Divining female leadership in the post pandemic era: By Dr Nagina Khan

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Is it a special touch that leads women into a space where they can lead then struggle with balancing their lives or do institutions expect too much of a sacrifice in exchange for leadership status?

As Jacinda Ardern makes an emotional exit, having come into power in 2017 at the age of 37 years, the second world leader to give birth while in office, following which she appeared in the United Nations General Assembly with her baby – Showing us that mothers can lead well because "they multitask every day" Jacinda said.

Within healthcare and academic institutions that isn't the experience for everyone. There are 70% of women in the health workforce, and women fill only 25% of senior and 5% of top health organization positions.[1] Process and pathways to leadership are fraught with competition and out of hours working. Institutions are good at adhering to policies that are inclusive however they still outwardly support women 30 years and below, and those that are willing to sacrifice other parts of their lives to remain on the pathway to a higher status. There appears to be no clarity when individuals do not conform to those identified pathways that are standardised. The style and way in which institutions feel they are supporting women are not entirely experienced as supportive by women themselves as compared with perception held by the institutions. Jacinda too suggests reasons for her resignation, are not related to the drop in the ratings of her and her political party's popularity but because she would like to take her daughter to school and to marry her long-term partner. These factors are a reality for a host of women lives, although institutions are sympathetic towards these factors and show understanding, they are essentially still restricting womens progression. Based on factors related to the fact that women may be the main providers of care for their families, whilst supporting perhaps the careers of their partners too.

Sympathy and not having productive pathways for a section of the workforce is essentially tantamount to turning a blind eye away from a number of individuals that can be part of the workforce. Simply shunning them into unmotivating positions that lead to nowhere, might not be the best method in institutions mainly because we are in a workforce crisis and fundamentally it will impact what Mubin et al., 2023 suggests,

- *the effect of work motivation on performance.*[2]

So, women that have grown and developed via having lived a life should not be so easily dismissed from traditional pathways and entry into standard pathways should not be a scarce opportunity for a few chosen individuals. Surely the saying *'beggars can't be choosers'* should come to mind when attempt to resolve the workforce crisis in our health systems everywhere. Women comprise the majority in frontline healthcare, as providers, care deciders, and caregivers, are the ones absent from health policy decisions, funding, where critical research decisions are made. Consequently, vital understandings from their leadership and lived experiences are also ignored.[1]

In contrast to men, women leaders are more likely to directly respond to the concerns of

- the community,
- to allocate funds toward education,
- health, and nutrition,
- to prioritize the needs of women, children, and marginalized groups, and
- to increase research on women's health issues.[1]

Geier, 2016 suggested that the nature of a leader is very influential in the leadership style to determine the success of becoming a successful leader, and is determined by the personal ability of the leader'[3] Interestingly, the pandemic too has shown that leaders who were flexible and adaptive to changing environment were able to respond effectively to the pandemic crisis. Therefore, having had life experience, multi tasking and perhaps having a feminine awareness of emotional aptitude during a crisis is in fact fundamentally useful to leadership that appears kind and aware of the confronting problems. Absorbing the stressors of subordinates requires much more than what is often listed in the role and responsibilities criteria when applying for leadership roles.

Womens health in health systems also reflects the position of women occupy, for example, women are experiencing depression and anxiety twice as often as men and experience more barriers in access to care.[4] Historically, persistently, and systemically marginalized individuals often experience greater frequency of mental health problems as the result of discrimination and harassment within western/ capitalism, colonisation, patriarchal societies.

There are also implicit biases in the health systems. Research illustrates, women in medicine and science are accountable to a higher standard compared to men, are seen as hostile while male colleagues are recognized as assertive and focused on less-important support tasks.[5] It is also well-documented that there exists gender pay gaps, with male doctors earning more than female doctors. There is a gender pay gap of 18.9% for hospital

doctors, 15.3% for GPs and 11.9% for clinical academics (once adjusted for differences in working hours). The total non-adjusted gender pay gap is 24.4% for hospital doctors, 33.5% for GPs and 21.4% for clinical academics.[6]

Batson et al., state that COVID-19 pandemic has laid bare the tremendous barriers to achieving equitable health policy decision making. To safeguard disparate views and opinions to inform policies and priorities, we require further diversity in global health leadership, mainly better depiction of women leaders.[1]

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