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**Article (Accepted version)
(Refereed)**

Original citation:

Harman, Sophie and Wenham, Clare and Manjoo, Rashida and Tanyag, Maria and Davies, Sara (2018) Why it must be a feminist global health agenda. *The Lancet*. ISSN 0140-6736

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This version available at: <http://eprints.lse.ac.uk/90412/>

Available in LSE Research Online: October 2018

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VIEWPOINT: WHY IT MUST BE A FEMINIST GLOBAL HEALTH AGENDA

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Abstract

Global health advocates recognise that gender is an issue in the field. This piece outlines how feminist research can advance gender equality in global health. This viewpoint has three aims. First, highlight some of the central findings of feminist research. Second, show how feminist research can be applied to the issues the women and global health movement is currently grappling. Third, make recommendations for a more inclusive feminist global health agenda. We focus on four themes in feminist research: 1. Feminist leadership is more than addressing gender quotas; 2. Gender diversity and intersectionality; 3. Hidden Burden of Care; and 4. Feminist method and knowledge production. Critical engagement with these four themes is integral to achieve gender equality at every level of global health.

Key Messages

- Feminist research is vital to move the women in global health agenda forward.
- Feminist leadership requires more than gender quotas: it requires formal and informal cultural change within institutions across global health governance. Quotas are important, but so too is reform towards feminist institutions and conditions.
- Inequalities exist across sex but also class, education, geography, income, race, physical and mental ability. Gender advocacy must promote inclusive participation and data collection to identify where discrimination and barriers to inclusion exist.

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- 24 - Global health is dependent on gender bias. Women predominantly occupy unpaid
25 roles as caregivers and health workers: this needs to be recognised and the labour
26 paid.
- 27 - Gender inequality is often informal and private: we need diverse methods of
28 research and research collaboration to expose, recognise, and address the informal
29 and hidden ways in which inequality takes place.
- 30 - Critical dialogue must be matched by gendered allocation of resources, support for
31 women's champions, and institutional reform to facilitate research and programs
32 that secure progressive gender rights in global health governance, leadership and
33 everyday practices.

34

35

36 **Main research article**

37 We need to re-think the interconnection between women, gender and global health.

38 Beyond increased physical risk factors, women are disadvantaged structurally; over-
39 represented in informal care roles; and under-represented in leadership, decision-making
40 and senior research roles (1). Global health policy and programs are often blind to women's
41 needs being different to men's (gender equity) and women's unequal position in society
42 (gender equality), rendering women 'conspicuously invisible' (2) (3). In response, initiatives
43 such as Women in Global Health have established a target of 50/50 representation in global
44 health leadership by 2030 (4). Tedros Adhanom Ghebreyesus has called for gender
45 'balance' in senior management roles at the World Health Organisation (WHO), including its
46 regional and country offices. However, as we outline below, addressing women's
47 representation in the workplace (i.e. quotas) is not the same as promoting gender inclusive
48 and gender mainstreaming practices (5).

49 In this viewpoint, we call for a feminist research agenda in global health. Feminist research
50 challenges structural and social power inequalities within patriarchal societies that produce
51 inequalities which disadvantage women (6) (7). Feminist research and methodology has
52 particular relevance in addressing some of the key issues the women and global health
53 movement is currently grappling with - 'substantive' representation, organized political
54 movement, the (role of the) welfare state, intersectionality, and sexuality (8). These feminist

55 insights inform four recommendations for global health: 1. Feminist leadership requires
56 more than gender quotas: it requires formal and informal cultural change within institutions
57 across global health governance; 2. Gender inequality cannot be addressed without tackling
58 race and socio-economic inequality: global health must be intersectional across research,
59 programme delivery and implementation; 3. Global health is dependent on women in
60 unpaid care roles: this needs to be recognised, calculated and the labour paid; and 4.
61 Gender inequality is often informal: we need diverse methods of research to expose,
62 recognise, and address the informal and hidden ways in which inequality takes place. These
63 four recommendations are fundamental to achieving women's representation and gender
64 inclusive practices at every level of science, medicine and global health.

65

66 **1. Feminist leadership is more than addressing gender quotas**

67 Quotas are an important beginning to address historic inequality and lack of representation
68 of women in the public sphere, but it will not address hierarchy or shift power relations to
69 the extent required (9). Feminist research has shown that emphasis on women's
70 representation – the 'inclusion project' (10) - will not on its own overturn unequal
71 structures, address rights abuses, or ensure gender sensitive policies (11). Women are not
72 inherently feminist or advocates for gender inclusive programming i.e. consideration of how
73 policies may affect men and women's lives differently or may reproduce gender stereotypes
74 (gender mainstreaming). Similarly, men are not essentially anti-feminist or against gender
75 mainstreaming. Feminist scholarship shows that change comes not only from formal
76 processes, such as employment law, positive discrimination, and effective return to work
77 initiatives. Change happens by addressing informal sites of hierarchy and exclusion, e.g.
78 holding meetings outside core hours, what is valued as 'quality' work (12)- Finally, change
79 requires a shift in perception so that those addressing gender and racial inequality are seen
80 as progressive rather than trouble-makers (14).

81 The women and global health agenda has begun by tracking the number of women in
82 leadership positions in academic and global health organizations and identifying the gender
83 representation gap (3) (15) (16). Quotas are important, but to achieve gender equality
84 requires substantive institutional change that recognises and is responsive to the formal and
85 informal ways inequality occurs. This includes institutional commitment to implement

86 formal changes (gender training for all staff, flexible working, spousal visa policies) and
87 informal practices (such as recognising informal roles within the workplace e.g. who takes
88 the notes, whose ideas are heard, who drives the cars in the field). Institutional culture
89 change is difficult and burdensome, and therefore requires everyone, not just female
90 leaders.

91

92 **2. Gender diversity and intersectionality**

93 Women are not a homogenous group (17). Gender intersects with additional drivers of
94 inequality and social determinants of health such as - age, geographic location, sexuality,
95 class, religion, ethnicity, citizenship, and disability (18) (19) (20) (21) (22) (23) (25) – that act
96 as barriers to participating in global health and accessing healthcare. For example, race and
97 gender intersect in understanding how and why maternal and neonatal mortality is
98 significantly greater among black women in USA (26). Globally, socio-economic status, race,
99 and gender intersect to restrict affordable and equitable access to health care services for
100 minority and indigenous women who may fear these services due to a history of forced
101 sterilisations and experimental health welfare programs (27). Finally, gender and socio-
102 cultural factors intersect as drivers of violence against women where the World Health
103 Organization (WHO) Multi-Country Study on Women’s Health and Domestic Violence has
104 shown a strong relationship between poverty, physical insecurity, and gender
105 discrimination (28).

106

107 Therefore, a feminist global health agenda must be intersectional. We must mainstream
108 intersectionality through research design (data sets which map intersectional inequalities),
109 programme delivery (tailoring delivery to specific needs of different populations) and
110 monitoring and evaluation (end of project assessments to see which populations benefited
111 and were disadvantaged by an intervention). An intersectional approach requires attention
112 to who is present and who is able to speak in global health research, programmes and
113 decision making.

114

115 **3. Hidden burden of care**

116 Feminist research has shown that women disproportionately provide the invisible care and
117 domestic labour in households and communities (28). Providing informal care and labour
118 has a negative impact on women's health and well-being (20). Often these same women are
119 faced with multiple burdens of care, but do not necessarily benefit from or receive care
120 themselves. Income and gender hierarchy often present structural barriers to access
121 healthcare (28) (29). An additional challenge is the social gender norms which are ascribed
122 to different forms of health labour (30). For instance, community health work, which is at
123 the frontline of health service delivery, remains voluntary and undermined by poor working
124 conditions in many parts of the world. Philanthropic foundations, donor states, and
125 recipient states have long benefitted from unpaid labour; a gendered political economy lens
126 advises us to ask who benefits and who is missing from funded health initiatives. Global
127 health institutions must recognise the gendered nature of unpaid care roles; calculate the
128 'unpaid healthcare labour wage' (31) provided by carers and community health care
129 workers; and, crucially, pay for this labour.

130

131 **4. Feminist Method**

132 Global health research, derived from public health and the biomedical sciences, recognises
133 positivist methods as the gold standard. Positivist methods are important in identifying and
134 analysing participation, membership quotas, and voting cleavages within health systems
135 data, but do not capture the whole picture of the gender division of labour and social-
136 economic vulnerability. Engaging feminist methodologies such as ethnography, participant
137 observation, participatory action learning/research and story-telling, encourages research
138 partnerships with minority and marginalised populations (32) (33). It can also expose false
139 assumptions in traditional data collection methods, such as the 'male-headed' household or
140 'female-headed' household variable to classify the 'worker' (34). Men may be present but
141 not work; women may work but not be formally employed or paid a wage. A feminist lens
142 demands more from the standard classifications of available data and asks what do those
143 terms mean in that particular social and economic context, which is vital for understanding
144 program implementation and delivery.

145 We need to include feminist methods in global health research to expose the formal
146 and informal ways in which gender inequality is manifest in health care access and delivery
147 (35). We need to look for the silences and pockets of exclusion in order to ensure
148 representation, inclusivity and reflexivity within research and program delivery. This means
149 actively considering whose voices are missing and what barriers to participation exist, and
150 the methods we use to reveal these.

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