Gendered Institutions in Global Health

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Introduction

Over-representation of women in the frontline healthcare sector and under-representation in health leadership reflects many gendered drivers, including norms and roles that have shaped the division of labour in the health workforce. But to what extent are the institutions and systems that house these unbalanced representations in themselves gendered?

This chapter adopts a feminist concept of gendered institutions (Acker, 1990, 1992, 2006) to analyse gender stratifications and the division of labour across the global health landscape. Entwined with the gendering of the processes and practices of the work and function of these institutions are pervasive hegemonic masculinities stemming from deep gendered stratifications in the organization of global health. The chapter argues that historically, institutions of international and global health have been organized along lines of gender and also other axes of privilege that have reproduced occupational patterns that have seen women predominate low-status care roles whilst men (of certain privilege) gravitate through "man-agerial" structures to roles of oversight and leadership, sustaining what Acker and others have conceptualized as inequality regimes (Acker, 2006; Risman & Davis, 2013). Being "stuck", as Rosabeth Kanter (1977) describes, at particular levels of large international organizations is a well-recognized phenomenon in organizations across all sectors. It is a known barrier in the United Nations (UN) system, prompting the establishment in 2012 of the UN System-wide Action Plan on Gender Equality and the Empowerment of Women that aims to drive progress with an annual accountability and monitoring framework. However, the question remains: do so-called

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enabling environments[1] disrupt the gender regimes, ideologies, practices, and symbols that go far deeper than the fixing of women and men and their unconscious bias at the level of the individual? Gender, argued by scholars of gendered institutions, is not only an individual attribute but also a major organizing system that structures patterns of interactions and expectations throughout and between organizations and their networks.[2]

Taking an institutional perspective facilitates a structural analysis of the gendered making of global health actors—often governed in multilateral or multi-stakeholder arrangements—that make visible the patching and fault lines of post-Beijing[3] approaches to institutional mainstreaming and their somewhat limited impact in transforming the global health workforce beyond its historical patriarchal pyramid.

Gendered Networks and Organizations

Historically, the delivery of health care at the frontline exhibits highly sex-selected divisions of labour with women as nurses and caregivers at the bedside and men as doctors, surgeons, and specialists. The early gendering of nursing as female is illustrated in the writing of Florence Nightingale when she observed, "every woman must at some time, or other of her life, become a nurse" (1860). The nursing role was in many ways seen as an extension of women's gendered social care role beyond the hospital. This care role contrasts with the professionalization of medicine in Europe from the late 1400s which was accompanied, during the nineteenth century, by the introduction of educational qualification, certification, and licensing, which structurally prohibited the entrance of women to the medical field. As such, women have since been clustered at the bottom of the medical hierarchy with lower salaries, precarious social protection, and narrowed career prospects.

The lesser place of women in society throughout the history and in the development of institutions of health care and medicine is an intractable challenge not only at the frontline, but as a pattern reproduced through health systems, processes,

[1] Understood here to be constructed through targets, parity goals, quotas, gender trainings, performance indicators, gender budgeting, monitoring, or any number of other gender mainstreaming technologies of governance (Prugl, 2011).

[2] The use of institutions and *their networks* is intentional. The politics and exercise of power in geopolitical constellations are shown in the literature to determine global health agendas and prioritizations (Shiffman et al., 2016; Shiffman & Smith, 2007, etc.), but to date no theorizing or evidence around the gendered dimensions, let alone the place of women, in such networks has been forthcoming. For this reason, I include as global health not only its institutions—old and new—but also the emergence of global health networks and their functioning that politically prioritize the global health agenda (Shiffman et al., 2015, 2016; Heller et al., 2019).

[3] At the Fourth United Nations World Conference on Women, 189 member states unanimously agreed the Beijing Declaration and Platform for Action that prioritized gender mainstreaming as a mechanism to achieve gender equality.

governance, ministries, and all the way through to modern-day global health institutions and networks. Whilst the composition of the medical and allied health professions has shifted in recent decades, the underlying girders of the organization of medicine and health remain gendered along patriarchal axes that typically place women in less well-rewarded care roles, and men in highly compensated and more powerful leadership positions.

More recently, the globalization of health beyond the nation state and towards the emergence of a network of institutions and sectors variously defined as global health actors has exposed the reproduction of the gendered hierarchies that stretch back in this history of health and medicine. The lack of women in the leadership of this new field of global health practice, power, and decision making has long since been observed (Doyal, 2002; Downs et al., 2014; Talib et al., 2017), and many "women-centred" arguments have been proffered to explain why this is the case, many of which perpetuate gendered assumptions around women and work. It is not the intention here to further substantiate these lines of argument but rather to examine the institutions and networks that maintain these gender regimes in global health.

Are Global Health Institutions and Processes Gendered?

During an interview in 2012, a senior member of the executive team of one of the newer global health actors explained how the organization was "gendered", by which was meant that it was gendered male just like medicine and global health. This was despite all number of measures in place across the full spectra of the organization from governance, statutes, policies, and everyday processes that had sought to proactively address gender inequity. Global health is networked, and, as further discussion suggested at the time, there was only so far any single organization in the landscape of actors that could act alone in the chain of global health partnerships. This insight resonates with a large literature on gendered organizations going back to the work of Joan Acker and the launch in 1994 of the journal *Gender, Work and Organization*. As an entry point to the intransigence of gender injustice in global health, this body of thinking enables us to move beyond the "women-centred" arguments that are often used to analyse "the problem of women" in global health, and move towards understanding the gendered dimension of health as a historical, economic, and politically constituted means of organizing and stratifying resources and capabilities.

When we examine global health and its networks and institutions as a priori gendered, we need to also clarify what is meant by the term "gendered". Gender has many meanings, but I argue here the perspective that gender is a concept of power and like all concepts of power—of which there are also many—it operates as a means of organizing, patterning, and ordering the world that is political, historical, economic, and social. As a concept of power, historically and to date, gendered relations of power have fed and sustained hegemonic patriarchal hierarchies.

The gendered hierarchies of global health are well-documented as issues of the sex division of labour, most notably in the (lack of) women leaders in global health, as the title of this book suggests. When we consider organizations as gendered, we seek to get beyond representation. It is an important leap to make that moves us from a corrective measures approach that often accompanies mainstreaming, to viewing the institutions and networks as units of analysis beyond composition of only its human resources. As Mastracci and Arreola (2016) note from a human resource management perspective, norms and practices based on stereotyped male and female workers persist beyond the changing compositions of a workforce and are rather stubbornly rooted in an organization's founding contexts. The history of medicine, international and global health, and its networks is thus significant.

Getting beyond representation towards deeply transformative and perhaps radical feminist thinking may take us beyond the current impasse to challenge the embedded hierarchies of power that are not only gendered but intersectionally stratified across the geopolitical landscape of medicine and global health. Further still, these gendered institutions of global health are not isolated from the wider global post-war economic order in which they are situated, but are entwined through global finance mechanisms, governance structures, and politicized funding streams in the neoliberal paradigm (Keshavjee, 2014). And as Nancy Frazer (2009) pointedly remarked, feminism in an age of neoliberalism is a dangerous liaison[4] where it risks becoming a handmaiden of capitalism.

Principal: Structure and Agency in the Neoliberal Global Health Landscape

There is a well-established literature on the neoliberalization[5] of global health (Keshavjee, 2014; Schrecker, 2016; Shakow et al., 2018; Bell & Green, 2016) that stretches far beyond the scope of this chapter; so too the feminist critiques of these neoliberal forces (Cornwall et al., 2008; Frazer, 2009; Goetz, 1997) that have shaped the post-Washington consensus (Bergeron, 2003) and even the "neoliberalization of feminism" (Prugl, 2014; Frazer, 2009) that promote individualistic solutions to gender oppression and advocate the "business case" of women's economic empowerment.

Whilst these are areas on which I shall reflect, with caution, towards the end of this chapter, I shall begin by re-examining the relevance of gendered organizations against which modern tools and techniques attempting to be gender transformative and even "disruptive" (Hay et al., 2019) are situated. A feminist gendered

[4] This line of argument is in reference to Fraser's theorizing on the globalizing financialized capitalism of the third regime of capitalism, the crisis of care, and role of "affective labour" and care work.

[5] The economic, political, and ideological neoliberalization of global health, it is argued, drives inequities.

organization approach renders visible the deep substructures against which neoliberal feminist activists have to function and which in fact may co-opt in producing veneers of non-substantive equality. The agency of actors, individual, and groups of women (and men), feminist or not, is inhibited by gendered structures of power.

Clinton and Sridhar's 2017 book-length case studies of the key global health actors adopt a principal-agent theorizing to examine the complex question of who governs global health. Although their analysis is not one that views organizations as a priori gendered, and nor do they gender the response to their core question, their assembled evidence coupled with my own fieldwork and participant observations of global health in what is so often described as the city of global health, International Geneva, during the past decade suggests that at least two approaches to the challenges of the gendered girders and regimes (Acker, 2006) in global health have evolved. Clinton and Sridhar's dichotomizing of the "traditional" and the "new" players with their very different networks of funding and governance relations to their *principals* (limited in their reading to member states) and *agents* (mainly, in their examples, secretariats) serve here to differentiate how these processes or technical fixes to gender have unfolded in global health institutions. Whilst the discussion in this chapter is not limited to the "old" and the "new" actors split used by Clinton and Sridhar, the different configurations of relations that institutions develop as agents with their principals (e.g. the World Health Organization (WHO) and its UN Member States and Executive Board, or Gavi, the Vaccine Alliance and its multi-stakeholder board) nevertheless determine the scope of gender responses that each organization can reasonably implement.

Transforming Gendered Organizations

The many institutions that comprise the global health landscape lay claim to policies of gender equality, mainstreaming, and other principles of gender audit.

The WHO provides an example of one of the approaches to addressing gender issues in global health. In 1995, the WHO's Director General (DG), Hiroshi Nakajima's Beijing statement focused almost entirely on women's health prioritization and, in particular, committed to addressing women's reproductive health, malnutrition, and violence against women. These priorities were later reflected in the structuring of the WHO with specific programmes to target these issues. As an organization operating by resolutions, a series of member state-agreed initiatives were introduced between 1997 and 2012 that took forward the Beijing agenda. These included the 1997 World Health Assembly (WHA) 50.16 Resolution on recruitment targets that were set to achieve parity by the close of the decade, and the 2003 WHA 60.25 Resolution to integrate gender resulting, the following year, in the publication of the Strategy for Integrating Gender Analysis and Actions into the work of the WHO, followed quickly in 2009 by WHA 62.14 Resolution that cemented gender as part of the new paradigm of thinking developed by the Commission on Social Determinants of Health.

Since 2014, the main activities around gender at the WHO (outside of women's health and human resource mainstreaming) have been housed under the unit for Gender, Equity, and Rights. As noted above with cross-reference to the case studies of Clinton and Sridhar (2017), the governance structure of the only treaty-making global health institution, the WHO, is comprised of member states alone and as such the secretariat (the agent) is a "servant" of those same member states. As a gendered organization it therefore also reflects the varied gender orders of the member state countries under whose governance its resolutions and decision making must operate. And, in this sense, globally, its capacity for transformative gender upheaval—if we think too of gender as a concept of power—is by definition circumscribed and limited to a consensus denominator. Whilst it sits at the global head of norm setting and standards, the operating space for radical disruption of the gendered-masculine history of global health and medicine at the WHO is just that—consensual norms rather than radical power shifting. Its history of passing resolutions and strategies to deal primarily (and until very recently) with gender as a women's health issue is a part of its gendered history.

The WHO is just one of many hundreds of organizations that comprise the landscape of partners that constitute global health, and as such, other new and sometimes quite innovative approaches of analysing (even with data) the gendered dimensions of these institutions have come to fruition. One such recent example is the Global Health 50/50 Report. This advocacy initiative, compiled by a core group of (mainly female) unpaid researchers, monitors and ranks organizations with the intention of advancing institutional transparency and accountability of over 200 global health actors.

The success of the Global Health 50/50 Report of 2019—which saw progress across all ten domains of measurement between 2018 and 2019—as a tool of change based on public ranking of health organizations constitutes a very different strategy from earlier approaches and is one that is embedded in ongoing efforts of gender mainstreaming whilst drawing on neoliberal and feminist technologies of governance and transparency. That it worked in year one is suggestive of the gendered nature of the organizations it measured. As a technology of governance and oversight in the Foucaultian sense, i.e. it seeks to change the conduct of organizations so that they become conducive to advancing gender equality, ranking tools like Report 50/50 gain political traction as a form of public audit, but one that relies on mainly patriarchal leadership to deliver for women.

Despite progress detailed in this first follow-up reporting, the intransigence of gendered divisions of labour in health speaks more to underlying structure and substructures that are, as noted by feminists such as Joan Scott (1986) and Sandra Harding (1986), gendered masculine and are the girders of entire bureaucratic systems and their networks.

Proportional parity has failed to equate with gender equity despite legal and policy initiatives within and between organizations that aimed to achieve just that (Guy & Fenley, 2013). Instead, argues Connell (2019), they have presumed simple dichotomies between women and men based on "loose liberal feminism" (2019) that has tended to celebrate high-achieving individual women in position of power

and leadership. In shifting our lens towards the gendered power relations of institutions and their networks, it is possible to elongate beyond any singular moment in time and form an analysis that exposes the deeper structural foundations seeded in the early days of biomedicine, colonialism, and the origins of international global health (Packard, 2016). To foreground the institutions and their networks as gendered hierarchies in global health can further illuminate the ways in which structure and agency and global health governance have evolved in recent years against a changing landscape of traditional and new players, most notably public-private partnerships (PPPs) and product development partnerships (PDPs). The political economy, financing, and governance of global health as detailed in case studies by Clinton and Sridhar (2017) remind us of the centrality of theory that articulate the relations between principals and agents that persist in global health governance. These deep structures are, in part, explicable with a gendered understanding of the operation of power in the relations that constitute neoliberal global health.

The new players in global health, namely but not exclusively forms of PPPs and PDPs, were almost all born post-Beijing and sought in at least their governance structures to address the hegemonic gendered patriarchies from which international public health had grown. But here again, as an approach to addressing gender in global health, these organizations have sought to think of gender as women and gender as an individual rather than an organizational concept of power, as outlined earlier in the Introduction.

In a series of interviews[6] conducted with several PPPs and their partners, respondents regarded policies on gender and equity as means of awareness-raising, to "enlighten people" to "think harder". Policies sought to address only representation (the counting women approach) which in itself exposed underlying gender bias assuming a lack of qualified women in the pipeline, fears of "tokenism", and risk of less capable women replacing better suited men. Such responses speak volumes to the problems associated with individual rather than institutional approaches. Not only do they tell us these institutions are gendered organizations even by Acker's 1990 definition that states "advantage and disadvantage, exploitation and control, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine" (1990:146), but they get us "stuck", as Rosabeth Kanter might suggest, in gender regimes that perpetuate hierarchies designed to serve the historically constituted patriarchal mode of operation in the practice of medicine and international health.

External pressure among PPP *principals*—often member states and donors with reputations for advancing gender justice and feminist policies—has been nevertheless demonstrated to be entry point to steer more radical organizational change in some organizations. For some, gender ear-marked funding and gender conditionality forces organizations to implement actions, at least at Headquarters. Country-level implementation remains problematic for reasons outlined above related to colonial histories in international health (Packard, 2016; Connell, 2019).

[6] Interviews conducted by Somerville during 2017–2018.

A second push, derived from a rights-based approach, typically builds strategic gender equality statements into the organization's mission where it constitutes part of an overall rights-based package, as it is the case with the WHO's Gender, Equity, and Rights team. All these approaches likely chip away at some of the girders that hold in place the processes and practices and gendered hierarchies that result eventually in the highly sex-segregated nature of the global health workforce.

Re-gendering for Global Health Justice

This discussion on the gendered nature of organizations in global health is not in itself intended to suggest that their gendered dimension should be erased or neutralized even if that were possible or desirable. The injustice stems from the hierarchies that are gendered patriarchal rather than that they are gendered per se. As a concept of power, gender operates everywhere; it is pervasive; it is one of the ways by which we organize societies and this is why we need to understand the way it functions in global health through its institutions and networks rather than only its individuals and representations.

Taking an organizational approach, whereby organizations and their networks are the unit of analysis that are gendered, allows us to move away from individuals as enacting and performing gendered norms, roles, and scripts, and rather look at the structures and institutional relations and networks that maintain intersecting forms of discrimination, and also the hegemony of the patriarchal system in which they exist.

In the 1980s BBC comedy show "Yes Minister", an all-white, male cabinet, discussed the merits of promoting women in leadership—then named positive discrimination—across the various government departments. The health minister reports that women are rather well represented in the sector. In fact, he cites the 80:20 ratio of women to men, much as it is today. What the scene illustrates with comical accuracy is the gendered nature of the cabinet office and the civil service as organizations where gender functions as a hierarchical tool of stratification. In the scene, all agreed, in principle, to positive discrimination—the sorts of short-term corrective measures we have come to mainstream as technological fixes to a short-term problem—a moment of "catch-up" to match the liberation and empowerment of women over the past century. To focus on numbers, on representation, rather than the gendered nature of organizations is to assume we know the problem is one of numbers, of balance, of parity and presence at the table. In this fictive comedy sketch, all the men at the table agreed on the principle of equality between women and men but, in a performance of hegemonic masculinity, were rendered incapable of action as each head of government department provided a "rational", mainly "cultural", reason why it was not the time or the place to take such well-principled

measures. The culture arguments, frequently still used to describe the status quo of organizations, are dangerous as so often they act to eschew what is in actuality the deeper challenge of gender. After 25 years of gender mainstreaming with limited success using technical fixes, tools, mechanisms, and other such technologies of government that guide conduct (Prugl, 2011), it is perhaps high time that we think again about the nature of the problem we are trying to solve.

The principal-agent theorizing used by Clinton and Sridhar captures inter-organizational types of power relations and governance, but when we view these organizations as also gendered, the simplicity of those apparent relations is compromised by cross-cutting and hierarchical girders. These institutions are able to deliver their outputs within the value systems that underpin their very existence as neoliberal institutions in a global arena. And so too is their approach to addressing gender as institutions that employ human resources as well as deliver programming and health interventions. Typically, the areas that are measurable, or what are often in these institutions called SMART (Specific, Measurable, Achievable, Realistic, and Timely) measures to change, occur in spaces where the problem is easily identifiable—and this is often women themselves. By empowering women through training and mentoring, together with institutional commitments and the use of morally appealing shout-out methods like pledging, these organizations can be seen to deliver on a set group of targets. They are deemed to be successful within the framing that supports them, and if we take a feminist perspective to gendered organizations outlined above, they are co-opted as the very girders of patriarchy. The solution to what becomes constructed in such organizations as the "problem of gender equality" (Prugl, 2016; Bradshaw et al., 2019) is the regulation of processes of inserting women, described also as the neoliberalization of feminism (Prugl, 2016). Solutions to the problem are amenable by intervention with policies that are often couched in efficiencies because they are in themselves measurable. Whilst such interventions may improve outcomes for individual entrepreneurial women, they do little to remove the structural barriers that perpetuate and reconstitute the gendered hegemony.

Some kinds of technologies of gender mainstreaming derive their success and are deemed appropriate and acceptable because they are rolled out in institutions gendered masculine and fit the types of measures that are valued. To "lean-in", to pledge parity goals and publicly rank organizations in a competitive ordering, and to call out "manels" appear to gain traction in what Raewyn Connell might describe as a rather public performance of masculinities that, I would argue, tell us a great deal about the ways in which global health institutions and their networks are organized along axes of gender that sustain and even grow gender orders that are historically patriarchal.

Until we accept that gender is a means by which societies, institutions, and systems organize themselves—that the injustices of gender stem from its patriarchal ordering, not as a gender problem in and of itself—we will never see gender as in need of attention all of the time.

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