Improving diversity in global health governing boards

Using available and openly accessible data, the Global Health 50/50 initiative, a UK-based publicly funded charitable organisation, aims to inform and drive action through regular monitoring of progress towards gender parity. The fifth annual Global Health 50/50 report, *Boards for All?*, spotlights the diversity—or lack thereof—of 146 governing boards in organisations active in global health.[1] The organisations that Global Health 50/50 reviews include UN agencies, bilateral funders, charities, private sector companies, and non-governmental organisations (NGOs).

The *Boards for All?* report documents how, of 2014 seats on the governing boards of these organisations, 40% are filled by women, 75% are held by people from high-income countries (HICs), 51% are occupied by US and UK nationals, 2·5% are held by nationals of low-income countries (LICs), and only 1% are occupied by women from LICs.[1] This disappointing geographical diversity in representation is unacceptable and needs to be addressed, because these global health governing boards have oversight of agendas that directly impact the lives, health, and wellbeing of people excluded from contributing to decision-making processes.

This report and Global Health 50/50 have an important advocacy role, exposing the chasm between rhetoric and reality in the governance of global health organisations and pressing for the identification of solutions to these challenges. We highlight three crucial considerations for advancing this agenda: the nature of governance and governing boards in global health, the value of representation, and the measures of success for gender equality.

First, the issue of governance and governing bodies in global health institutions is important at a time when many global health institutions are being called on to decolonise and rebalance the power dynamics of how they engage across countries and communities towards the development of sustainable, relevant, and acceptable solutions.[2,3] Global health institutions need to approach the identification of future board membership from low-income and middle-income countries (LMICs) with the same attentiveness and professionalism they use to seek any other board member. The scramble from some institutions to address gender parity and diversity often results in fairly small numbers of LMIC women, often educated in HICs, called upon to fulfil multiple board roles. This situation largely maintains the status quo in global health institutions through homogenisation and implicit protection of those who are already in privileged positions.[4] A board committed to recognising and addressing diversity and inclusion needs to encourage representation by a broad range of individuals, and to be continually diligent in this regard. To advance this goal, organisations need to take steps to enable effective participation. Questions organisations need to consider include where, when, and how are meetings held to facilitate access to those who, for instance, have multiple conflicting roles and responsibilities in their professional and personal lives? Are there expanded opportunities for training potential board members to enhance their confidence and ability to engage? Do the formats of meetings enable and encourage participation by people based in LMICs?

Second, the possible outcomes of board diversity are themselves diverse,[5] and can encompass task-related diversity (eg, education, expertise, and experience), non-task-related diversity (eg, age, gender, and ethnicity), and structural diversity (eg, board independence or part of management).[6] In pursuing an equity agenda in global health, other factors should also be included in the selection of board members, such as socioeconomic

status, disability (various forms), or denominations of faith. The measure of performance, the type of diversity, the context and role of the board, the organisational mission, the regulatory environment, and the organisational sector are all relevant. Additionally, consideration needs to be given to how to facilitate the most effective participation. More diverse boards can in some settings be less effective because members have little in common, which might result in factions and internal conflict.[6] A board can also be more effective because the members bring different perspectives and skills. Without an effective board chair, this diversity and inclusion of different perspectives will be lost. In other cases, diversity might have little impact on board functioning and serves only as a token of broader representation.[7]

Whether diversity improves performance is separate from the equity claim that the inclusion of people from diverse backgrounds is a social good.[8] The benefits to society of embracing diversity are laudable and should be unashamedly explicit, rather than pursued just for better organisational outcomes.[6] Global health institutions need to be transparent about the purpose of diversity in their boards. Although the social benefit is good, it might not be a priority for commercial boards. All organisations should have strategies to ensure diversity is managed to support performance improvement. The organisations also need to be clear about the kinds of diversity they seek (task, non-task, or structural diversity) and how they would measure diversity and assess its impact, including over time.

Third, the success of Global Health 50/50 and the attention it has captured show there is demand for this approach and greater accountability for gender equality and equity in global health. There is a need to continue innovating and exploring the metrics to inform solutions. Gender parity is merely a proxy indicator of equity, which is the desirable social value to which all global health organisations should aspire. Data from the latest Global Health 50/50 gender and health index pit the "worst performers" in terms of board diversity (eg, Exxon, General Electric, and The International Council of Beverages Associations) against the "high" and "very high performers" (eg, UN agencies, bilaterals, and health-related NGOs and non-profit organisations). This approach provides some notion of benchmarking, but it also invites complacency from the "high performers". For organisations with global health as part of their core business, particularly bilateral and multilateral agencies and international NGOs and philanthropic organisations, increased scrutiny and accountability in relation to the diversity of their boards are required. It is not sufficient, for instance, to place women in positions of authority without the resources and mandate for them to effectively perform as leaders, and without the support and expectation of staff to embrace women's leadership. Future iterations of the Global Health 50/50 report would benefit from extending the measures to include more granular measures of accountability. Without relinquishing the need for continued performance, peak industry bodies and large multinational corporations are also still obliged to diversify their boards for social equity.

Looking ahead to the future reports from Global Health 50/50, transparent criteria need to be developed on representation and diversity that are responsive to the objectives and outcomes of specific global health institutions. As part of the commitment, global health organisations should invest in making diversity a performance benefit by better understanding its impact, including a coherent membership search strategy that moves beyond the established and well known pool of LMIC experts.

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1   Global Health 50/50. Boards for all? A review of power, policy and people on the boards of organisations active in global health. Cambridge: Global Health 50/50, 2022. https://globalhealth5050.org/2022-report/ (accessed April 7, 2022).

2   Kentikelenis A, Rochford C. Power asymmetries in global governance for health: a conceptual framework for analysing the political-economic determinants of health inequities. *Globalisation Health* 2019; **15:** 70.

3   Burki T. Fresh questions over Gates Foundation governance. *Lancet* 2022; **399:** 508.

4   Sheikh K, Bennett SC, el Jardali F, Gotsadze G. Privilege and inclusivity in shaping global health agendas. *Health Policy Plan* 2017; **32**: 303–04.

5   Beji R, Yousfi O, Loukil N, Omri A. Board diversity and corporate social responsibility: empirical evidence from France. *J Bus Ethics* 2021; **173:** 133–55.

6   Adams RB, de Haan J, Terjesen S, van Ees H. Board diversity: moving the field forward. *Corporate Governance Int Rev* 2015; **23:** 77–82.

7   Elmagrhi MH, Ntim CG, Malagila J, Fosu S, Tunyi AA. Trustee board diversity, governance mechanisms, capital structure and performance in UK charities. *Corporate Governance Int J Business Soc* 2018; **18:** 478–508.

8   Sarhan AA, Ntim CG, Al-Najjar B. Board diversity, corporate governance, corporate performance, and executive pay. *Int J Fin Econ* 2019; **24:** 761–86.