# INVESTING IN THE POWER OF NURSE LEADERSHIP

## WHAT WILL IT TAKE?

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# FOREWORD

On behalf of the Nursing Now campaign, I am delighted to see the voices of nurses around the world speak to the gender-related barriers to and facilitators of nurse leadership. I give my thanks to the many partners and contributors toward this effort.

As we prepare for 2020, a year that United Nations member states at the 72nd World Health Assembly declared as the Year of the Nurse and the Midwife, in honor of the 200th anniversary of Florence Nightingale's birth, the spotlight is finally beginning to shine through the cracks and highlight the unending dedication, perseverance, and struggle of nurses and midwives around the world. With this spotlight will come the first-ever State of the World's Nursing report, which will provide a crucial picture of nursing worldwide and its vital contribution to the Sustainable Development Goals, universal health coverage (UHC), and the World Health Organization (WHO)'s "triple billion" targets.

**Barbara Stilwell**
Executive Director
Nursing Now

As nurses and midwives make up half of the total health workforce, we can see that this spotlight is rightly deserved, and that nurses and midwives have been operating without the recognition they deserve for far too long.

The Nursing Now campaign, launched in 2018, builds on years of advocacy by nursing professional groups to improve health by raising the profile of nursing globally. Run in collaboration with the WHO and the International Council of Nurses, Nursing Now seeks to empower nurses to take their place at the heart of tackling 21st century health challenges and maximize their contribution to achieving UHC. The development of Nursing Now alongside WHO Director-General Dr. Tedros Adhanom Ghebreyesus' recent commitment to nursing, including the appointment of Elizabeth Iro to the position of Chief Nursing Officer, signalled to the international community that nurses are an integral part of the health system and significant contributors to UHC, and this message is carried into 2020 with the WHO's full support.

We know that investing in nurses and midwives brings more women into the workforce and thereby contributes to greater women's economic empowerment and gender equality broadly. However, too often women's contributions go unrecognized and their voices go unheard. Globally, women's labor contributes $3 trillion to health, roughly half of which goes unpaid. The time is up on women's work remaining invisible.

This report is a huge step toward uncovering the mechanisms of these inequities for nurses. The research presented here allows us to hear directly from nurses about the challenges they face and what they need to succeed. With a large number of respondents from geographically diverse settings, the data gathered in this report are invaluable to our efforts to advance nurse leadership and the status of the nursing profession.

Investment in nurses and addressing gender-related barriers to leadership will improve health for all, and I look forward to the galvanizing change this spotlight will bring.

**Barbara Stilwell**
Executive Director, Nursing Now

# ACKNOWLEDGEMENTS

# ACRONYMS

**APPG**      United Kingdom All-Party Parliamentary Group on Global Health

**CEDAW**      Convention on the Elimination of all Forms of Discrimination Against Women

**CSA**      Central and South Asia

**ECSACON**      East, Central, and Southern Africa College of Nursing

**EAP**      East Asia and Pacific

**EUR**      Europe

**ICN**      International Council of Nurses

**ILO**      International Labour Organization

**LAC**      Latin America and the Caribbean

**MENA**      Middle East/North Africa

**NGO**      Non-governmental organization

**OECD**      Organisation for Economic Co-operation and Development

**SSA**      Sub-Saharan Africa

**STEM**      Science, Technology, Engineering, Math and Medicine

**THET**      Tropical Health and Education Trust

**UHC**      Universal health coverage

**UN**      United Nations

**UNESCO**      The United Nations Educational, Scientific, and Cultural Organization

**WHO**      World Health Organization

# EXECUTIVE SUMMARY

Meeting Sustainable Development Goal 3 by 2030—which includes achieving universal health coverage (UHC) and access to quality essential health services to all—requires urgent action to address a projected shortfall of 18 million health workers by 2030, primarily in low- and middle-income countries. The World Health Organization (WHO) estimates that nurses and midwives represent 50% of this projected shortage, making it imperative that constraints are eliminated on realizing the full power of the nursing and midwifery workforce.

Women only comprise 25% of health system leadership roles. Addressing the gender-related barriers to leadership that exist within the nursing profession and outside of it is critical to ensuring sustainable delivery of essential health services and primary health care to all communities.

This report is the product of a collaboration among IntraHealth International, the Nursing Now campaign, and Johnson & Johnson. It draws from a review of existing literature, a survey of 2,537 nurses and nurse-midwives from 117 countries, and eight key informant interviews of nurse leaders to provide an in-depth analysis of the gender-related barriers to and facilitators of nurse leadership. The report derives from that analysis a set of recommendations for policymakers and implementers at the global, national, and institutional levels to accelerate strengthening nursing leadership and gender equality in the global nursing workforce. In-depth interview data were thematically analyzed using Nvivo 12 based on key themes that included: socio-cultural norms, structural barriers (e.g., lack of child care, training opportunities), family-work life balance, discrimination, and sexual harassment.

## KEY FINDINGS

This report substantiates other research findings that there is a constellation of barriers at work in nursing leadership that marginalize and exclude especially female nurses from decision-making roles and career progression. Gender discrimination, bias, and stereotyping inhibit opportunities for nurses to develop skills, perpetuate the gender pay gap, and result in unequal treatment in the health workforce between women and men.

### Societal and cultural perceptions about specific roles of women and men are an important barrier to women's leadership

The perception of nursing as a "feminine" and "nurturing" profession, and the devaluation of work associated with women, were cited as barriers to women's advancement in the profession and the status of nursing in the health workforce as a whole. Nurses face stereotypes of women and nurses. Nurses' competency and authority are distrusted.

### The "glass ceiling" and "glass escalator" effects co-exist in nursing

Expectations of female nurses' domestic responsibilities greatly contributed to female nurses experiencing a perceived "glass ceiling," inhibiting their advancement with respect to their male colleagues. Respondents also noted a "glass escalator" effect, resulting in rapid advancement of male colleagues with less experience due to their ability to "talk the talk." Just over half of survey respondents (52%) stated that they believed that men are favored more for promotion than females as a significant barrier to females obtaining nurse leadership positions. Respondents perceived that there were less "hoops to jump through" for men, opening up opportunities for them to move quickly up the ladder.

### Female nurses have to juggle paid and unpaid work

Although respondents said that both women and men face challenges managing work and home life, respondents overwhelmingly indicated that those challenges impacted women more than men. Respondents and interviewees cited women's "two full-time jobs," in that they are expected to essentially maintain a full load of responsibilities both at work and at home.

### Nurses perceive limited decision-making authority regardless of gender

Both male and female respondents felt that they lacked decision-making authority in their roles as nurses in a clinical service context. Biases were observed between female and male nurses once they moved into a leadership position. Some female

nurses faced challenges in establishing authority both as a woman in that position and as a nurse in relation to doctors. In some settings, there is a perception that nurses are there to serve doctors and are not professionals in their own right.

### Respondents cited a lack of self-confidence as a barrier to assuming leadership positions

A lack of confidence was a cited hindrance to assuming leadership roles. Respondents also indicated that, where success was had, it was due to them gaining confidence over time and through experience. Respondents also strongly indicated a desire for more preparation for leadership in the form of mentoring and learning how to speak well in large meetings to increase their confidence and participation.

### Facilitators to success in women's leadership include family and spousal support, leadership training, access to networks and mentorship

Interviewees that had risen to leadership positions in organizational hierarchies cited the support of family members (spouse or other relatives) in the sharing of domestic care tasks as a very important factor in their success. Respondents also indicated that they were able to take on more leadership responsibilities once their children had gotten older and no longer

needed as much care. Respondents cited leadership training (92%) and mentorship (86%) as important facilitators for success in assuming leadership positions.

## KEY RECOMMENDATIONS

### Work to change the perception of the nursing profession as a "soft science" and to elevate the status and profile of nursing in the health sector

- The WHO, International Labour Organization (ILO), and International Council of Nurses (ICN) should convene a discussion with other relevant multilateral agencies and international health workforce associations to generate and apply knowledge and discuss joint programming to improve the regulatory environment for nursing, reform health professional education, and develop nursing leadership.
- Multilateral organizations such as the WHO, ILO, Global Financing Facility for Women, Children and Adolescents, UNESCO, and all multilateral institutions should implement multi-stakeholder campaigns, including the WHO-ILO-OECD Working for Health Five-Year Action Plan, to challenge gender norms in the nursing workforce and to develop materials and messaging that emphasize the significant knowledge needed for success in the profession and rigorous nature of

the work and promote nursing as a scientific and technical education category—that is, science, technology, engineering, math, and medicine (STEM) profession.

- Global actors should advocate for at least 75% of countries to have a Chief Nursing Officer or Chief Government Nurse as part of their senior management team in health with oversight and authority to manage budgets, create nurse leadership training programs, promote nurse recruitment, and regulate nurse education, thereby signaling the importance of the nursing profession. This position should have concrete pathways to coordinate nurse leadership training programs with ministries of education, labor, gender, finance, and other relevant national and local agencies.
- Governments should recruit for the health minister position and all leadership positions in government in such a way that ensures nurses' eligibility.
- Government and private health professional education systems should introduce institutional management and instructional reforms and adapt best practice education models (e.g., transprofessional education) to local contexts to reduce gender stratification, break down hierarchical chains of command, improve teamwork, and broaden nurses' decision-making scope.
- Clinics, hospitals, and other facilities—both public and private—should include a nurse on their board and/or managerial staff on the same level as other directors/managers.
- Employers should set a standard plan for ensuring that nurses and other health worker employees do not face professional disadvantage should they become pregnant.

## Address occupational sex segregation and eliminate the perception of nursing as "women's work"

- International campaigns, advocacy groups, and coalitions should develop materials and messaging that normalize men as nurses as well as women in male-dominated health workforce cadres.
- Global research partners (such as Health Systems Global) should work with the WHO, ICN, and ILO to agree on and further learning on the cross-cultural portability of the "glass escalator" and to identify factors that are salient in both nursing

and leadership in a given country context, including the drivers of gender segregation, the intersection of other social variables with gender, reasons for women's entry into and exit from leadership positions, and forms of sexual and gender harassment in nursing leadership. They should test ways to counter gender bias (such as "metrics-based bias interrupters") and address gender bias in hiring, evaluation, and promotion practices.

- Governments should ratify a revised ILO Convention 149 and Recommendation 157, operationalize the Convention in health sector nursing policy, and ensure that nurses are adequately and fairly paid as key players in delivering and expanding access to essential health services, both within nursing and in relation to other health workforce cadres.
- Governments should develop feasible and efficient data collection/analysis strategies to generate national information on horizontal and vertical segregation in the nursing workforce using sex disaggregated data.
- Hospitals, clinics, and medical schools should audit their promotion and hiring practices to ensure that they are not sorting men into leadership roles and women into service delivery.
- Schools should implement gender-transformative education policies to "de-gender" professions, including nursing and medicine.

## Eliminate employer discrimination on the basis of gender or child-bearing status

- Ministries of health should standardize job descriptions and requirements—including leadership requirements—of nurses and all cadres of health workers to eliminate unconscious discriminatory criteria from determining hiring or promotion practices.
- Governments should ensure sufficient numbers of and equitable geographic access to nurses and put favorable conditions in place to enable nurses to take time off when needed without fear of professional disadvantage or over-burden of other staff. (e.g., pregnancy cover, maternity protection policies, flexible hours).
- Governments should institute national paid leave policies that allow caretakers to attend to children, elderly, and other dependents.

## Build nurses' self-confidence and sense of preparedness to assume leadership positions

- Global advocacy organizations, campaigns, and coalitions should map nurse leadership development programs and assess them in relation to skills and competencies that nurse leaders need to lead in gender-influenced systems.
- Nursing schools should work to connect students and graduates with nursing leadership development programs and employment networks.
- Workplaces should ensure that managerial positions include flexibility, set core working hours, and have an expectation of continuing some clinical work to open up opportunity for women to pursue managerial tracks while balancing family responsibilities.

## Ensure workplace environments that are safe and responsive to work/life balance and allow for employee flexibility to fulfill both formal work and unpaid care responsibilities

- Multilateral agencies working to promote nurse leadership should advocate for the revision of the ILO's Nursing Personnel Convention No. 149, Recommendation No. 157, by integrating other ILO labor standards that promote gender equality to explicitly address the gender bias and discrimination with respect to: protection from direct and indirect discrimination based on pregnancy, family and child care responsibilities; equal pay for work of equal value; achieving better work-life integration in working hours and shift work; and improved occupational safety and health (including prevention of workplace violence/sexual harassment).
- Governments should ratify the revised ILO Convention 149 and operationalize it in national nursing policy.
- Workplaces—especially those that employ nurses—should foster an environment that not only respects but promotes the necessity of strong work/life balance through policies that enable workers to fulfill their families' needs and a culture that recognizes the importance of family obligations for all workers regardless of sex.

## Ensure opportunities for nurses to access funding for leadership development, higher education, or other professional development

- Multilateral organizations and international donor assistance agencies should invest in long-term and reliable finance mechanisms to provide scholarships for economically disadvantaged nursing students and/or nurses pursuing higher-level education in other countries.
- Governments should invest in long-term and reliable grant programs for nurses to pursue leadership training and development courses.

## Foster increased access to professional networks and mentoring schemes for nurses

- The WHO, ILO, and other multilateral agencies should commit funding to extending the reach of the ICN Global Nursing Leadership Institute and other similar networks.
- The ICN should continue to foster strong connections among program alumni, educational institutions, and youth networks and provide platforms for knowledge sharing and discussion.
- Governments should develop and strengthen professional nursing associations and ensure equitable geographic, socioeconomic, and cultural representation of all geographic areas and ethnic, tribal, or other such groups.
- Health facilities; nursing, midwifery, medical, and public health schools; and other training institutions should promote membership of national nursing associations.
- Institutions should regularly identify nurses for nomination to the Global Nursing Leadership Institute or to other national nurse leadership trainings and ensure that their staff are able to participate without adverse impact on their job.

# INTRODUCTION

Recent literature has highlighted the stark gender inequality in the health workforce, in which women make up 70% of the total health and social care workforce yet comprise only 25% of health system leadership roles.[85] This report aims to build on the existing literature to emphasize the contribution made by nursing to the broader health workforce, a profession typically dominated by women. Exploring gender segregation in nursing leadership, the report suggests new ways to tackle the systemic gender inequities in the health workforce.

Policy changes and investments in gender equality and female empowerment of the global health workforce are now firmly embedded in the recommendations of multilateral reports. These include the United Nations High-Level Commission on Health Employment and Economic Growth; the report of the 2018 Gender Equality Advisory Council to the G7 Presidency; the 2019 World Health Organization (WHO)/Global Health Workforce Network/Women in Global Health Global Health: Delivered by Women, Led by Men report;[85] the WHO *Gender equity in the health workforce: Analysis of 104 countries* report;[9] and the seminal 2016 *Triple Impact Report: How developing nursing will improve health, promote gender equality, and support economic growth*,[2] commissioned by the United Kingdom All-Party Parliamentary Group on Global Health (APPG). Collectively, these reports call attention to the massive potential greater investments in the health workforce hold for economic growth and women's economic empowerment—especially in low- and middle-income countries—as well as the entrenched gender barriers that prevent the maximum impact of such investment.

As the *Triple Impact* report emphasizes, bold actions to strengthen nursing globally are central to achieving universal health coverage (UHC). The report identifies particular concerns for the status and profile of nurses and nursing leadership. Nurses are too often:
- neither allowed nor enabled to work at the full potential of their competence
- subordinate to and subject solely to the direction of doctors
- invisible, and their clinical and other contributions underestimated
- without opportunities to develop leadership, occupy leadership roles, and influence wider policy
- faced with inadequate training and professional development or are unable to share their learning.[2]

The *Triple Impact* report points out that while nursing "is not and should not be seen as an exclusively female profession, the vast majority of nurses are women and this is likely to continue for the foreseeable future." Further, the report notes that the way nurses are treated in a particular society is often a reflection of how women are treated.[2] Dr. Jane Salvage, APPG adviser and former WHO Chief Nurse, stated, "If nursing leaders could solve [these problems], they would already have done so; but these deep and broad social and cultural realities and attitudes are too difficult to be tackled by nurses alone. We have to help opinion leaders and policymakers within and beyond health and social care to understand these issues, appreciate their gravity, and lend their weight to solving them."[2]

Building on the *Triple Impact* report, IntraHealth International, Nursing Now, and Johnson & Johnson entered into a partnership in 2018 to explore gender as a system of inequality in nursing and nursing leadership and to propose a set of actions to catalyze changes to raise the status and profile of nursing and strengthen nursing leadership. Drawing directly on the experiences of nurses and nurse leaders, this report analyzes the gender-related challenges faced by nurses, and derives from the analysis a set of recommendations for policymakers and implementers at the global, national, and institutional levels to accelerate strengthening nursing leadership and gender equality in the global nursing workforce.

Nursing and midwifery occupations represent a significant share of the female workforce—with 20.7 million jobs held worldwide.[86] Discrimination and inequalities based on pregnancy, family responsibilities and age, sexual harassment, gender stereotyping, and occupational segregation

co-occur in constellations that impede both women's assumption of health sector leadership and the development of the robust workforces needed to realize UHC.[55, 56]

The analysis produced for this report was designed to stimulate new thinking to scale up actions to tackle these well-known problems, acknowledging that such actions will require collective and individual development of senior nursing leaders as well as changing the gendered systems that constrain them (Salvage 2019, Personal Communication).

Such an effort involved identifying both the gender-related barriers to nurse leadership globally and the facilitators of and pathways into nurse leadership in the strategic policy and advocacy, clinical service, and education and research spheres of nursing. The assessment approached nursing leadership in terms of a particular workforce problem—occupational segregation—and drew from the Charles and Grusky conceptual framework of the drivers of occupational segregation to frame major questions, including cultural, systemic, and economic factors.[17]

**FIGURE 1: DRIVERS OF THE GENDER SEGREGATION OF NURSING LEADERSHIP** (ADAPTED FROM CHARLES AND GRUSKY, 2005)

**Cultural mechanisms:**
- Gender beliefs, stereotypes, ideologies—e.g., male primacy (men as more status worthy because of greater competence) to account for vertical segregation; gender essentialism (belief in innate traits of men and women (more nurturing) to account for horizontal segregation: doctors and leaders are men; nurses and nurturers are women
- Employer gender discrimination (individual bias)
- Institutional gender discrimination (e.g., embedded in policy or disparate impact due to unresponsiveness to employees' "feminine" gender roles, organizational gendering and inequality generating processes)
- Internal processes: Preferences; self-evaluation or appraisal of the likelihood of actually being able to land a job
- Expected sanctions: Compliance with gender role expectations, or sanctions for violating expectations of femininity or masculinity
- Labor force commitment: The job holder's investment in the paid workforce, other priorities/objectives, such as starting a family, developing as an artist, etc.

**Economic factors:** The need to be employed, or the means to prepare for entrance exams and ultimately qualify (tutors, cost of exams) or to pay for education

**Access to networks:** Informal or formal, such as "old boys" professional or personal networks, including family, friends and close colleagues

# METHODOLOGY

This research, designed as a rapid gender assessment and analysis, took place from September 2018 through March 2019.

The study was designed to be hypothesis generating rather than hypothesis testing. It was intentionally broad in scope in order to identify key barriers and facilitators of nursing leadership that warrant more in-depth inquiry. The research was grounded in a gender-relational perspective that gives central place to the patterned relations between women and men—and among women and among men of different race, ethnicity, and age—that constitute gender as a social structure of inequality.[68]

For this report, we defined a **"nursing leader"** as a registered nurse who is a strategic, policy, or political thought influencer and/or clinical/service leader.

**Strategic, policy, educational, and political influencers such as:**
- government chief nurses and other senior nurse policymakers
- heads of national nursing regulatory bodies
- senior post-holders in influential regional and global organizations including the WHO, other UN organizations and non-governmental organizations (NGOs)
- senior nurse politicians
- senior executives in high-level programs for safeguarding the public and improving the quality of nursing
- presidents and chief executives of national nursing associations and large specialist nursing associations worldwide; and deans of faculties of nursing or leaders of education and research

**Clinical/service leaders such as:**
- chief executives and directors of nursing in non-profit and for-profit health service provider organizations, including major hospitals, primary health and public health services, including:
    - CEOs
    - heads of nursing services
    - chief administrators

## PHASES OF RESEARCH

**Study design:** The objectives of the design phase were to identify, organize, and engage primary intended users; identify intended policy, advocacy, and programming uses of the results; focus priority questions; and identify and develop appropriate and feasible methods to generate credible findings. Activities included a half-day meeting of high-level nursing and midwifery stakeholders on the sidelines of the 73rd UN General Assembly in September 2018, a two-day meeting of senior nursing leaders and educators in October 2018, and a follow up consultation in November 2018.

**Data collection:** A global survey of nurses elicited opinions and perceptions related to the influence of gender on nursing and nursing leadership, nurses' experience of gender-based discrimination and harassment in nursing work, facilitators of and barriers to advancement of nurses as leaders, and nurses' recommendations to strengthen nursing leadership. A key informant interview guide elicited information about the pathway into leadership of ten nurse leaders recommended by Nursing Now. The researchers reviewed and synthesized relevant literature to provide the research context to frame the gender assessment and interpret the results.

**Interpretation of results:** The researchers held a teleconference in March 2019 with the same senior nursing stakeholders who had participated in the October 2018 consultations to review findings; vet, validate, or expand conclusions; and guide the formulation and relevance of the recommendations. After the preliminary results were vetted, a second draft was prepared for a round of external comment by a larger group of nursing stakeholders.

### ACCESSING THE DATA SET OF SURVEY RESPONSES

Throughout this report, there are references to Appendix A. This appendix is available in the online version of the report available at **www.intrahealth.org/investing-in-nurse-leadership**.

# DATA COLLECTION METHODS AND STRATEGIES

**Global survey of nurses:** The researchers administered the survey through the Survey Monkey platform. Participants were solicited through an open call. Links to the survey were posted on the Nursing Now, International Council of Nurses (ICN), and Tropical Health and Education Trust (THET) websites to invite nurses to "opt in" to the survey. If participants indicated that they were not or had not formally been a certified nurse as per the ICN definition, they were screened out of the survey. The survey was posted on Twitter by IntraHealth International, Nursing Now, and Johnson & Johnson and retweeted by affiliated organizations (e.g., East, Central and Southern Africa College of Nursing [ECSACON]) and individuals. Emails asking to forward the survey link to local networks were sent to national nursing associations that had email contact information posted on their websites or on the ICN affiliate listing. The open call produced a total of 3,706 respondents and, after data cleaning, 2,537 eligible records. Records were deemed eligible if the respondent answered at least 30% of the survey questions in addition to questions related to demographics. Survey respondents spent an average of 25 minutes answering the survey. The English version of the survey was posted from January 9, 2019 to February 8, 2019 and Spanish and French versions were posted from January 23, 2019 to February 11, 2019. Descriptive statistics were generated for quantitative data including cross-tabs of each question by gender and region. Open-ended questions were used for triangulation for both the quantitative survey data and in-depth interviews.

**Nurse leader interviews:** The researchers conducted interviews with nurse leaders to shed light on their pathways into leadership positions. Participants in the interviews were recommended by high-level Nursing Now stakeholders based on a reputation for successful leadership and were selected by the research team in a manner meant to achieve geographic and gender diversity. Interviewees received an informed consent form. Interviews were conducted by online teleconference. Each interview took, on average, 60 minutes and was recorded for ease of transcription. Originally targeting ten nurse leaders, the final sample included eight, with seven female and one male nurse leaders.

Interview data were thematically analyzed using Nvivo 12. The analysis utilized an inductive and deductive approach. The analysis was structured enough to ensure that important themes were not missed but flexible enough to allow for the exploration of themes arising from the interviews. Key themes that function as barriers (and facilitators) of leadership were identified before the analysis and included: stereotyping, socio-cultural norms, structural barriers (e.g., lack of child care, training opportunities), family-work life balance, patterns of bias and discrimination, and sexual harassment.

**Literature synthesis:** The researchers conducted the literature synthesis to frame the research questions, describe forms of bias and discrimination that had been documented in prior social science or workforce research, and to compare findings for (in) consistency during the triangulation of data. The researchers synthesized literature and information in the following areas (please see Literature Reviewed and References):

- gender and the workforce
- leadership and women in leadership
- gender segregation in nursing, including the glass ceiling and glass escalator
- gender bias; stereotyping
- violence and harassment against health workers
- nurse leadership training
- mentoring
- nursing and labor standards, including review of the International Labour Organization (ILO) Nursing Personnel Standard No. 149 and Recommendation No. 157; documentation on ILO's new convention on sexual harassment; and other ILO standards related to gender equality (equal opportunity, maternity protection, workers with family responsibilities, equal remuneration, and standards related to working hours, shift work, and social protection).

**Protection of human subjects:** The surveys and interviews were reviewed by four research methodologists and underwent IntraHealth internal human subjects' protection review. Neither the survey nor the interviews incurred physical risk and involved minimal to no psychological risk. Taking the online survey was by definition written consent and informants did not provide their names. The survey described the respondent's rights and confidentiality of the information given. The survey gave contact information for further information or to express concerns. All participants were informed in clear terms that their participation was completely voluntary, and they were free to refuse to answer any question, take a break or leave at any time during the session without fear of harm or negative consequences.

In the nurse interviews, written consent was waived in exchange for oral consent. The consent form was sent in advance of the interview and oral consent to participate was confirmed at the time of the Skype interview.

## LIMITATIONS

The global survey was only able to reach nurses with adequate internet access. This likely limited responses from nurses playing service leader roles at the frontline.

The global nature of the assessment, short timeframe, and limited budget ruled out the mapping of existing leadership training and development programs and mentoring approaches and networks that could be expanded and "engendered" to strengthen nursing leadership. Such a mapping would have made for a more complete assessment.

Likewise, the timeframe and budget ruled out using a full range of potential methods, such as country-based focus groups and in-depth interviews with early career nurses and nursing students (who likely have different experiences of gender discrimination, including sexual and gender harassment), review of administrative data, and key informant interviews from fields other than nursing. To overcome these limitations, we triangulated the data (e.g., accepting closed-ended survey responses if they were consistent with responses from open-ended survey questions, from the interviews, and from the literature).

Results related to the intersection of gender with other socio-demographic variables such as race, ethnicity, disability, and religion were not apparent in this study. While the survey asked respondents about their perceptions about the importance of race, ethnicity, disability, and religion as barriers to leadership, it did not ask respondents to identify their own race, ethnicity, disability, or religion, so it was not possible to statistically test associations between those variables and responses. This analysis was limited to using respondents' perceptions about how they believed race, ethnicity, disability, and religion impact leadership progression. The survey did not inquire about, for example, tribal affiliation, which would have likely been a more salient variable in some settings.

# FINDINGS

In this section, we present findings and results from the survey (responses to both the closed- and open-ended questions), which were substantiated by data from the nurse leader interviews and findings from the literature synthesis. Tables with all the findings are found in Appendix A (with regional cross-tabulations starting at Table 41).

## RESPONDENT CHARACTERISTICS

### Online Survey

A total of 2,537 current or former nurses from 117 countries provided eligible responses to the survey. Using an adaptation of World Bank regions to categorize responses,[84] approximately one-third were elicited from Europe (EUR), with the UK and Spain contributing the largest number, followed by East Asia and Pacific (EAP) (19%) and Latin America and the Caribbean (LAC) (17%). For a list of countries by region see Table 80 in Appendix A.

The percentage of responses by gender in each region (Figure 3) illustrate that females comprise the majority of respondents from each region. Male respondents in sub-Saharan Africa (SSA) represented the largest percentage in any region at nearly 40% compared to the second largest percentage of male responses—EUR—at 17%.

The majority of respondents (57%) reported their relationship status as married (no difference was noted by gender or region). Twice as many female respondents reported being divorced or separated than males. When asked about children and dependents, the majority reported having at least one dependent. The greatest percentage of respondents reported having no children/dependents (36%), followed by one child/dependent (16%). Given the dominance of responses from EUR, this finding is likely a reflection of the current demographic situation of declining birthrates on the continent. When the data are analyzed by region there is much variability. SSA had the largest percentage of those with four or more children/dependents at 30%, followed by respondents in the Middle East/North Africa (MENA) region at 9%. Respondents in EUR and the LAC region

**Figure 2. Number and percentage of respondents by region**



Middle East and North Africa
n=114 (4.5%)

Sub-Saharan Africa
n=240 (9.5%)

No data
n=21 (0.8%)

Latin America and the Caribbean
n=437 (17.2%)

North America
n=252 (9.9%)

Europe
n=943 (37.2%)

Central and South Asia
n=43 (1.7%)

East Asia and Pacific
n=487 (19.2%)

Total
n=2537 (100.0%)
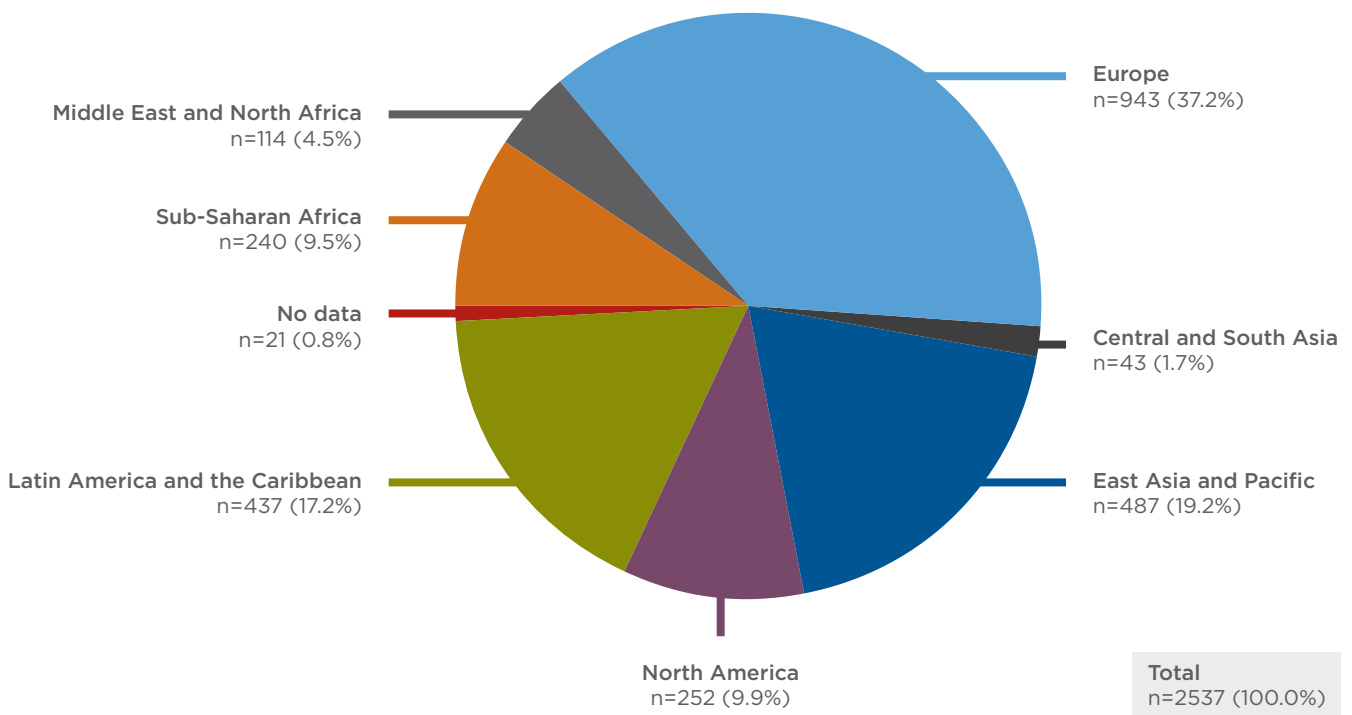
## Figure 3. Respondent gender by region

**Q2. How would you describe your gender?**  ■ Female  ■ Male

| Region | Female | Male |
|---|---|---|
| Sub-Saharan Africa | 144 (61.8%) | 89 (38.2%) |
| Middle East and North Africa | 96 (85.7%) | 16 (14.3%) |
| Europe | 777 (82.8%) | 161 (17.2%) |
| Central and South Asia | 36 (83.7%) | 7 (16.3%) |
| East Asia and Pacific | 421 (87.3%) | 61 (12.7%) |
| North America | 219 (87.6%) | 31 (12.4%) |
| Latin America and the Caribbean | 379 (87.7%) | 53 (12.3%) |
| Total | 2072 (83.2%) | 418 (16.8%) |

## Figure 4. Nurse leaders by region

**Q8. Based on the examples provided, do you consider yourself to be a nurse leader?**  ■ No  ■ Not Sure  ■ Yes

| Region | No | Not Sure | Yes |
|---|---|---|---|
| Sub-Saharan Africa | 28 (11.8%) | 15 (6.3%) | 194 (81.9%) |
| Middle East and North Africa | 23 (20.2%) | 30 (26.3%) | 61 (53.5%) |
| Europe | 436 (46.5%) | 89 (9.5%) | 413 (44.0%) |
| Central and South Asia | 6 (14.0%) | 5 (11.6%) | 32 (74.4%) |
| East Asia and Pacific | 234 (48.0%) | 38 (7.8%) | 215 (44.1%) |
| North America | 83 (32.9%) | 12 (4.8%) | 157 (62.3%) |
| Latin America and the Caribbean | 48 (11.1%) | 42 (9.7%) | 341 (79.1%) |
| Total | 858 (34.3%) | 231 (9.2%) | 1413 (56.5%) |

had the largest percentage of respondents with no children/dependents (42%) (see Table 4.2 in Appendix A).

Approximately two-thirds of respondents reported either a Bachelor's degree in Nursing (31%) or a Master's degree (35%) as their highest educational credential. There is some regional variation with educational credentials. The largest percentage of respondents with PhDs came from North America (34%) and the fewest from the MENA and SSA regions at 3% and 6% respectively. There was no difference by gender (see Table 5.2 in Appendix A for a more detailed breakdown).

The majority of respondents currently worked or formerly worked as a clinical service provider (67%) followed by educator or researcher (21%) and strategic, policy, or political influencer (11%). There is no difference by gender or region.

The highest percentage of respondents have been working, or worked as, a nurse between 15 and 20 years (14%). Although there were more female nurse respondents in the survey, male nurses comprised the greatest percentage of those with less than 15 years' experience (33% men vs. 21% women).

Respondents were provided with the definition of "nurse leader" and were asked if they identified themselves to be a nurse leader based on that definition. Just over half of respondents said "yes" (56%). Figure 4 outlines the percentage of nurse leaders by region. There are some notable differences in responses. Eighty-two percent of respondents from SSA considered themselves as nurse leaders with the second largest percentage from LAC (79%). The lowest percentage identifying as nurse leaders came from the EUR and EAP regions (44%). Approximately one quarter of respondents from the MENA region don't know if they are nurse leaders, which is significantly more than the second largest percentage (Central and South Asia, 15%) unsure of their status. There was no difference by gender.

### Nurse Leader Interviewees

Table 1 outlines interviewee characteristics. The recruitment criterion was: A nurse who is a registered nurse who has had an impact on the nursing field or on UHC. The categories of nurse leader were: strategic/policy leader; educational/research leader; or clinical/service leader.

**Table 1. Nurse leader interviewee characteristics (n=8)**

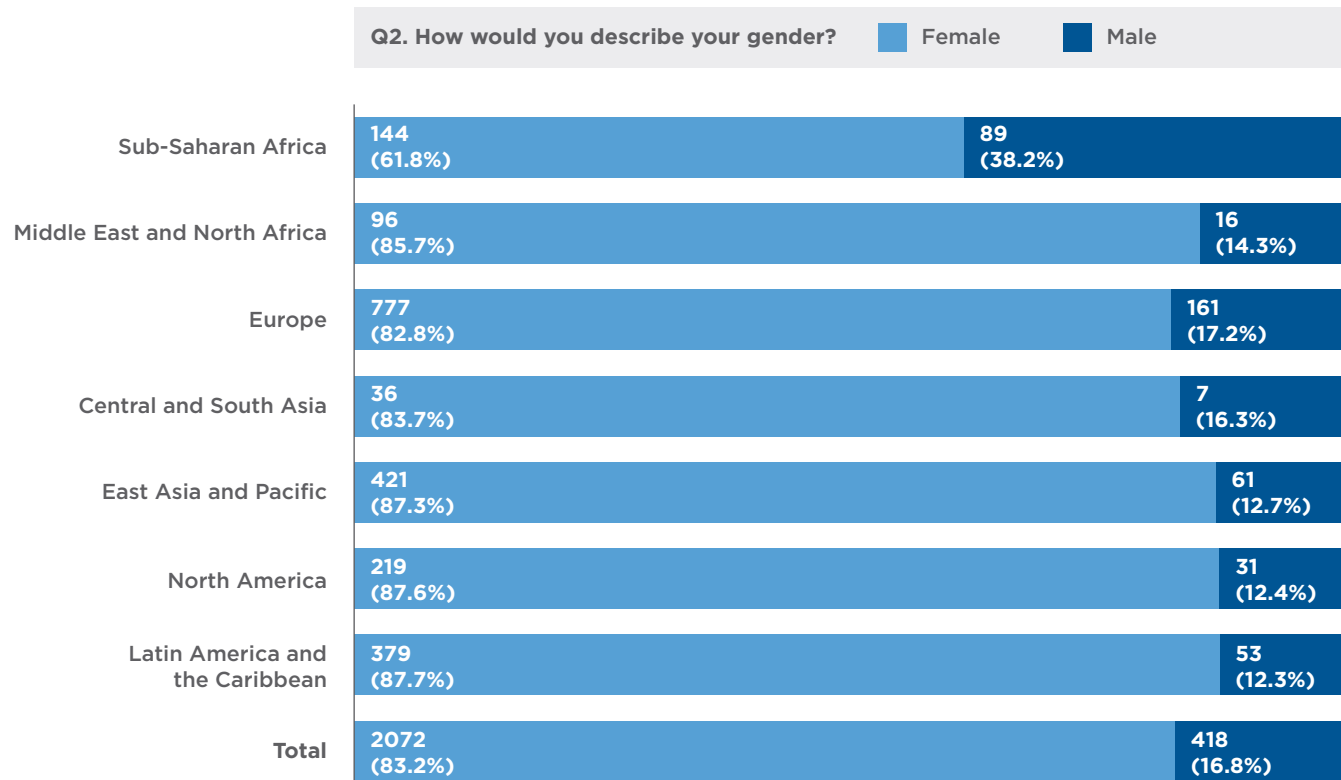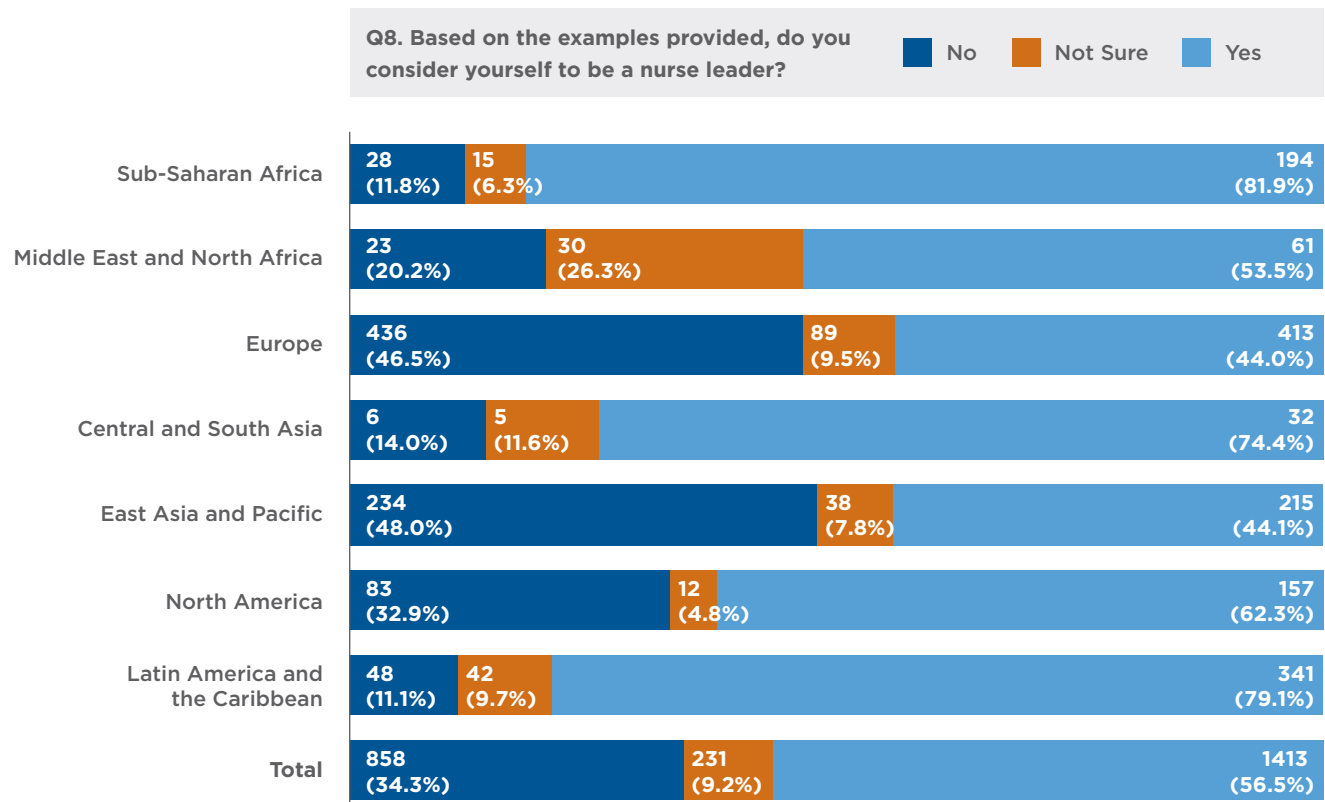| Region | Type of Nurse Leader | Gender | Approximate Years Nursing Experience | Highest Educational Level |
|---|---|---|---|---|
| East Asia-Pacific | Education/Research | Female | >20-25 | PhD |
| Europe/Central Asia | Strategic/Policy Leader | Female | >25-30 | Nursing qualification in medical school |
| Middle East | Education/Research and Strategic/Policy Leader | Female | >40 | Doctor in Nursing Science |
| Sub-Saharan Africa | Clinical/Service | Female | >30-35 | PhD |
| East Asia-Pacific | Strategic/Policy Leader | Male | >25-30 | PhD |
| Sub-Saharan Africa | Education/Research | Female | >30-35 | PhD |
| Sub-Saharan Africa | Strategic/Policy Leader Clinical/Services | Female | >40 | PhD |
| Europe/Central Asia | Education/Research and Technical | Female | >40 | RN, MD |

# FACTORS THAT CONTRIBUTE TO THE SEGREGATION OF NURSING AND LEADERSHIP POSITIONS

## Gender Beliefs, Stereotypes, and Ideologies

By far the largest category in the Charles and Grusky framework, the cultural mechanisms driving occupational segregation include socio-cultural norms, beliefs, and stereotypes surrounding the role of women and men; for example, the attributes of a good man or woman, what roles are appropriate and what their labor should be. Gender stereotypes that underpin occupational segregation hold, for example, that women are by nature not suited to performing the same jobs or tasks as men and that men are not suited to doing the same jobs or tasks as women. Thus, we see the concentration of women in nursing because women are believed to be naturally more suited for care work, and that men are concentrated at the tops of hierarchies because of greater presumed competence.[55] Research has demonstrated the association between leadership and supposed male-typed traits such as agency, assertiveness, or decisiveness,[26, 55, 69] which challenges women's leadership.

Gender stereotyping is such that even when women hold power, they are perceived as illegitimate leaders.[69] The perception of women's illegitimacy results in women's voices not being heard when they are in leadership positions.[69] Male primacy and gender essentialism are terms that describe key stereotypes that drive occupational segregation. "Gender essentialism" refers to beliefs about inborn nature or traits of men and women, and "male primacy" refers to beliefs about the greater value or status worthiness of men.[17, 55] Perceptions of leadership as male-typed start at a young age with boys being far more likely than girls to gain childhood leadership experience.[11] Gender bias and stereotyping function similarly in science, technology, engineering, math, and medicine (STEM) careers.[45, 68, 81]

**Findings:** The assessment found that a number of socio-cultural beliefs and stereotypes emerged as impacting the role of nurse leaders in addition to the perception of nursing as a profession. Approximately 65% of survey respondents indicated that the belief that men and women have specific roles in society and health care is a "very important" or "important" barrier to women obtaining leadership positions. When this result was analyzed by gender, 67% of respondents stated that this perception acted as a barrier to leadership for females compared to 54% for males (see Table 36.1.2 in Appendix A). The perception of nursing as a "nurturing" and "feminine" profession emerged as a consistent finding among both men and women, and across regions. This finding was substantiated in interviews with nursing leaders.

> Even if we had students, male students, at nursing schools, they all left [the] nursing profession. Almost 99% left [the] nursing profession because it was considered a very [female] profession. It's not for men. **—Nurse leader, Europe/Central Asia.**

*In South Sudan most people perceive nursing as a women['s] profession. Men who enter this profession have been looked at as outsiders. Many individuals feel that a man does not belong in a feminine profession.* **—Survey respondent.**

*Males are called doctors and females are nurses even if they [the women] are doctors. This is mostly by the patients.* **—Survey respondent.**

*I think that society has placed nursing in a "gender" type profession for years, and that if a man was in a nursing role he was considered to have "something wrong" with [him], which I believe is ludicrous. In these modern times where men are "allowed" to be more caring and nurturing it is more acceptable. People need to understand that nursing is an amazing career for those of ANY gender!* **—Survey respondent.**

Higher levels of occupational segregation in the labor market are associated with stronger tendencies to devalue women's work.[14] Reskin (1988) noted that the wage gap is associated with the segregation of men and women into different jobs, and that occupations traditionally dominated by women pay less at least in part because the workforce is majority female. Devaluation is linked to systems of social differentiation, and while femaleness is not always devalued, its deviation from maleness in a culture that reserves virtues for men entails the devaluation of women. Following this, differences from the male norm would be perceived as inferior, and as a result, men's activities would typically be valued above women's, regardless of content.[67]

**Findings**: Approximately 75% of survey respondents said they do not believe that there are aspects of nursing that make it more suitable for one gender. However, when survey respondents were asked about barriers to leadership and advancement, a number of biases, stereotypes, and experiences of discrimination that result in gender segregation, emerged.

*That clinical work is for women, and male nurses' jobs are to be nurse educators; male nurses should not be midwives.* **—Survey respondent.**

*A nursing college accepted two men into a program for midwives. They were not granted study leave because it was felt that midwifery is for females and our population was not accustomed to this.* **—Survey respondent.**

*Male nurses are in mental health and women in maternity or pediatrics.* **—Survey respondent.**

*In my experience men are discriminated against in nursing and midwifery. In Australia men comprise 10% of the nursing workforce and 2% of the midwifery workforce. Men are seen as less competent [than] women and [are] seen as having less ability to care. There are no programs addressing the lack of men in the profession as there would be if the gender balance were the other way around. Particularly in midwifery men have to prove themselves and even then are begrudgingly "allowed" to participate in what is seen as women's work but never truly accepted.* **—Survey respondent.**

**Findings:** The results suggest that although there may not be a conscious belief that one aspect of nursing is more suitable for one gender than for another, the reality seems to be that some aspects of nursing itself are sex-typed. This suggests that the gendered division of labor of the larger society is reproduced in beliefs about nursing. Male nurses shared experiences of working in a female-typed profession and how tasks are sex-typed.

*In 1985, when I first started nursing...In general nursing, many of the manual labour jobs were saved for me just because I'm male and in mental health nursing, males were expected to take the lead in restraints and restrictive practices. While I firmly believe some of these opinions still exist and gender-based decisions are unintentionally practiced, the barriers of gender are being eroded.* **—Survey respondent.**

Another survey respondent shared the belief that the gendered division of labor is divided into "clean" and "dirty" work. This sentiment reflects male primacy in the avoidance of "dirty" work and the socio-cultural norm in many countries that women undertake cleaning duties in the household.

> *I feel female nurses are left to do the 'dirty' work— toileting and showering—while the male nurses take over the 'clean' work—procedures, dressing, and paperwork.* **—Survey respondent.**

More men entering the nursing profession could help address nursing shortages. However, there are challenges and potential consequences. While there are multiple advantages in decreasing gender segregation in nursing in order to achieve UHC, female nurses might be subject to greater and unfair competition for leadership roles and job openings[4] especially in societies where women are not making strides in entering male-dominated professions, and where women rely on female-typed jobs to make a living and support their families. Despite the numerous labor market and individual disadvantages of gender segregation, it can nevertheless protect women from competition and maintain demand in one of the comparatively few occupations where women have an advantage.[4]

## Gender Bias and Employer and Institutional Discrimination

Employer bias and institutional discrimination against women in the workforce and in leadership progression have been extensively documented.[1, 14, 26, 55, 57, 59, 70, 80, 81, 89] Sanctions for transgressing gender roles have also been studied, including the identity work that men do in order to cross over into female-identified work such as nursing.[47, 48, 51, 73] Male advantage in the workforce[12, 17, 55] is perhaps most clearly seen in the "glass escalator," an effect documented in several studies whereby men bring their privileged status in the wider culture with them when they enter predominantly female occupations.[75] Glass escalator research, up to now concentrated in the global North,[50, 53, 64, 66, 73, 75, 76, 82] suggests that males by virtue of membership in the dominant culture experience preferential treatment and ride an invisible "glass escalator" into leadership positions at faster rates than their female counterparts in the profession. While men report the experience of discrimination on entry into stereotypical female professions, this appears to come from outside the profession, while within the profession, men have been largely accepted and able to advance relatively quickly. In predominantly female professions, men are likely perceived as more competent and more prepared for leadership,[55] and receive higher compensation.[66]

Perceptions of leadership as male-typed start at young ages with boys being far more likely than girls to gain childhood leadership experience with greater participation in debate teams and student governance.[15, 28] Once adults, men in the health sector and STEM careers have easier paths to leadership than women.[45, 46] For example, nearly half of all doctors in the United Kingdom are women, but they are poorly represented at the physician leadership level.[47] These disparities hold true even when accounting for job-related skills, education requirements, and levels of experience.[40]

Biased evaluations are an important obstacle to women's hiring, promotion, performance evaluation, and compensation. Female applicants are often evaluated more poorly than men: In one study, science faculty members were asked to evaluate two fictitious students' applications. Both male and female faculty members evaluated the male candidate better than the female despite no objective differences in the applications. There is similar research demonstrating higher rejection rates of CVs whose sole difference was the word "mother."

**Findings:** The fact that 35% of survey respondents stated a belief that men are, or should be, dominant, is a barrier to female nurses obtaining leadership positions. Several of the nurse leaders interviewed stated that men have final decision-making authority.

But it is in the quotes from interviews together with open-ended survey responses that it is possible to see how male primacy stereotypes[17] and the way female candidates with more experience are bypassed (and how pregnancy appears to trigger marginalization) contribute to the "glass ceiling"/"glass escalator" effects in a female-dominated profession:

> *Because in my country...in my culture, I believe, we have to respect older people and seniors and something like that. And for woman, women have to respect men. And men, in my country, men have more power than women. And this has an impact in the health sector.* **—Nurse leader, East Asia-Pacific.**

*In a 90% female dominant field of nursing, I often see about a 50% or less in upper leadership positions. It is not representative of the rest of the nursing population as a whole. I have heard the comment many times from upper leadership that they need a "little testosterone" added to the group when deciding on leaders. ... I have also experienced scrutiny from executive leaders for hiring a nurse or employee who is pregnant.* **—Survey respondent.**

*Whenever there is a male applying for a senior position he is always the successful candidate. This is because female panel members are socialized to believe that the male makes a better leader and is superior to them.* **—Survey respondent.**

*While males with limited nursing experience who can 'talk the talk' get promoted quickly. Whereas female nurses with many years' experience often do not get considered for leadership roles.* **—Survey respondent.**

*So, this issue you are talking about, my grant will never be perfect like the one of my male counterpart. So usually then the review committee also, you will find that the candidates are males. If you are invited to go there, you will find that you are the only woman there and they are all males. So it's obvious when they see a female application they will just put it aside, regardless of reading the proposal or trying to interrogate the proposal, they will choose a male and that is a fact. You will find that if we go to this senior management meeting the outcome of grant selection is that most of them are given to males. There will be one woman against five males. So these are the things that you are talking about on the glass ceiling. These are the invisible barriers and they derail our promotion to higher levels in nursing leadership roles.* **—Nurse Leader, sub-Saharan Africa.**

**Findings:** Just over half of survey respondents (52%) stated that they believed that men are favored more for promotion than females as a significant barrier to females obtaining nurse leadership positions.

*Male counterparts seem to breeze through positions and receive promotions despite lacking the skills, knowledge and competence.* **—Survey respondent.**

*I still think there is this misconception that males are leaders. That is why women in the applications, in the CVs that we are to look at, we find that all the applicants are males. Do women not apply to those positions, or women are not chosen in those positions? That is the question that we need to interrogate.* **—Nurse leader, sub-Saharan Africa.**

*In my experience men get promoted so easily; recently I was in a temporary NUM [Nurse Unit Manager] role for 18 months. I have a Master's in health management and lost the permanent position to a male graduate nurse with zero clinical or management experience...that is what it's like. I keep applying for leadership jobs and keep getting told I need more experience but male graduate nurses get the jobs! How is this equitable??!!!* **—Survey respondent.**

There were different reasons cited as to why men progress faster than women. Open-ended survey questions suggest that women advance more slowly because if they are married, they must manage a job, household responsibilities, and child care. A nurse leader interviewee shared her own experience that home responsibilities limited her time to apply for funding that could advance her career:

*I am a nurse leader and my problem comes when we have to apply for funding as I have indicated somewhere in this interview, you will find that the applicants are males. One thing that makes more applicants to be males is that they don't do anything at home. When I leave here I'm still going to cook, I am still going to attend to the household, but for the man, he can stay here after work and go home and sleep. They go to bed and sleep, eat and sleep. So the application, these males I'm talking about, might be black or white doesn't matter. When they reach us they don't usually have anything attached to what they do, they will all just continue waiting at work and finish the proposal. For me now, as we are talking, I'm still going to be here the coming hour trying to finalize a grant. Mind you I must go home and cook, and clean, and do whatever.* **—Nurse leader, sub-Saharan Africa.**

Other female nurse leaders cited the lack of time to leverage formal and informal networks as a way to accelerate advancement. One interviewee shared her own experience that even when she achieved a

senior leadership position her power was eroded by men's informal networking after work hours of which she was not part of.

> *I used to see the culture where a lot of informal work was done late in the evening in the pub. And that would be physicians and administrations, and men predominantly. And women with or without children would choose to go home. I remember one of my director of nursing colleagues would have a formal management meeting, various things would be agreed, then the men would go off to the pub and she would go home, and the next day she would find half the decisions had been changed.* **—Nurse leader, Europe.**

## Intersection of Gender and Other Axes of Exclusion

Intersectional gender research in the US has demonstrated that black men, black women, and white women waited longer than white men for managerial promotions in female-dominated fields[76] pointing to the importance of accounting for other axes of social exclusion from power and resources. It is possible that a "glass escalator" effect exists for any set of males who belong to a dominant cultural group working in occupations typed for cultural minorities. Wingfield noted that shared racial status is important for determining "who rides the glass escalator" (in the US) and that black male nurses' experiences might more closely resemble those of white male nurses' experiences in predominantly black settings.[82] This observation suggests the need to test the cross-cultural portability of the concept and identify cross-cultural specificities in the context of cultural majorities and minorities.

Findings related to intersectional identities and their relation to nurse leadership were not salient in the qualitative portions of this study and require further research.

**Findings:** In response to a survey question about how important other sociodemographic variables (race, ethnicity, disability, religion) were in female nurses' path to attaining leadership positions, analyzed by region, North America ranked highest for race as important or very important (48% of respondents from US and Canada) (see Table 36.4 in Appendix A). The Middle East and North Africa ranked highest for disability, with 53% saying that it

was important to very important to female nurses' path into leadership (See Table 36.6 in in Appendix A).

## Professional and Family Work

Studies have found that women often face discrimination related to motherhood and family responsibilities in health, including STEM, careers,[5, 7-10] which are then used as rationales for bypassing women for leadership. Strong policies supporting paid leave, lactation breaks/spaces, and child care services were found to at least retain women in the workforce,[11] but these policies are not in place at all organizations.

**Findings:** The expectations of women to juggle the responsibilities of managing the household and child care act as a formidable barrier to leadership advancement. Although respondents believed that both men and women face challenges managing work and home life commitments, 65% of respondents stated that women are more impacted than men.

> *Men have support at home, which allows them more to participate in non-mandatory career building activities offered at work. With fewer child care responsibilities at home and are rarely a single parent working to support their families.* **—Survey respondent.**

> *Females have at least two full-time jobs— home and work—while men have limited home responsibilities plus work.* **—Survey respondent.**

> *In my organization, approximately 25% [of the] nursing workforce are men, yet only 30% education, management, or executive positions [are] held by women. I was once overlooked for [a] middle management job as I was of childbearing age, even though single and deemed "infertile" by doctors. The successful candidate was similar aged married man who was undergoing IVF treatments with his wife! I left the organization rather than challenging it. Recently I've been declined a few positions as they are full-time hours or rotating rosters, which is impossible for me as a single parent. My son's father has pursued his career during pregnancy/infancy/child care reshuffles and he was never asked about parenting responsibilities by an employer. I am*

*lucky to find an organization that values family life & my skill base, but that has meant stepping back from clinical leadership, which is what I enjoy most.* —**Survey respondent.**

Although a majority of survey respondents and interviewees stated that their workplace had policies in place to prevent workplace discrimination and promote inclusion and work-life balance, respondents and interviewees did not always believe those policies could counter disadvantage. Open-ended responses to the survey questions demonstrate that a number of women believe they were passed over for advancement or not considered due to the assumption they will eventually take time off work due to pregnancy or to care for children ("maternal wall" bias). The data from the survey substantiate this, with 65% of respondents stating that exclusion from consideration for leadership based on pregnancy, maternity, and family responsibilities was a "very important" or "somewhat important" barrier to advancing into leadership.

*My male and female colleagues started to underestimate my professional abilities and lessen automatically my responsibility since I announced that I am pregnant.* —**Survey respondent.**

*I have heard senior managers state that they prefer male nurses when applying for higher-level roles because they do not take maternity leave.* —**Survey respondent.**

*I used to take my children to work so when I would go on work trips, you would sense that some people would think that I was too busy with my family. And my other daughter has had very poor health at one point, so I would say I can't go somewhere because my daughter is unwell, people do not appreciate it. It was almost as if they thought I didn't want to go. But they don't know it's important. So I kind of thought people think, "well she has to do it anyway so; let's ignore her." Rather than appreciating the balance.* —**Nurse leader, sub-Saharan Africa.**

There is the perception among survey respondents and interviewees that male nurses may progress more quickly into leadership positions and advance quicker once they are in those positions. Some respondents stated that they believe men progress faster into leadership positions and advance through those positions because they don't have to take time

off to look after children. Moreover, after the birth of a child men are more likely to work full-time, which gives them more time to gain experience to prepare them for leadership roles (in the survey, nearly twice as many women than men reported working part-time). Finally, a few respondents shared their belief that men are able to get leadership positions and advance more quickly because they are the minority and are purposively selected and promoted more quickly than women ("glass escalator").

*It appears that male nurses progress faster than female nurses in some areas due to their ability to work full-time; whereas some female nurses choose to work part-time because of children and care requirements.* —**Survey respondent.**

*Since men are a minority in nursing they are often considered for promotion sooner than women with the same education/qualifications.* —**Survey respondent.**

One survey respondent shared a slightly different experience in nursing education, which suggests that the "glass escalator" may be confined to mobility into higher-paying jobs:

*Over the course of my career I have heard more discussion within groups of nursing as to how easy it is for a male nurse to climb the ladder within health care. There are not as many hoops that men have had to jump through. In education arenas I have not seen this as prevalent in leadership roles. In fact, trying to get men to move into education roles has been difficult, many have voiced to me that there is no money in education.* —**Survey respondent.**

## Sexual Harassment

**Findings:** Sexual harassment was not salient as a factor affecting nursing leadership in this study. The pattern of survey responses to closed-ended questions reflected the most frequent response of "Don't know," suggesting that additional or different study methods are needed to elicit data on the operation of sexual harassment in female-dominated health occupations. This is because some survey respondents and interviewees alluded to experiences that affected themselves or their colleagues. One interviewee described witnessing instances of sexual harassment in rural areas or when traveling over

land and another described incidents that were more implicit than overt, such as the suggestion that a superior is "owe[d] something" in exchange for getting someone their job. Another interviewee suggested that she had experienced sexual harassment, but did not recognize it as such at the time.  More qualitative research is needed to assess the forms and effects of sexual harassment in both educational and work settings, over the course of a nurse's education and career.

## Perception of Affirmative Action

**Findings:** The results of the study indicate that affirmative action policies either did not play a role in advancement or were not perceived as helpful. Sixty percent of respondents, male and female nurse leaders, indicated that preferential treatment did not facilitate their leadership positions. One interviewee pointed out that affirmative action policies to help women get into leadership roles are not always that helpful and could undermine women's efforts. The latter may be due to stigma attached to affirmative action.

> *I think the policies are needed to facilitate that. Like for example, you gave two examples of sexual bias, especially the equity one—or affirmative action policies. They work to our advantage and to our disadvantage, because when we are in this space, people think we are just here because of affirmative action, despite being qualified, despite having those qualifications and earning those skills and competencies to work the same way as men. So those policies are there—sometimes they facilitate us, and sometimes you are just seen as a body, just a warm body who was put there because of this policy.* **—Nurse leader, sub-Saharan Africa.**

## Limitations on Nurse Decision-Making and Perception of the Softness of Nursing

Recent research has shown that men may be over represented in senior leadership positions in nursing. For example, a study conducted in the United Kingdom demonstrated that while men represented only 11.3% of the nursing workforce, they held 17% of senior leadership positions.[14] Research has also demonstrated the association between leadership and supposed male-typed traits such as agency, assertiveness, or decisiveness, meaning that

leadership itself is considered to be masculine.[5, 16, 17] These stereotypes prevent women and nurses from ascending career ladders because leadership itself is perceived as masculine.[15] Gender discrimination and perceptions are such that even when women hold power, they are perceived as illegitimate leaders.[15] The perception of women's illegitimacy results in women's voices not being heard when they are in leadership positions.[15]

Women vastly outnumber men in nursing, with men only making up 8.9% of the nursing workforce.[9] This may set the stage for the "soft skills" imputation and lesser status associated with nursing. Additionally, female-dominated professions have historically been undervalued and under-compensated, which makes them less prestigious and less attractive to potential male candidates.

Many men find the societal expectations to embody masculinity incompatible with working in a traditionally female profession. Men who enter nursing may experience a misalignment of their gender and occupational identities and expend a great deal of energy on "identity work" to resolve this.[31] Men working in "feminine" jobs often use various strategies such as using more precise titles when referring to what they do—e.g., "Ward nurse with a management function"—to align social and occupational identities.[32] This prioritization of male-typed job elements also pushes men in female-dominated fields to pursue leadership, a male-typed role.

**Findings:** This study explored the degree to which nurse leaders have decision-making authority. At the clinical services leadership level, both men and women reported similar degrees of decision-making authority. Fifty percent of male and female clinical service leaders stated they had decision-making authority over patient care but just over half of men and women stated they did not have decision-making authority regarding work schedules or policies that govern patient care. Moreover, 80% of men and women stated they do not have decision-making authority over budget allocations. Fifty percent of men and women stated they do not have decision-making authority regarding professional development for themselves or others. The results indicate that both female and male clinical services leaders have similar—and limited—degrees of decision-making authority in the clinical care setting. Since the survey did not ask respondents about how decisions are made in their clinical service context,

it is difficult to determine if clinical services leaders are having their decision-making authority usurped or curtailed because nurses are disenfranchised as an entire profession, or if all clinical services cadres (e.g., doctors, pharmacists) have similar limits to their decision-making.

At the higher levels of nursing, biases against female nurse leadership become clear. Respondents reported that nursing is perceived as secondary to the field of medicine and nurses function in a support role to doctors. Nursing is perceived as a "soft science" profession, with medicine perceived as the "hard science" profession; thereby ascribing to doctors a superiority over nurses and consequently greater decision-making authority. Secondly, socio-cultural norms express expectations that women have less decision-making authority than men. In many parts of the world where more males than females are doctors, the doctor-nurse dynamic is further skewed in favor of doctors.

> *There is something about nursing that has a stigma of being secondary, tertiary even towards medicine...towards anything else. It [nursing] is a serving position.* **—Nurse leader, sub-Saharan Africa.**

> *To recognize that nurses need to have university education and they can make decisions was a huge challenge. But they are not making decisions, it is the doctors.* **—Survey respondent.**

> *But in my country, there is a lack of policy support in the nursing profession. Currently, there are some laws or regulations that concern nurses' profession. But there is still a limit when compared to others. This profession in [country] is a low profession. We have a low image.* **—Survey respondent.**

Notably, a number of respondents alluded to, or stated, that nursing as a profession will not be taken seriously until more men join the ranks, almost as if the inferior status of nurses would be upgraded by association with the perceived superior social power of men:

> *I have been nursing for 43 years; I am a feminist; I truly believe that young female nurses have more respect and acknowledgement of their skills and leadership abilities today... I also feel that men in nursing has supported the professional*

> *acknowledgement for all health professionals so that nurses are now being seen as important in the role of patient's overall care. There is still a long way to go and empowering both female & male nurses during their training is essential.* **—Survey respondent.**

> *Because in our country, and in most African countries, nursing is a predominantly female profession. So, we've been trying to push forward. Usually when there are more women in the profession, people do not take it seriously.* **—Nurse leader, sub-Saharan Africa.**

Seventy-seven percent of survey respondents, regardless of gender or region, stated that stereotyped images of doctors as dominant and nurses subservient is a "very important" or "somewhat important" reason why female nurses struggle to advance into leadership positions. These stereotypes, which underpin the gender segregation of nursing and leadership functions such as decision-making, tend to be gender essentialist[4] or male primacy stereotypes:

> *Some people think of nurses as servants.* **—Survey respondent.**

> *In [country], nurses are seen as slave of doctors. It's a shame—doctors' mentality should be changed. Nurses need to be a leader, not doctors.* **—Survey respondent.**

Slightly more than 50% of respondents stated that perceptions of nursing as an essential or "inborn" characteristic, and not a science, is a "very important" or "somewhat important" reason why female nurses don't advance into leadership.

> *They [society] might think women are suitable to be a nurse because nurses are like an angel. In my country people view nurses as angels.* **—Nurse leader, East Asia-Pacific.**

Most of the female nurse leaders interviewed described experiences of deference to doctors or doctors not sharing decisions, and these instances were not restricted to lower level leadership positions in a local setting or experiences from long ago. Rather, a number of these experiences occurred in senior leadership positions in global organizations and within the past two decades:

*You know as a profession they think the nursing profession is just an assistant to medical doctors. I talked to one of the key people from [organization] about what to do about the nursing workforce and then this person asked medical doctors to check what to do. How can the medical doctor evaluate if the nursing workforce is working well in the health centers? They don't understand the concept of the nursing profession. They don't understand the standard of nursing practice, so how could they check—how can they evaluate effectively?* **—Nurse leader, East Asia-Pacific.**

*For nursing to have a voice in the national public it is very difficult because it is being discounted. And in all of our human resource planning, we would have to sit together with the medical association, and the nursing association and the others and see what [are the] changing health care needs with the changing population and make decisions together. But …the docs aren't into it. So that's problematic…as a profession it doesn't have the glory that medicine has.* **—Nurse leader, Middle East.**

One respondent shared her own experience with the large degree of decision-making authority that doctors had over her appointment in a senior leadership position in a European health system:

*But then at one place I actually got the job, but then the medical staff, who didn't know me, met and said they weren't having a nurse and a woman, and apparently according to a friend of mine that was in that meeting, there were references to "petticoat power." So the job was taken away from me even though I had actually been appointed, because the most senior people in health services said you couldn't start a job without the support of the medical staff. You cannot separate them [nursing and gender], can you? I believe it was because I was a nurse. But you can't separate [the two]..sort of almost integral to each other.* **—Nurse leader, Europe.**

**Findings:** Female and male nurses both face bias and discrimination from medical doctors; however, results of the survey and interviews indicate that women feel those biases and discrimination more acutely. Fifty-seven percent of survey respondents stated that female nurses are more likely to face not being seen as a leader compared to 33% of men. Female nurses are more likely expected to be subservient to doctors than male nurses (67% vs. 45%).

Results from the surveys and interviews indicate that biases and discrimination against female nurse leadership, and in particular decision-making, occur at all levels of nursing from the clinic to higher education.

*I cannot be associate professor being a woman within my appointment, so I need to work harder and prove to them, to the management of the university, that being a woman doesn't mean that I don't work hard. I worked hard for those past four years and then within that period which is a long period for some, I obtained it. Because I think that if it was a man, for sure he could have just been given the position straight away, but because of my gender that is why I was given another year, another two, three, four years, to prove to these people that I can have a leadership position.* **—Nurse leader, sub-Saharan Africa.**

*I feel a doctor will listen to male nurse before listening to a female nurse. I will have people saying I do not know what I'm talking about only for someone with more experience to tell them I was right.* **—Survey respondent.**

*I can't say I blame gender or whatever, I blame the system as a whole. Because the department here is run by women, but the Dean makes the decision[s]. I have been here for five years now, and in those five years I have seen two male deans. I don't even think they are thinking of having a female dean. So those are the things that you can see that the society still sees us as inferior despite being in education or academic. And then another thing talking about that, is in research, usually we do an application to apply for research funding and basically when we look at the funding outcomes in most cases they will say that men get it.* **—Nurse leader, sub-Saharan Africa.**

## Hindrances to and Facilitators of Leadership

Interventions proposed to address barriers to getting women into leadership are equal opportunity and gender equality policies, systems for reporting gender discrimination or harassment, gender-specific leadership training, and peer mentoring.[43] Several

programs exist to promote women in leadership. In Australia, two programs were created to promote women in STEM and leadership. The Science in Australia Gender Equity Program partnered with universities to promote gender equity and women in leadership in STEM fields, and Australia now has 83% of all universities participating in this program. Another program, Male Champion of Change, attempts to drive change in males and teach them to be accountable for their actions. Both programs are set to be evaluated in 2019.[45] The United States' National Science Foundation has a program called Advance geared towards giving grants to institutions that will promote women and gender equity in STEM and academia. This program seeks to enhance institutional structure (i.e., recruitment, promotion, and tenure policies) and work-life support (e.g., life transition policies, dual career hiring), and provide equitable career support (mentoring) and empowerment training (e.g., promotion search committees).[56]

Many nurses assume leadership roles without formal leadership training and, at times, without a formal orientation.[65] Nurse leadership skills in clinical nursing are associated with better staff retention and improved patient outcomes (reduction in mortality and adverse patient events).[65] Nursing education often focuses on clinical competencies and neglects elements such as finance and costs.[65] There are very few publications on nurse leadership training programs. One example is the International Council of Nurses' five-month long Global Nursing Leadership Institute, which focuses on teaching nurses policy and political skills, with a focus on how nurses can shape, influence, and implement policy decisions.[66] International nursing honors fraternity Sigma Theta Tau also has several leadership programs focused on nurses developing personal and academic leadership in a variety of nursing specialties. The Florence Nightingale Foundation has several UK-based leadership programs geared toward a variety of different groups including army nurse leaders, community nurse leaders, UK National Health Service (NHS) leadership programs, and leadership programs for nurses with learning disabilities.[67]

Traditional mentoring focuses only on career and often has a power-imbalanced one-on-one relationship between the mentor and the protégé.[69, 70] Feminist mentoring differs from traditional mentoring by offering a focus on nurturing

relationships through self-disclosure, personal and emotional needs, working towards social change, and being thoughtful about power issues, while usually still maintaining the one-on-one relationship.[70] One study found that male mentors often only focused on career goals while female mentors also focused on psychosocial support.[71] Feminist models of mentoring are built on women's lived experiences and are a reciprocal relationship between mentor and protégé based on empowerment and solidarity.[72] This personal relationship can help connect personal and political experiences,[69] and focus on empowerment, self-esteem, and knowledge building.[73] Research has highlighted the importance of these feminist relationships in nursing specifically as a female-dominated field.[72] Such mentoring relationships have been shown to help women acquire tenure and other administrative titles.[73] In addition, mentors can directly help women gain access to management roles, and those in management roles who had mentors had higher job satisfaction.[74]

**Findings:** Of qualitative survey responses to a question asking about the hindrances to assuming leadership roles, the most salient were: lack of self-confidence, lack of child care, rigid duty-rosters and full-time working hours, work-life conflict, and gender discrimination. Nurses also mentioned lack of access to higher education or enough education.

Organizational culture and practices comprised another set of hindrances, though not necessarily gender-related, including politics and bullying, and lack of management support, such as feeling unappreciated/unrecognized/unsupported by a supervisor.

Of survey responses to a question asking how hindrances to leadership had been overcome, several qualitative responses suggested that hindrances actually had not been overcome, but that where they had been overcome, it was because their children grew up, were more independent and no longer needed as much care, or that they had developed confidence, which came with experience.

The results from the survey show that the three top facilitators of nursing leadership as indicated by being "very important" or "important" to nursing leadership advancement are: supportive family or spouse (92%), leadership training (92%), and receiving assignments that prepared them for leadership (91%).

Family and spousal support were cited as important reasons for nursing leadership advancement.

> So, all you really need is support... support of your spouse, support of your parents, otherwise, if you don't it can be difficult. My late mother and my mother-in law came in many times to support and take care of the babies when I was studying and I had to travel overseas. **—Nurse Leader, sub-Saharan Africa.**

> Or change responsibilities in the family together, for example, so men can take care of the children, or help their wife, or help his wife to do household chores...such as washing clothes or cleaning house, or washing dish is maybe help. The wife, to help her have more time now and is not too tired. And the wife can spend the time in her work. **—Nurse leader, Southeast Asia.**

> I was lucky enough to have support, especially when it came to motherhood and childbearing. I remember when I was needed one time in [country] and I was breastfeeding my child. And you know my husband said, "I'm going to buy a plane ticket for the babysitter [to go with you]" so I had somebody taking care of the baby while I attended workshops and all that. So they [family] facilitated it, but you really need the support. Otherwise there can be real barriers. **—Nurse leader, sub-Saharan Africa.**

There are some notable differences in reported facilitators of leadership between the survey and the nurse leader interviews. Although 92% of survey respondents believed training is important in advancement, and approximately 40% of respondents want leadership training, interviewees were less enthusiastic about the value added of formal leadership. One interviewee praised her training, but most interviewees communicated a belief that training was not a panacea—rather, the key to building leadership skills is to apply the skills and knowledge learned in training:

> I think training and courses on leadership are often important. In my career and in my advancement to nurse leadership I did have that variable. I have the nursing management qualification from [country] and I went through the African leadership course. I think we cannot just move, we should deconstruct the myth that leaders are born—leaders need education, we

> need training to be a leader. **—Nurse leader, sub-Saharan Africa.**

> Yes I think that getting the practice. You know, you can be trained on the theory but if you are not applying that information then it is not giving you—you are not acquiring any skills. So, the fact that where I am working right now at [organization] in a senior leadership position has made it possible for me to actually apply the theories that I have learned from this leadership training to put them into practice. So say one of the key things is to apply what we have learned. **—Nurse leader, sub-Saharan Africa.**

A consistent and strong finding from the interviews is the beneficial roles of a mentor or coach; 86% of survey respondents stated this as "very important" or "important."

> The first lady I met when I started my PhD in nursing, I just admired her and wanted to be like her. But, for me to be a writer in nursing it was a gynecologist from Norway that mentored me. And she said to me, "look here, I want you to be a professor in nursing one day. And I want to work with you. Let's do this research together, and I will hold you by the hand." And she did. And then I got my name out there so I could graduate and build my reputation. **—Nurse leader, sub-Saharan Africa.**

> For my PhD I had a particular slave driver who was a very good mentor. She had already looked at my CV, said I need a private pact with you for every assignment that you make. I want to make sure that you also only get your grade when you present it at an international conference. And it was like "will you pay for that?" And she was like "there is funding, if it is accepted whether it is a poster." So right away my publishing came about. She was very, very good at saying "uh uh no that is not publishable"; "that is not presentable"; or "do it again." And I found myself already, before I finished my PhD to be asked to attend and present at the conferences. Especially because I was interested in HIV, which at the time was a new area, I was able to publish. **—Nurse leader, sub-Saharan Africa.**

Another important facilitator of leadership that emerged in the interviews is the role of higher education as a foundation to build competence,

credibility, recognition, and confidence. This was a consistent finding across all types of nursing background and countries. Respondents and interviewees stated that competence, credibility, and confidence are critical aspects of nursing leadership.

> *I must say… the challenges we face in leadership is recognition. I remember what pushed me to do a PhD. I went to a meeting after my Master's degree. I had a colleague of mine with a PhD and every time she spoke, everybody would listen. And me with my Master's, I would say the same points, and nobody would acknowledge me. So, I said to myself: this is a status issue. So, I decided I should get my PhD. I also knew it was because I was a woman. Because men, if they speak even without a PhD, many times they receive recognition.*
> **—Nurse leader, sub-Saharan Africa.**

However, the preponderance of PhDs in the sample of nursing leader interviewees is in striking contrast to the finding that only 11.4% of survey respondents had completed a PhD. A larger proportion of respondents in the survey sample held Master's degrees (35%), suggesting a potentially larger pool of potential nurse leaders. These findings lead to reconsidering the value of a PhD as an essential leadership credential. Given that it is feasible for so few in terms of family responsibilities and costs, it may be that nursing's professionalizing pursuit of academic status has been to the detriment of other routes to leadership development (Salvage 2019, Personal Communication).

**Findings:** Nurse leader interviewees stated that they must work to prove their competence in order to build credibility, typically with doctors, as an important step in establishing their leadership. This may be a manifestation of a form of bias referred to as "prove it again" in relation to individual nurses.

> *I think it was important to show [competence] in my leadership. So I need to work harder and prove to them, to the management of the university, that being a woman doesn't mean that I don't work hard. I work[ed] hard for those past four years, and then within that period which is a long period for some, I obtained it. Because I think that if I was a man, for sure he could have just been given the position straight away, but because of my gender that is why I was given another year, another two, three, four years, to prove to these people that I can have a leadership position.* **—Nurse leader, sub-Saharan Africa.**

> *Experience and education overcome self-confidence issues.* **—Survey respondent.**

Another interviewee made the argument that competence and credibility are not gained by education alone but by being able to articulate what nursing contributes to health care. The need to establish the contribution of nursing may indicate "prove it again" bias for the profession.

> *I think we've got to make sure that we look for a place on the table, we look for an equal place, an equitable place, and equal place at the table in health care policy. But we've got to be able to make sure we know what we contribute. It is not enough to say we are leaders and we want to make policy. I mean, we have got to be clear in being able to define what we actually contribute.*
> **—Nurse leader, Middle East.**

## Informal and Formal Networks

Access to formal networks can diminish occupational segregation through access to professional contacts, mentors, and influencers. Informal networks of friends who have information about employment and leadership opportunities, and family networks, which help nurses balance work and family obligations, may also diminish challenges in assuming leadership positions.

**Findings:** The role of informal and formal professional networks emerged in the interviews as an important facilitator because networks can provide access to knowledge, perspectives, advice, experience, support, and the added weight of authority to assist with challenges and meet leadership goals.

> *I think the most important component in the ICN course that I received was being as nurse leaders we need to be politically astute, we need to engage with high level people, and we need to have networks. Those networks are important because it is not…because you don't know everything. From the networks, you are able to request assistance from people who have passed through that or who can share some challenges.*
> **—Nurse leader, sub-Saharan Africa.**

*I think the most important thing I needed to succeed was the network. And by the network, I mean to know people outside the country. Because inside the country, we cannot find the same people who have the same perspective. It's so hard. So we need to get the foreign people because they have the higher education, they have perspective…so we need to consult with them and make networks. So sometimes we need to invite them to talk with the stakeholders in [country]. This is my success also. And the second point is that we need to work with our own. So even though we don't have a big team, we need to have a small team…we need to discuss regularly, we want to move forward. So we pick up [an] issue and we discuss together, and if we cannot find any solution, then we can consult with our network.* **—Nurse leader, East Asia-Pacific.**

*Part of it [networking] is having close good professional friends who are supportive and who are supportive over a lifetime. I have… quite a few very good friends, international, friends from different countries, who are nurses. And I guess what is by now, all in leadership positions. And you got to nurture that friendship. And that's a great help. That doesn't just go for leadership or for nursing, that would go for anything.* **—Nurse leader, Middle East.**

Leveraging highly visible organizations, perceived to be highly influential, can add weight to nursing leaders' efforts to address gaps in the health system that nurses feel they could not otherwise do on their own. One nurse leader interviewee shared his experience that by leveraging his networks at the

WHO he was able to draw attention to the nursing practice environment in his country:

*I talked with WHO regarding the nursing practice environment in [country] and the nurse staffing issues which is related to the nursing care quality. So I talked with them [WHO]…to be my intermediate. So I believe that WHO people have the power to influence my leaders so they can propose it [evaluation] of the nursing workforce in [country]. So they asked the minister [Minister of Health] to invite me to be on the [evaluation] team.* **—Nurse leader, East Asia-Pacific.**

This same nurse leader shared another story of leveraging his foreign network in order to influence policy after he was unsuccessful in lobbying for a nursing code of ethics:

*I'm not sure in other countries, but in [country], we need foreign people in our network. So, for example, I created a code of ethics for nursing in [country]. One of the ward medical doctors put me in my place when I talked about compassionate care…he cannot accept it. So I invited two nurses from the United States to explain to him to be in the code of ethics because he didn't listen.* **—Nurse leader, East Asia-Pacific.**

# WHAT NURSES NEED TO LEAD

To some extent, the cultural drivers of gender stratification can be addressed through gender-transformative education[30] and gender-transformative nursing and human resources policies. The term "gender transformative" refers to policies and programs that promote the relative position of women, girls, and marginalized groups and attempt to transform the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.[59, 83] For example, the International Labour Organization classified the 1977 Nursing Personnel Convention (C 149) as an up-to-date instrument in 2005.[39] However, the Convention No. 149 and Recommendation 157 could be further revised to be transformative, by integrating other ILO labor standards that promote gender equality to explicitly address the gender bias and discrimination with respect to: protection from direct and indirect discrimination based on pregnancy, family, and child care responsibilities, achieving better work-life integration in working hours and shift work, and improved occupational safety and health, including prevention of workplace violence/sexual harassment.

Research findings suggest that there is a constellation of related discriminations at work in women's experience in the health sector that marginalize women and distance them from power centers,[55, 56, 57, 72] which suggests that they should be addressed together in nursing, health, and human resource policy and programming.

Gender-transformative education systems[30, 59] can also address drivers of occupational segregation and raise the status and profile of nurses in the initial socialization of nurses and doctors, especially in countries where there are strong professional hierarchies between men and women, doctors and nurses. In 2010, the independent Commission on Education of Health Professionals for the 21st Century released a comprehensive report on health professional education,[30] which called for institutional and instructional reforms in health professional education to target a variety of systemic deficiencies, including persistent gender stratification of professional status. It put forth as one of its proposed reforms attention to ensuring equal opportunities through more flexible working arrangements and career paths that accommodate temporary breaks, and actively addressing gender discrimination and subordination as part of both instructional and institutional governance reforms. Opportunities for team-building, reduction of professional silos and hierarchical patterns of interaction and decision-making, the devaluation of nursing and its contribution, and nurses' worthiness for decision-making vis-à-vis doctors and men, can all be tackled in health professional education if there are deliberate instructional and institutional governance reforms that prepare nurses and doctors to balance profession and family and to work cooperatively alongside each other as equal partners with equal status with mutual interests in serving populations.[2, 30, 59] Good practice models need to be identified starting with lessons learned from trans- and inter-professional training models.

Regulatory, policy, and educational reforms, combined with leadership development can challenge stereotypes and the gender and professional hierarchies that constrain nurses' ability to fully and effectively function in multiple service and policy leadership roles. Economic factors can also play into access to education and leadership development, salary levels, the status of work (such as its part-time nature), contractual arrangements, and access to institutional support for nursing leadership.

**Findings:** Survey respondents were asked to rank the top five out of 12 items they felt would interest them in a higher-level nursing job. The following items were ranked most often in the top five requests: having equipment and resources to perform the job (47%), leadership training (45.3%), good and fair salary (45%), having clear decision-making guidelines (38%), and decision-making support from senior management (35%). Figure 5 on the following page illustrates the ranking of all 12 items. The percentages indicate the proportion each item was ranked in the top five. For example, 45% of respondents ranked "leadership training" as number one, two, three, four, or five.

Notably, among respondents who ranked "leadership training" as one of their top five important items, 44.6% ranked training as number one (see Table 40.1-12 in Appendix A). It is striking that "Clear policies about gender equality in the organization/at work" ranks the lowest, given the perceptions of gender inequality and female disadvantage presented above. It is not clear if this is because gender inequality is normalized or if it is because respondents do not think equal opportunity/nondiscrimination policies are effective as a facilitator for advancement in leadership.

**Findings:** Table 2 suggests that being comfortable speaking one's mind (67%), knowing how to formulate policy, (67%), being able to effectively advocate for a position (66%), having public speaking skills (62%), being able to identify or cope with different types of gender discrimination (59%), having confidence in the exercise of power (58%), and knowing how to counter sexual harassment (55%) are important capabilities for nursing leaders.

**Figure 5. What would it take to make you interested in a higher-level nursing job? Select five most important things: 1 being the highest, 5 the lowest (n=2537)**

| Category | % |
|---|---|
| Clear policies about gender equality in the organization/at work | 8% |
| Training on discrimination and sexual harassment and how to cope with this | 10% |
| Organizational programs to integrate work and family responsibilities (including breastfeeding) | 17% |
| Clear selection criteria for promotion into leadership jobs | 20% |
| Clear understanding of what my authority is | 22% |
| Training in assertiveness and being confident in using my voice | 30% |
| Having a mentor | 34% |
| Support for my decisions from the senior management of the organization | 35% |
| Clear guidelines for decision-making in the organization | 38% |
| Good and fair salary | 45% |
| Training in leadership | 45% |
| Having the equipment and other resources to perform the job | 47% |

% respondents rated request in top five

**Table 2. Leadership capabilities**

| Q42: Assuming that you have the right education, training, and experience, if you want to become a senior leader in the nursing world, to what extent do the following capabilities matter? Do they matter a lot, matter somewhat, or don't matter? | | | | | |
|---|---|---|---|---|---|
| | Doesn't matter | Matters a lot | Matters somewhat | Total | Missing |
| Having confidence in the exercise of power | 2.4% | 58.1% | 17.5% | 78.0% | 22.0% |
| Having public speaking skills | 0.9% | 62.3% | 15.0% | 78.2% | 21.8% |
| Being comfortable speaking your mind in a group of senior managers | 1.1% | 66.9% | 10.3% | 78.3% | 21.7% |
| Knowing how to counter sexual harassment | 5.6% | 55.3% | 17.2% | 78.0% | 22.0% |
| Being able to identify or cope with different types of gender discrimination you are experiencing or perceive others experiencing | 3.5% | 59.4% | 15.2% | 78.0% | 22.0% |
| Knowing how to engage in formulating policy | 1.2% | 66.8% | 10.1% | 78.1% | 21.9% |
| Knowing how to effectively advocate for a position | 1.7% | 66.4% | 9.8% | 77.9% | 22.1% |
| Having political connections | 18.8% | 28.4% | 30.6% | 77.8% | 22.2% |

## SUCCESSES IN NURSING LEADERSHIP IN THE FACE OF GENDER BIAS AND DISCRIMINATION

The nurse leaders who were interviewed played various roles and succeeded in making significant contributions over their long careers to public education, raising the profile and status of the nursing profession, conducting educational research, making policy and practice improvements, providing service leadership and mentorship/role modeling, and improving the health of populations, despite the many patterns of gender bias and discrimination and medical domination that challenged their decisions or competence.

### Success story #1: Global South nurse leader at the helm of the global professional nursing association

One nurse leader shared her successes over her career, including serving as president of a Sigma Theta Tau chapter and as a senior leader within the International Confederation of Midwives. Her experience and recognition as a nurse leader did not go unnoticed—she has been invited to speaking engagements across the globe as an expert on human resources to improve maternal and newborn health, which has raised the visibility of nursing as a profession that can impact health systems.

### Success story #2: Elevating the nursing profession one radio broadcast at a time

One nurse leader explained that the challenges of nurses gaining recognition for their contribution and the importance of nurse leadership was not just from within the health system but also from society at large. She started a radio program to educate the public about nursing in order to change attitudes and raise the status and profile of nursing: "The challenge in recognizing the importance of nurses and nurse leaders was two-fold [recognition from doctors and the public]. First, to recognize that nurses need to have university education, and they can make decisions, was a huge challenge... including attitudes from population. When I started my regular call-in line on radio I invited nurses to share their practice, to share poetry and sing songs. We showed a lot of things about nurses. Because it was a regular program people could call and ask questions. I think it changed people's attitudes about nursing."

She continued with another example of the radio program: "At the very beginning I invited students, my nursing students to speak and to answer questions for hotline. I think that for a couple of months everyone that was calling to this hotline, everyone was complaining about nurses who killed or did something bad to their family members. And when we started sharing information about what nurses are doing, then more and more people from the public started calling to say nurses are fantastic. And they would like to send a greeting to a nurse who was caring for somebody's child. I think that the public influence was very important culturally. And, for developing leadership positions, I think that... it is important of course for nurses to have education... it is also very important to communicate with

[the] public, to show what nurses can do, to show advancement."

## Success story #3: Education for the next generation

During this nurse leader's tenure as a leader at a nursing college, she wanted to ensure that nurses did not have to leave the country to pursue a graduate education, as she had done, so she and her team established the first graduate nursing degrees at her college and improved the existing undergraduate program: "Through my team, our team leadership, we developed four graduate programs. So, we started a Master's degree, six of them, and then three PhD programs. The idea was that not every nurse should go out of the country because many of the issues stay at home. So now these programs are up and running. We also diversified the undergraduate programs. When I started in leadership, there were only four, and by the time I left the college in [country], there were almost 20 undergraduate programs. We also pushed the college of nursing to become a WHO center, and [to be] a leader in the profession of nursing which really put the school in a good position." These programs raised the status of nursing through increased competence.

## Success story #4: Using political power to address violence against women

Another nurse leader shared a story of how she used her influence as a minister in an African country to address domestic violence and abuse by developing domestic violence and marital laws. Recognizing that domestic violence and male marital power were health issues, this nurse leader collaborated with other ministers, often facing opposition, and worked to change laws that negatively impacted women and women's health: "I found myself collaborating… to change the laws of the country that were not working well for women. For example, we developed a domestic violence bill. Couples sometimes experience violence where there are no parents and nobody to counsel them [the couple] so we came up with a domestic violence bill. We had to ensure that communities knew about the bill and could implement it."

"When I became a leader, I made sort of policies on sexual harassment. Because I was coming into a situation, for example, right here, in the [a multilateral organization] for example, where you have people who are really high up that big, and their country

directors, and… where sometimes you know someone would say 'you know I hired you therefore you owe me this.' So I had to sit down and actually have a policy on sexual harassment, on cultural diversity and all that. And actually had people forced to undergo online training on that. …And I said 'If you are in my region, you are taking it.' But guess what? As a result, my region got to be the only region where was less bullying, there were less cases of harassment, whether sexual or power."

## Success story #5: Nursing leader research, advocacy, and impact at the frontline, national, and international levels

A nurse leader described how her research and advocacy mobilized communities and made an impact on health at a national level: "Because of the public health aspect, I think that's really what catapulted me into leadership. I was the first person to document the impact of HIV and AIDS on women in [country]. I was one of the cofounders for the society of women in AIDS in Africa, which was an NGO. So that here was a nurse, who had students, who was also running an NGO and it was really great. And that's where the leadership began, and back then I had managed to get all the people who were living with HIV to also form their own organizations, and to give them that support."

This nurse leader raised the profile of nursing and broadened nurses' scope of practice: "My greatest achievement is really the leadership in the AIDS response. I was able to show nurses that they can be great leaders. Because you know when HIV came in a lot of countries, doctors thought that they were the only ones affected by the epidemic but I was able to show them, no it is actually us. We are more with the communities, we can do quite a lot more for them. We are the educators, they trust us with the results, and all that so that it was really an achievement in that I got the nurses to participate, to prescribe for our patients and what happened? Just the reductions in the mother-to-child transmissions. Which is now less than 1%. I just feel like this has been a great achievement."

# CONCLUSIONS AND RECOMMENDATIONS

Nursing leadership operates in gendered health systems that are often dominated by men and majority-male professions, making nursing and leadership gender-segregated roles. In this section, we address the drivers of occupational segregation.

## CULTURAL MECHANISMS

Gender norms, expectations, beliefs, and stereotypes about the appropriate roles of women and men in society play out in the nursing profession and in the leadership "job" in various ways. These are implicated in several forms of gender bias and discrimination documented in this study: the maternal wall, the glass ceiling/glass escalator, prove it again, direct discrimination against pregnant women, and indirect discrimination related to family responsibilities and, possibly, educational qualification. Female nurse leadership is also hampered by two significant challenges: 1) perceptions of nursing as a "soft science," thereby less rigorous and inferior to medicine or surgery; and 2) gender essentialist and male primacy stereotypes, which in combination account for the perceived lower status of this female-dominated profession.

Governments that have ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) have an obligation to eliminate harmful stereotypes. CEDAW's Article 5 (a) requires signatories to "modify the social and cultural patterns of conduct of men and women" in an effort to eliminate practices that "are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women." CEDAW would seem to require adopting measures, including temporary special measures such as affirmative action, to eliminate occupational segregation based on gender stereotypes. Promoting nursing as a STEM career may also be an effective strategy to raise its status, supplemented by efforts to address the gender drivers within STEM itself.

The quicker ascent of male nurses into higher-level leadership is evidence of male advantage in the "glass escalator" effect in a female-dominated profession, which in these data is facilitated in part by the "maternal wall." A pro-male bias, or male advantage, is evident when men are put into leadership when "a little testosterone is needed." The presumption that men are naturally more competent manifests as the "prove it again" bias where women must constantly prove that they are competent, while men are perceived not to have to "jump though as many hoops." The "glass escalator" effect also comes into play when male nurses are hired or promoted because, unlike female nurses, they will not require time off for pregnancy. Moreover, they are perceived to be less likely to take time off from work to care for children and look after the household.

### To raise the profile and status of nursing leadership in UHC, we recommend:

**Global**

- The WHO, ILO, and ICN should convene a discussion with other relevant multilateral agencies and international health workforce associations to generate and apply knowledge and discuss joint programming to improve the regulatory environment for nursing, reform health professional education, and develop nursing leadership.
- Multilateral organizations such as the WHO, ILO, Global Financing Facility for Women, Children and Adolescents, UNESCO, and all multilateral institutions should implement multi-stakeholder campaigns, including the WHO-ILO-OECD Working for Health Five-Year Action Plan, to challenge gender norms in the nursing workforce and to develop materials and messaging that emphasize the significant knowledge needed for success in the profession and rigorous nature of the work and promote nursing as a scientific and technical education category—that is, categorized as a STEM profession.
- Global actors should advocate for at least 75% of countries to have a Chief Nursing Officer or Chief Government Nurse as part of their most senior management team in health with oversight

and authority to manage budgets, create nurse leadership training programs, promote nurse recruitment, and regulate nurse education, thereby signaling the importance of the nursing profession. This position should have concrete pathways to coordinate nurse leadership training programs with ministries of education, labor, gender, finance, and other relevant national and local agencies.

**National**
- Governments should recruit for the minister of health position and all leadership positions in government in such a way that ensures nurses' eligibility.
- Government and private health professional education systems should introduce institutional management and instructional reforms and adapt best practice education models (e.g., transprofessional education) to local contexts to reduce gender stratification, break down hierarchical chains of command, improve teamwork, and broaden nurses' decision-making scope.

**Institutional**
- Clinics, hospitals, and other facilities—both public and private—should include a nurse on their board and/or managerial staff on the same level as other directors/managers.
- Employers should set a standard plan for ensuring that nurses and other health worker employees do not face professional disadvantage should they become pregnant.

## SANCTIONS FOR VIOLATING EXPECTATIONS OF MASCULINITY OR FEMININITY

As evidenced in the findings, there are misperceptions and penalties related to transgressing gender norms. Patients sometimes perceive male nurses as doctors or question if a male nurse "has something wrong with him" by choosing to work in a female dominated profession. This is borne out by research that finds that men's movement into female-dominated jobs is often perceived as a step down in status, which may explain men's lower representation in nursing. A major barrier identified by research to men's entry into nursing has less to

do with treatment in the profession as it has with the social and cultural sanctions applied to men who do "women's work."

### We recommend:
**Global**
- International campaigns, advocacy groups, and coalitions should develop materials and messaging that normalize men as nurses as well as women in male-dominated health workforce cadres.
- Global research partners, such as Health Systems Global, should work with the WHO, ICN, and ILO to agree on and further learning on the cross-cultural portability of the "glass escalator" and to identify factors that are salient in both nursing and leadership in a given country context, including the drivers of gender segregation, the intersection of other social variables with gender, reasons for women's entry into and exit from leadership positions, and forms of sexual and gender harassment in nursing leadership. They should test ways to counter gender bias, such as "metrics-based bias interrupters," to address gender bias in hiring, evaluation, and promotion practices.

**National**
- Governments should ratify a revised ILO Convention 149 and Recommendation 157 and ensure that nurses are adequately and fairly paid as key players in delivering and expanding access to essential health services, both within nursing and in relation to other health workforce cadres.
- Governments should develop feasible and efficient data collection/analysis strategies to generate national information on horizontal and vertical segregation in the nursing workforce using sex disaggregated data.

**Institutional**
- Hospitals, clinics, and medical schools should audit their promotion and hiring practices to ensure that they are not sorting men into leadership roles and women into service delivery.
- Schools should implement gender-transformative education policies to "de-gender" professions, including nursing and medicine.

## EMPLOYER AND/OR INSTITUTIONAL DISCRIMINATION

Discrimination may be direct—such as evidence of pregnancy-related discrimination—or indirect. The results revealed considerable evidence for the disparate impact when the conditions of women's lives limit their ability to access opportunity (e.g., unshared household responsibilities and lack of child care resulting in time poverty, missed opportunities to access training and education, or inability to meet other explicit or implicit criteria for leadership, such as a higher-level certification or time to submit a funding proposal).

### We recommend:
**National**
- Ministries of health should standardize job descriptions and requirements—including leadership requirements—of nurses and all cadres of health workers to eliminate unconscious discriminatory criteria from determining hiring or promotion practices.
- Governments should ensure sufficient numbers of and equitable geographic access to nurses and put favorable conditions in place to enable nurses to take time off when needed without fear of professional disadvantage or over-burden of other staff (e.g., pregnancy cover, maternity protection policies, flexible hours).
- Governments should institute national paid leave policies that allow caretakers to attend to children, elderly, and other dependents.

## INTERNAL PROCESSES

Evidence of preference for direct clinical care and self-assessment as lacking competence and lack of self-confidence emerged from the survey qualitative data. Respondents indicated a strong desire for more training and education in advocacy and policy, as well as guidance on how to improve their ability to speak to superiors and grow networks.

### We recommend:
**Global**
- Global advocacy organizations, campaigns, and coalitions should map nurse leadership development programs and assess them in

relation to skills and competencies that nurse leaders need to lead in gender-influenced systems.

**National**
- Nursing schools should work to connect students and graduates with nursing leadership development programs and employment networks.

**Institutional**
- Workplaces should ensure that managerial positions include flexibility, set core working hours, and have an expectation of continuing some clinical work to open up opportunity for women to pursue managerial tracks while balancing family responsibilities.

## TENSIONS BETWEEN LABOR MARKET AND FAMILY COMMITMENT

It is not just bias that facilitates men's advancement—generally, socio-cultural norms still appear to dictate that women are responsible for children and household chores. As one respondent stated, women have "two jobs." Given that men are not often expected to manage the household and care for children, they have more time to dedicate to their careers and undertake activities that can lead to advancement. The constraints on time that household and family commitment have on female nurses' advancement is reflected in this study by the fact that survey respondents and interviewees stated that a supportive family and spouse to help manage the household and care for children was a significant contributor to their advancement in nursing leadership. For many survey respondents, female nurses were able to assume leadership positions only after their children had grown and needed less care.

### We recommend:
**Global**
- Multilateral agencies working to promote nurse leadership should advocate for the revision of the ILO's Nursing Personnel Convention No. 149, Recommendation No. 157, by integrating other ILO labor standards that promote gender equality to explicitly address the gender bias and discrimination with respect to: protection

from direct and indirect discrimination based on pregnancy, family, and child care responsibilities; equal pay for work of equal value, achieving better work-life integration in working hours and shift work; and improved occupational safety and health, including prevention of workplace violence/sexual harassment.

**National**
- Governments should ratify the revised ILO Convention 149 and operationalize it in national nursing policy.

**Institutional**
- Workplaces—especially those that employ nurses—should foster an environment that not only respects but promotes the necessity of strong work/life balance through policies that enable workers to fulfill their families' needs and a culture that recognizes the importance of family obligations for all workers regardless of sex or gender.

## ECONOMIC FACTORS

Financial barriers were implicated in some nurse leaders' ability to access funding to obtain leadership development or higher education, including travel overseas for graduate degrees.

### We recommend:
**Global**
- Multilateral organizations and international donor assistance agencies should invest in long-term and reliable finance mechanisms to provide scholarships for economically disadvantaged nursing students and/or nurses pursuing higher-level education in other countries.

**National**
- Governments should invest in long-term and reliable grant programs for nurses to pursue leadership training and development courses.

## ACCESS TO INFORMAL NETWORKS

Leadership development programs, mentoring, informal and formal professional networking, and career planning can all contribute to stronger nursing leadership. There are many types of leadership development programs, both inside and outside the field of nursing. For example, the ICN Global Leadership Institute is a one-week residential course with pre- and post-online modules attended by 30 people a year. However, the need expressed by respondents in this assessment far exceeds the availability of accessible, regional leadership development at a scale to meet the need.

### We recommend:
**Global**
- The WHO, ILO, private sector partners, and other multilateral agencies should commit funding to extending the reach of the ICN Global Nursing Leadership Institute and other similar networks.
- The ICN should continue to foster strong connections among program alumni, educational institutions, and youth networks and provide platforms for knowledge sharing and discussion.

**National**
- Governments should develop and strengthen professional nursing associations and ensure equitable geographic, socioeconomic, and cultural representation of all geographic areas and ethnic, tribal, or other such groups.

**Institutional**
- Health facilities and nursing, midwifery, medical, public health schools, and other training institutions should promote membership of national nursing associations.
- Institutions should regularly identify nurses for nomination to the Global Nursing Leadership Institute or to other national nurse leadership trainings and ensure that their staff are able to participate without adverse impact on their job.

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**ACCESSING THE DATA SET OF SURVEY RESPONSES**

Throughout this report, there are references to Appendix A. This appendix is available in the online version of the report available at **www.intrahealth.org/investing-in-nurse-leadership**.

# DEFINITIONS

**Direct and indirect discrimination:** Discrimination can be direct, when factors unrelated to merit, ability, or potential are used as a reason for exclusion; or it can be indirect and have disparate impact when an apparently neutral law, criterion, policy, or practice has a disproportionate negative impact on a particular group. The law, criterion, policy, or practice may seem fair and neutral because it applies to any/everyone, but it can only be complied with by those without the attribute or personal characteristic. For example, when the selection criterion for a top leadership job is having an MD.

**Gender:** A system of social relations of greater or lesser status and advantage, with cultural beliefs and distributions of resources at the macro (organizational and societal) level, patterns of behavior and organizational practices at the interactional level, and selves and identities at the individual level.[2, 6]

**Gender bias:** An inclination or prejudice for or against persons belonging to particular genders that inhibits impartial judgement, in a way considered to be unfair that often results in discrimination.

**Gender discrimination:** Any distinction, exclusion, or restriction made on the basis of socially constructed gender roles and norms that prevents a person from enjoying full human rights. Practices that place individuals in a subordinate or disadvantaged position in school, the workplace, or the labor market based on characteristics (e.g., race, sex, age, or other attribute) that bear no relation to the person's competencies or the inherent requirements of the job. Discrimination occurs when bias is enacted.

**Gender essentialism and male primacy:** Refers to the beliefs about nature of men and women, and "male primacy" refers to beliefs about the greater value or status of men.[1]

**Gender hegemony:** Culturally dominant beliefs and norms related to the ideal relations between men and women, masculinity and femininity.[7] [In this report, "medical hegemony" refers to culturally dominant beliefs about nursing vis-à-vis medicine.]

**Gender order/Gender regime:** The structure and patterns of gender relations in the larger society and in institutions, respectively, having typically masculinized structures of work and rewards, beliefs, values, language, meanings, and images related to masculinities and femininities.[2] The structure and patterns of gender relations in an institution is its "gender regime." The institutions through which health care is delivered (e.g., hospitals, clinics, private practices) have well-defined gender regimes.[2]

**Gender segregation:** A pervasive and widely documented form of social inequality and labor market rigidity in which women and men are expected to work in culturally defined occupational roles dominated by their gender. In horizontal segregation, women are concentrated in similar occupational groups and economic sectors, whatever the country or culture concerned, while men are distributed across a wider range of occupations. Women often hold caring and nurturing occupations such as nurses, social workers, and teachers and remain horizontally segregated from men who are typically concentrated in technical, diagnostic, managerial, or strength-based jobs: scientists, physicians, managers, police officers, etc. In vertical segregation, women are concentrated at the lower or intermediate levels of hierarchies and professions, and are represented significantly less than men at senior level.[4]

**Glass ceiling practices:** Practices include women's initial placement in relatively dead-end jobs; not getting job assignments that lead to advancement; not being promoted or closer scrutiny of women's performance relative to men's before being promoted; and lack of access to informal networks and opportunities for mentoring. Invisible barrier to reaching top leadership and management positions.[11]

**Glass escalator:** An effect documented in several studies whereby men bring their privileged status in the wider culture when they enter predominantly female occupations. Men are often accepted and well-integrated in the female-dominated profession and work culture, and given fair if not preferential treatment in hiring and promotion decisions, despite their being in a minority.[8,9]

**Hegemonic masculinity:** The masculine position that is dominant among multiple configurations of masculinity that are hierarchically organized along lines of domination (of men over women, of powerful men over less powerful men, of adult men over younger men). Generally associated with the subordination and oppression of women. A form (or forms) of "emphasized femininity" has been postulated, characterized by women's accommodating the interests and desires of men (i.e., compliance with the unequal structuring of gender relations and collusion in the unequal distribution of power). Other forms of masculinity and femininity may exist, shaped around strategies of resistance or cooperation. In a male dominant gender order or organizational regime, masculinity is defined through a difference with femininity, and femininity is a position of subordination in relation to masculinity. The specific features of masculinity and femininity that ensure men's dominance over women as a group varies depending on context and must be analyzed in each cultural setting.[2]

**Maternal wall:** Refers to practices that use maternity, family responsibilities or child care as an excuse to not offer opportunities to mothers. For example, passing mothers over for promotion; eliminating jobs during maternity leave or offering a demotion or less desirable assignments after childbirth and at return to work; the 'executive schedule' which requires overtime; marginalization of part-time workers; and expectations that workers who are 'executive material' will relocate their families in order to take a better job. Often manifests in pregnancy and family responsibilities discrimination.[10]

**Prove it again:** Women often have to provide more evidence of competence than men do to be seen as equally capable, a problem documented in scores of social science studies on double standards, attribution bias, leniency bias, recall bias, and polarized evaluations.[10]

**Stereotypes:** Generalized beliefs or preconception about the attributes or characteristics that are or ought to be possessed by, or the roles that are or should be performed by, members of a particular social group.[3] Gender stereotypes underpin occupational segregation and hold, for example, that women are by nature not suited to performing the same jobs or tasks as men and or men are not suited to doing the same jobs or tasks as women (i.e., the concentration of women in nursing because women are believed to be naturally more suited for care work); or that men are concentrated at the tops of hierarchies because of greater presumed competence.[5]

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