privilege pervades, contributing to gender inequalities in career progression.

Organisational change requires translating commitments to gender equality into practice through action-oriented, publicly available workplace policies and plans.

60% of organisations have publicly available workplace policies with specific measures to promote gender equality.

Figure 4. Notable progress in availability of workplace gender policies

Among the 139 organisations reviewed consistently from 2018 to 2020:

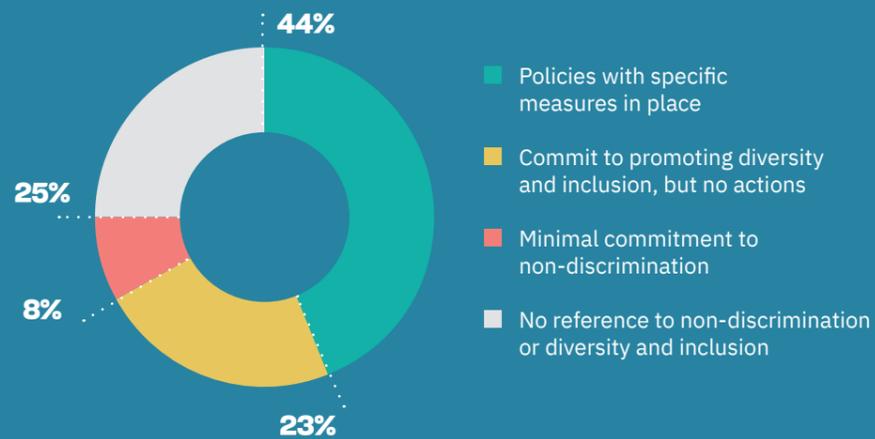


[Read more on page 44.](#)

Workplace gender equality policies outnumber broader diversity and inclusion policies

44% of organisations have publicly available policies to advance diversity and inclusion (beyond gender diversity) in their workforce.

Figure 5. Workplace diversity and inclusion policies in the public domain



[Read more on page 50.](#)

A fraction of organisations have transparent board diversity and inclusion policies:

Just 28 organisations (14%) have policies available in the public domain on how they seek to advance gender equality, diversity and inclusion in their governing bodies.

[Read more on page 53.](#)

03 Who holds Power and enjoys Privilege?

54 years until gender parity in positions of authority

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-quarter of organisations have reached parity (45-54% women) in their governing bodies and senior management.

Figure 6. Gender parity and disparity in senior management and governing bodies



Global health is making progress towards parity, albeit slowly.

- **Organisations with at least one-third women in senior management: 65%, up from 56% in 2018**
- **Governing bodies with at least one-third women: 51%, up from 47% in 2018**

Parity at the very top? Not any time soon.

Despite the recent wave in media and public attention to clearing the path for women's ascent in the workplace, the number of women reaching the top (executive) has barely budged.

73% of executive heads are men.

Figure 7. No meaningful change in number of women leaders



The trend is slightly more encouraging among board chairs.

68% of board chairs are men.

Among the organisations reviewed three years in a row, the percentage of women board chairs increased from 20% in 2018 to 26% in 2020.

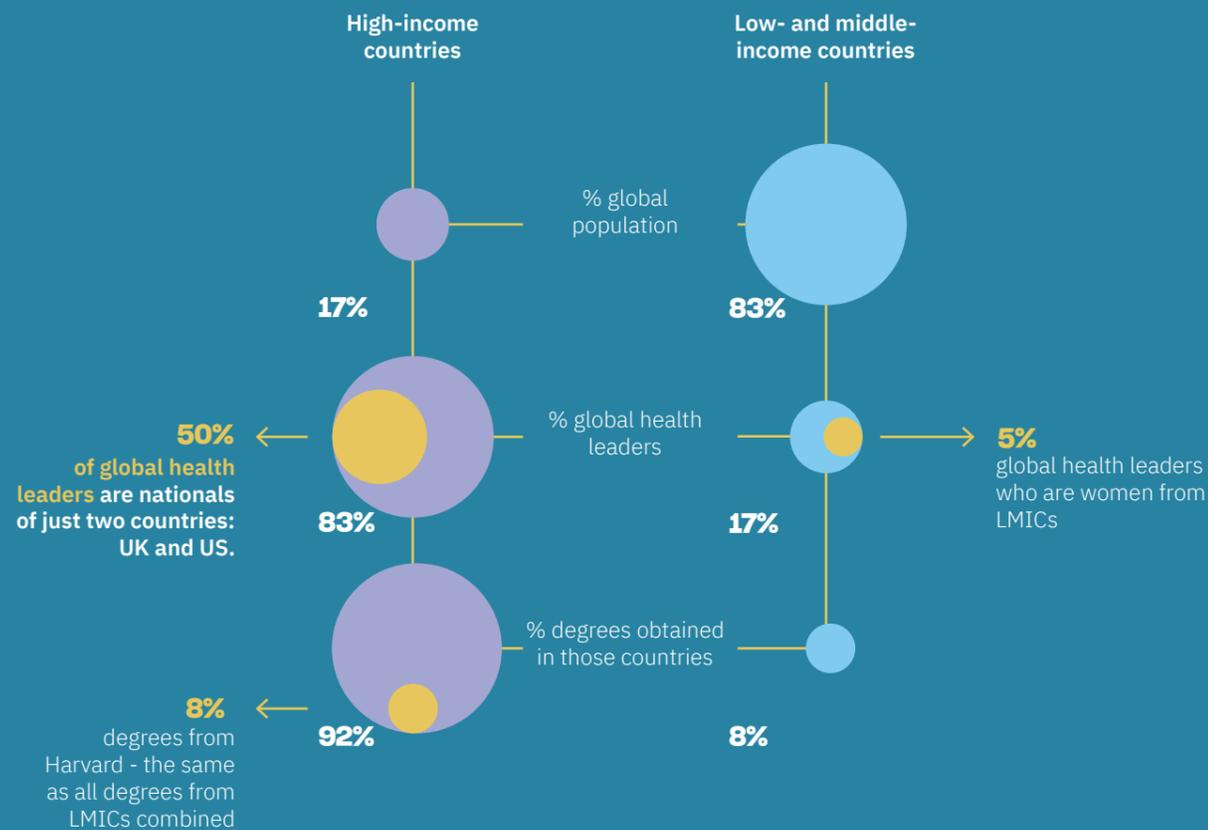
[Read more on page 58.](#)

Global organisations are led by and located in high-income countries³

Gender provides but one social identity through which to understand privilege, discrimination and inequality.

17% of CEOs and board chairs are nationals of low- and middle-income countries (home to 83% of the global population).

Figure 8. Population size versus leadership



92% of CEOs and board chairs completed their highest education in high-income countries (this includes 60% of nationals of LMICs).

The same number of leaders attended a single institution—Harvard (23)—as those who completed their education in all LMICs combined (23).

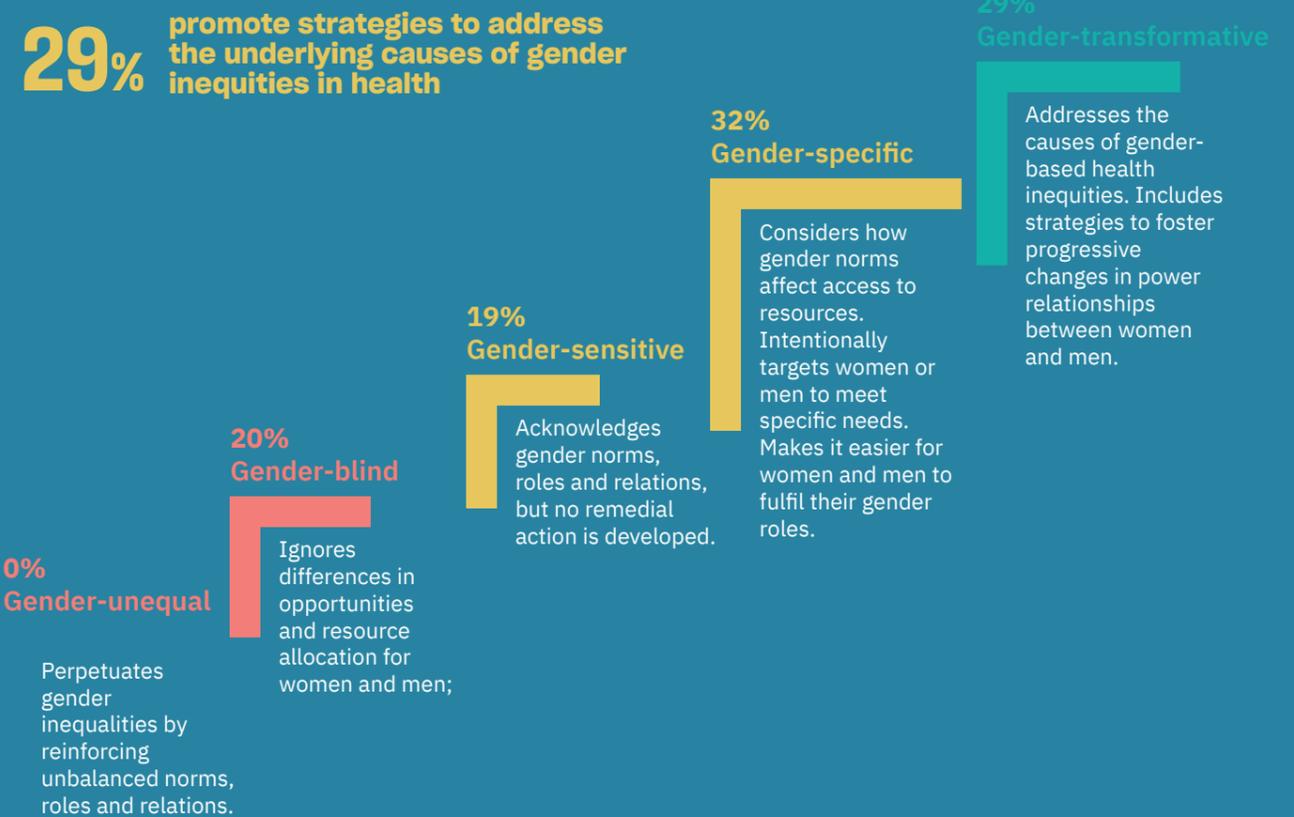
04

Do global organisations address the gendered Power dynamics that drive inequalities in health outcomes?

Strategies to advance health veer from gender-transformative to gender-blind

Gender plays a crucial role in the distribution of ill-health across all populations and influences the success of health interventions. Yet we find strategies to advance health range widely from gender-transformative to gender-blind.

Figure 9. Gender-responsiveness of organisational approaches (applying the WHO scale)⁴



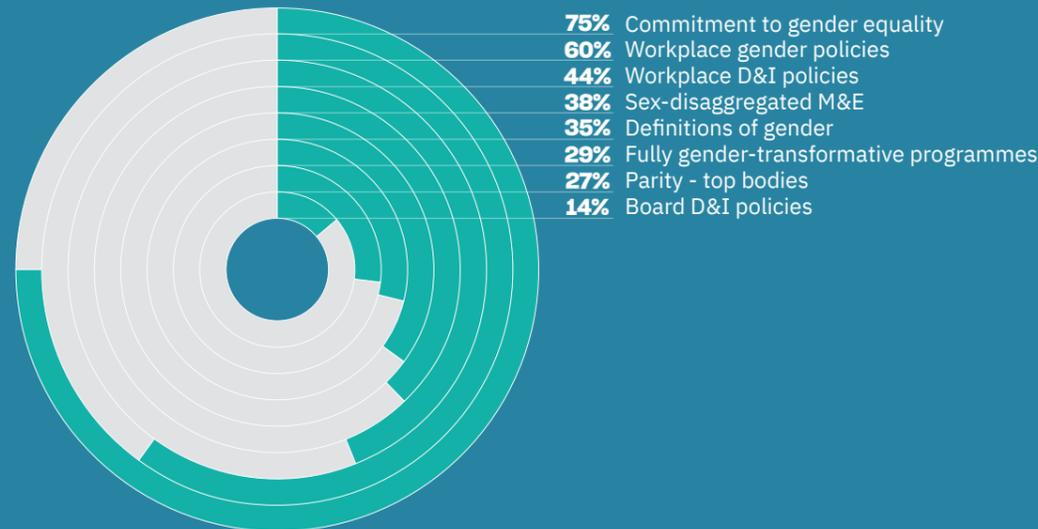
[Read more on page 74.](#)

The global health agenda: which priorities and for whom?

Summary of Section 3

On the road to gender equality in global health

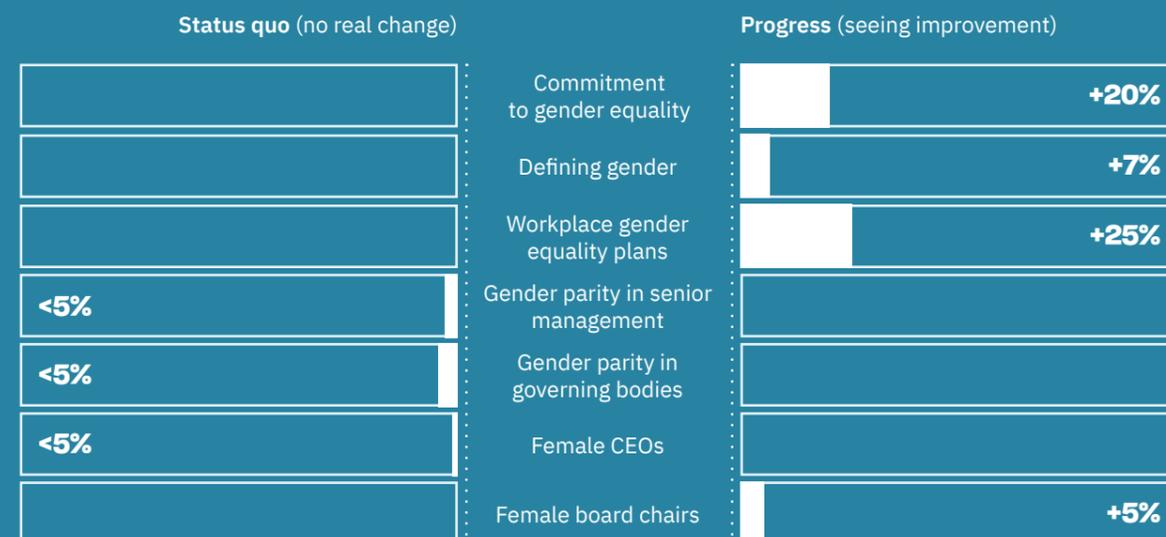
Figure 10. Overview of organisational performance



Progress, 2018-2020

Notable increases have been observed since the first GH5050 report, particularly in the number of organisations declaring a commitment to gender equality and publishing workplace gender equality policies. We see far less progress towards parity in leadership and decision-making bodies, recognising that time may be a factor. Growing policy commitments to equality mark an important step forward—though it remains to be seen whether staff and leadership will embrace such policies and translate them into organisational change and more equitable outcomes for people. At the current rate, parity will remain out of reach for several more generations.

Figure 11. Progress, 2018-2020

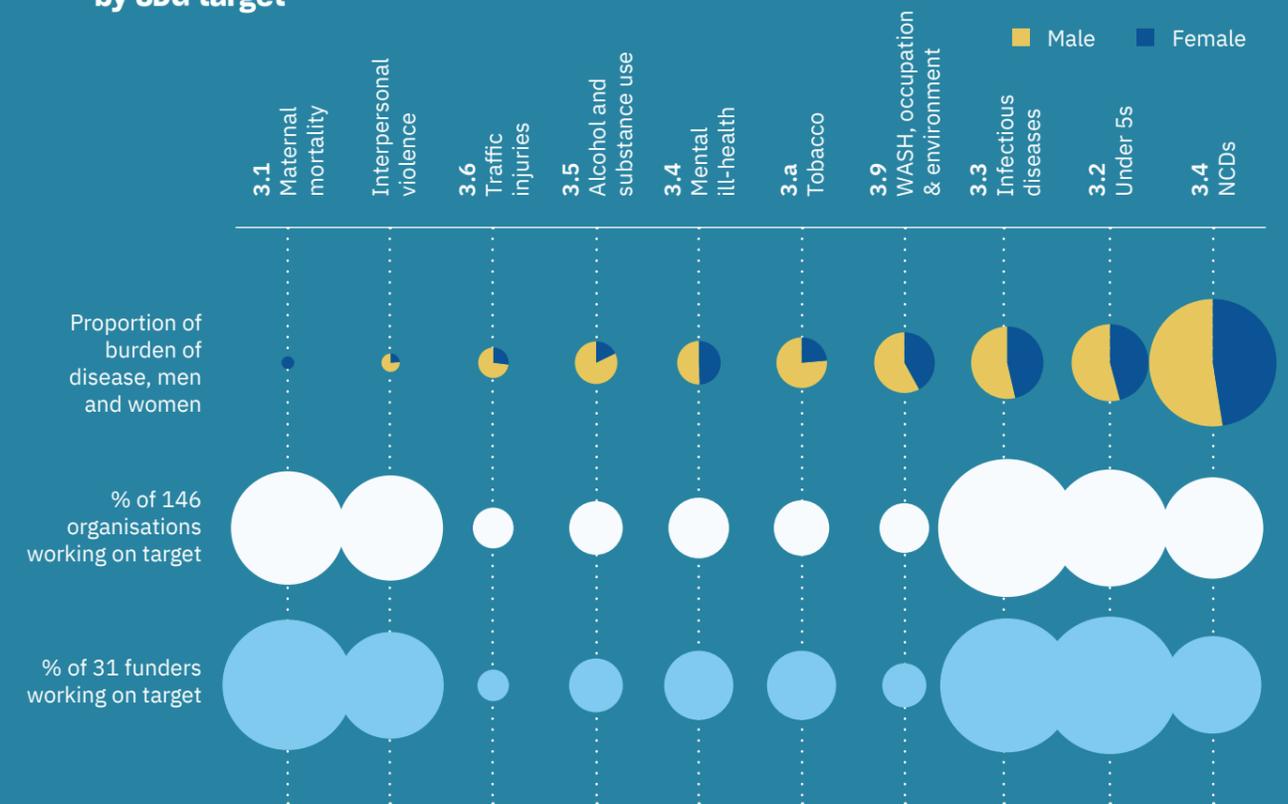


The global health agenda: which priorities and for whom?

The SDGs set the most comprehensive agenda to date for advancing health and well-being for all. A dedicated goal on health (SDG 3) includes 13 targets that are meant to drive action on the greatest health challenges facing the global population.

An analysis of the stated health-related priorities of the organisations in our sample, however, reveals notable mismatches. We find a mismatch between attention paid by organisations (all, and financing subset) to some targets and global burdens of disease associated with those targets. Of note, those health issues that represent a continuation of the MDG agenda—maternal and child mortality and infectious diseases—continue to receive the largest proportion of attention of the global health ecosystem. The newer SDG-era targets, particularly NCDs, do not receive proportional attention from funders or other organisations.

Figure 12. Organisational priorities compared to global burden of disease, by SDG target



Read more on page 89.

Global Health: How Global?

Figure 13. Headquarters of 198⁵ organisations across the globe

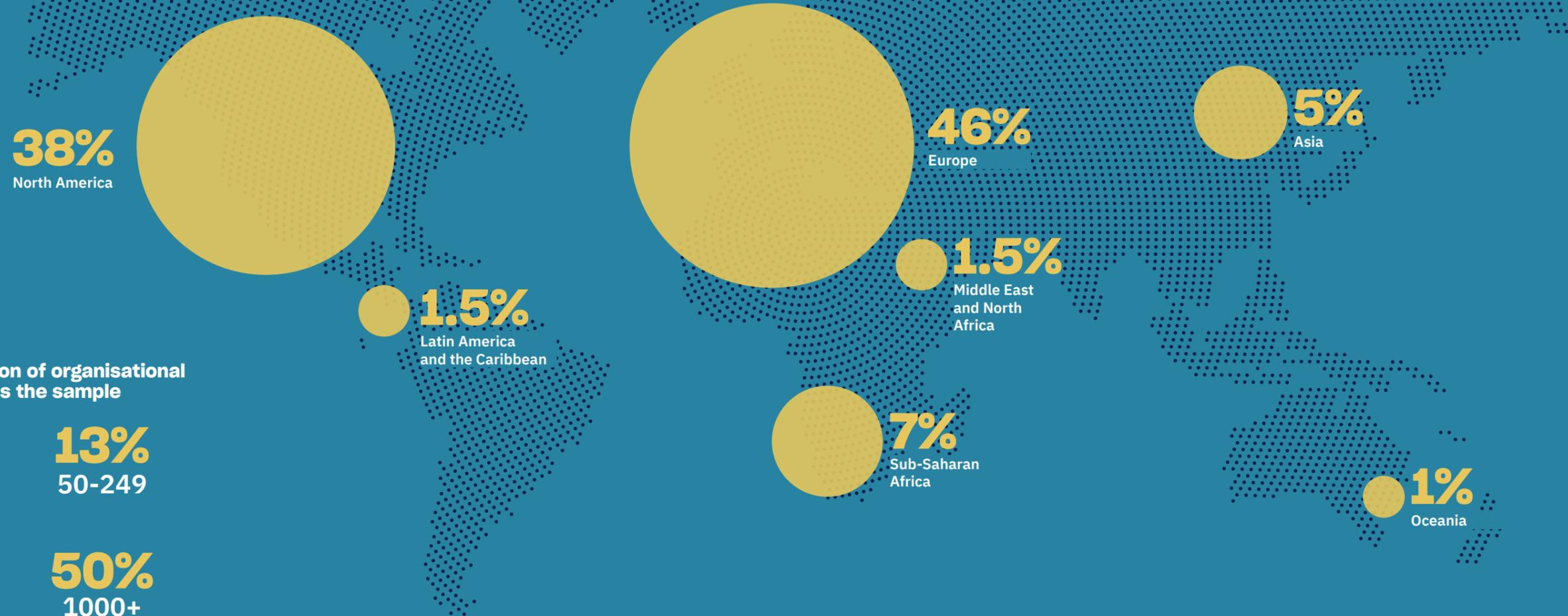
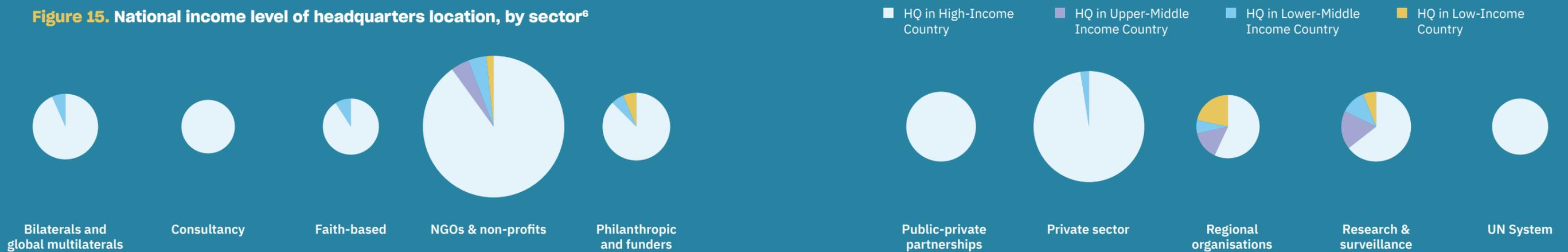


Figure 14. Distribution of organisational size (# staff) across the sample



Figure 15. National income level of headquarters location, by sector⁶



Section 2

Our findings



Examining the equality- and gender-related policies and practices of 200 global organisations active in health and health policy

Untitled
(Johannesburg, South Africa. 2018)
Micha Serraf

Two non-binary people in a golden field in Johannesburg. Drawing on the visual language of afrofuturism, Serraf explores gender and African-ness, and the construction and deconstruction of identity, belonging, blackness, queerness and masculinity. Neither confrontational nor judgmental, passive nor resigned, it presents a vision of a different kind of gender-fluidity, one that is warm, natural and powerfully expressive.

Micha Serraf is a Zimbabwean photographer and artist navigating post-apartheid South Africa.

I. Commitment to Redistribute Power

PUBLIC COMMITMENT TO GENDER EQUALITY

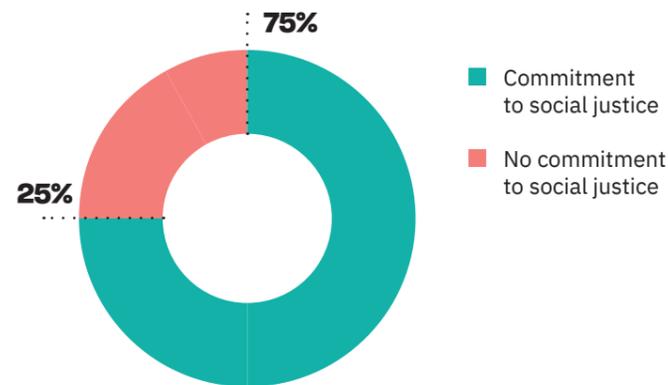
Organisations report a fast-growing commitment to gender equality and social justice

GH5050 reviewed the visions, missions and core strategy documents of organisations to identify commitments to gender equality and to social justice more broadly.

Findings

75% of the 200 organisations assessed make some form of documented commitment to equity, social justice, human rights and/or health for all.

Figure 16. Organisations that make some form of commitment to social justice



75% (149/200) also publicly state their commitment to gender equality in their mission, vision or major strategies.

Figure 17. Organisations that publicly commit to gender equality

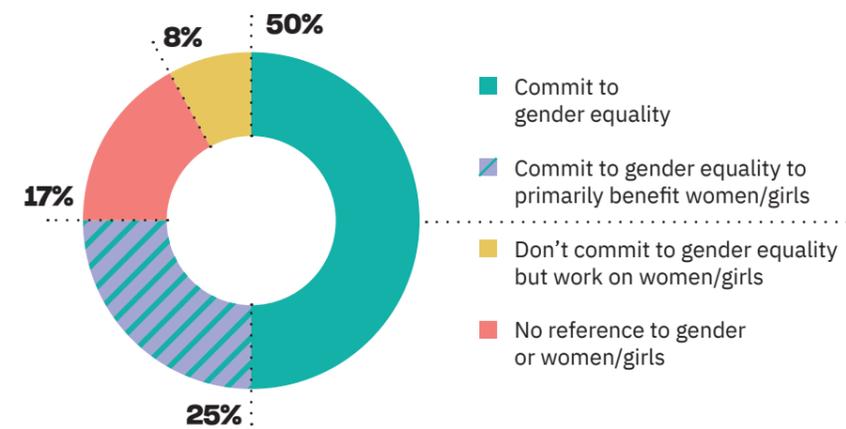
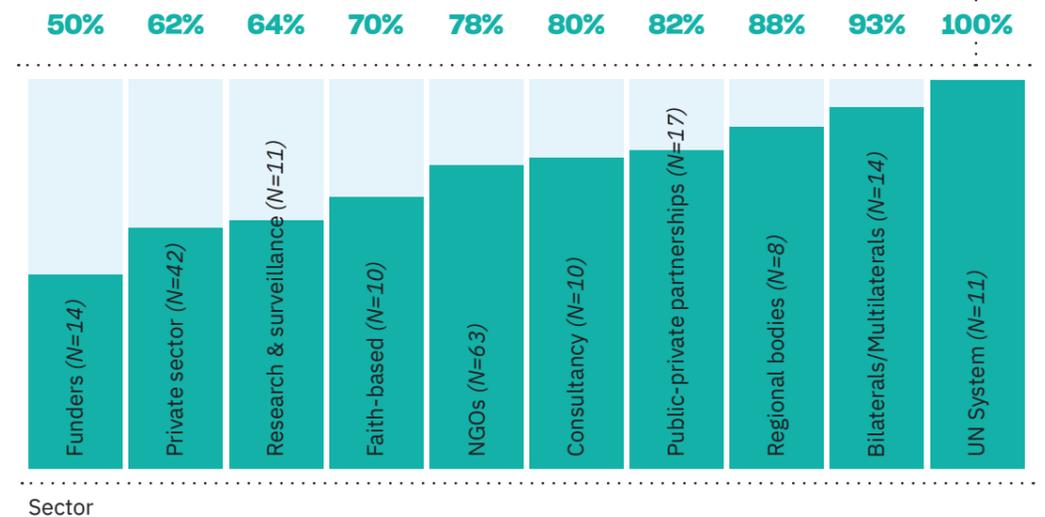


Figure 18. Organisations that publicly commit to gender equality, by sector

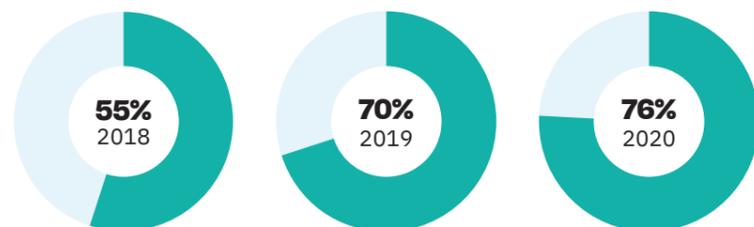


The perception that gender is not relevant to organisations' core work, regardless of their field or industry, appears to be shifting: from 2018 to 2020, the proportion of organisations that are silent on gender decreased from 32% to 17%. However, nearly one out of five organisations in our 2020 sample have yet to publicly state their commitment to gender equality.

We also see signs that organisations are increasingly embracing a more inclusive and comprehensive concept of gender equality—one in which all people, regardless of their gender, will benefit from tackling restrictive gender norms and shaping a more just society.

Figure 19. Public commitments to gender equality on the rise, 2018 to 2020 (139 organisations)

% commitment to gender equality



Examples of organisations' commitment to gender

Gavi has committed to increasing immunisation coverage by 1) supporting countries to overcome gender-related barriers to accessing immunisation services and 2) promoting equity of access and utilisation for all girls and boys, women and men to immunisation and related health services that respond to their different health needs.⁷

The Southern African Development Community (SADC) Member States have committed to mainstreaming gender into the SADC Programme of Action and Community Building initiatives as a prerequisite for sustainable development. The goals to deepen regional integration and strengthen community building can only be realised by eliminating gender inequalities and marginalisation of women throughout the SADC region.⁸

Box 2. Corporate commitments to the SDGs and to gender equality

The number of organisations committed to gender equality include 23 private sector companies (out of 42 total companies in our sample). These companies are participants or signatories of the [UN Global Compact](#)⁹ and have specifically addressed SDG 5 (on gender equality and women's empowerment) in their most recent Letter of Commitment of Participation. The UN Global Compact is a voluntary initiative based on CEO commitments to implement universal sustainability principles and to take steps to support the SDGs.

Several companies have also adopted the [Women's Empowerment Principles](#).¹⁰ Developed by UN Women and the UN Global Compact, these principles offer seven steps to guide business on empowering women in the workplace, marketplace and community and include specific measures to promote and measure gender equality.

GH5050 has recognised these commitments as a proxy for an explicit commitment to gender equality.

Buren Dalliance
2018 in Lyon, France
Marie Muller Priqueler

Part of the photographer's erotic-feminist project [La Chatte au Miel](#), which explores the nature of the naked female body and the sexualisation of the female form. Rather than dwelling on the body itself, Priqueler's imposing architectural image visually captures the structural and social conditions that shape women's lives.

Marie Muller Priqueler is a feminist photographer based in France.



In conversation with
Catherine Ohura

CEO, GHIT



*Catherine Ohura,
first row, second
from right.*

GHIT Fund: Diversity is hardwired in our DNA

The Global Health Innovative Technology Fund is a Japan-based international public-private partnership that mobilises Japanese industry, academia, and research institutes to create new drugs, vaccines and diagnostics for malaria, tuberculosis and neglected tropical diseases that affect the world's poorest people.

Advancing gender equality was one of your key priorities when you took the helm of the Fund last year. Why is that, and what have you focused on first?

We have long known that diversity, including gender diversity, is key to effective, innovative organisations. In the for-profit world, diversity relates directly to sales and profits. In global health, where organisations are striving to create a healthier world, it is even more critical to embrace diversity as a mechanism to maximise our ability to deliver on our missions.

So diversity is not just a question of fairness, it's a driver of success. A growing body of evidence shows that this is the case. We need to be using this data to get buy-in from leaders. We need male allies in this push for gender equality, and in my experience, data is essential to securing that support.

When I joined GHIT, there was already a lot of work underway to promote diversity. I was keen to unite those initiatives and policies into a single corporate strategy with a clear vision—and ensure accountability at the highest levels of our governance. Having gender equality as a business pillar incentivised staff to consider gender in our external work. We are now looking ahead to how we can integrate a gender focus into all aspects of our business portfolio, partnerships and programmes.

How has the Fund made this focus on diversity central to the organisation?

We are fortunate to have a truly diverse team—not just in terms of gender and nationality, but also in experience and perspective. Most of our employees have lived and worked in countries different to their own. Therefore, part of the reason we have been able to make such progress recently, is due to diversity already being part of our DNA.

Bringing about more diverse organisations must be embraced as an imperative by top leadership—it can't be a second or third rung priority. At GHIT, we have also seen the value of having employees who truly value it too. An essential part of our hiring process is looking at how candidates think about and embrace diversity. At GHIT, we also see this as an issue for everyone.

If you had three takeaways for other organisations, what would they be?

First, I would encourage all organisations to embed diversity into their hiring process. We need diverse workforces, but we also consider an understanding of the value of diversity as a core competency. Particularly in global health, which necessitates cross-country and cross-sectoral collaborations, this should be non-negotiable.

Second, I think it is critical for organisations to ask themselves what success looks like. All organisations should be setting gender- and diversity-specific KPIs. Without measurable, transparent goals, it's very difficult to be accountable for progress. Mechanisms like Global Health 50/50 have helped us with that—and perhaps in the future, a ranking system in the Report would provide organisations with another way to track progress.

Third, consider how global health can be a force for equality across society. GHIT Fund, for instance, is unique to Japan in how diverse we are. We want our progress to inform and inspire similar progress across Japan. As a sector I think we have a responsibility to drive broader social change in our own national context. Who better to do this?

DEFINITION OF GENDER

Seizing the power to claim the narrative: organisations show little progress in defining gender

Defining gender in a way that is consistent with global norms is a political act—in that it confronts efforts around the world that try to manipulate the term, hijack it or erase it entirely. Anti-gender movements are visible across most regions. Their core assertions—particularly that the very concept of gender sows confusion and destabilises the traditional family and the natural order of society—have been embraced and recited by leaders and political parties at the highest levels of power.



Substituting the word “sex” with “gender” in international spaces like the UN is part of a global feminist scheme to dissolve the family and remake society.

— Religious institution



I directed the Ministry of Education, with a view toward the full protection of children, to prepare a draft law that prohibits gender ideology in elementary schools.

— Head of State



In this contested environment, it becomes essential for organisations active in global health or health policy to be clear and consistent in their definition of gender as a social construct rooted in culture, societal norms and individual behaviours.

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 structures and institutions, and thus begin to address the distribution of power across and within societies, institutions and organisations. A gender lens transforms technical agendas into political ones.

Findings

While we see a growing commitment to gender equality, the meaning of gender remains undefined by the majority of organisations under review.

Just **35%** of organisations (70/200) define gender in a way that is consistent with global norms (see [glossary](#) for definition). This proportion has changed little since 2018. An additional **11%** of organisations define gender-related terms (e.g. “gender diversity”) but do not provide a definition of gender in their work. Only **18** organisations have definitions that are explicitly inclusive of non-binary gender identities, including transgender people.

Among the organisations reviewed since 2018, a slight increase of 6% in those that define gender has been registered: **9 organisations** have added a definition of gender to their policies or websites.

Figure 20. Organisations that define gender in line with global norms

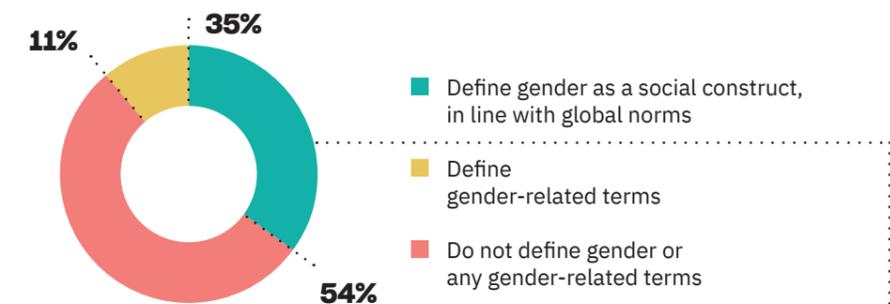
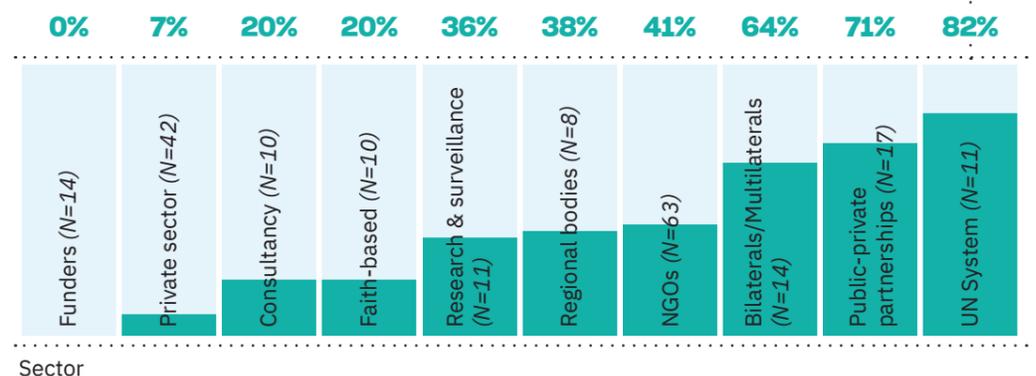


Figure 21. Organisations that define gender in line with global norms, by sector



Examples of organisations' definitions of gender

Partners in Health. "Our Vision of Gender Equity in Health: One definition of gender is "the socially constructed norms that impose and determine roles, relationships, and positional power for all people across their lifetime." Gender--which is related to, but separate from, biological sex--is ever evolving in any given individual, community, and society. It impacts all aspects of our lives, health chief among them."

Amref Health Africa. "Gender is socially constructed and is related to how we are perceived and expected to think and act as men or women because of the way society is organized. For instance, women cook, wash and take care of babies. Men head families, inherit land and provide leadership. These roles can, however, be played by either sex as they are not biologically pre-determined."

Figure 22. Definition of gender is associated¹⁴ with a range of organisational characteristics



KEY TAKEAWAYS FROM OUR FINDINGS

Commitment to gender equality is on the rise, with substantial year-on-year increases. In contrast, use of global norms around the definition of gender remains low. The evidence suggests that commitment and definition are mutually reinforcing—with a definition providing 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, we believe that clarity in organisational commitments to gender equality is long overdue.

Gender equality yet to be prioritised.

There is a continued lack of commitment to gender equality from almost one-fifth of our sample. This includes organisations from all sectors, but is particularly pronounced among funding agencies, of which just 50% have stated a commitment to gender equality.

Time to define.

Organisations should be clear about what they mean by gender—currently only one-third define gender in a way which is consistent with global norms.

Funders need to show the way.

Funding agencies, who generally exert a powerful influence on the sector, also perform particularly poorly in defining gender, with no funders offering a definition.

Defining gender linked to work on health equity.

Our analysis shows those organisations that define gender are also more likely to also be committed to addressing the underlying gendered determinants of ill-health i.e. tackling the inequalities in power and privilege that are associated with an increased risk of illness or lack of access to care.

II. Policies to tackle Privilege and Power imbalances in the workplace

WORKPLACE GENDER EQUALITY POLICIES

60% of organisations have workplace gender equality plans

Gender plays an important role in career trajectories. Organisations in the global health sector ought to lead on justice and fairness, but instead male privilege pervades, contributing to the paucity of women in senior roles. Support for gender equality in the workplace means fostering a supportive organisational culture for all staff and requires corporate commitment, clear policies, specific measures particularly at times of career transition points, and accountability for redressing structural barriers to women’s advancement.

The majority of organisations operate in countries with legal frameworks that protect workers against discrimination, including equal employment opportunity 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.

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: Mentoring, training and leadership programmes; targets for women’s participation at senior levels; policies for gender-responsive recruitment processes; gender analysis and action in staff performance reviews and staff surveys; regular reviews of organisational efforts towards gender equality, and; reporting back to all staff.

Findings

Figure 23. Organisations with workplace policies to promote gender equality

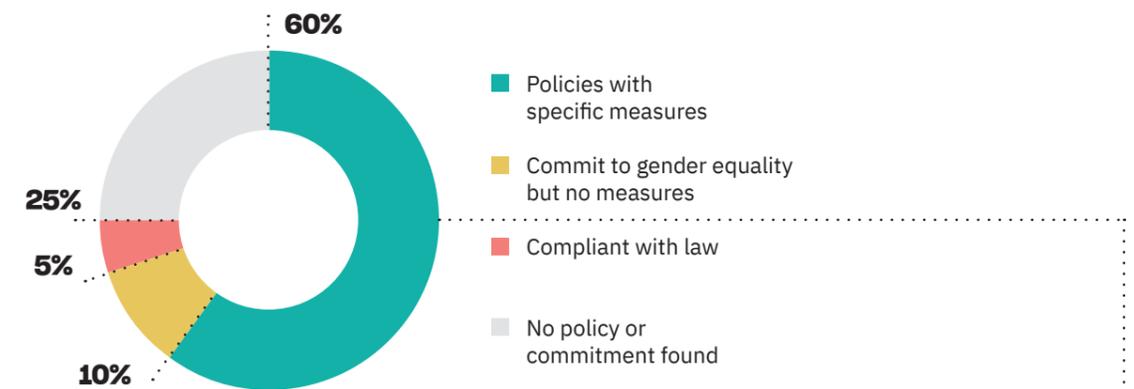


Figure 24. Organisations with workplace policies to promote gender equality, by sector



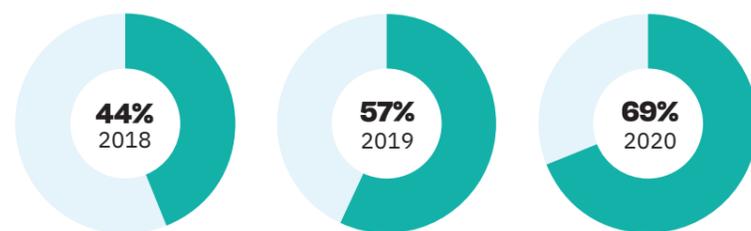
Nearly 60% of organisations reviewed have workplace gender equality policies which contain explicit targets, strategies and/or plans. No commitments or policies of any kind were found for one-quarter of organisations.

GH5050 made the decision not to assess the performance of very small organisations—those with ten or fewer staff—for this variable, 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. Nine such organisations are included in the 2020 sample and have been recorded as ‘not applicable’.

Among the sample of organisations reviewed over three years, progress has been made: in 2020, **69% had workplace gender equality policies (up from 57% in 2019, and 44% in 2018)**.¹² Thirty-one organisations appear to have adopted, enhanced and/or publicly released their workplace gender equality policies in the past two years.

Figure 25. Workplace policies to promote gender equality

Among the 139 organisations reviewed consistently from 2018 to 2020



Change is possible

31 organisations have adopted, and/or published workplace gender equality policies in the past two years

Organisations with workplace gender equality policies are

3.7
times more

likely to have external programmes that address the root causes of gender inequality (i.e. ‘gender-transformative’).

All United Nations (UN) agencies and UN-hosted initiatives are required to participate in the UN System-wide Action Plan (UN-SWAP) on gender equality and the empowerment of women. This mandates that UN agencies have policies and measures in place to systematically (and measurably across 17 indicators) mainstream gender into all major functions of the UN system. This system-wide framework shifts the UN results upwards, despite the fact that several of these organisations do not publish specific policies to promote gender equality in the workplace on their own websites.

Examples of workplace gender equality policies

In 2018, the **SRHR Africa Trust** established [#Workplace5050](#), a civil society-led network committed to “gender equity plus, as a first step towards realising the vision of safe, inclusive workplaces.” It includes a nine-point commitment to ensure that employers, workers, the private sector, donors and academics take the necessary measures to transform unequal gender relations, in the broader context of justice, inequality & discrimination.¹³

Plan International “is committed to fostering a positive working environment for all, regardless of gender, ethnicity, sexual orientation and other differences. To create an enabling and safe workplace, we are adopting the principles of feminist leadership to promote diversity and equality in the workplace. This recognises the structural inequalities within workplace that contribute to discrimination and uncovers the root causes of power abuse and how it manifests itself.”¹⁴

Reckitt Benkiser has committed¹⁵ to increase accountability and report on its gender pay gap in its top five markets (USA, the UK, China, India and Mexico), covering nearly 50% of its global workforce. This is the first commitment by a FTSE¹⁶ company to go beyond the UK reporting requirement, which makes it compulsory for companies with more than 250 employees to report their gender pay gap figures every financial year.

In conversation with
Samantha Stokes-Baydur

Deputy Head of Human Resources,
 Global Fund to Fight AIDS, Tuberculosis and Malaria



The Global Fund: Taking a hard look at our gender policies

The Global Fund is a partnership designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics. It mobilises more than US\$4 billion a year to support programs run by local experts in more than 100 countries.

We understand that the Global Fund undertook a gender assessment. Why was it done and can you tell us a bit about it?

The Global Fund is committed to a workplace that embraces diversity, thrives on discussion and is constantly learning. In 2018, we undertook a Gender Assessment to examine where we stand and how we can enhance the Global Fund from this perspective. It was important for us to evaluate whether any aspects of our human resources (HR) practices may adversely impact certain genders. HR led the initiative, and to ensure impartiality, an external firm conducted the analysis.

Over three-months, PwC undertook a systematic assessment of our HR policies, practices and processes and their application, as well as anonymized HR data. In parallel, they conducted a benchmarking exercise with other organisations with strong reputations of robust approaches to gender equality. PwC also ran focus groups to obtain feedback from employees, including the Staff Council, and gauge perceptions around gender equality at the Global Fund.

What did you learn?

We were pleased to learn that the organisation is gender-balanced, with a high degree of understanding among staff of the importance of gender equality. The Global Fund's parenting policy was affirmed as among the most advanced compared to

benchmarked organisations/best practice. We were concerned however that while there is no "glass ceiling" when promoting women, there is evidence of a "sticky floor" for women at one grade level who are promoted at a noticeably different rate than men. Promotions at other grades are considered gender neutral.

How have you used the results?

These results led us to establish some practical solutions, including monitoring and course-adjusting our recruitment and talent strategy, addressing unconscious bias and creating awareness of the language and terms we use. LinkedIn Learning, available to all staff, offers approximately 25 training sessions on unconscious bias.

In 2019 the Global Fund invested in the leadership development of some of its senior female staff from 'implementor' countries. The Global Fund also keeps a close eye on gender during succession planning, to ensure we have gender-balance in our next generation of leaders.

We see organisations increasingly adopting diversity and inclusion policies to address systems of power and privilege alongside and beyond gender. What is the Global Fund doing to bring about a more diverse and inclusive organisation?

With over 100 nationalities represented amongst our 750 staff and with people with varied professional backgrounds, diversity is at the core of our organisational culture.

In 2020, we're looking forward to welcoming a dedicated staff member within HR who will be responsible for Diversity and Inclusion matters including developing a D&I strategy. The GH5050 results brought a realisation that our commitment to diversity is not very explicit on our website and we will review this content in the near future.

We see a diverse workforce as essential to shaping real-world solutions that improve health for people. The Global Fund is investing heavily in training for all of our leaders. We are strengthening leaders' agility in adapting to the diversity of our staff, and their abilities in creating a psychologically safe environment, where all opinions are heard.

WORKPLACE DIVERSITY AND INCLUSION POLICIES

At the intersection: workplace gender equality policies outnumber broader diversity and inclusion policies

Gender provides one lens—albeit universal and fundamental—through which to understand inequalities in who wields power and enjoys privilege. Recognising the dynamic interconnectedness of gender with other social identities and stratifiers is integral to understanding privilege and disadvantage in the workplace, and thus to developing solutions that benefit all women, men and people with non-binary gender identities and building a truly diverse workforce.

Like any organisational imperative, advancing diversity and inclusion requires clear policies, deliberate focus and sustained action. GH5050 assessed which organisations 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.

Diversity is the representation of varied identities and differences (gender, race, ethnicity, disability, sexual orientation, gender identity, national origin, tribe, caste, socio-economic status, neurodiversity, etc.), collectively and as individuals.

Inclusion builds a culture of belonging by actively inviting the contribution and participation of all people, and strives to create balance in the face of power differences.

Findings

44% of organisations have committed to promoting diversity and inclusion in the workplace and have specific measures in place (15% fewer than organisations with gender policies). One-quarter of organisations reviewed make no public reference to non-discrimination, or diversity and inclusion (D&I).

Figure 26. Organisations with workplace diversity and inclusion policies

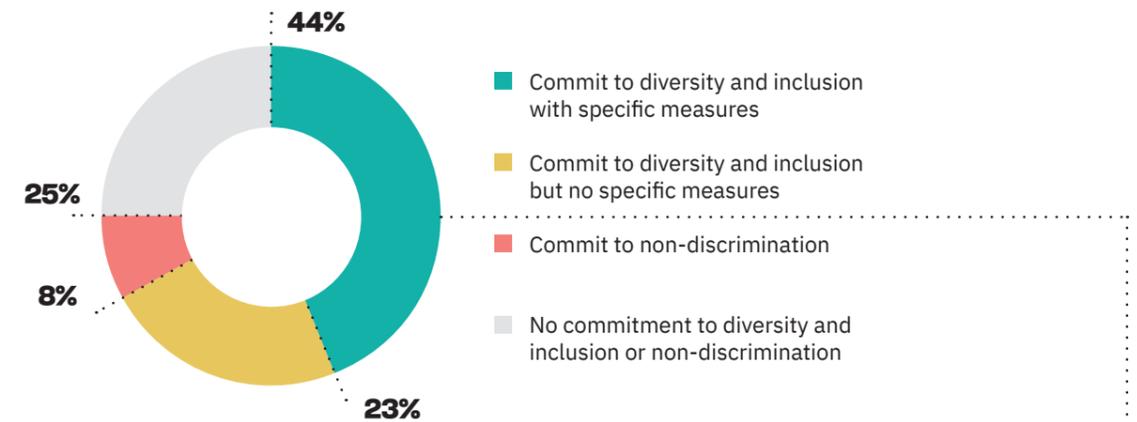
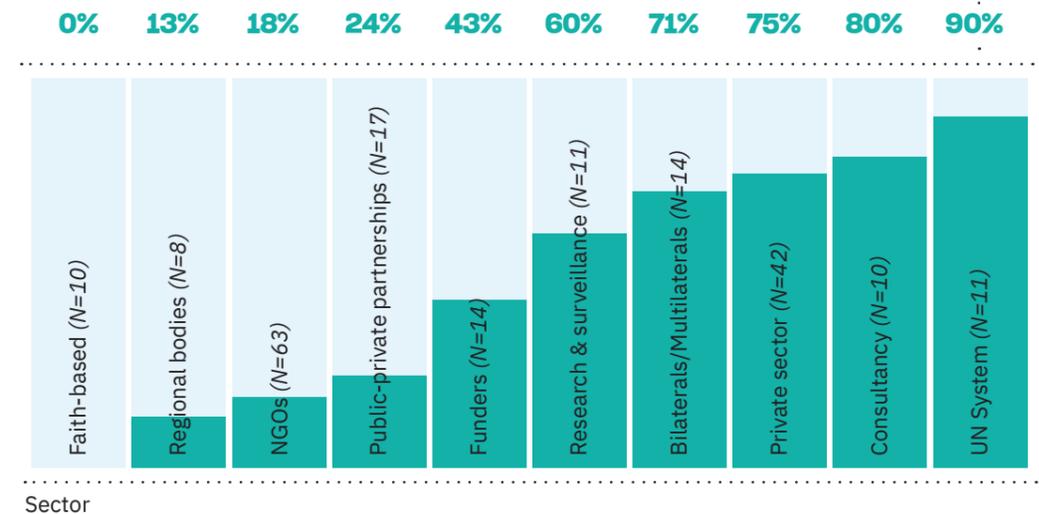


Figure 27. Organisations with workplace diversity and inclusion policies, by sector



Gender-responsive policies and programmes go hand in hand:

Organisations with workplace diversity and inclusion policies are

11
times more

likely to have gender-transformative approaches in their programmes.

Examples of diversity and inclusion policies

The **Ford Foundation's** Diversity, Equity and Inclusion policy¹⁷ lays out why diversity is essential to more effective philanthropy in a changing world. It has a task force to guide progress across the foundation, and publishes the gender and race/ethnicity breakdown at various levels of the organisation. It lays out a number of steps being taken to incorporate diversity, equity and inclusion in their grant making and internal systems.

The Pro-equity **Committee** of Gender and Race of **Fundação Oswaldo Cruz (Fiocruz)** informs actions across the foundation to combat institutional racism, gender inequality and discrimination based on sexual orientation. It develops pro-equity guidelines and oversees related actions, in work relations, public service and in the production of knowledge.¹⁸

The **Salvation Army** **commits** to positive action for people with disabilities, guaranteeing interviews to applicants with a disability who meet the minimum requirements of the job.¹⁹ Applicants applying to work in the area of homelessness who have a personal experience of homelessness are also guaranteed an interview.

Recognising that inequality and poverty disproportionately affect people who are differently-abled, **Safaricom** has set a **target** that five percent of its workforce will be comprised of differently-abled people by 2021.²⁰

BOARD DIVERSITY POLICIES

A fraction of organisations have board diversity policies in the public domain

Advancing diversity in governing bodies is an issue rooted in principles of power, representation and equity.

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.

Globally, gender diversity on boards is increasing. Progress is likely due in part to growing regulation around the world. Some countries have set strict quotas for women's board representation in public and state-owned organisations. Countries include Australia, Iceland, Norway and Spain, which have quotas of 30-40% female board members, and India and Israel, which mandate at least one female board member.²¹ Other countries have set non-binding targets, such as the UK, or require companies to release statistics on the gender, age, nationality and tenure of their board members, such as Chile.²²

Generally stricter regulation mandating some minimum level of diversity is associated with more gender-diverse boards.²³ Strong regulations are in place in many of the countries with the highest percentage of female board members, while those with less stringent regulations or no mandates tend to have fewer women on boards. However, social norms often drive the regulatory framework, and how that regulatory framework is fulfilled—thus societies that are already more gender-equal may be more likely to have stronger regulations in place.

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

Findings

Just **28 organisations (14%)** have policies available in the public domain that indicate how they seek to advance diversity and representation in their governing bodies.

These 28 organisations are almost **four times** more likely to have gender parity on their boards compared to the 170 organisations that we understand to have boards, but do not have policies (or do not have them publicly available).

Figure 28. Organisations with board diversity policies

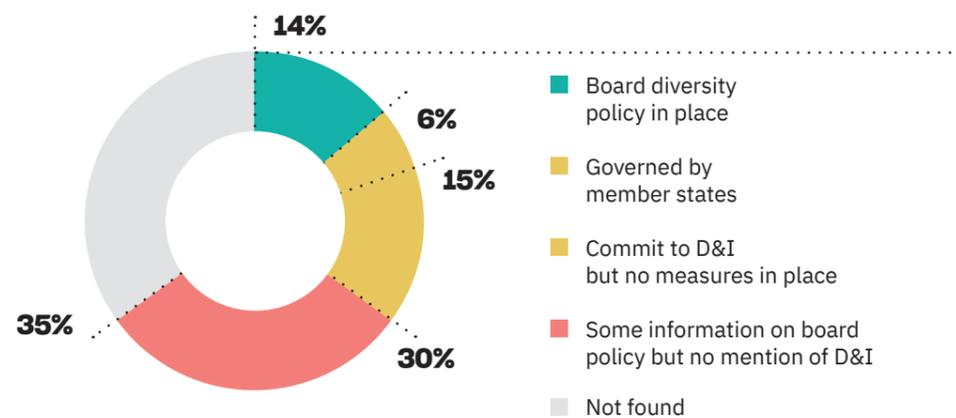
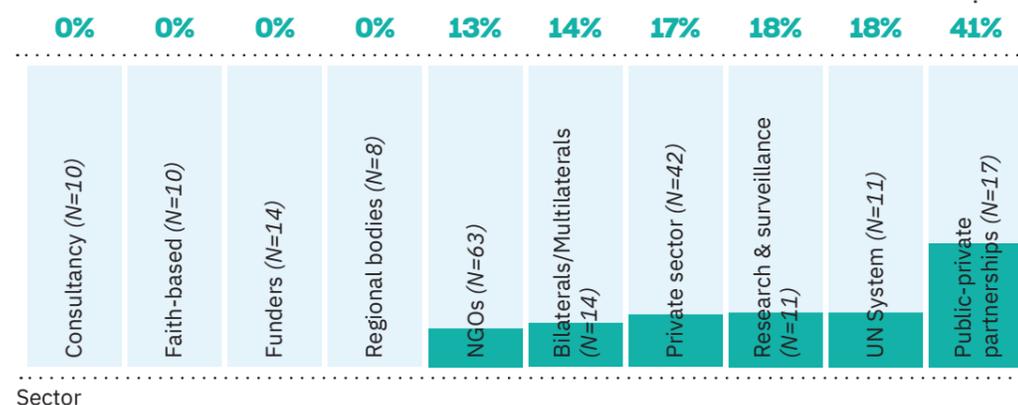


Figure 29. Organisations with board diversity policies, by sector



30 organisations in our sample have fewer than 3 women on their governing bodies—despite significant evidence suggesting that it takes a critical mass of at least 3 women to fully reap the benefits of gender diversity.²⁴

We recognise that the composition of a number of organisations’ governing boards is determined by country affiliation (member states), 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. Even among these organisations however, we do note good practice in tracking and reporting gender representation, e.g. by the World Food Programme, in an effort to encourage board members to promote parity in their own delegations.

Examples of board diversity policies

Population Services International: “Through the work of the Board Nominating & Governance Committee, Board composition is continually reviewed, monitored and assessed. The Committee utilizes tools to catalog the intersecting contributions of current Board members – gender, race, age, geographic location, background, sector, skillset and other valued attributes – and actively aligns any necessary rebalancing to ongoing recruitment efforts.”

Sonke Gender Justice: “The board has a commitment to 25% youth representation and includes standing positions for the following sectors: Women’s advocacy organisations; People living with HIV and AIDS; Youth and children, and; Faith based organisations.”

KEY TAKEAWAYS FROM OUR FINDINGS

Organisational policies matter. They are the building blocks that not only provide rules, norms, standards and guidelines for organisational composition, culture and ‘ways of working’, they are also the standards and means through which organisations can be held to account. 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.

We recognise that workplace policies and workplace culture is influenced by more than its leadership. The presence of active trade unions or other mechanisms for representing employees’ rights should 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.

We encourage transparency of workplace equality policies. We also recognise that given the contested, sometimes violent, nature of debates surrounding gender in some places, in 2020 a small number of organisations are taking a deliberate decision to keep their gender-related policies internal as a means to protect the organisation and its staff.

Gender equality policies on the rise.

The number of organisations with policies to advance gender equality in the workplace appears to be increasing. Organisational policies are equally likely to be in place irrespective of the geographical location of the headquarters or the gender of the CEO or board chair.

Not enough policies are in the public domain.

Some organisations may have robust equality and/or diversity policies that were not captured in our report as they are not in the public domain. We believe that a lack of transparency diminishes people’s power to know, demand, benefit and hold organisations to account.

More gender, less diversity.

Organisations are more likely to have policies to promote gender equality than diversity/inclusion in the workplace—an issue that organisations in global health should be aware of and responding to.

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 (though less well on measures of parity)—particularly when compared to NGOs or public-private partnerships (PPPs). 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 bring to its health partnerships—including support to strengthen internal workplace policies of organisations that are currently lagging.

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.

III. Who holds Power and enjoys Privilege?

GENDER PARITY IN SENIOR MANAGEMENT AND GOVERNING BODIES

Inching towards gender parity in global organisations

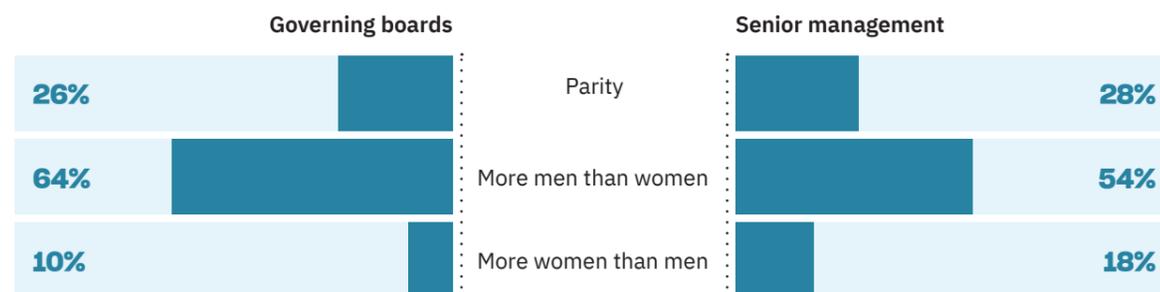
The number of women and men in positions of authority provides a strong measure of equity in career advancement, decision-making and power.

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.

Findings

Figure 30. Decision-making bodies still disproportionately male

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



We see indications of progress towards equal representation of women and men in decision-making bodies, albeit slowly. Among the organisations reviewed since 2018, the number of organisations with at least one-third women in these positions has grown from 56% to 65%. Eleven (11) organisations increased the representation of women in senior management from less than one-third (Red) to 35-44% (Amber). While parity (Green) figures haven't moved substantially, organisations are moving in the right direction.

Figure 31. Since 2018...



Will we wait for parity until 2074?

At the current rate of change, it will take:

54 years to reach gender parity in senior management and 37 years on governing bodies.²⁵

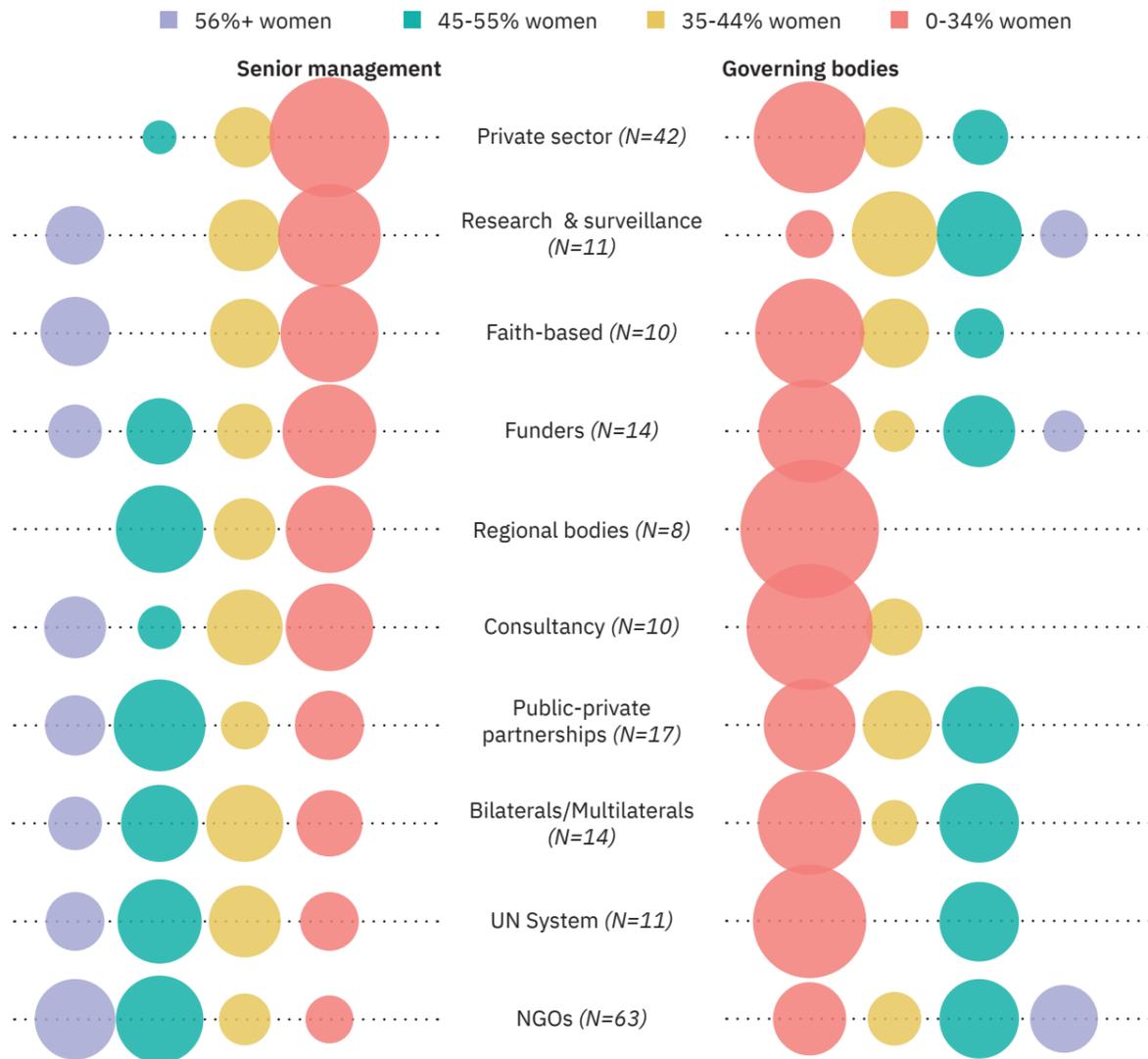
Can we shave a few decades off of that forecast?

1 in 8 Organisations with senior management composed of a single gender:

14 Organisations have no women in their senior management – organisations are evenly split across six sectors

12 Organisations have no men in their senior management – 9 of which are NGOs

Figure 32. Gender parity in decision-making bodies, % of organisations by sector

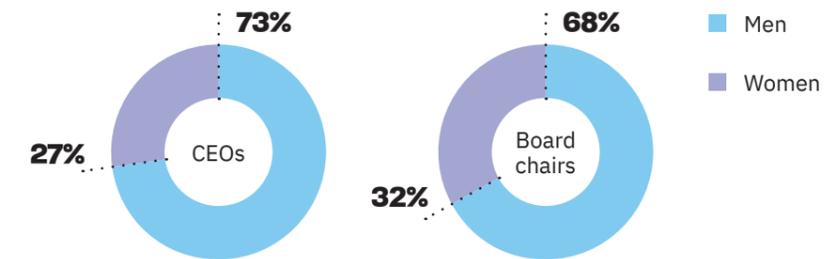


GENDER OF CEOS AND BOARD CHAIRS

Parity at the top? Not anytime soon.

Despite the recent wave in media and public attention to clearing the path for women's ascent in the workplace, the number of women reaching the top (executive) has barely budged.

Figure 33. Gender of CEOs and board chairs



From 2018 to 2020, the total number of female CEOs increased by 1 (from 41 to 42 out of 139 CEOs total).

This isn't merely a result of slow turnover at the top. On average, one in five organisations under review welcome a new CEO each year. In 2019, 64% of these new CEOs were male. Simply, men continue to be succeeded by other men.

There may be an indication that progress towards parity is on the horizon: among CEOs under the age of 44 (of which there are only 16), women and men are more equally represented. Whether this is a sign of generational progress, or will turn out to be another example of female attrition along the career pathway, remains to be seen. This finding reinforces growing evidence that the gender pay gap is an age issue. Even in contexts where the gender pay gap is close to zero at early professional stages, gaps widen substantially later in life.²⁶

Trends are slightly more encouraging among board chairs.

Deeper Dive

68% of board chairs are men. Among the organisations reviewed three years in a row, seven outgoing male board chairs were succeeded by women, increasing the percentage of women board chairs from **20% in 2018 to 26% in 2020**. Faster progress is due to more rapid turnover in board chairs: 30% of organisations saw new chairs in 2019.

Figure 34. Distribution of women and men CEOs by age range

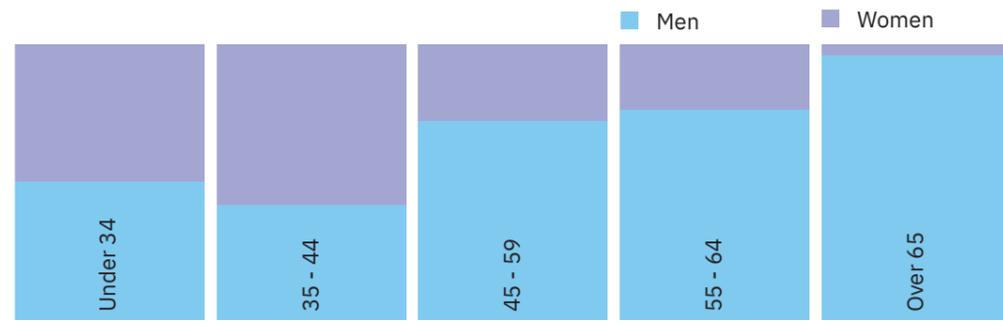


Figure 35. Women CEOs and Board Chairs, by sector

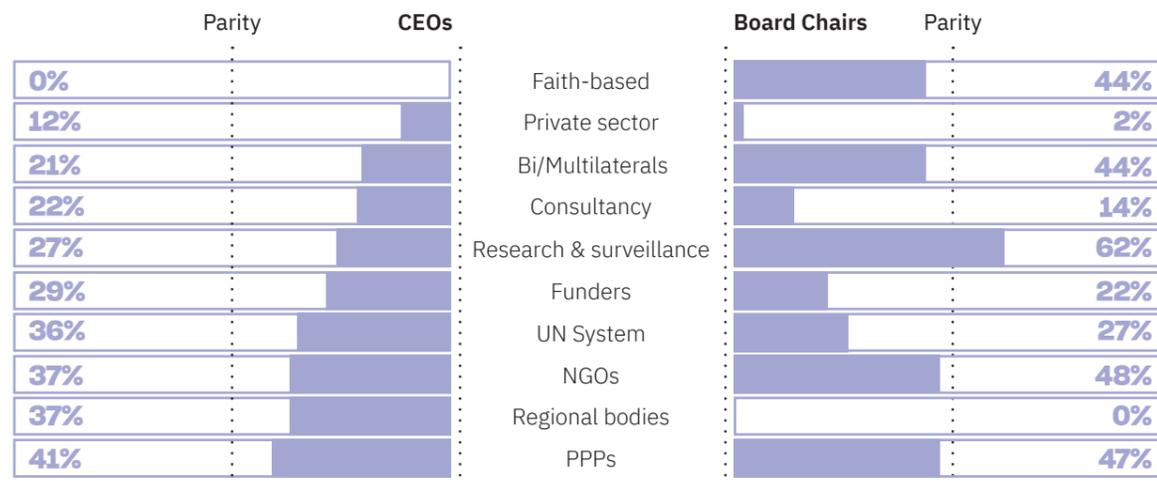


Figure 36. Organisational characteristics associated with women's leadership and gender parity in leadership²⁷

Women CEOs

3X more likely to be heading smaller organisations (<50 employees) compared to larger organisations (1000+ employees)

5X more likely to lead an organisation with a workplace diversity policy

6X more likely to have parity in governing body

Women Board Chairs

5X more likely to be chairing organisations with workplace diversity policy

Parity in senior management

4X more likely to have a woman CEO

6X more likely to have a workplace diversity policy

6X more likely to have a woman board chair

8X more likely to be a small organisation (<50 employees)

Parity in the board

4X more likely to have a board diversity policy

4X more likely to be a small organisation (<50 employees)

6X more likely to have a workplace diversity policy

DEMOGRAPHICS OF CEOS AND BOARD CHAIRS

Power in global health remains firmly in the grasp of high-income countries

GH5050 gathered publicly available demographic information in addition to gender on the CEOs and board chairs of the 200 organisations in our sample. This information included: nationality, highest educational degree attained, university where that degree was attained and approximate age. These proxy measures provide insights into who runs global health.

Findings

17% of CEOs and board chairs are nationals of low- and middle-income countries (LMICs). These same countries are home to 83% of the global population. An additional six CEOs are dual nationals of a high-income country (HIC) and an LMIC.

Just 8 women CEOs and 8 women board chairs are nationals of LMICs. 50% of leaders come from just two countries: UK and US.

Figure 37. Geography of global health leadership

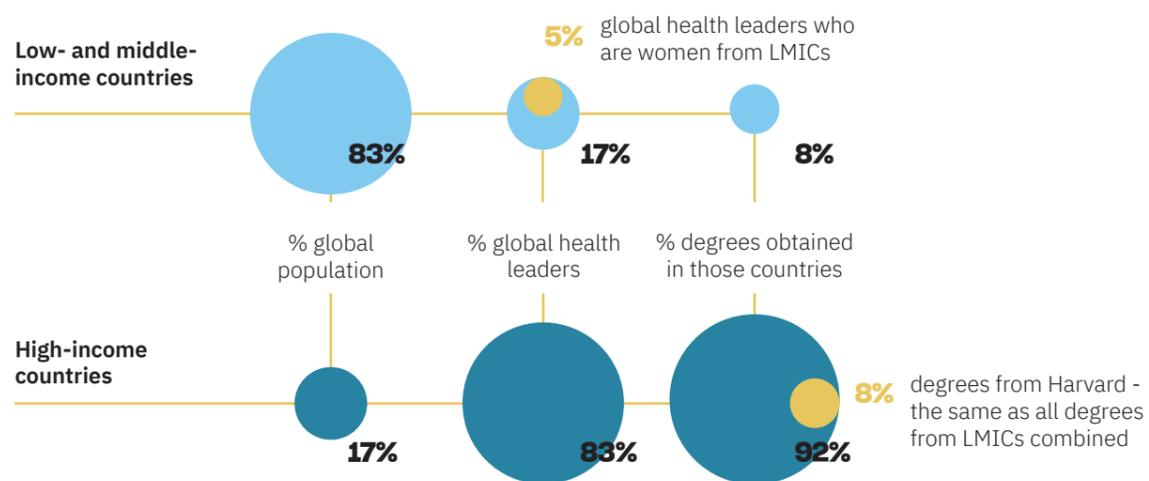
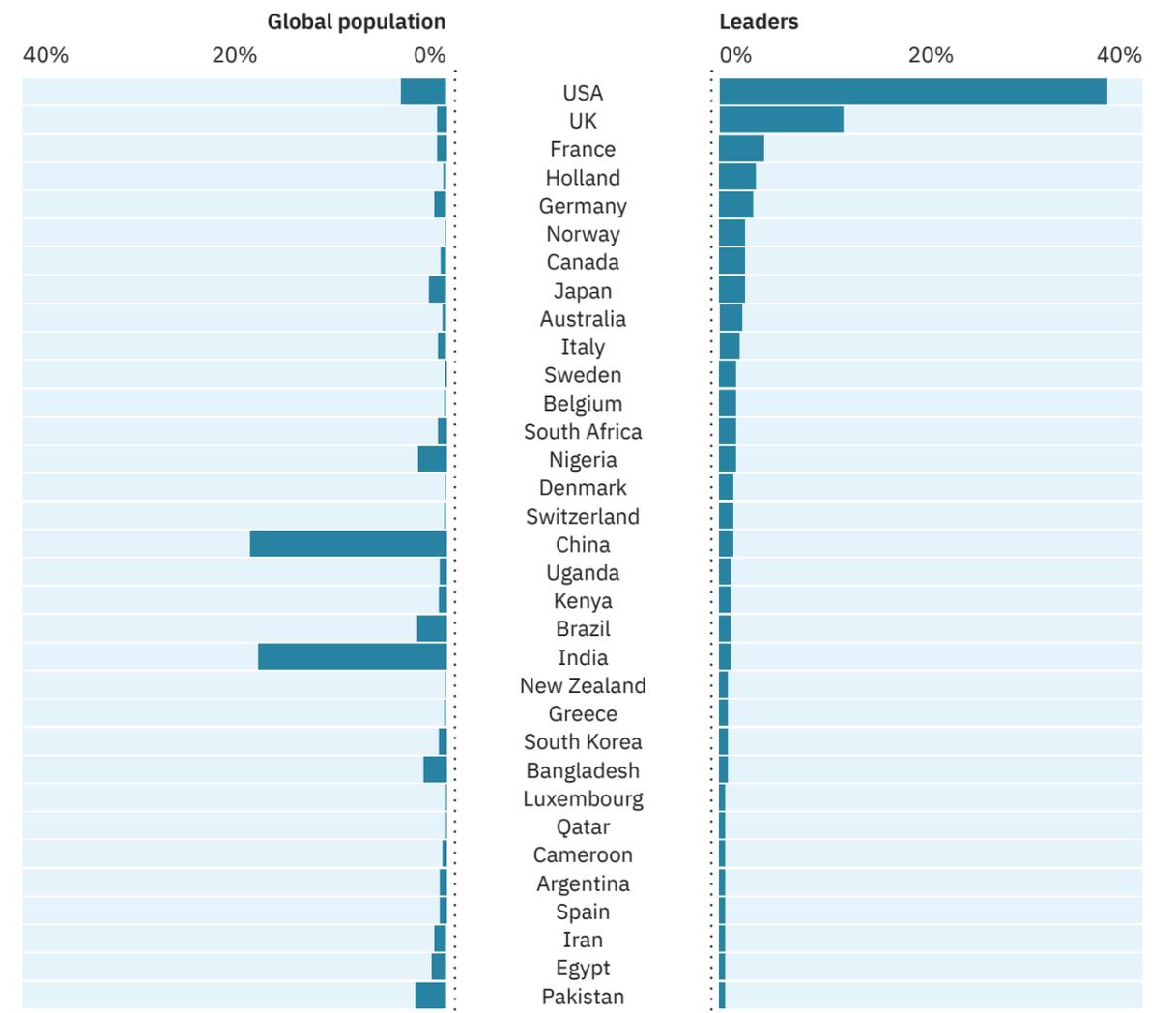


Figure 38. Nationality of the CEOs and Board Chairs of 200 organisations active in global health



These additional countries are each represented by one leader: Algeria, Barbados, Belarus, Brunei, Chad, Eritrea, Ethiopia, Finland, Georgia, Ghana, Guinea, Jordan, Morocco, Niue, Palestine, Panama, The Philippines, Romania, Russia, Rwanda, Saudi Arabia, Senegal, Serbia, Slovakia, Sudan, Tanzania, Trinidad & Tobago, Tunisia, The United Arab Emirates.

Figure 39. Nationality of CEOs and board chairs by income level

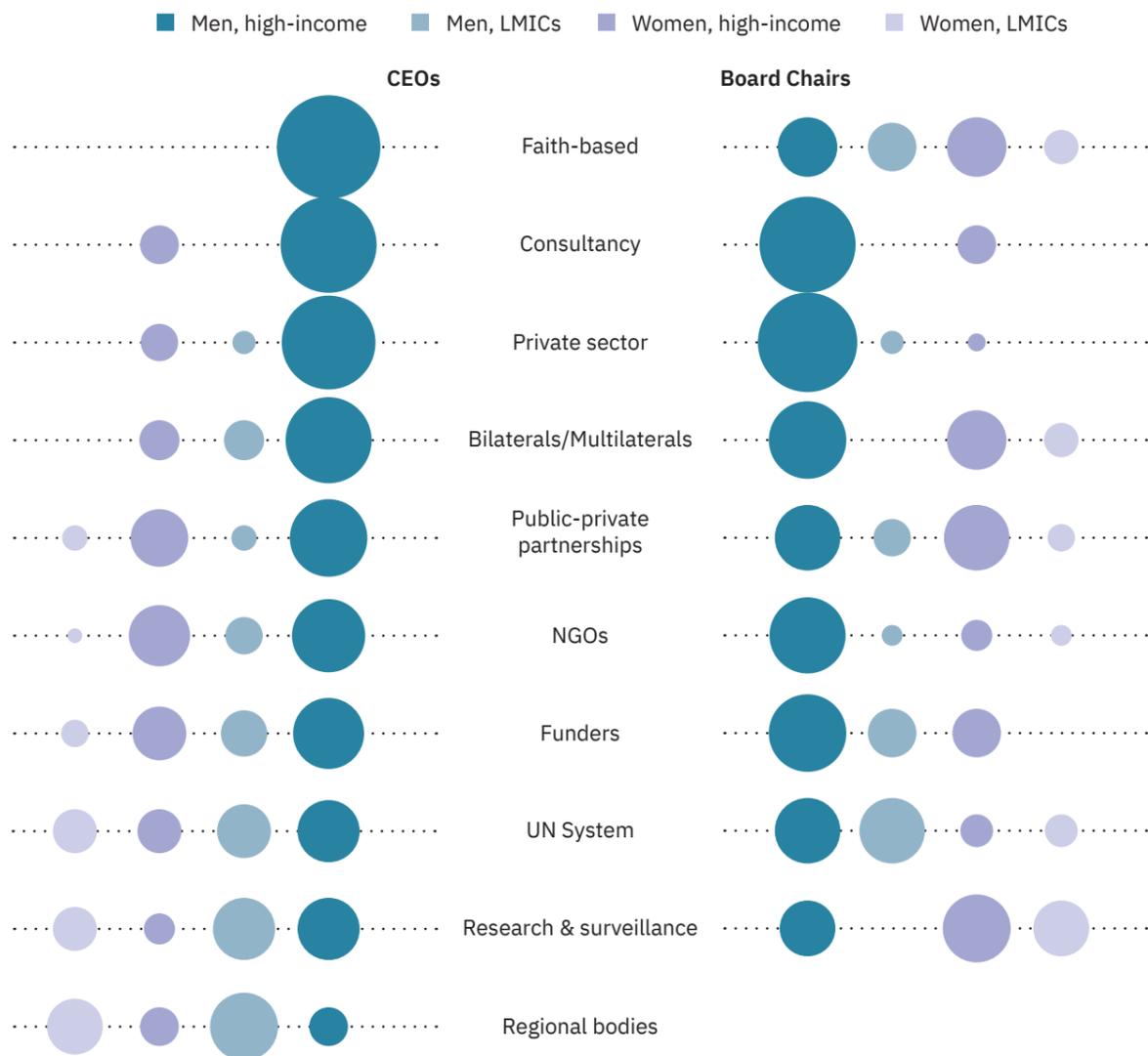


Figure 40. Who leads where?

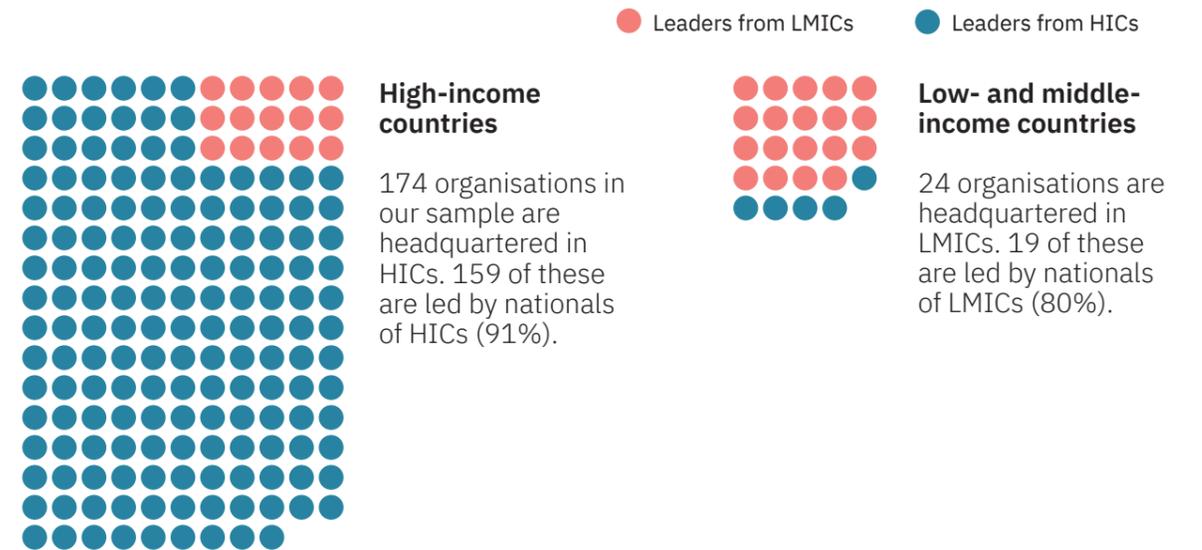


Figure 41. Power, privilege and education



Deeper Dive

Power and privilege are not always obvious. A closer look at the axes of power—including financial power, normative power, regional power and for-profit power—provides a more fine-tuned look at the profiles of the most influential actors in the global health ecosystem.

Figure 42. Profiles of power and privilege in global health



Financial power = organisations that channel the bulk of global development assistance for health.

Top ten bilateral donors (in 2016), multilaterals and public-private partnerships that distribute DAH globally, and all funders in our sample. Top ten bilateral donors (2016): USA, UK, Germany, France, Norway, Netherlands, Japan, Canada, Italy, Sweden; Multilaterals that distribute DAH globally: European Commission, World Bank, UNICEF, Unitaid, WFP; PPPs: Gavi, Global Fund; All funders and philanthropies in our sample.

Normative power = bodies charged with setting global health norms. *The nine UN system agencies under review, except for UNICEF and WFP given their inclusion in the financial power analysis.*

Regional power = bodies that set regional political and health agendas. *All 8 regional organisations under review in 2020.*

For-profit power = for-profit private sector companies engaged in influencing global health policy. *All 42 private sector companies under review in 2020.*

³² Normative and regional bodies were not included in this analysis on board chairs, given lack of information regarding these appointments.

KEY TAKEAWAYS FROM OUR FINDINGS

Workplace policies are among the building blocks for equitable career advancement. Who reaches the very highest levels of leadership within any organisation also reflects broader social factors, including legislative, educational and domestic.

If the legislative environment does not uphold principles of fairness and non-discrimination, employees have little recourse to workplace justice if they are treated unfairly. If appointment to the topmost positions is reliant upon having a degree from a globally-ranked university, then the available talent pool narrows to that sliver of global society that has access to those universities. If women and men have equal opportunities for career advancement but lack equitable sharing of caring and domestic responsibilities, women may be forced to make choices pitting home against working life.

We thus recognise that data on who holds power and enjoys privilege within organisations reflects more than the policies of a single organisation. Nonetheless, such data can provide insights into organisation-level inequalities that can and should be addressed and their commitment and measures to doing so.

For the first time, this report examines the individual characteristics of leadership beyond gender, including age, nationality and educational attainment. We would have liked to measure a broader range of characteristics, but are limited (understandably) by the data that is in the public domain about individual leaders. Thus, we are not in a position to measure class, sexuality, disability, caste, or any one of a range of potential intersecting inequalities. Analysing race/ethnicity is further complicated by the lack of a globally-agreed definition of categories.³³ Despite these caveats, the available data have highlighted a number of areas for reflection and response in all organisations working in global health.

The absence of diversity and representation within the upper reaches of global health can no longer remain unchallenged. It is time for global health to reconsider its values and the norms it perpetuates, shift the status quo and become more inclusive and better able to represent the diversity of global views and voices.

Gender equality in decision-making bodies is increasing at a snail's pace.

There is some indication of progress towards gender equality at the senior levels of management and governance. Our estimate that it will take 54 years to reach gender parity in senior management however is unacceptable. Among the 60% of organisations with gender equality policies and strategies in the public domain, there is a need for evaluation of whether these strategies are working. For all organisations, the time has come for critical self-reflection of what more they could be doing to promote gender equality in career progression.

Stepchange needed to advance towards gender parity at the top.

At the very highest levels of leadership (board chair, CEO), progress towards parity has stalled. When women do make it to the top, they are more likely to be running smaller organisations with fewer than 50 employees.

More than a numbers game.

We realise that parity in leadership is more than just a 'numbers game', it is an opportunity to exercise more inclusive norms and values across the entire organisation. For example, organisations with more gender equality in leadership are also more likely to have workplace policies to support diversity in the workplace and in the board. The time has come to consider more radical and progressive reforms to ensure that women have a fair chance at exercising power in and changing the values and norms of global health.

Lack of diversity and opportunity on the basis of nationality, age and education.

Leadership across the global health sector is mainly in the hands of older (> 45 years) men from high-income countries. Within those organisations wielding financial power (i.e. bilateral and multilateral funding agencies, private foundations), the concentration of leadership characteristics (men, over 45, national of and educated in a high-income country) is even more pronounced.

Run in the global north by the global north.

Global health headquarters (HQ) remain firmly rooted in high-income countries. Among the few we have identified based in low- and middle-income countries, organisations tend to be led by nationals from the global south. It is time for organisations in global health to look at the redistribution of headquarters functions outside of the global north, e.g. by transferring HQs to the global south, or dispensing with the notion and pursuing a partnership structure across different geographical settings.

One singular truth?

The current leadership in global health (irrespective of nationality and gender) have mainly received an education from a relatively limited pool of elite institutions in the global north. We recognise that changing this is a long-term goal, but believe this finding highlights the need to strengthen the quality, capacity and brand recognition of teaching and research institutions across the breadth of LMICs. This is an essential step to ensuring the redistribution of power, including the power of networks, and privilege in global health leadership in the future.

In conversation with
Dr Rosanna Duncan

Chief Diversity Officer, Palladium



Palladium: Give diversity and inclusion a seat at the top table

Palladium works with governments, businesses, and investors to solve the world's most pressing challenges.

Why has Palladium made diversity a key aspect of its business approach?

Diversity has been a competitive advantage for some time, but for us, it's a license to operate. Not only is it good for our people, but the range of perspectives we're able to harness spark the creativity and innovation we need to solve complex problems in challenging environments—something that's crucial to our business.

Where do you see the simpler fixes - and where is it harder to make progress?

Unfortunately, there's no silver bullet or simple fix! Real change takes time and can only be achieved when everyone works together. The difficulty can lie in helping the organisation to think about diversity beyond gender, and to see that everyone is responsible—from executives to the front line—for creating a diverse and inclusive environment.

What have you learned that might help other organisations confronting similar challenges?

One, give D&I a seat at the top table. One of the biggest risks is the perception that D&I is compartmentalised, a bolt-on to HR, or of too little strategic value to merit proper commitment.

Two, hold senior leaders accountable and be transparent about progress. At Palladium we hold quarterly forums and require senior leaders to report on our KPIs to all staff, including targets on equal pay and blind recruitment.

Three, keep the conversation flowing, internally and externally. We keep diversity top of mind by constantly sharing ideas, debating issues, and encouraging our people at all levels to develop their own thought leadership in this space.

What should we be watching for in terms of D&I over the coming years?

Gender is just one piece of the "inclusion jigsaw." Women are not a homogeneous group, and gender parity does not equal diversity or inclusion when women are only being recruited and promoted from the same privileged backgrounds as their existing male counterparts. We're going to see more analysis of how different types of inequality intersect, and will be able to shift our recruitment practices, selection criteria, cultures, and unconscious biases toward the necessary action for meaningful change.

As more Boards and CEOs wake up to the reality that real change must be driven from the top, we're going to start seeing more Chief Diversity Officers.

What gets measured gets done, and diversity is no exception. Improving the quality of the metrics at Palladium has had a huge impact, and as data science continues to increase in popularity, more companies will choose to equip their D&I leaders with ever more sophisticated data and set more ambitious KPIs.

IV. Addressing the gendered Power dynamics of inequalities in health outcomes

GENDER-RESPONSIVENESS OF GLOBAL HEALTH PROGRAMMES

Strategies to advance health veer from gender-blind to gender-transformative in our sample

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). We would therefore expect that their policies and programmes are 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 (see Figure 43).

In previous years, GH5050 reviewed this variable by assessing simply whether gender was mentioned in programmatic strategies. In an effort to apply a more meaningful and specific measure of the extent to which organisations acknowledge gender inequalities and take action to address them, GH5050 assessed organisational approaches based on WHO's gender-responsiveness scale.³⁴

Box 3. Applying an intersectional lens to gender programming

To complement an analysis of the gender-responsiveness of organisational approaches to health and well-being, GH5050 originally sought to explore whether organisations take into account the multiple identities and vulnerabilities that contribute to health inequities among the populations they aim to serve. Such an intersectional approach enhances understanding of not only who is left behind but why and how.

While, for reasons of capacity, we were unable to systematically assess the extent to which organisations are applying such a lens to their programmes, we did identify several organisations that have adopted an intersectional approach. A few are highlighted below.

Swedish International Development Agency: "An intersectional approach examines the ways in which diverse socially and culturally constructed categories interact at different levels to produce different forms of power relations and inequalities...Thus, it is necessary to be very specific about which group of women or men that is referred to as the specificities vary a great deal."³⁵

Promundo: "Men's health must be understood via an intersectional approach; norms about manhood interact with other social factors, such as the acute vulnerability of racial/ethnic and sexual minorities as a result of systemic and structural forces. Indeed, there are vast regional

disparities in age-standardized morbidity and mortality rates among the World Health Organization regions, which attest to the extent to which poverty, living conditions, and occupation-related risks drive men's ill health.³⁶

Health Poverty Action "takes an intersectional approach to health justice...We campaign at all levels to tackle the power imbalances at the root of poor health. This includes working with community leaders to stamp out violence and discrimination against women; advocating to ensure people who are excluded can have a say in the running of health services; pushing for fairer global systems in areas such as tax and trade, and ending the so-called 'war on drugs' to replace it with a public health approach."³⁷

Johnson & Johnson has implemented a strategy to increase enrollment of underserved and underrepresented populations in clinical trials. The company's GRACE (Gender, Race and Clinical Experience) trial was the largest trial to focus on women of color taking HIV drugs to date.³⁸

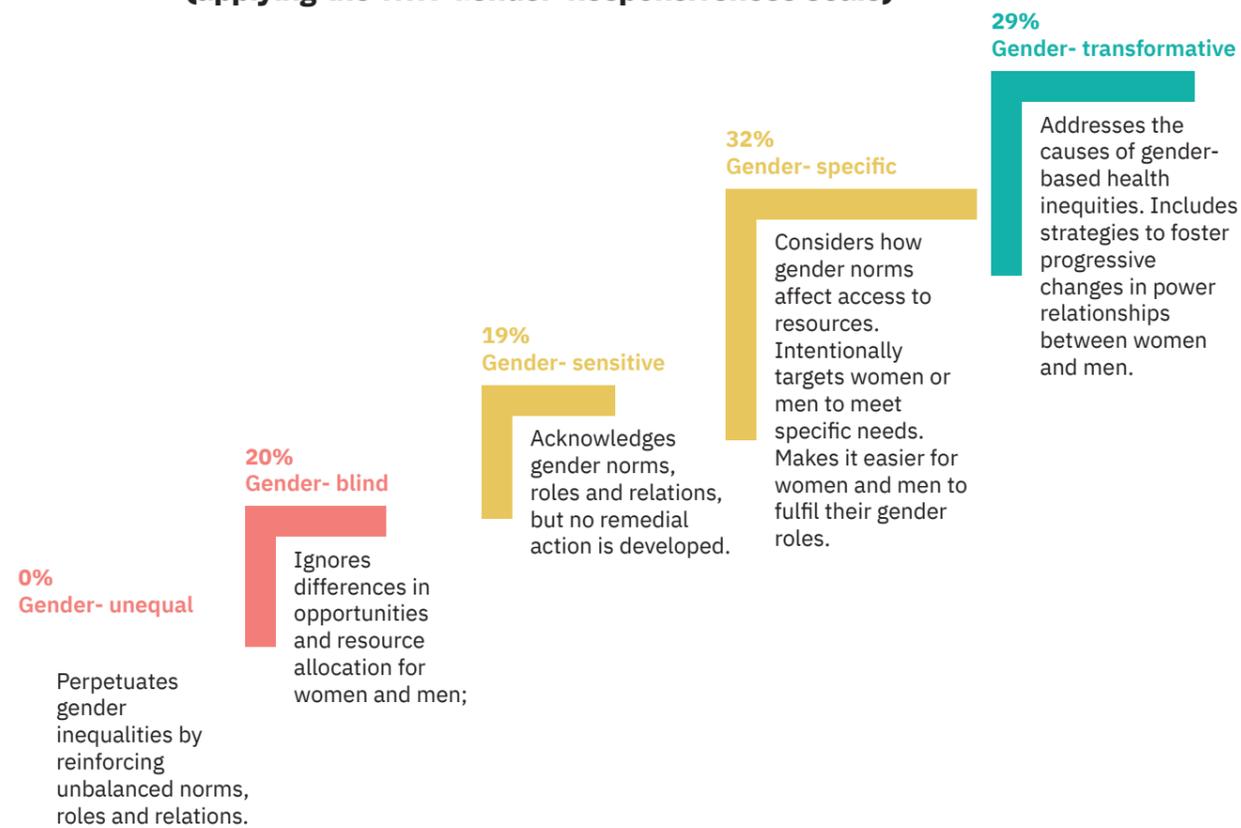
Findings

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. A total of 29% of organisations promote transformative strategies to address the systemic inequalities underlying the gendered distribution of power and privilege in health programmes. Around two-fifths of these organisations focus on women and girls as the primary beneficiaries, while the majority address gender norms in both girls and women and boys and men.

An additional 50% of organisations were classed as being gender-sensitive or -specific. Gender-sensitive approaches (19% of organisations) recognise gender norms, but do not propose remedial actions to address gender inequities in health outcomes. Gender-specific approaches (32% of organisations) 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. 20% of organisations reviewed were entirely gender-blind, but no organisations were gender unequal.

Of the 158 total organisations (80%) with strategies found to be gender-responsive, 95 were primarily focused on meeting the needs of women and girls. None focused on primarily meeting the health needs of men. Sixty-three are gender-responsive to meet the needs of both women and men, and only 12 specifically mention the health needs of transgender populations.

Figure 43. Gender-responsiveness of organisational approaches (applying the WHO Gender-Responsiveness Scale)³⁹



Examples of gender-responsive approaches

BRAC’s “integrated gender transformative approach strengthens the voice, choice and space for women and girls to combat violence and eliminate all forms of gender discrimination with the active engagement of men and boys. BRAC works for transforming socio-cultural gender norms; building capacity of staff and stakeholders; creating a supportive working environment; and advocating for gender equality and gender justice at all levels through gender mainstreaming.”⁴⁰

The **Framework Convention Alliance** “emphasizes the need for gender-responsive tobacco control programming in order to counteract the tobacco industry’s targeting and exploitation of gender norms, and to address gender-specific vulnerabilities to tobacco-related harm.” Recognising gendered differences—including that men are more likely to smoke than women, women constitute two-thirds of the deaths caused by second-hand smoke, and rates of smoking among women are increasing—the Alliance calls for not just sex-disaggregated data, but thorough gender analysis on tobacco use and tobacco-related harm.⁴¹

Figure 44. Organisational approaches to address underlying gender-related drivers of ill-health, by sector



In conversation with
Dr Gatherine Kyobutungi

Executive Director, African Population
 and Health Research Center



APHRC: Gender equality will drive better African research

Based in Kenya, APHRC is the continent's premier research institution and think tank, committed to generating an Africa-led and Africa-owned body of evidence to drive policy action for an effective and sustainable response to the most critical challenges facing the continent.

How has APHRC integrated gender into its programmes?

The vision of APHRC is to transform African lives through research. This vision is not just about the evidence we generate—its about who owns this research, whose voices are heard and how strengthening the capacity of African researchers can build more equitable societies.

Women in sub-Saharan Africa constitute just 30% of researchers. This reflects gender relations in Africa and the pervasive idea that women are primarily mothers and care providers. This inequity challenged us to establish a gender-responsive doctoral programme.

Today, our flagship programme, *The Consortium for Advanced Research Training in Africa* (CARTA), is tailored to advance gender equality. It includes 1) a higher cut-off age for women, who are more likely to start doctoral studies later due to childbearing; 2) supporting women fellows who are mothers to attend seminars with their infants, and covering the costs of childminders; and 3) providing maternity leave.⁴² CARTA also encourages fathers to take on greater childcare responsibilities and celebrates female role models in research.

APHRC was a high-performer in our 2019 Report. Has this process influenced your approach to gender?

We found the GH5050 exercise valuable, in particular by making us reflect on and confront the gaps it revealed in our performance. For example, while we track gender-related outputs, our human resources reports—where gender-disaggregated data on staff is reported—need to be better incorporated into our overall corporate M&E framework. We plan to update the framework based on the Report findings to ensure we are capturing internal gender challenges and linking them to our theory of change.

In what ways has APHRC sought to challenge power imbalances among partners?

Establishing principles of what constitutes mutually beneficial partnerships versus what could be potentially exploitative has been critical to challenging power dynamics. One primary principle is ensuring involvement in research conceptualisation right from the start (as opposed to being approached for “partnership” after the research has been conceptualised, fleshed out, funded and is ready for implementation). In this way research can be truly co-owned. Engaging potential partners on the basis of these principles, while not pleasant, has resulted in greater respect in the longer term.

The Center has an underlying capacity strengthening ethos in everything we do - and this includes capacity to challenge unequal power dynamics. The most visible imbalances are still north-south. Northern academics hold unequal power in research collaborations (e.g. larger share of funds, information asymmetry, more infrastructure to publish, fellowships benefitting northern students, etc.).

Over time, we have built a cadre of independent, respected researchers that can negotiate engagement in research partnerships on equitable terms by being mindful of these dynamics in academia and having the skills to navigate them.

Going forward, we hope to cultivate an environment where people are learning to trust and build equitable relationships, which is necessary if we want to move beyond the paternalistic way of operating. Our vision is that robust and replicable evidence generated by African researchers will drive the continent's policy agenda to resolve some of the most critical development issues of our time.

SEX-DISAGGREGATED MONITORING AND EVALUATION DATA

The power of data

In assessing this variable in previous reports, GH5050 deemed the sex-disaggregation of a single data point to be sufficient for an organisation to score positively. This year, we have raised the bar and instead require organisations to show consistent sex-disaggregation of data across core reports, policies and/or strategies in order to score positively.

World Health Organization publishes its first sex-disaggregated edition of *World Health Statistics*

Dr Samira Asma, Assistant Director-General, for Data, Analytics and Delivery, World Health Organization



For the first time, World Health Statistics 2019 reported sex-disaggregated data. This was a landmark. It sends a signal that averages are not good enough measures if we are to address health equity. We will simply not be able to deliver on our Agenda 2030 commitment to leaving no one behind if we do not have disaggregated data. Countries need this data to make evidence-informed decisions that help us to achieve a healthier, safer and fairer world.

Although we are making progress, there are still far too many blind spots in the world—places where we lack basic information to monitor, protect, and improve health. It is utterly unacceptable that at least eight of the SDG 3 indicators—which can and should be sex-disaggregated—are not. This includes indicators on disease incidence and prevalence as well as access and use of services. WHO will continue to work with countries to strengthen data and health information systems and rapidly scale up analytic capacity to advance policy and programme improvement. To do this, it is imperative and urgent for the international community to dramatically step up investments in data systems if we are going to meet our commitment to the Sustainable Development Goals, and protect and promote health and well-being, especially for those who will benefit most.

Findings

Fewer than four out of ten organisations commit to and fully sex-disaggregate data on programmatic delivery.

This includes roughly half of research and surveillance bodies, one-third of NGOs and one-fifth of private funders. No faith-based organisations in our sample disaggregate their M&E data by sex.

Figure 45. Organisations that sex-disaggregate

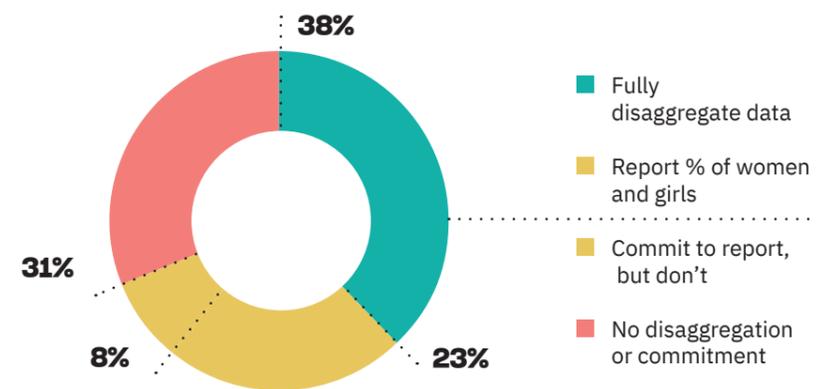


Figure 46. Organisations that sex-disaggregate M&E reporting, by sector



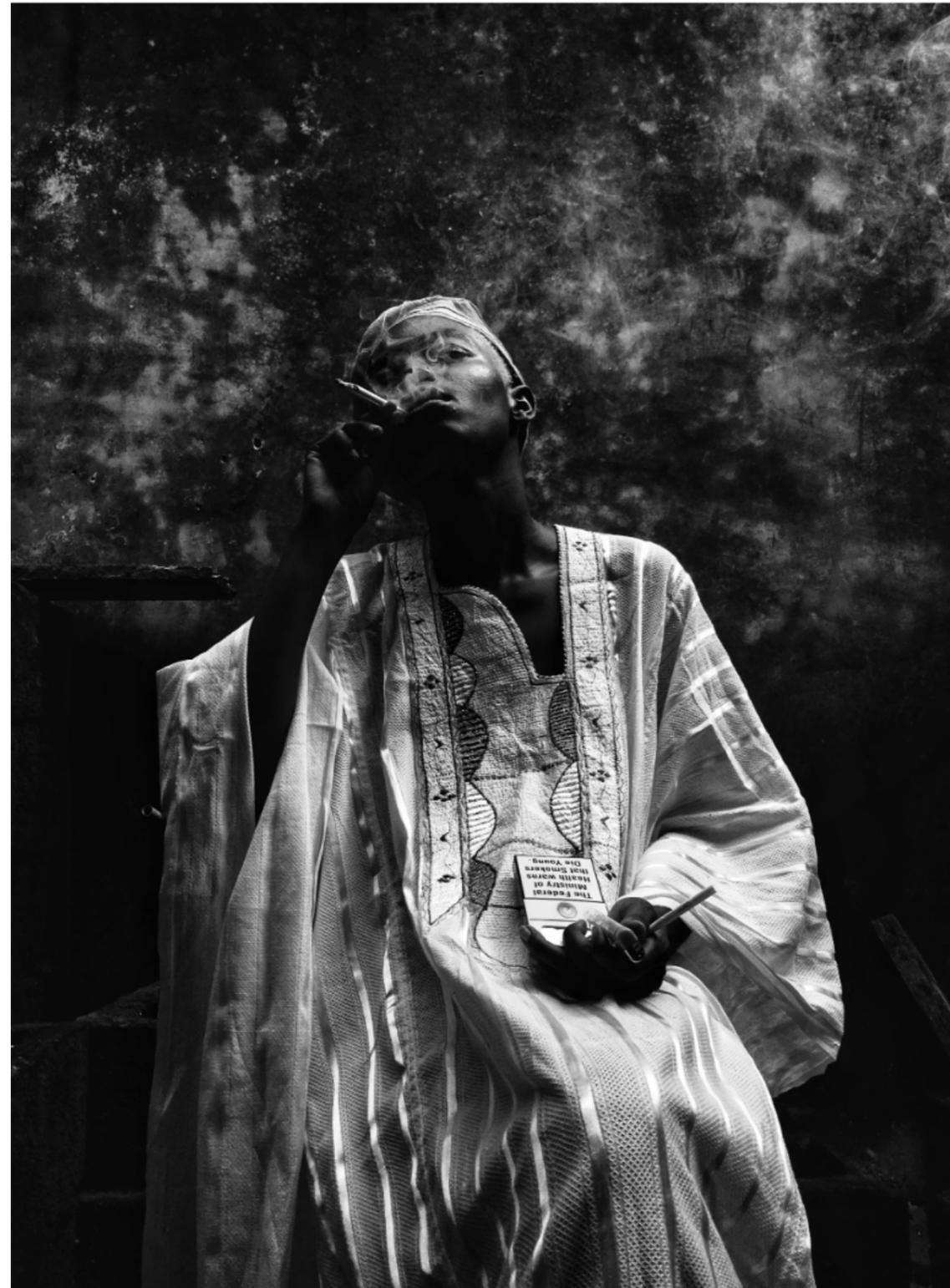
The power of data in strengthening the HIV response in South Africa

Dr Yogan Pillay, Deputy Director General, Department of Health, South Africa

The need to collect, analyse and course correct on the basis of sex disaggregation of health data is incontrovertible—it must be done.



We have concrete experience of the need for and benefits of sex disaggregated data in South Africa to ensure that our interventions are targeted to get the best possible health outcomes. Because we collect disaggregated data, we know the HIV infection and prevalence rates of women and men as well as treatment rates. This has enabled us to, for example, assess progress against the UNAIDS 90-90-90 targets by sex. In addition to sex, we also need granular data by age band so that we can assess the burden of disease and access to care for adolescents as well as for people beyond reproductive age. Our data for example suggests vastly different HIV infection rates among adolescent girls and young women as compared to their male peers. We can also determine which groups—which are generally men—have lower rates of timely access to services, including treatment, and can ensure our programmes respond to these differences.



Dogoyaro
(Benin City, Edo State, Nigeria. 2019)
Nnebuife Kwubei

A woman wearing traditional masculine attire smokes a cigarette and sips on the dogoyaro liquor. In her depiction of a woman smoking and drinking, behaviours not commonly acceptable for women in Nigeria, Nnebuife comments on the ways gender norms shape identity and limit possibilities. This role-playing also raises questions of what equality should look like, and our associations of empowerment and independence with behaviours that are harmful to our health.

Nnebuifé Kwubéi is a student at the University of Benin, Nigeria.

KEY TAKEAWAYS FROM OUR FINDINGS

Like every other social construction, 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, rather than simply focusing on the specific gender-related needs of certain groups in the population.

There has been a tendency within global health to equate gender to the needs of women and girls. This risks the perpetuation of the ideas that gender is a ‘problem’ associated only with women and girls, and that the gendered norms, behaviours and expectations of men and boys do not carry health-related consequences. Both ideas carry negative implications for the health outcomes of everyone. It is, therefore, both highly consequential and heartening to see that the majority of the norm-setting multilateral agencies apply gender-responsive approaches to address the underlying structural issues for men, women and transgender people.

We understand that men have greater relational power than women in most spheres across most if not all societies. Yet when it comes to their health, they face greater risk exposures, in part because of gendered roles, expectations and behaviours in society. An intersectional lens highlights that power disparities among men along other axes, such as socioeconomic status, are equally important determinants of health inequities.

Transforming unhealthy gender norms.

Fewer than one-third of organisations in our sample take a gender-transformative approach to their programming. Such approaches embedded in the work of global health organisations have been shown to yield more effective outcomes (the body of published evidence is focused on the health of women and girls). While programmes that are gender-sensitive or gender-specific are a step in the right direction, global health organisations should also be focusing their attention on the structures and norms that lie at the heart of gender inequalities and their impact on health outcomes.

Gender impacts everyone’s health.

When organisations state a population focus for their policies and programmes, it is predominantly on improving the health of women and girls. Forty percent of organisations that are responding to gender in some way do so to meet the needs of everyone, whereas 60% are focused on the health of women and girls. Among the organisations that include a focus on men and boys, they tend not to do so in a gender-responsiveness manner—despite the body of evidence showing the role that gender plays in everyone’s health outcomes.

Failure to recognise and address the role that gender plays in the health of everyone is likely to mean that no one’s health needs are fully met. It means that women and girls will continue to be targeted by policies and programmes that respond to their sex-specific needs (e.g. associated with reproduction) but that fail to address underlying inequalities that drive poor health outcomes across other areas (e.g. their increased exposure to health-harming products). It means that the global health system will remain generally silent on the role that gender plays in determining poor health outcomes among men and boys, despite the impact of widespread inequalities in the distribution of economic and political power on their well-being. It is time for the global health system to recognise and address health risks rooted in long-standing social, economic and gender inequalities that impact on the health and well-being of everyone.

Sex-disaggregated data is a minimum requirement.

Fewer than half of organisations report sex-disaggregated data. The lack of sex-disaggregated reporting among funders and research and surveillance organisations is particularly concerning. This is a lost opportunity for understanding the distribution of ill-health, who is benefitting from interventions, and who is being left behind.

HIGH SCORERS

GH5050 identified 13 very high-scoring organisations and a further 27 high-scoring organisations. High scorers per sector have also been recognised. Scoring is based on performance across the four dimensions of the 2020 analysis (Section 2). It does not reflect analysis of organisations' SDG-related focus, or whether their programmatic approaches focus on a specific sex. In the future, GH5050 will continue to explore applying more specificity in its scoring to capture the gender-responsiveness of programmatic policies and strategies.

13 Very high scorers

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Population Services International (PSI)
Global Affairs Canada	SRHR Africa Trust
International Planned Parenthood Federation (IPPF)	Swedish International Development Cooperation Agency (Sida)
Joint United Nations Programme on HIV and AIDS (UNAIDS)	UNHCR, the UN Refugee Agency
Nutrition International	UNICEF
Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)	Unitaid
	United Nations Development Programme (UNDP)

27 High scorers

Abt Associates*	National Institutes of Health (NIH)
Africa Population and Health Research Centre (APHRC)	Palladium*
BRAC	PATH*
CARE International	Plan International
Foundation for Innovative New Diagnostics (FIND)*	Reproductive Health Supplies Coalition
GAVI, the Vaccine Alliance	Scaling Up Nutrition Stop
Global Alliance for Improved Nutrition (GAIN)	TB Partnership
Global Fund to Fight AIDS, Tuberculosis & Malaria	UN Women
Health Action International	Unilever*
Jhpiego	United Nations Office on Drugs and Crime (UNODC)
Management Sciences for Health (MSH)	United Nations Population Fund (UNFPA)
Medicines Patent Pool (MPP)	World Bank Group World
Mercy Corps	Food Programme
	World Health Organization (WHO)

*High scorers with important progress still to be made on one or more variables.

High scorers by sector⁴³

Bilaterals and multilaterals	Consultancies	Private sector	Regional organisations
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Palladium	Abt Associates	African Union Commission (AUC)
Global Affairs Canada		Unilever	
Swedish International Development Cooperation Agency (Sida)	Non-governmental and non-profit organisations	Public-Private Partnerships	Research & surveillance
Unitaid	International Planned Parenthood Federation (IPPF)	Nutrition International	African Population Health Research Center (APHRC)
	Population Services International	Partnership for Maternal, Newborn and Child Health (PMNCH)	National Institutes of Health (NIH)
	SRHR Africa Trust		

⁴³ High scorers are not presented for Faith-based organisations or Funding and philanthropies, as no organisations from these sectors scored in the top 20%. Given the fact that many workplace policies are system-wide for UN system agencies, high-scorers have not been presented for this sector.

Section 3

The global health agenda

Which priorities and for whom?



Life Partners
(Karnataka, India)
Digwas G Hegde

A husband and his transgender wife stand in front of their home of 40 years. In 2014, India's supreme court enshrined transgender rights into law. This was a landmark achievement for the trans community, though activists argue that it still fails to recognise the fundamental right to self-identify. This image encourages us to consider the lived realities behind national debates without sensationalising the trans experience.

Digwas G Hegde is a fine art and travel photographer from India.

Global burden of disease among women and men

The Sustainable Development Goals set out an extensive agenda that aims to leave no one behind. SDG 3, the health-specific goal, includes 13 targets to drive action and impact on the greatest health challenges facing the global population by 2030.

Over the past 25 years, the burden of ill-health has shifted considerably. The relative contribution of infectious diseases is falling in many parts of the world. At the same time, non-communicable diseases (NCDs—particularly heart disease, lung disease, cancers and diabetes) are now responsible for the greatest proportion of morbidity and premature mortality (below the age of 70 years) globally. The SDG agenda reflects this shift and has set targets for a wide range of diseases and conditions, including NCDs. The SDG agenda substantially expands the preceding Millennium Development Goal (MDG) agenda, 2000-2015, which focused on a narrower set of global health issues, namely HIV, tuberculosis, malaria, and maternal and child mortality.

Sex-disaggregated data on major causes of illness and premature mortality give us some indication of how the burden of disease is distributed within and between populations. Such data can help identify where attention and resources should be allocated to most effectively reduce the overall levels of population ill-health. Over the past 25 years, data from the World Bank and later from the Institute for Health Metrics and Evaluation (IHME) has consistently shown that men suffer higher rates of ill-health and lower life expectancies than women. Much of this difference can be accounted for by men's higher exposure to tobacco, alcohol and poor diets as well as violence and traffic-related and occupational injuries. Conversely, while women live longer, a large proportion of those extra years of life are likely to be spent suffering from chronic illnesses.⁴⁴

Are global health organisations aligned with the health agenda established by the SDGs?

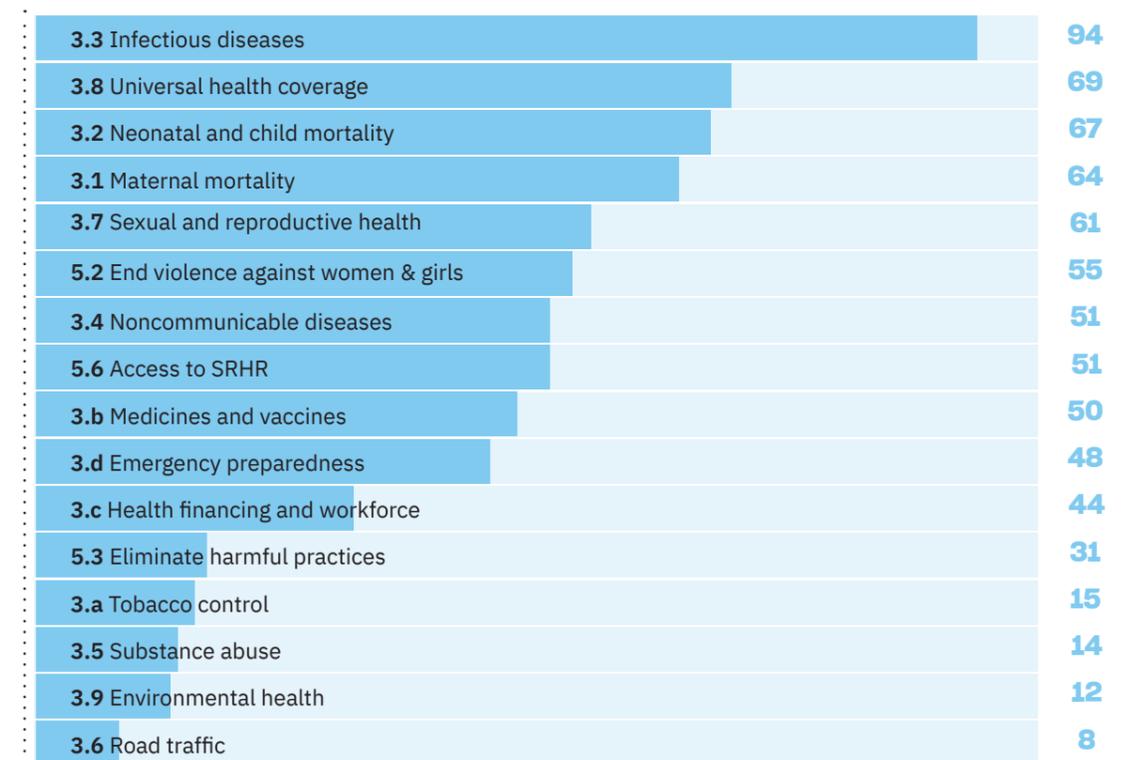
To explore the extent to which global health organisations are working across the SDG health agenda, GH5050 reviewed the mission statements and core strategies of 146 organisations in our 2020 sample. We identified organisations' stated priorities⁴⁵ and assessed how they align to the targets of SDG 3 and three targets of SDG 5 ("the gender equality goal"). These latter targets were: 5.2 (elimination of all violence against women and girls);⁴⁶ 5.3 (elimination of harmful practices such as child marriage); and 5.6 (universal access to sexual and reproductive health and reproductive rights).

We did not include the 42 private sector companies nor the 10 consultancy companies in this sub-analysis. Many of the private sector companies generally seek to influence global health policy, but do not have global health promotion or action to advance the health-related SDGs as a core function. This means that identification of their priorities in line with SDG targets is difficult to assess from their websites.

One organisation was excluded as the focus of work is on patents, and another was excluded as it was originally classified as being a for-profit and therefore ineligible for inclusion.

In total, 740 stated priorities that aligned with the SDG 3 and the health-related SDG 5 targets were identified among the 146 organisations (see Figure 47).

Figure 47. Number of organisations (146 in total) that state a focus on SDG 3 and health-related SDG 5 targets

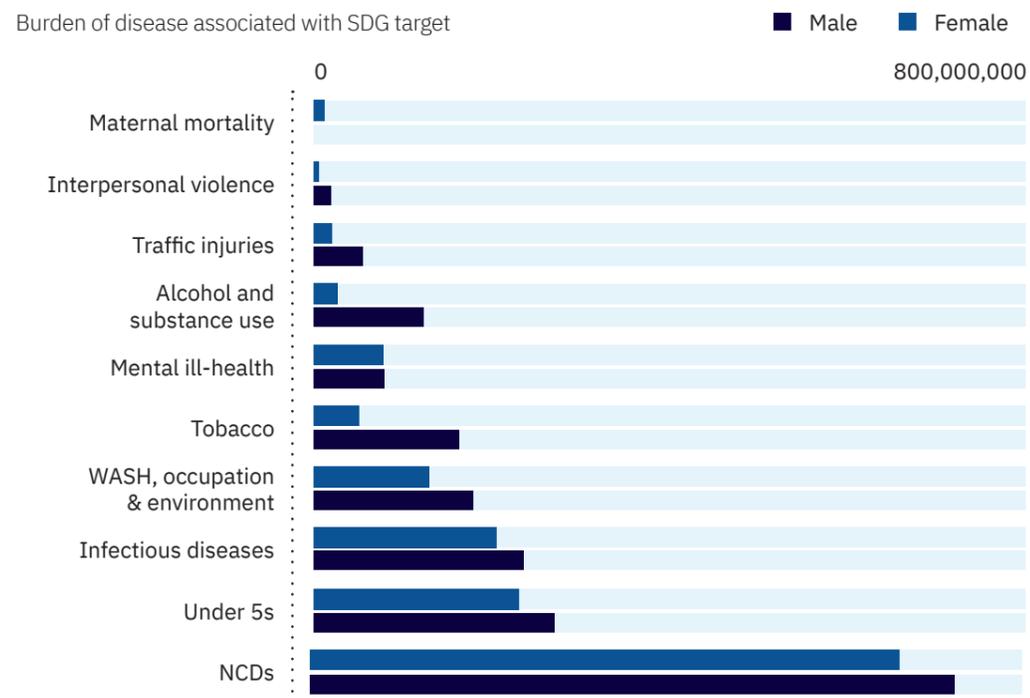


What is the burden of disease associated with the SDG health-related targets?

We find that not all health-related SDG targets receive the same amount of attention from global health organisations—ranging from 94 organisations that prioritised work on target 3.3 (infectious diseases) to 8 that prioritised work on target 3.6 (road traffic injuries and deaths).

One explanation for this could be that some targets represent areas that have a lower burden of disease in the global population. We therefore calculated the burden of disease associated with each target (where possible, see Box 4) in order to compare to the number of organisations focusing on each target (Figures 48 & 49).

Figure 48. Burden of disease (disability-adjusted life years) among women and men across select SDG3 targets and interpersonal violence

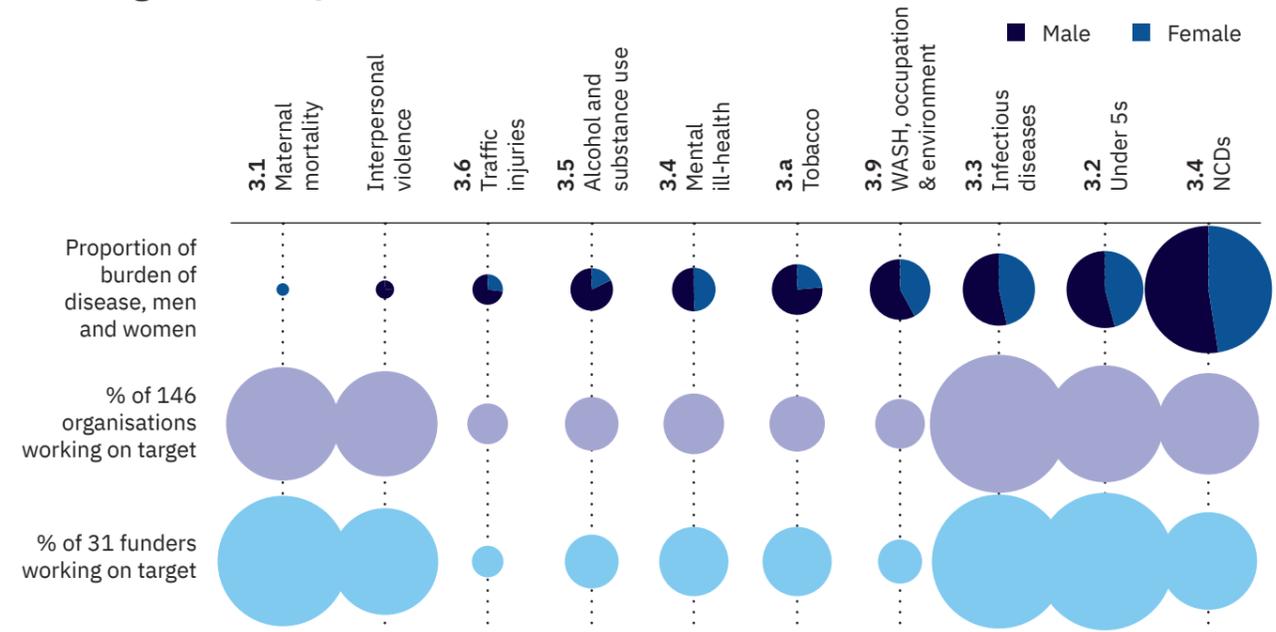


Are organisational priorities aligned with the distribution of the burden of disease?

Figure 49 compares the burden of disease and organisational priorities. It presents the organisational focus of two groups: the overall sample of 146 organisations, and a subset of 31 organisations that are classified as exerting financial power (see page 69).

We found a mismatch between attention paid by organisations (all, and financing subset) to some targets and global burdens of disease associated with those targets. Of note, those health issues that represent a continuation of the MDG agenda—maternal and child mortality and infectious diseases—continue to receive the largest proportion of attention of the global health ecosystem. The newer SDG-era targets, particularly NCDs, do not receive proportional attention from funders or other organisations.

Figure 49. Assessing alignment: global burden of disease compared to organisational priorities



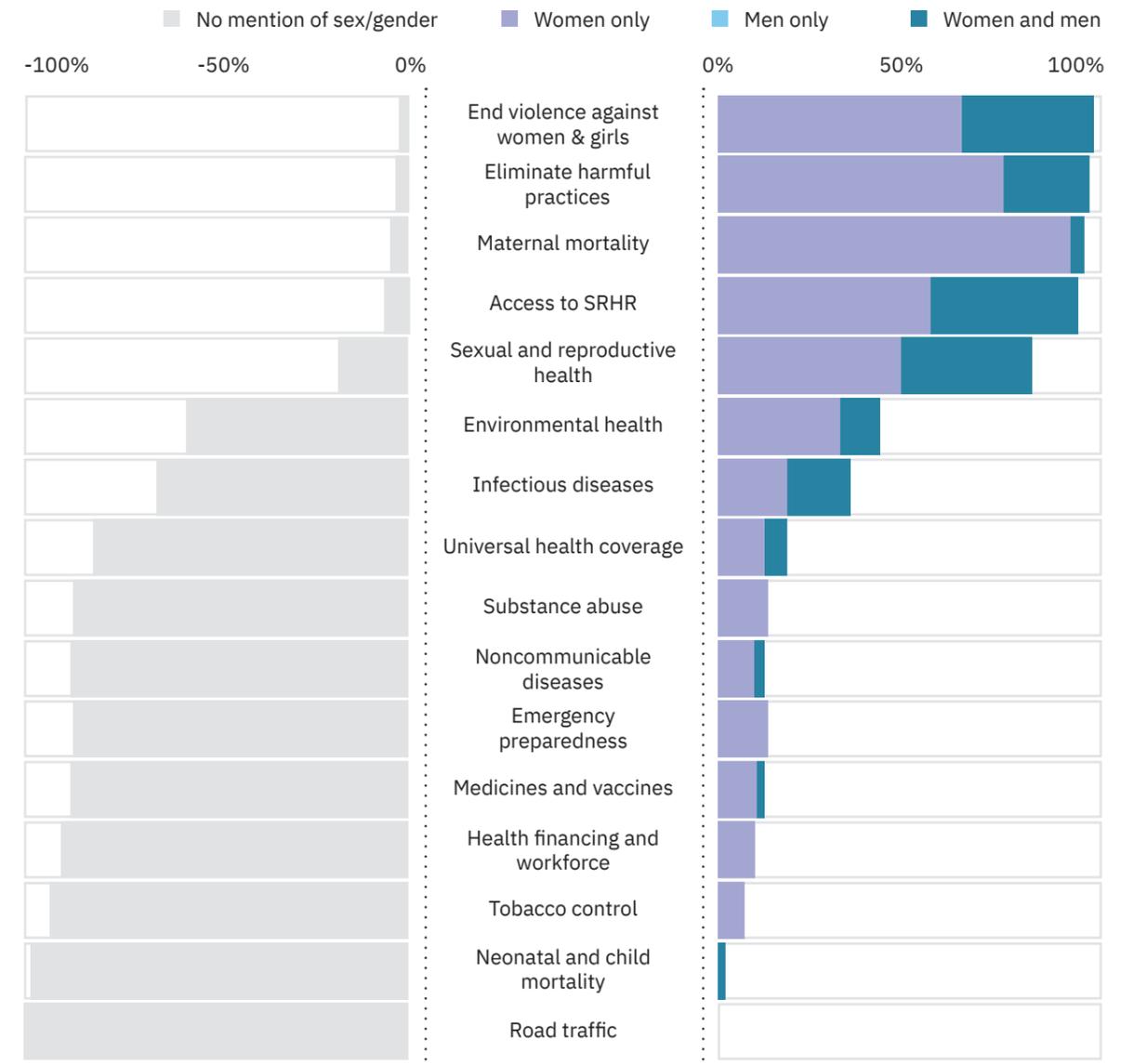
Health issues that represent a continuation of the MDG agenda continue to receive the most attention of the global health system. Newer SDG-era targets, particularly NCDs, do not receive proportional attention.

Which populations do global health organisations target?

Given the differences in the distribution of DALYs between men and women, we also assessed whether organisations mentioned targeting specific populations—i.e. women and girls, men and boys, both or neither—in relation to their programmatic priorities. We found 72 organisations focused on one sex only. We did not find any organisation working solely on men’s health; all organisations with a single-sex/gender focus were concerned with advancing the health of women and girls. The other 74 organisations were either focused on the whole population or did not specify who they were targeting. For the sex-specific SDG targets (3.1, 5.2 and 5.3, i.e. reducing maternal mortality, and eliminating violence and harmful practices suffered by women and girls), a focus on women and girls would seem to be consistent with the aims of the targets. For other targets, however, the rationale for a sex-specific focus is less clear.

A sex-specific focus is not synonymous with being fully gender-responsive, and Figure 43 (page 76) highlights that the majority of organisations are not gender-transformative in their policies and programmes. This is despite the role that gender plays in driving risk exposure and health outcomes across all targets.⁵⁰

Figure 50. Organisations that specify a population focus in their programmatic priorities, by SDG target



Box 4. Calculating the burden of disease attributable to SDG 3 and SDG 5 targets

There are a number of ways of calculating the burden of disease. We used the disability-adjusted life year (DALY⁴⁷) estimates (2017) generated by the Institute for Health Metrics and Evaluation (IHME). Attributing DALYs to SDG 3 and 5 targets is imprecise as DALY data are intended to capture all premature mortality and morbidity and are generally not presented aligned to SDG targets. However, we have taken an “inclusive” approach and included all DALYs potentially associated with an SDG target. For example, target 3.4 is “By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being”—leaving open to interpretation the exact definition of an NCD. In this case we included all DALYs under the label ‘NCD’ in the IHME data, but calculated the burden attributed to mental ill-health separately. Similarly, for target 3.2 “End preventable deaths of children and neonates under 5 years old” we have included all DALYs in the under 5s and for target 3.3 “end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases”, we included all DALYs attributed to communicable diseases.

We recognise that this may lead to an overestimation of DALYs associated with some targets but believe that the general patterns of alignment between DALYs, SDG targets and attention paid by organisations represent a valid comparison (Figure 49).

For some targets—namely, alcohol and substance use, tobacco use, environmental and pollution exposure—the DALYs are calculated from risk of exposure rather than from individual diseases/conditions. Several of the health-related targets in SDG 3 and SDG 5 concern access to services, and we were not able to calculate DALYs for these targets (i.e. target 3.7 “Ensure universal access to sexual and reproductive health-care services”, 3.8 “Achieve universal health coverage” and 5.6 “Ensure universal access to sexual and reproductive health and reproductive rights”).

Measuring disease burden associated with SDG targets (2017 data)⁴⁸

SDG target	Method of measuring DALY burden associated with the target
SDG 3.1: Reduce maternal mortality	All DALYs associated with maternal health at all ages [cause]
SDG 3.2: End preventable deaths of children and neonates under 5 years old	All DALYs in the under 5s [cause]
SDG 3.3: End epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	All DALYs associated with all communicable diseases at all ages [cause]
SDG 3.4: Reduce premature mortality from non-communicable diseases and promote mental health and well-being	Split into two categories of DALYs: 3.4 Mental ill-health = mental disorders plus self-harm at all ages [cause] 3.4 NCDs = all NCDs except mental health and substance use, at all ages [cause]
SDG 3.5: Prevention of substance abuse, including narcotic drug abuse and harmful use of alcohol	DALY risk data—alcohol use plus drug use, all ages [risk]
SDG 3.6: Halve the number of global deaths and injuries from road traffic accidents	All DALYs associated with transport injuries, all ages [cause]
SDG 3.9: Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	DALY risk data—environmental and occupational risks, all ages [risk]
SDG 3.a: Strengthen the implementation of the WHO Framework Convention on Tobacco Control	DALY risk data—tobacco, all ages [risk]
SDG 5.2 (expanded): Eliminate all forms of violence against all women and girls ⁴⁹	DALYs associated with interpersonal violence, all ages, all genders [cause]

KEY TAKEAWAYS FROM OUR FINDINGS

Global health organisations wield power (financial, normative) at both global and national levels. Priorities set by these organisations about which health issues and which populations should be targeted have an impact on who benefits and which conditions receive adequate attention. Measuring the distribution of ill-health within and across populations has been a core function of global health research and surveillance organisations for many years, and the global health sector benefits from having extensive and robust empirical evidence that can contribute to decisions around priority-setting.

Prioritisation and neglect.

Some health-related SDG targets get more attention than others, and some with high DALY burdens seem particularly neglected (e.g. NCDs and environmental health). Analysis of the distribution of the burden of disease and corresponding organisational focus across different SDG targets is not intended to pit targets against each other, but, rather, to highlight gaps in attention and funding. While recognising that factors other than the burden of disease are important in setting priorities, we should expect to see greater alignment between burden of disease and the priorities of global health organisations than our report finds.

Our analysis has shown that the global health sector is stuck in the MDG era, failing, for example, to adequately address the rising burden of NCDs. While it is important that the unfinished MDG agenda is addressed, a full five years into the fifteen-year SDG agenda, we believe that global health organisations must also ramp up action on the new SDG elements.

Population-specific focus.

Our report has shown that around half of all organisations that state a population focus are targeting attention and resources to women and girls. Much of this is associated with sex-specific reproductive needs, while some programmes also focus on the gendered inequalities that drive violence and harmful practices suffered by women and girls. Our analysis of sex-disaggregated DALYs across SDG targets has shown that for some targets (e.g. alcohol, tobacco, substance use), the burden in men is much greater than in women—but no organisations are focusing specifically on men. Apart from their work addressing sexual and reproductive health and ending violence and harmful practices, the vast majority of organisations make no distinction between the health-related risks and needs of women and men.

As organisations shift towards addressing the full range of SDG health-related targets, we encourage them to not only consider the sex-disaggregated distribution of disease associated with each target (now, and likely future trends), but also to ensure that they integrate a fully gender-transformative approach for each target. Taking a gender lens to the SDG targets will not only promote more equitable outcomes, but is likely to result in more effective policies and programmes that deliver better health for everyone across all health-related targets.

Glossary of gender-related terms

This glossary presents how GH5050 understands these concepts and applies them in this report.

Diversity

The representation of varied identities and differences (gender, race, ethnicity, disability, sexual orientation, gender identity, national origin, tribe, caste, socio-economic 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

Gender

Gender refers to the roles, behaviours, activities, and attributes that a given society at a given time considers appropriate for men and women and people with non-binary gender identities. In addition to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, gender also refers to the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialisation processes. They are context/time-specific and changeable.

Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over power and resources, as well as decision-making opportunities. Gender is part of the broader context of sociocultural power dynamics, as are other important criteria including class, disability status, race, poverty level, ethnic group, sexual orientation, age, etc.

Gender-blind

The failure to recognise that the roles and responsibilities of men/ boys and women/ girls are assigned to them in specific social, cultural, economic, and political contexts and backgrounds. Projects, programmes, policies and attitudes that are gender blind do not take into account these different roles and diverse needs. They maintain the status quo and will not help transform the unequal structure of gender relations.

Gender equality

Women, men, non-binary and transgender people, 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-transformative

Addresses the causes of gender-based inequities and includes ways to transform harmful gender norms, roles and relations, including addressing power in relationships.

Intersectionality

“Intersectionality moves beyond examining individual factors such as biology, socioeconomic status, sex, gender, and race. Instead, it focuses on the relationships and interactions between such factors, and across multiple levels of society, to determine how health is shaped across population groups and geographical contexts.”⁵¹

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.

Performance by sector

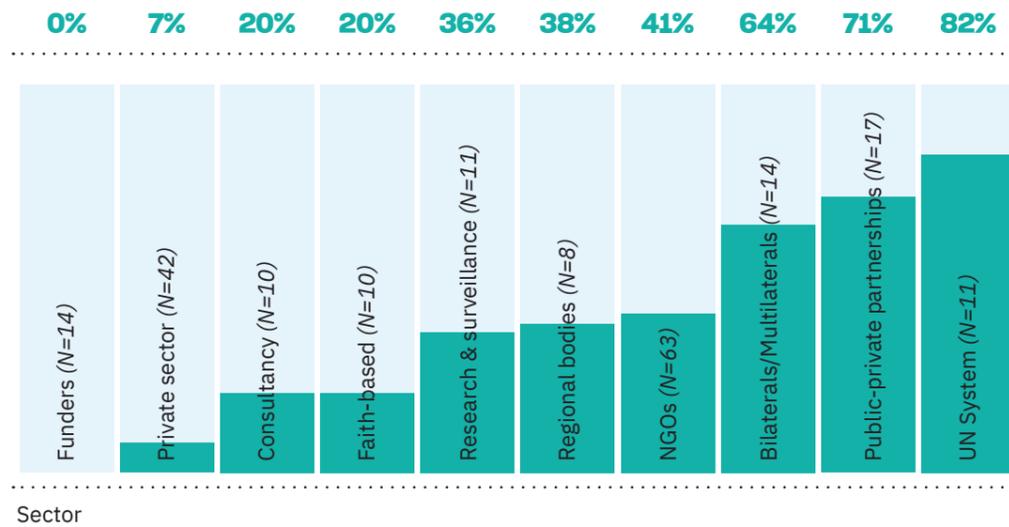
Organisations that commit to gender equality



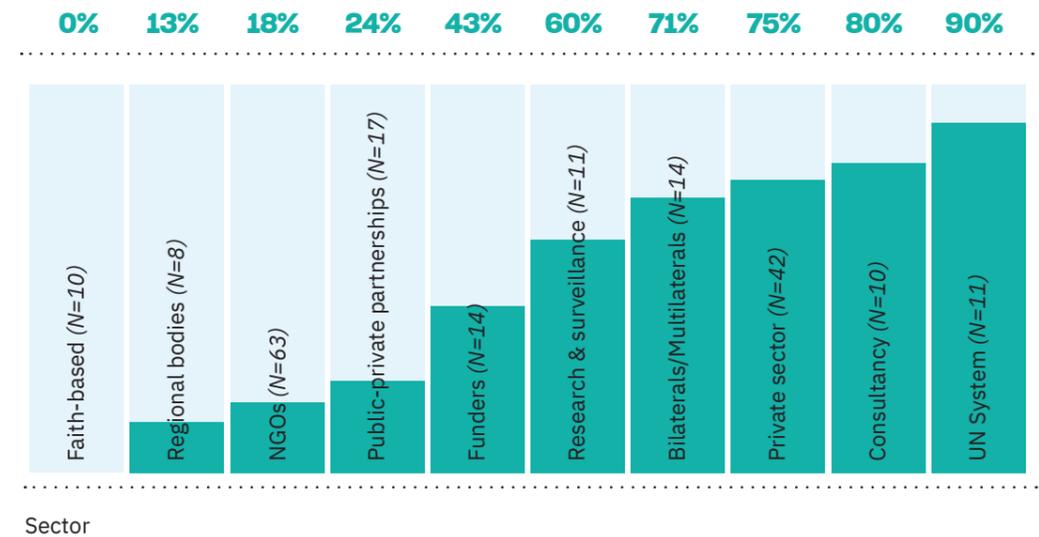
Organisations with workplace gender equality policies



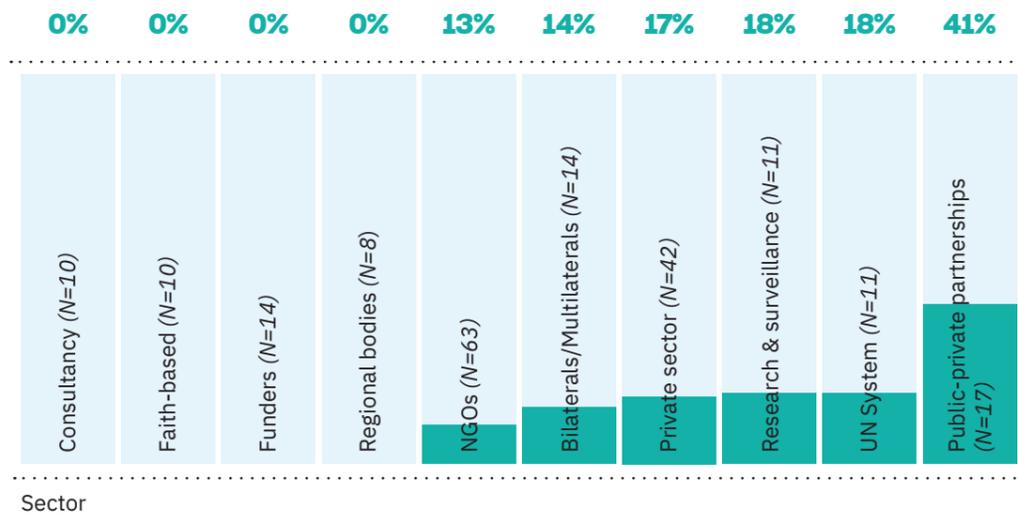
Organisations that define gender in line with global norms



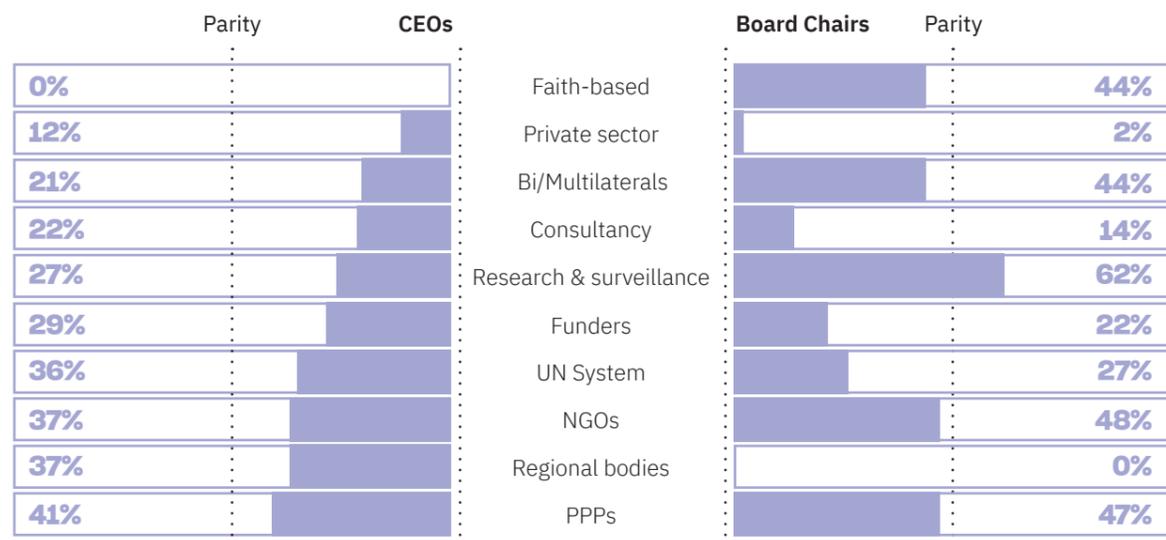
Organisations with diversity and inclusion policies



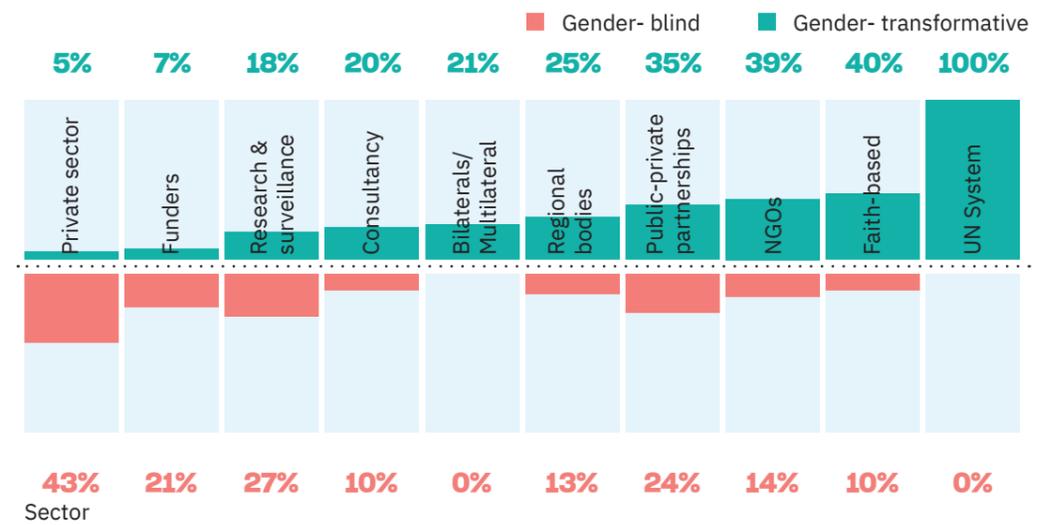
Organisations with board diversity policies



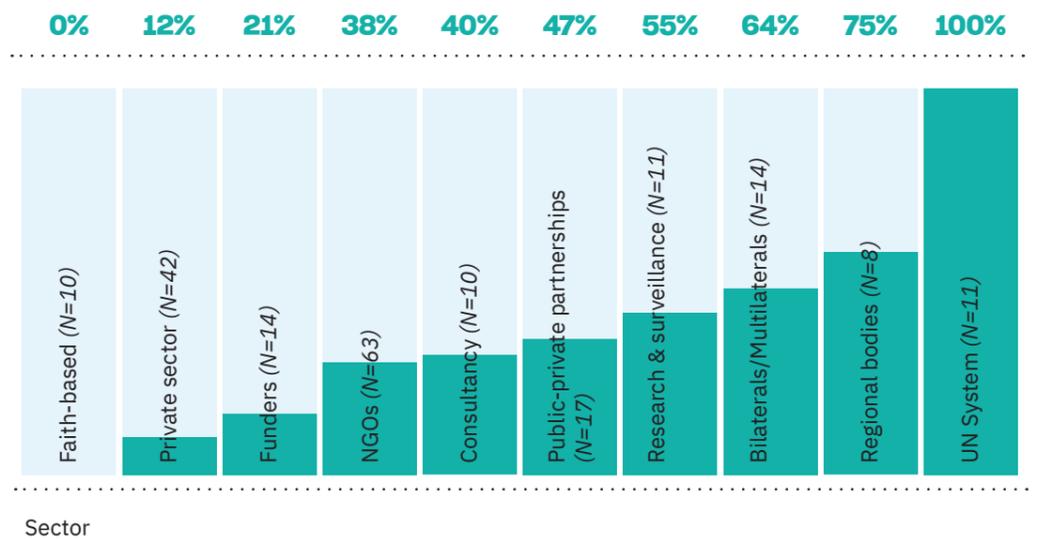
Women CEOs and Board Chairs



Organisational approaches to address underlying gender-related drivers of ill-health



Organisations that sex-disaggregate M&E reporting



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 'epistemological 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 200 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. Rather, organisations under review have been identified as having demonstrated an interest in influencing global health and/or global health policy.

Over the past three 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 2020 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,⁵² or companies that contributed to consultations on the Uruguay Road Map on noncommunicable diseases⁵³
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 2020 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. 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).

Data on the gender and geography of power are drawn solely from publicly available information. Aside from gender, data on the individual characteristics of leadership have been aggregated and are not presented in an individually attributable manner.

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 2020 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, this year we reserved the Green scoring for those organisations regularly reporting 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 and Globalization and Health) prior to 2017.

Organisational priorities were assessed by reviewing publicly available information on each organisation's website. An organisation was deemed to be paying attention to an SDG target when its stated priorities, strategic focus as well as programmatic

areas aligned with the target. Where an organisation's work contributed to the achievement of a target, it was also noted whether the sex of the target population was specified. Two reviewers independently assessed how each organisation's work linked with each SDG target. Any disagreements were resolved by discussion with a third reviewer.

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.

Strengths and limitations

The methods described above have been discussed with the head of ethics of University College London, where GH5050 is housed, and found to be in compliance with international norms. 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.

List of organisations

To view the full GH5050 Gender and Health Index and explore individual organisation's performance, visit globalhealth5050.org/data.

Bilaterals & Global Multilaterals

Agence Française de Développement (AFD)

Department for International Development, UK (DFID)

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

European Commission

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	McKinsey & Company
Dalberg	Mott MacDonald
Deloitte	Palladium
John Snow, Inc	PwC
KPMG	Rabin Martin

Faith-Based Organisations

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

NGOs & Non-Profits

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

Funders and Philanthropies

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

Research & Surveillance

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

Public-Private Partnerships

Clean Cooking Alliance	Global Road Safety Partnership (GRSP)
Drugs for Neglected Diseases Initiative (DNDi)	International Vaccine Institute (IVI)
Foundation for Innovative New Diagnostics (FIND)	Medicines for Malaria Venture
GAVI, the Vaccine Alliance	Nutrition International
Global Alliance for Improved Nutrition (GAIN)	Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)
Global Fund to Fight AIDS, Tuberculosis & Malaria	RBM Partnership to End Malaria
Global Handwashing Partnership (GHP)	Scaling Up Nutrition
Global Health Innovative Technology Fund (GHIT Fund)	Stop TB Partnership
	TB Alliance

Regional Organisations

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

Private Sector

AB InBev	General Electric	International Food and Beverage Alliance (IFBA)	Pfizer
AbbVie	Gilead	Johnson & Johnson	Philips
Abt Associates	GlaxoSmithKline (GSK)	Keuhne + Nagel	Reckitt Benckiser Group (RB)
Becton, Dickinson and Company	GSMA	Laerdal	Safaricom
BP	Heineken	McCann Health	Sumitomo Chemical
Bristol-Myers Squibb	Intel	Medela	Teck Resources
Coca-Cola	International Council of Beverages Associations (ICBA)	Medtronic	TOMS
Consumer Brands Association (formerly The Grocery Manufacturers Association)	International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)	Merck	Unilever
DSM	International Federation of Pharmaceutical Wholesalers Foundation	Mylan	US Council for International Business (USCIB)
Eli Lilly and Company	Novartis	Nestle	Vestergaard Frandsen
ExxonMobil	Novo Nordisk		

United Nations System

Food and Agricultural Organization of the United Nations (FAO)	UN Women	United Nations High Commissioner for Refugees (UNHCR)
International Labour Organization (ILO)	UNICEF	United Nations Population Fund (UNFPA)
Joint United Nations Programme on HIV and AIDS (UNAIDS)	United Nations Development Programme (UNDP)	World Food Programme
	United Nations Office on Drugs and Crime (UNODC)	World Health Organization (WHO)

Footnotes

¹ GBHealth. Business, Health and the SDGs. <http://www.gbchealth.org/focal-point-roles/post-2015-working-group/>

² World Health Organization. (2017). Governance: Development of an outcome document for the WHO Global Conference on NCDs. <https://www.who.int/ncds/governance/outcome-document-global-conference/en/>

³ As calculated by the World Bank.

⁴ https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

⁵ 198 rather than 200 organisations given that two organisations in our sample have a decentralised structure and no official headquarters.

⁶ Calculated using the World Bank Atlas method. Low-income economies: GNI per capita of \$1,025 or less in 2018. Lower middle-income economies: GNI per capita between \$1,026 and \$3,995. Upper middle-income economies: GNI per capita between \$3,996 and \$12,375. High-income economies: GNI per capita of \$12,376 or more. <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>

⁷ <https://www.gavi.org/about/programme-policies/gender/>

⁸ <https://www.sadc.int/issues/gender/>

⁹ <https://www.unglobalcompact.org/>

¹⁰ <https://www.weeps.org/>

¹¹ Associations are statistically significant. They do not inform any interpretation of causation. They have not been controlled for confounders.

¹² These totals differ slightly than those reported in previous reports. In 2020, GH5050 scored those organisations with 10 or fewer staff as NA for this variable and removed those organisations (totaling 6) from the denominator of these calculations.

¹³ <http://www.satregional.org/join-workplace-50-50/>

¹⁴ <https://plan-international.org/publications/policy-gender-equality-inclusion>

¹⁵ <https://www.rb.com/media/news/2019/april/rb-announces-significant-steps-to-drive-diversity-and-inclusion/>

¹⁶ Financial Times Stock Exchange, an index of the 100 largest (by Market Capitalisation) companies listed on the London Stock Exchange.

¹⁷ <https://www.fordfound.org/about/people/diversity-equity-and-inclusion/>

¹⁸ <https://portal.fiocruz.br/pro-equidade>

¹⁹ https://www.salvationarmy.org.uk/sites/default/files/media/terms_and_conditions.pdf

²⁰ https://www.safaricom.co.ke/sustainabilityreport_2019/ebook/71/#zoom=z

²¹ <http://documents.worldbank.org/curated/en/455971467992805787/Women-business-and-the-law-2016-getting-to-equal>

²² <http://www.fundacionmicrofinanzasbbva.org/revistaprogreso/en/disclosure-of-information-by-chilean-listed-companies/>

²³ <https://corpgov.law.harvard.edu/2017/01/05/gender-parity-on-boards-around-the-world/>

²⁴ Joecks J, Pull K, Vetter K. Gender Diversity in the Boardroom and Firm Performance: What Exactly Constitutes a “Critical Mass?” *Journal of Business Ethics*, 2013, 118(1):61-72.

²⁵ Calculated based on observed annual increase of 1.4% in proportion of organisations with senior management at parity (45-55% women), and 2% among boards, between 2018 and 2020.

²⁶ https://ec.europa.eu/eurostat/statistics-explained/index.php/Gender_pay_gap_statistics#Gender_pay_gap_much_lower_for_young_employees

²⁷ Statistically significant correlations. No assessment of causation. No control of confounders.

³² Normative and regional bodies were not included in this analysis on board chairs, given lack of information regarding these appointments.

³³ Morning A. (2015) Ethnic Classification in Global Perspective: A Cross-National Survey of the 2000 Census Round. In: Simon P., Piché V., Gagnon A. (eds) *Social Statistics and Ethnic Diversity*. IMISCOE Research Series. Springer, Cham

³⁴ https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

³⁵ <https://www.sida.se/contentassets/a3f08692e731475db106fdf84f2fb9bd/gender-tool-analysis.pdf>

³⁶ <https://promundoglobal.org/wp-content/uploads/2018/11/Masculine-Norms-Mens-Health-Executive-Summary-1.pdf>

³⁷ <https://www.healthpovertyaction.org/change-is-happening/our-approach/>

³⁸ <https://www.jnj.com/innovation/5-ways-johnson-johnson-is-helping-revolutionize-clinical-trials>

³⁹ https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf

⁴⁰ <http://www.brac.net/program/gender-justice-and-diversity/>

⁴¹ https://www.fctc.org/wp-content/uploads/2018/09/FCACOP8Brief_Gender_EN.pdf

⁴² Anne M. Khisa, Peter Ngure, Evelyn Gitau, Justus Musasiah, Eunice Kilonzo, Emmanuel Otukpa, Marta Vicente-Crespo, Catherine Kyobutungi, Alex Ezeh & Sharon Fonn (2019) Gender responsive multidisciplinary doctoral training program: the Consortium for Advanced Research Training in Africa (CARTA) experience, *Global Health Action*, 12:1, DOI: [10.1080/16549716.2019.167000](https://doi.org/10.1080/16549716.2019.167000)

⁴⁴ Kyu, Hmwe Hmwe, Abate, Degu, Abate, Kalkidan Hassen, Abay, Solomon M, Abbafati, Cristiana, Abbasi, Nooshin, . . . Accrombessi, Manfred Mario Kokou. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 392(10159), 1859-1922.

⁴⁵ A ‘priority’ includes one of the following health-promoting activities articulated in an organisation’s corporate documentation: healthy population (promote healthy lifestyle, prevent risk factors, prevention of disorder and health problems), populations with risk (health promotion and screening, action on risk factors, build resilience, maintain healthy lifestyle), population with symptoms (early detection, treatment & care, maintain healthy lifestyle, disability limitation and rehabilitation), population with known disorder (treatment & care, maintain healthy lifestyle, disability limitation & rehabilitation) - as outlined in Figure 3 in Kumar and Preetha <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3326808/>

⁴⁶ As per the focus of SDG 5.2, we captured only those organisations that have violence reduction programmes with women and girls as their core focus. We note with concern however that interpersonal violence between men is not included the SDG agenda.

⁴⁷ From WHO: One DALY can be thought of as one lost year of “healthy” life. The sum of DALYs across the population measures the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. See: https://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

⁴⁸ IHME data from <http://ghdx.healthdata.org/gbd-results-tool>

⁴⁹ SDG 5.2 is specific to the violence suffered by women and girls. In our calculations we have used IHME data for all forms of interpersonal violence suffered by all people - i.e. we include men and boys as well as women and girls, since eliminating violence is important to the health and wellbeing of everyone.

⁵⁰ Manandhar M, Hawkes S, Buse K, et al. “How gender interacts with health and relates to progress across the Agenda 2030 for Sustainable Development.” WHO Bulletin 2018. <http://dx.doi.org/10.2471/BLT.18.211607>

⁵¹ Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, 391(10140), 2589-2591.

⁵² GBHealth. Business, Health and the SDGs. <http://www.gbchealth.org/focal-point-roles/post-2015-working-group/>

⁵³ World Health Organization. (2017). Governance: Development of an outcome document for the WHO Global Conference on NCDs. <https://www.who.int/ncds/governance/outcome-document-global-conference/en/>

⁵⁴ Hawkes, S., & Buse, K. (2013). Gender and global health: Evidence, policy, and inconvenient truths. *The Lancet*, Volume 381 (9879), pp.1783-1787. [https://www.thelancet.com/article/S0140-6736\(13\)60253-6/pdf](https://www.thelancet.com/article/S0140-6736(13)60253-6/pdf)

⁵⁵ Hawkes S, Buse K, & Kapilashrami A. (2017). Gender blind? An analysis of global public-private partnerships for health. *Globalization and Health*, 13 (1) pp.1-11. <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0249-1>

Some rights reserved: Global Health 50/50 Report 2020 by Global Health 50/50 is licensed under a Creative Commons Attribution NonCommercial 4.0 International License. Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that Global Health 50/50 [GH5050] endorses any specific organisation, products or services. The use of the logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: ‘This translation was not created by GH5050. The GH5050 are not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition.’ Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Third-party materials: If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third party-owned component in the work rests solely with the user.

General disclaimers: All reasonable precautions have been taken by the authors and GH5050 to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the authors/GH5050 be liable for damages arising from its use.

The named members of GH5050 alone are responsible for the views expressed in this publication and such views do not necessarily reflect the views of their employing organisations or the organisations to which the Advisory Council members are affiliated.

To minimise the potential for conflicts of interest, collective members affiliated with organisations reviewed by GH5050 are not engaged in reviewing or coding any institutional policies.

