

Challenging Underrepresentation of Women Leadership in Global South during COVID-19

Laila Hanifah

10.22146/globalsouth.63228

International Relations Department,
Universitas Pembangunan Nasional “Veteran” Yogyakarta
laila.hanifah@gmail.com

The WHO's analysis of gender equity in the health workforce of 104 countries has recorded that 70% of the global health workforce is women, while only 25% of them have the opportunity to be decision-makers in COVID-19 leadership. This large percentage has targeted women to be the majority group to get an infection exacerbated by fatigue and mental stress both in the workplace and family. The situation is worsened in Global South due to the low score of the global health system and a high gender gap that leads to inequality. Some important arguments reinforced why women's leadership during the crisis is matters and should be considered. This research will compare several case studies between Global North and Global South countries led by women and men as decision-makers in the COVID-19 pandemic case and in the end, these case studies would challenge women leadership in Global South. The success of the leadership parameter will be assessed from the total number of COVID-19 cases and total deaths from January 17th until October 21st, 2020. The findings found that the underrepresentation of women as decision-makers and policies in COVID-19 leadership led to the length of pandemic management and an increase in the number of COVID-19 cases in the Global South. In further explanation, the research identified several significant factors that explain why women leadership could be more successful to overcome the COVID-19 pandemic in Global South.

Keywords: *underrepresentation; women; gender; COVID-19; Global South*

Introduction

Gender issues has been one of the global agenda for the last few decades, starting in 1979 when UN General Assembly hosted the CEDAW (Convention on the Elimination of Discrimination Against Women). Because of the convention, women's involvement is considered to be the success indicator of development at the national and international levels. However, in its journey, this approach is less effective. It because the development approach that focuses only on women has not resulted in significant progress. Therefore,

the focus of development in terms of gender then shifted from the perspective of women only to women, men, and institutions (Human Development Report, 2019). To respond to the evaluation, the 4th World Conference on Women was held in Beijing in 1995. The world officially recognized gender mainstreaming as a major effort to achieve equality, empowerment, and peace. Gender mainstreaming then became the spirit of subsequent international conventions which was reflected in Millennium Development Goals (MDGs), the global development agenda from 2000-2015. The

struggle for gender mainstreaming is continued in Sustainable Development Goals (SDGs), which is stated in its fifth point, Gender Equality, that expected can be achieved by 2030.

To follow up on this vision, a few comprehensive studies on gender in many sectors at the global level have been conducted, including the health and social workforce sector. The health and social sector, with 234 million workers, is one of the largest and fastest-growing employers in the world, especially women (International Labor Organization, 2017). The 2019 World Health Organization's analysis of 104 countries showed that approximately 70% of health and social sector workers are women, but there are two sad facts about this percentage. First, only 25% out of 70% hold leadership roles (Boniol, et.al., 2019). Second, women earn an average of 28% less than men (Labour Force Survey, 2018).

Boniol et.al. analyzed that the salary gap of health workers between men and women can be attributed to a variety of factors, including less representation of women in senior positions, fewer opportunities for career advancement, and gender discrimination. The gender gap in health leadership is a barrier to achieve the SDGs (Global Health Security, 2019), and the underrepresentation of women at the top position as decision-maker will be the focus of this discussion.

Consistent with Labor Force Survey, even though women are the majority of global health and social workers, the role of women as drivers of health is often not acknowledged. The main conclusion of this report is that gender inequality in the health and social workforce weakens the health system. In turn, when it's

correlated with the context of the current global health situation, will affect the handling of the COVID-19 pandemic in many countries with a high gender inequality gap.

The role of women in COVID-19 decision making is essential because the majority of people on the front lines of the pandemic are women (International Labor Organization, 2020), women's livelihood and quality of life have been greatly affected by the pandemic (Doward, 2020; Gross, 2020). The lack of personal protection equipment, makes women more vulnerable to COVID-19 contagion, with 70% of women who contracted the virus being infected at work (Vincenza & Lara, 2020). Women seem to be carrying a disproportionately greater share of the COVID-19 related caregiving load at home, such as child care and remote schooling (see, e.g., Cohen & Hsu, 2020; Miller, 2020) which will indirectly lead to women's mental stress because of the double burden from the workplace and family. Jang et.al. (2020) elaborated on the work-life balance among Korean gastroenterologists, reporting more burnout and work-life imbalance among young women doctors. They spent more hours with their family doing household chores as compared to men while holding the same academic position. Women doctors also reported a lack of support from their husbands/partners. In Italy, 68% of working women with partners have dedicated more time to housework during the lockdown than before; and only 40% of men did the same (Del Boca, et.al. 2020).

Through this brief explanation, thus, the fight between *das sollen* and *das sein* in this study becomes: the gender mainstreaming has

been the officially agreed strategy to promote gender equity in health internationally vs. the majority of the health workforce comprising of women and only a quarter are at the table of experts and in senior leadership roles making impactful critical decisions.

Interestingly, Taiwan, New Zealand, Germany, Finland, Iceland, Norway, and Denmark, countries all helmed by women, stood out on the global stage for having dealt with the ravages of the global pandemic most effectively (Coscieme, 2020). The successful story of women leaders in Global North has become an international topic of conversation. A similar question about the women leadership of COVID-19 in the Global South wants to be raised by this research.

Since the Global North has a better health system, this could be one of the reasons that the leadership is running more effectively. It is different from what happens in Global South. American Public Health Association (2008) noted that health systems in developing countries face similar challenges, including financial and human resource constraints, limited institutional capacity, poor infrastructure, nonexistent or weak health information systems, systemic health inequities, and a lack of transparency and accountability. These reports have given the Global South countries several blows at a time since national and regional responses to the COVID-19 pandemic and their outcomes have been avidly compared across the world. Apart from health conditions, the Global south gendered socio-political cultural context also needs to be highlighted. It will be explained more comprehensively in the next sub-chapter.

But even so, this study will examine why in the end leadership abilities are the most determining factor in handling COVID-19 cases. Therefore, this paper will be conducted by the research question, “How do women leadership could be more successful to overcome the COVID-19 pandemic in Global South?”

Methodology

This study used a qualitative research design. Qualitative research is an approach to exploring and understanding the meaning that several individuals or groups of people think comes from social and human problems. This qualitative research process involves questions and procedures that arise, collecting specific data from participants, analyzing data inductively starting from specific themes to general themes, and then the researcher provides an interpretation of the meaning of the data obtained. The final report of a qualitative study has a flexible structure or framework. Anyone involved in this form of research must apply a research perspective that is inductive, focuses on individual meanings, and translates the complexity of a situation (Creswell, 2007). Then, this research will compare several case studies between Global North and Global South countries led by women and men as decision-makers in the COVID-19 pandemic which will be presented in a table that summarizes these data forms. The leadership success parameter will be assessed from the total number of COVID-19 cases and total deaths from January 17th until October 21st, 2020.

According to 36 countries considered, 10 have a Global North women-led government (Denmark, Estonia, Serbia, Switzerland,

Finland, Germany, Iceland, New Zealand, Norway, and Taiwan) and 10 a Global North men-led government (Canada, Russia, France, Italy, Japan, Spain, Netherlands, China, UK, and the USA). While for Global South, 8 a Global South women-led government (Bangladesh, Barbados, Bolivia, Ethiopia, Nepal, Slovakia, Trinidad and Tobago, and Georgia) and 8 a Global South men-led government (Brazil, India, Mexico, Indonesia, South Africa, Argentina, Iran, and Peru).

The 10 men-led Global North and 8 male-led Global South countries are drawn from the world's largest countries. The sample of countries taken from Global North is more than Global South. These two steps were taken to show a significant difference of ability from the women-led Global South with the three other grouped countries: whether or not in the end the women-led Global South countries with fewer proportions than others succeeded in overcoming the COVID-19 pandemic.

In the case study analysis, this research tries to follow the case study structure of Lincoln & Guba (1985)—the problem, context, issue or problem, and “lessons” that can be taken. The epilogue at the end of this research reflectively presents the experiences of these countries to be used as an example in Global South countries to provide the same portion of women leadership as decision-makers in the case of the COVID-19 pandemic.

Research Findings

To understand the underrepresentation of women in the COVID-19 decision-making leadership in the Global South, it is important to know the socio-political and cultural context in

the Global South in the very first place. In this way, we can take a more comprehensive picture of the situation in the Global South according to the current gender political context. Several important arguments for putting women in the decision-making chairs during the COVID-19 pandemic and the best practices that have already been proven will be presented.

Global south gendered socio political-cultural context

The phrase “Global South” refers broadly to the regions of Latin America, Asia, Africa, and Oceania which are often politically marginalized or culturally low incomes (Dados & Conell, 2012), some of the countries included in the region are an exception.

Before discussing gender inequality in statistics, let's take a look at the gender situation in the Global South especially women as part of a vulnerable workforce to see the vast differences between men and women.

Gender inequality creates structured social disparities between women and men, and this is more pronounced in the southern world. Intersections of gender and caste in India further marginalize women, preventing them from accessing the paltry state benefits available to workers generally and women workers in particular. Other than that, in Nigerian, women form over 60 percent of the Nigerian peasant labor force (Britwum, 2016). In Ghana, over 80 percent of working women are in the informal economy – and the figure for Zimbabwe (Chinguno, 2013) is 90 percent. Again, Britwum (2016) explained that different historical and cultural contexts create social structures with distinct privileges and corresponding

disadvantages beyond gender relations.

From the brief explanation above, it is indicated that heterogeneity between men and women in terms of employment opportunities is very clear, and is still far from homogeneous opportunities.

Several reports must be considered to capture the conditions of the Global South gendered socio-political cultural context in solid numbers.

First, based on the Gender Inequality Index (GII), Human Development Report 2019 summarized GII into the regional dashboard and showed the gender inequality score: Sub-Saharan Africa 0.573, Arab States 0.531, South Asia 0.510, Latin America and Caribbean 0.383, East Asia and the Pacific 0.310, Europe and Central Asia 0.276. The higher point indicated the higher inequality in those regions, and as can be seen, the region which is dominated by the Global South countries had the high point. Second, the 2020 Global Gender Gap ranked 153 countries covered by the annual report. From the top ten countries, there are only two countries from Global South. It is from Latin America, Nicaragua at the 5th, and one from Sub-Saharan Africa, Rwanda at the 9th. While the bottom ranks are dominated by other Global South regions such as Middle East, North Africa, South Asia, and Pacific countries. One of the indicators to assess the Global Gender Gap is political empowerment, which across the four sub-indexes, on average, occupies the largest gender disparity among other indicators such as economic participation and opportunity, educational attainment, health, and survival. Gender disparity in terms of political empowerment implies that inequality in terms

of leadership and political opportunities for women is still large.

The gender gap in the Global South is caused by at least two things, traditional gender socialization and structural barriers in political involvement, particularly in leadership. Those reasons are confirmed with international research that has identified cultural, structural, organizational, and personal barriers to women entering medical leadership roles. These include gender stereotypes, inadequate childcare, inflexible working hours, hierarchical structures, and a lack of appropriate training and mentoring (Chris, et.al., 2011). At a structural level, conservative social norms and androcentric career pathways made it difficult for women to balance the pressures and demands of maternity leave, child-rearing, care-giving and running a household with leadership roles (Bismark, et.al., 2015).

The experience of Scandinavian countries with equitable parental leave suggests that 'family reasons' are—at least in part—a structural barrier to women returning to the workforce, rather than an inherently biological one (Oláh & Bernhardt, 2008). As a result, women are more likely to choose specialties based on factors relating to lifestyle, working hours, work flexibility, and domestic circumstances (Harris, Gavel, & Young, 2005). With the closure of schools in many countries, women have been disproportionately required to combine paid work, unpaid domestic work, and home-schooling children (Wenham et.al., 2020).

Critical scholars also recognize that the effects of the global order on women in the South depend on intersecting identities, such as caste, class, ethnicity, race, and religion (Basu,

1995). When gender identities overlap with other identities, they combine and intersect to generate distinct prejudices and discriminatory practices that violate an individual's equal rights in society. Intersectionality, the complex and cumulative way the effects of different forms of discrimination combine, overlap, or intersect—are amplified when put together. In countries with higher biases, overall inequality is higher. Overall, the biases appear more intense for more enhanced forms of women's participation (Human Development Report, 2019). From this research, it can be seen that women in the Global South face multidimensional traditional gender socialization due to their identity, which intersects with other identities. Where it meets with higher bias and discrimination, particularly in terms of women's participation. While they still should spend twice as much time as men undertaking childcare and unpaid household work, the impact of those barriers is disproportionately greater for women, who are still strongly attached to the traditional gender environment.

Then women's structural barriers in political involvement in Global South could be seen from the gender composition at the current government. This research obtained some important notes from the 2020 UN Women Report about Global South's women representative in government: 1) Women's parliamentary representation in the Pacific region has been historically low. It remains the only region in the world to have an accountable amount of parliaments without any women members. Three countries in the region still have no women in their national parliaments: the Federated States of Micronesia, Papua New Guinea, and Vanuatu, 2) Women's political

empowerment in Asia consistently slower growth. Since 1995, at 6.8 percentage points, Asia has recorded the slowest growth rate of any region since the adoption of the Beijing Declaration and Platform for Action in five sub-Saharan African countries, women account for 10 percent or less of parliamentarians, 3) In 2020, the share of women in parliaments stands at 16.6 percent – a fourfold increase in representation since 1995. And in 2019, the United Arab Emirates became the region's first country to achieve parity. Until recently, the region still included parliaments with no women at all is in gulf countries, 4) The region has a long track record of applying equality measures, with 16 countries in Latin America having enacted quota laws. Interestingly, three of the top five countries with the highest share of women parliamentarians are located in Latin America and the Caribbean (Bolivia, Cuba, and Mexico). Even though these three countries from Latin America scored the highest, the rest of Latin American countries are still in a long struggle to achieve political equality.

In the highest position of the state, 21 out of 193 country leaders in the world are women, 8 out of 21 women leaders are from Global South: Bangladesh, Barbados, Bolivia, Ethiopia, Nepal, Slovakia, Trinidad and Tobago, and Georgia (UN Women, 2020). The number of women leaders from the Global South scored 0.04% percentage points, a very few points even if it's added with the number of women leaders from Global North. While in the COVID-19 global leadership, 10 out of 31 members and advisers of the World Health Organization Emergency Committee on COVID-19 are women, and 4 out of 10 women

are from Global South: Trinidad and Tobago, Cameroon, South Africa, and Uruguay.

Overall, the Global South gendered socio-political cultural context correlated with the underrepresentation of women in COVID-19 decision-making leadership can be portrayed through the strong traditional gender socialization and the low gender composition of the current government, both at national and global levels. The Gender Inequality Index and the Global Gender Gap helped to statistically reinforce the reasons why the underrepresentation of women leadership in the Global South still occurs.

Why women's leadership during a crisis matter?

The role of women's leadership is essential because women are more likely to be working in jobs requiring continued risk of exposure to the virus, due to the feminized nature of sectors such as health, education, and retail (Birch & Preston, 2020; Foley et.al., 2020), as has been said by prior data that 70% of the global health workforce is women. At the same time, women also form a large group within those experiencing poverty and hardship, both from their existing disadvantaged position, and amplified during the COVID-19 period stemming from the loss of income with COVID-19's impact on the labor market (Rubenstein, Bergin, & Rowe, 2020).

Albeit, other urgent reasons put women in serious positions so that the involvement of women's leadership is important. Another area in which COVID-19 has impacted women is in the context of violence, and specifically, domestic violence, which has increased as a result of social isolation since it is hard to predict the long-

term gender impact of COVID-19 (Abramson, 2020). In Indonesia, the National Commission on Violence Against Women noted that domestic violence against women increased during the Covid-19 pandemic with psychological and economic violence domination.

Those build on an argument that gender is relevant to representation, and the underrepresentation of women in government makes the system unrepresentative (Cass & Rubenstein, 1995). Women's representation and engagement in leadership roles would put women and girls' issues at the forefront of the global agenda, challenge the traditional hierarchies of knowledge and power by highlighting under-valued and unrecognized knowledge and advocate for more inclusive, diverse, and representative decisions (Pineda & Purdue, 2019.) Italy has also seen, at the policy-making level, a lack of women's inclusion in national responses to the pandemic; a higher number of women than men whose job could not be converted to telematics work; including a significant increase of domestic violence and aggression against women by cohabiting partners (Cristoferi & Fonte, 2020).

Research showed that women express substantially greater levels of concern than men on a wide variety of COVID-19 dimensions. It also confirmed that female workplace leaders are also more likely than their male counterparts to take a cautious approach to COVID-19 (Brooks & Saad, 2020). Women are seen to respond more strongly and intensely than men when anticipating negative outcomes (see Fujita et.al, 1991; Kring & Gordon, 1998). Moran and Del Valle (2016) conducted a meta-analysis of 85 studies of responses to

respiratory outbreaks around the world and found that women were approximately 50% more likely to practice non-pharmaceutical preventative behaviors (i.e., using masks, extra handwashing, etc.) during outbreaks than men. As COVID-19 deaths began to add up, national leaders were faced with an urgent decision: prioritize economic growth and market openness or shift toward people's wellbeing. Leaders who opted for the former demonstrated a short-term vision and lack of understanding of the fact that social wellbeing (and a healthy environment) is the basis for a healthy economy. The results showed that this is the case for most men leaders, while women leaders did not hesitate to adopt precautionary measures, even when they posed immediate economic costs (Coscieme, 2020). Prior studies consistently showed that women are more likely to perceive risks and find them problematic (Slovic, 1999), women leaders could be seen as being significantly more risk-averse than male leaders in the domain of human life, though, in the domain of the economy, these women leaders were prepared to take more risk than male leaders. There are gender differences in attitudes to risk and uncertainty.

When appraising why women leaders were so effective during this crisis, they collectively demonstrated some prominent traits. Kamani et.al (2020) analyzed that women demonstrated strength, adaptability, perseverance, grit, empathy, passion, and tenacity. Together they were thoughtful, intentional, consultative, inclusive, and deliberate in their leadership styles. The most essential element for women leading health care systems is the drive for equity, challenging

status quos and norms, and building a common vision of health by listening. Women leaders integrated input from scientists, public health epidemiologists, and infectious disease experts, demonstrating humility rather than procrastinating difficult decisions and surrounding themselves exclusively with sycophantic political allies. They universally provided continuous, transparent updates with candid and concise explanations that outlined the rationale behind their strategies, thus engaging their citizens' trust and compliance with their national policies.

The theoretical explanations above indicated that women leaders reacted more quickly and decisively in the face of potential fatalities to the crisis.

The impact of women leadership during pandemic COVID-19

Table 1 below presents summary statistics based on the dependent variables by gender of the country's leaders.

Table 1. Summary statistic based on dependent variables by gender leaders

Dependent variable	List of countries	Total cases	Total deaths	The death rate in percentage
Global North Women-led	Denmark	36,373	688	2%
	Estonia	4,127	71	1,7%
	Serbia	36,608	780	2,1%
	Switzerland	86,167	1,884	2%
	Finland	13,849	351	3%
	Germany	380,762	9,875	3%
	Iceland	4,193	11	0%
	New Zealand	1,556	25	2%
	Norway	16,603	278	2%
Taiwan	548	7	1%	

		Cases	Deaths	Mortality Rate	
Global North	Men-led	Canada	201,437	9,778	5%
		Russia	1,447,335	24,952	2%
		France	901,346	33,611	4%
		Italy	434,449	36,705	8%
		Japan	93,933	1,679	2%
		Spain	988,322	34,210	3%
		Netherlands	244,103	6,804	3%
		China	91,565	4,746	3%
		UK	762,546	43,967	6%
		USA	8,124,633	218,641	3%
Global South	Women-led	Bangladesh	391,586	5,699	1%
		Barbados	222	7	3%
		Bolivia	139,890	8,502	6%
		Ethiopia	90,490	1,371	2%
		Nepal	139,129	765	1%
		Slovakia	31,400	98	0%
		Trinidad and Tobago	5,298	97	2%
	Georgia	21,208	172	1%	
	Men-led	Brazil	5,250,727	154,176	3%
		India	7,651,107	115,914	2%
		Mexico	854,926	86,338	19%
		Indonesia	368,842	12,734	3%
		South Africa	706,304	18,656	3%
		Argentina	1,002,662	26,716	3%
Iran		539,670	31,034	6%	
Peru	870,876	33,820	4%		

Source: Dataset constructed by authors from WHO and Worldometer (January 17th - October 21st, 2020).

These are raw statistics that are useful to illustrate inferences from the data, it is clear that women-led countries have fared better in terms of the absolute number of COVID-cases and deaths, with men-led countries having nearly double the number of deaths as women-led ones. And to assess countries with high and low mortality rates, this study calculated the number of deaths from the number of cases in a percentage. Successful leadership has a mortality rate below 3%, while above 3% is less successful. As could be seen, 6 countries with male leaders and only 1 country with a female leader have a mortality rate above 3%. Statistically, female leaders are more successful

in flattening mortality than male leaders.

During this global catastrophic phase, media reports have shown that among the countries that have managed to limit the negative effects of the coronavirus are countries led by women, such as New Zealand, Norway, Germany, Denmark, Taiwan, Finland, and Iceland among others (Wittenberg-Cox, 2020). To explain it further, this section examines what policies have been carried out by women leaders who have succeeded in flattening the curve of COVID-19 cases and compares them to each other.

New Zealand's Prime Minister Jacinda Ardern was prompt in implementing restrictive measures early on, resulting in limited contagion and a much shorter lockdown than neighboring countries in the Pacific. On March 14, New Zealand announced the earliest and toughest self-isolation measures of any country. Because of the leadership's quick response, New Zealand has been lauded for its rapid health interventions, border closures, and prime ministerial leadership.

In Scandinavia, the only country that prioritized economic objectives and, as a consequence, did not impose any serious restrictions was Sweden (led by a male prime minister), while all other countries of the region (led by women) took immediate measures. While Norway implemented strict lockdown for almost two months, and Denmark closed upper primary schools (above age 12) from 13 March to 17 May, Sweden opted for a 'herd immunity' approach, placing economic priorities ahead of health concerns, keeping second schools (under age 16) open whilst under isolation (OECD, 2020). This resulted in Sweden in the highest COVID-19 mortality

rate across Nordic countries by the end of May 2020, with 40.5 deaths per 100,000 population, compared to 9.7 for Denmark and 4.4 for Norway (Coscieme, et.al, 2020). Finland's Prime Minister Sanna Marin, 34, governs with a coalition of four female-led parties and has fewer than 10 percent as many deaths as neighboring Sweden (Taub, 2020).

Iceland's Prime Minister Katrin Jakobsdottir started crowd restrictions of no more than 20 people gatherings on March 16. Universities and high-schools went into remote teaching, while primary schools and nurseries were kept open. Businesses were mostly run from employee's homes. As the number of COVID-19 cases started dropping at the beginning of April 2020, crowd restrictions became progressively less stringent (Coscieme, et.al., 2020).

In Europe, Angela Merkel in Germany has had a lower death rate than Britain, France, Italy, or Spain. She armed with the strong political leadership in the form of Chancellor Angela Merkel, have shown what a well-funded public health system can achieve in terms of patient care and societal intervention, even when German states differ in the severity and longevity of public health measures (Dodds, et.al., 2020).

Taiwan's Prime Minister Tsai Ing-wen, building on the country's previous experience with SARS, introduced targeted measures and medical checks early on, while the epidemic was still in its initial phase in the Chinese city of Wuhan (Wang et.al., 2020). She has led the most successful example in the world at containing the virus, using testing, contact tracing, and isolation measures to control infections without a full national lockdown (Taub, 2020). This massively reduced the risk

of an outbreak effectively.

While in Canada, Brazil, and the United States whose leaders are men, the world has witnessed clashes and disagreements over the imposition and severity of public health measures, as well as the purchasing and distribution of emergency medical supplies. Within the United States, protestors have gathered to complain about social distancing and lockdown measures, and much of the anger is being directed towards governors who have issued strong 'stay at home' orders. In federal Belgium, the mortality rate is one of the highest when compared with other European countries. In Spain, there have been sharp regional variations in health-care provision, social care, and public health, with major cities such as Madrid and Barcelona being worse affected (Dodds, et.al., 2020).

Comparing with the Global South case with the women leaders, Barbados authorities implemented a full-lockdown on March 2020 and announced that new travel restrictions have been implemented in August, amid the coronavirus disease pandemic. Barbados's Prime Minister Mottley has been praised by the World Health Organization for her handling of the coronavirus crisis, and is proud of the island's "strong public health regime". While in Trinidad and Tobago's response to the COVID-19 pandemic resulted in the country being ranked number one in a report published by the University of Oxford on May 1, 2020. Ensuring that key mitigation and containment strategies were well-coordinated, collaborative, evidence-informed, and timely was critical to the success of the health system response to COVID-19. The country's health

system response is a reminder that even in developing countries, fraught with many health system challenges, a combination of political will, decisiveness, respect for science, and the utilization of evidence-informed policies can have positive outcomes for populations during a health crisis (Hunte, et.al., 2020).

Most media also evaluated Slovakia as the most successful European country in the fight against the spread of COVID-19 (Walker & Smith, 2020). As The Guardian reported that the obligatory wearing of masks outdoors, now common to much of Europe, was implemented very early in Slovakia and may also have helped stop the spread.

While in Global South with men leaders, India only took 170 days to reach the first million cases, even though implemented lockdown already. President of Brazil, Bolsonaro, failed to take seriously the need to mitigate the potential impacts of the pandemic, ignoring scientific findings that were against his beliefs and showing more concern about an economic recession than the spread of the virus. It already made Brazil be the second-highest number of COVID-19 cases in the world. Indonesia experienced confusion when it comes to choosing health and economic priorities and chooses a new normal policy instead. Jakarta, the capital city of Indonesia, implemented massive social restrictions. The lockdown was carried out independently by several regions at the rural level. The confusion and indecisiveness of the government have brought Indonesia into the top 20 with the highest number of virus cases.

From the data and comparison above, several syntheses were obtained: 1) Global

South and Global North countries with women leaders show no difference, both of them have resulted in low cases of COVID-19 transmission, 2) The cases of the COVID-19 virus in Global South and Global North countries with male leaders show a high number of cases, 3) Thus it can be concluded that one of the factors of successful leadership in crisis such as during the COVID-19 pandemic based on the leadership ability of the leader as the commander-in-chief in the country, and these achievements are carried out by women leaders.

Even though it must be recognized, that leadership performance cannot be the simple factor for the success of these women leaders, other factors such as a good gender equality index and a progressive society are also the determining factors. Several other women are probably fighting for the same thing, especially in the Global South with high levels of gender inequality. But, one thing that must be noted here is that the achievements of women leaders are the solid best practice. Further, the spirit of women's political empowerment should be encouraged to truly challenge the current status quo.

A lesson learned from pandemic COVID-19: a future women leaders in the global south

There are reflective questions that must be addressed. Why women's voices in the Global South are underrepresented during the COVID-19 crisis? Why it is important to have more women leaders during COVID-19?

The answers to these questions lie in the rooted social and cultural notions of what constitutes and reward competence (Ely & Meyerson, 2000). Women often have to face

strong conventional societal expectations to be caregivers and homemakers; men similarly are expected to be breadwinners (Galvan & García-Peñalosa, 2018), this is the reason women get a double burden in the family while they are also health and social workers who are most at risk to be affected.

These deeply rooted assumptions might explain some of the main obstacles to women's participation in decision-making roles, politics, and organizations that generally prevail over women's competencies and abilities. These include the remake of processes of hiring and promoting (at the local and state levels of governance), often based on clientelism rather than meritocracy, and the dismantling of structural discriminatory processes based on masculine practices that exclude women and femininity from positions of authority and decision-making (Kanter, 1977). The exclusion of women from decision-making at the national level was denounced as the absence of an indispensable condition of democracy.

The Global South led by women has shown the same success as the Global North led by women. This confirms that women in Global South have the same leadership abilities as women in Global North. The South or the North is not the only determinant of the success in handling COVID-19, because based on data USA has the highest number of cases instead. De Jong (2017) observed that 'there is a tendency of gender and development analysis to separate phenomena occurring in the Global North and Global South, despite their obvious 'interrelatedness', this is the reason why there should not be a distinction between the leadership opportunity toward women in North or South.

Countries that have excluded women from leadership roles in responding to the coronavirus, such as Italy, the UK, and the USA, have had a higher number of deaths and the longest period of emergency. These countries have also failed, so far, to consider the disproportionate impact that coronavirus has and will have on women corresponding to economic opportunities, work-life balance, gender, and domestic violence (CARE, 2020). To counteract the underrepresentation, two strategies are needed. First, Global South women should not be blocked in access to positions of decision-making by the differential structures of opportunity and power (Ely & Meyerson, 2000). The lack of equal numbers of women in positions of policy development and public leadership presently may account for why the national and global response has not comprehensively paid attention to the differential impacts on the broad spectrum of women (Rubenstein, Bergin, & Rowe, 2020). Second, gender equality in politics is not only about numbers. Equal opportunities and policies are not enough. These policies still accommodate existing systems but do not fundamentally challenge the status quo (Ely & Meyerson, 2000). Furthermore, as the 2019 Human Development Report suggested that the approaches to promoting women in leadership roles must include cultural changes in stereotyping, implementation of gender equality policies, and access to mentoring programs and sponsors.

This research intends to challenge the underrepresentation of women in COVID-19 decision-making leadership based on best practices. Although it seems difficult to

dismantle the strong traditional gender socialization, hopefully, the aftermath of the pandemic crisis might bring a more socially just future for women living in Global South.

Conclusion

Once when UNDP said, “the world is not on track to achieve gender equality by 2030,” in 2019 Human Development Report is not completely wrong. The underrepresentation of women as political actors and decision-makers is the main reason for all women’s misery in the world during the pandemic crisis, especially in the Southern world. Strong traditional gender socialization coupled with multidimensional gender norms, structural barriers to getting onto the highest position, a marginalized political condition, and low incomes are the highest wall for Southern women. But even so, even though they constitute less than 1% of the global leadership percentage among 193 countries, women in the South can prove their worth through the leadership story that is rarely highlighted in the international conversation since more spotlight is given to Global North women.

Southern women have more or less cracked the tallest and most violent glass ceilings in global masculine politics. The pandemic has proven to the skeptical observer that women can lead successfully. Hopefully, this pandemic will open new gates to a more equitable gender, especially in terms of political empowerment and involvement in the Global South. In the end, based upon the best practice and comparisons that have been done in this research, challenging the underrepresentation of women in COVID-19 decision-making leadership in the Global South is plausible.

References

Book

- Basu, A. (Ed.). (2018). *The challenge of local feminisms: Women’s movements in global perspective*. London: Routledge.
- Britwum, A. O. (2015). Gender inequality and the labour movement. In *Combating Inequality: The Global North and South* (pp. 31–44). Taylor and Francis Inc.
- Chinguno, C. 9. *Trade Union Leadership and Gender: Cases from Zimbabwe. Labor and Globalization*, pp. 180-196.
- Creswell, J. W. (2007). *Qualitative Inquiry & Research Design*. Sage Publications, Inc. (2nd ed., pp. 731–750). Sage Publications, Inc. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=buh&AN=2778048&site=ehost-live>
- De Jong, S. (2017). *Complicit sisters: gender and women’s issues across North-South divides*. Oxford University Press.
- Kanter, R. M. (1977). *Men and women of the corporation*. New York: Basic Books.

Conference Paper

- Galvan, E., and C. Garcia-Peñalosa. 2018. *Gender Norms and Labour Supply: Identifying Heterogeneous Patterns across Groups of Women*. Preliminary version of paper presented at the Eighth Meeting of the Society for the Study of Economic Inequality, 3–5 July, Paris. Retrieved from <http://www>.

ecineq.org/ecineq_paris19/papers_
EcineqPSE/paper_255.pdf

Report

Australian Bureau of Statistics. (2009). Trends in Household Work. Australian Social Trends March 2009, 19-24.

Global Health Security. (2019). Global Health Security Index. Retrieved from <https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf>

International Labour Organization. (2017). Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services. Geneva: International Labour Organization.

Komisi Nasional Anti Kekerasan terhadap Perempuan. (2020). Kajian Dinamika Perubahan di Dalam Rumah Tangga Selama Covid 19 Di 34 Provinsi di Indonesia. Jakarta: Kompas Perempuan.

Labour Force Survey. (2018). Office. Retrieved from <https://www.cso.ie/en/statistics/labourmarket/labourforcesurveylfs/>

Organization for Economic Co-operation and Development. (2020). Country Policy Tracker. Tackling Coronavirus (COVID-19): Contributing to a global effort. Paris: OECD.

United Nations Development Programme. (2019). Human Development Report 2019. New York: United Nations Development Program.

Retrieved from <http://hdr.undp.org/en/content/human-development-index-hdi>

United Nations Development Programme. (2018). Gender Inequality Index. New York: United Nations Development Program. Retrieved from <http://hdr.undp.org/en/content/gender-inequality-index-gii>

United Nations Women. (2020). The World for Women and Girls: Annual Report 2019-2020. Retrieved from <https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/unwomen-annual-report-2019-2020-en.pdf?la=en&vs=3903>

World Economic Forum. (2019). The Global Gender Gap Report 2020. Cologny: World Economic Forum. Retrieved from http://www3.weforum.org/docs/WEF_GGGR_2020.pdf

Journal Article (retrived online, with DOI)

Birch, E., & Preston, A. (2020). The Australian labour market in 2019. *Journal of Industrial Relations*, 0022185620909147. doi: <https://doi.org/10.1177%2F0022185620909147>

Bismark, M., Morris, J., Thomas, L., Loh, E., Phelps, G., & Dickinson, H. (2015). Reasons and remedies for underrepresentation of women in medical leadership roles: A qualitative study from Australia. *BMJ Open*, 5(11). doi: <https://doi.org/10.1136/bmjopen-2015-009384>

Brooks, D. J., & Saad, L. (2020).

- Double Whammy: Why the underrepresentation of women among workplace and political decision-makers matters in pandemic times. *Politics & Gender*, 1–13. doi: <https://doi.org/10.1017/s1743923x20000628>
- Carnes, M., Morrissey, C., & Geller, S. E. (2008, November 1). Women's health and women's leadership in academic medicine: Hitting the same glass ceiling? *Journal of Women's Health*. doi: <https://doi.org/10.1089/jwh.2007.0688>
- Coscieme, L., Fioramonti, L., Mortensen, L. F., Pickett, K. E., Kubiszewski, I., Lovins, H., ... & De Vogli, R. (2020). Women in power: female leadership and public health outcomes during the COVID-19 pandemic. *medRxiv*. doi: <https://doi.org/10.1101/2020.07.13.20152397>
- Dados, N., & Connell, R. (2012). The global south. *Contexts*, 11(1), 12–13. doi: <https://doi.org/10.1177%2F1536504212436479>
- Dodds, K., Broto, V. C., Detterbeck, K., Jones, M., Mamadouh, V., Ramutsindela, M., ... Woon, C. Y. (2020, May 26). The COVID-19 pandemic: territorial, political and governance dimensions of the crisis. *Territory, Politics, Governance*. Routledge. doi: <https://doi.org/10.1080/21622671.2020.1771022>
- Ely, R. J., & Meyerson, D. E. (2000). Theories of gender in organizations: A new approach to organizational analysis and change. *Research in Organizational Behavior*, 22, 103–151. doi: [https://doi.org/10.1016/s0191-3085\(00\)22004-2](https://doi.org/10.1016/s0191-3085(00)22004-2)
- Foley, M., Williamson, S., & Mosseri, S. (2020). Women, work and industrial relations in Australia in 2019. *Journal of Industrial Relations*, 0022185620909402. doi: <https://doi.org/10.1177%2F0022185620909402>
- Fujita, F., Diener, E., & Sandvik, E. (1991). Gender Differences in Negative Affect and Well-Being: The Case for Emotional Intensity. *Journal of Personality and Social Psychology*, 61(3), 427–434. doi: <https://doi.org/10.1037/0022-3514.61.3.427>
- Ham, C., Clark, J., Spurgeon, P., Dickinson, H., & Armit, K. (2011). Doctors who become chief executives in the NHS: From keen amateurs to skilled professionals. *Journal of the Royal Society of Medicine*, 104(3), 113–119. doi: <https://doi.org/10.1258/jrsm.2011.110042>
- Harris, M. G., Gavel, P. H., & Young, J. R. (2005). Factors influencing the choice of specialty of Australian medical graduates. *Medical Journal of Australia*, 183(6), 295–300. doi: <https://doi.org/10.5694/j.1326-5377.2005.tb07058.x>
- Hunte, S. A., Pierre, K., Rose, R. S., & Simeon, D. T. (2020, August 1). Health systems' resilience: COVID-19

- response in Trinidad and Tobago. *American Journal of Tropical Medicine and Hygiene*. American Society of Tropical Medicine and Hygiene. doi: <https://doi.org/10.4269/ajtmh.20-0561>
- Jang, E. S., Park, S. M., Park, Y. S., Lee, J. C., & Kim, N. (2020). Work–Life Conflict and Its Health Effects on Korean Gastroenterologists According to Age and Sex. *Digestive Diseases and Sciences*, 65(1), 86–95. doi: <https://doi.org/10.1007/s10620-019-05842-w>
- Kamani, L., Pausawasdi, N., Hooft, J. E. V., Sethi, A., & Sachithanandan, S. (2020). Redesigning the Landscape for Women and Leadership: Insights Gained from the Covid-19 Pandemic. On Behalf of Women in Gastroenterology Network Asia Pacific (WIGNAP) and Women in Endoscopy (WIE). *Clinical Endoscopy*, 53(5), 620–622. doi: <https://doi.org/10.5946/ce.2020.202>
- Kring, A. M., & Gordon, A. H. (1998). Sex Differences in Emotion: Expression, Experience, and Physiology. *Journal of Personality and Social Psychology*, 74(3), 686–703. doi: <https://doi.org/10.1037/0022-3514.74.3.686>
- Miller, K., & Clark, D. (2008). Knife before wife: An exploratory study of gender and the UK medical profession. *Journal of Health, Organisation and Management*, 22(3), 238–253. doi: <https://doi.org/10.1108/14777260810883521>
- Moran, K. R., & Del Valle, S. Y. (2016). A meta-analysis of the association between gender and protective behaviors in response to respiratory epidemics and pandemics. *PloS one*, 11(10), e0164541. doi: <https://doi.org/10.1371/journal.pone.0164541>
- Nemec, J. (2020). Government transition in the time of the COVID-19 crisis: Slovak case. *International Journal of Public Leadership*, ahead-of-print(ahead-of-print). doi: <https://doi.org/10.1108/ijpl-05-2020-0040>
- Oláh, L. S., & Bernhardt, E. M. (2008). Sweden: Combining childbearing and gender equality. *Demographic Research*, 19, 1105–1144. doi: <https://doi.org/10.4054/DemRes.2008.19.28>
- Pineda, A., & Purdue, S. (2019). Researching women’s leadership in Asia and the Pacific—reflections on feminist research approaches in design and in practice. *Gender and Development*, 27(3), 449–465. doi: <https://doi.org/10.1080/13552074.2019.1664039>
- Priola, V., & Pecis, L. (2020). Missing voices: The absence of women from Italy’s COVID-19 pandemic response. *Gender in Management: An International Journal*. doi: <https://doi.org/10.1108/GM-07-2020-0218>
- Rembacken, B. J., Dixon, S., Albuquerque, A., Fairbrass, K., & Pana, M. (2019, October 1). Barriers and bias standing in the way of female

- trainees wanting to learn advanced endoscopy. *United European Gastroenterology Journal*. SAGE Publications Ltd. doi: <https://doi.org/10.1177/2050640619877603>
- Rubenstein, K., Bergin, T., & Rowe, P. (2020). Gender, Leadership and Representative Democracy. *Democratic Theory*, 7(2), 94–103. Doi: <https://doi.org/10.3167/dt.2020.070212>
- Russo Rafael, R. de M., Neto, M., de Carvalho, M. M. B., Leal David, H. M. S., Acioli, S., & de Araujo Faria, M. G. (2020). Epidemiology, public policies and covid-19 pandemics in Brazil: What can we expect? *Revista Enfermagem*, 28, 1–6. doi: <https://doi.org/10.12957/REUERJ.2020.49570>
- Ryan, M. K., & Haslam, S. A. (2005). The glass cliff: Evidence that women are over-represented in precarious leadership positions. *British Journal of Management*, 16(2), 81–90. doi: <https://doi.org/10.1111/j.1467-8551.2005.00433.x>
- Sarkar, K., Khajanchi, S., & Nieto, J. J. (2020). Modeling and forecasting the COVID-19 pandemic in India. *Chaos, Solitons and Fractals*, 139. doi: <https://doi.org/10.1016/j.chaos.2020.110049>
- Sheldon, N. A., Lincoln, Y. S., & Guba, E. G. (1986). Naturalistic Enquiry. *The Statistician*, 35(3), 395. doi: <https://doi.org/10.2307/2987760>
- Slovic, P. (1999). Trust, emotion, sex, politics, and science: Surveying the risk- assessment battlefield. *Risk Analysis*, 19(4), 689–701. doi: <https://doi.org/10.1023/A:1007041821623>
- Sobral, F., Carvalho, J., Łagowska, U., Furtado, L. M. G. P., & Grobman, M. (2020). Better safe than sorry: leadership sense making in the time of COVID-19. *Revista de Administração Pública*, 54(4), 758–781. doi: <https://doi.org/10.1590/0034-761220200262x>
- Van, K., Quinlan, M., Kriesler, P., Junor, A., Baum, F., Chowdhury, A., ... Rainnie, A. (2020). The COVID-19 pandemic: Lessons on building more equal and sustainable societies. *Economic and Labour Relations Review*, 31(2), 133–157. doi: <https://doi.org/10.1177/1035304620927107>
- Wang, C. J., Ng, C. Y., & Brook, R. H. (2020). Response to COVID-19 in Taiwan. *JAMA*, 323(14), 1341. doi: <https://doi.org/10.1001/jama.2020.3151>
- Wenham, C., Smith, J., & Morgan, R. (2020, March 14). COVID-19: the gendered impacts of the outbreak. *The Lancet*. Lancet Publishing Group. doi: [https://doi.org/10.1016/S0140-6736\(20\)30526-2](https://doi.org/10.1016/S0140-6736(20)30526-2)
- Journal Article (retrieved online, without DOI or page numbers)**
- Cass, D., & Rubenstein, K. (1995). Representation/s of women in the Australian constitutional system.

Adelaide Law Review, The, 17(1), 3. Retrived from: <http://classic.austlii.edu.au/au/journals/AdelLawRw/1995/2.html>

Garikipati, S., & Kambhampati, U. (2020). Leading the Fight Against the Pandemic: Does Gender ‘Really’ Matter?. Retrived from: <https://ssrn.com/abstract=3617953>

Working Paper

Boniol, M., McIsaac, M., Xu, L., Wuliji, T., Diallo, K., & Campbell, J. (2019). Gender equity in the health workforce: analysis of 104 countries (No. WHO/HIS/HWF/Gender/WP1/2019.1). World Health Organization.

Electronic source

Abramson, A. (2020). How COVID-19 May Increase Domestic Violence and Child Abuse. American Psychological Association. www.apa.org/topics/COVID-19/domestic-violence-child-abuse

American Public Health Association. (2008). Policy Statement: Strengthening Health Systems in Developing Countries. Washington, DC: American Public Health Association. Retrieved from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/23/09/09/strengthening-health-systems-in-developing-countries>

Biswas, Soutik. (2020). Why India’s COVID problem could be bigger than we think. Retrieved from <https://www.bbc.com/news/world-asia-india-54176375>

CARE. (2020). Where are the women? The Conspicuous Absence of Women in COVID-19 Response Teams and Plans, and Why We Need Them. Retrieved from https://insights.careinternational.org.uk/media/k2/attachments/CARE_COVID-19-womens-leadership-report_June-2020.pdf

Cohen, Patricia, and Tiffany Hsu. (2020). Pandemic Could Scar a Generation of Working Mothers. Retrieved from <https://www.nytimes.com/2020/06/03/business/economy/coronavirus-working-women.html>

Cristoferi, C.,and Fonte, G. (2020). In Italy, support groups fear lockdown is silencing domestic abuse victims. Retrieved from <https://www.reuters.com/article/us-health-coronavirus-italy-violence-idUSKBN21M0PM>

Del Boca, D., Oggero, N., Profeta, P., Rossi M. C., and Villosio, C. (2020). Prima, durante e dopo Covid-19: disuguaglianza in famiglia. La Voce. Retrieved from <https://www.lavoce.info/archives/66645/prima-durante-e-dopo-covid-19-disuguaglianza-in-famiglia/>

Doward, J. (2020). One third of UK women are suffering from lockdown

- loneliness. Retrieved from <https://www.theguardian.com/world/2020/jun/14/one-third-of-uk-women-are-suffering-from-lockdown-loneliness>
- Fioramonti, Lorenzo., Coscieme, Luca., and Trebeck, Katherine. (2020). Women in power: it's a matter of life and death. Retrieved from <https://www.socialeurope.eu/women-in-power-its-a-matter-of-life-and-death>
- Gardawold. (2020). Barbados: New COVID-19 travel restrictions implemented as of August 3. Retrieved from <https://www.garda.com/crisis24/news-alerts/365966/barbados-new-covid-19-travel-restrictions-implemented-as-of-august-3-update-6>
- Gross, T. (2020). Pandemic Makes Evident 'Grotesque' Gender Inequality In Household Work. Retrieved from <https://www.npr.org/2020/05/21/860091230/pandemic-makes-evident-grotesque-gender-inequality-in-household-work>
- Hickey, Bernard. (2020). We must go hard and we must go early. Retrieved from <https://www.newsroom.co.nz/2020/03/14/1083045/we-must-go-hard-and-we-must-go-early>
- Miller, Claire Cain. (2020). Nearly Half of Men Say They Do Most of the Home Schooling, 3 Percent of Women Agree. Retrieved from <https://www.nytimes.com/2020/05/06/upshot/pandemic-chores-homeschooling-gender.html>
- Taub, A. (2020). Why Are Women-Led Nations Doing Better With Covid-19. Retrieved from <https://www.nytimes.com/2020/05/15/world/coronavirus-women-leaders.html>
- Walker, S. and Smith, H. (2020). Why Has Eastern Europe Suffered Less from Coronavirus than the West?. Retrieved from <https://www.theguardian.com/world/2020/may/05/why-has-eastern-europe-suffered-less-from-coronavirus-than-the-west>
- Wittenberg-Cox A. (2020). What Do Countries With The Best Coronavirus Responses Have In Common? Women Leaders. Retrieved from <https://www.forbes.com/sites/avivahwittenbergcox/2020/04/13/what-do-countries-with-the-best-coronavirus-reponses-have-in-common-women-leaders/#75ef00e73dec>
- World Health Organization. (2020). COVID-19 IHR Emergency Committee. Retrieved from <https://www.who.int/groups/covid-19-ihremergency-committee>
- World Health Organization. (2020). WHO Coronavirus Disease (COVID-19) Dashboard. Retrieved from <https://covid19.who.int/>
- Worldometer. (2020). Coronavirus Updates. Retrieved from <https://www.worldometers.info/>