Kalaitzi S. Navigating barriers to gender equality in the European Union context: The case of healthcare sector [Dissertation: University of Maastricht, 2019]. SEEJPH 2020, posted: 01 June 2020. DOI: 10.4119/seejph-3492

PHD DISSERATATION

Navigating barriers to gender equality in the European Union context: The case of healthcare sector

Stavroula Kalaitzi[1]

[1] Department of International Health, Care and Public Health Research Institute (CAPHRI), Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, The Netherlands.

Corresponding author: Stavroula Kalaitzi, PhD;
Care and Public Health Research Institute (CAPHRI), Department of International Health, Maastricht University;
Address: Duboisdomein 30, 6229 GT Maastricht, The Netherlands;
Telephone: +306932285055; Email: valia.kalaitzi@maastrichtuniversity.nl.

Abstract

Context: Progress towards achieving gender equality in the European Union context is reported slow and fragmented, although some achievements have been made. Scholarship has been discussing extensively the gendered barriers, yet their manifestation on a comprehensive and prevalence basis has received scant attention so far. Highlighting the big picture of all (in)visible gendered barriers and their manifestation in relation to countries' specificity may contribute in understanding better the missing link between policy and practice. This study aims firstly, to identify comprehensively the gendered barriers and their prevalence, and secondly, to gain deeper insights on how a persisting policy problem at the EU and Member States level remained poorly addressed for over two decades.

Methods: A mixed methods approach was adopted to ensure the qualitative research quality criteria. The systematic literature review, questionnaire and semi-structured interviews methods to obtain and analyze data were included. Qualitative analysis was supplemented by the fundamental tenet of feminist research on the centrality of women.

Results: Twenty-six gendered barriers with quantitative logic and varying degree of prevalence were identified and depicted in the Barriers Thematic Map (BTM) across healthcare, academia and business sectors. Twenty and twenty-one gendered barriers in Greek and Maltese healthcare settings were found respectively unveiling the country's specificity in barriers' manifestation. The sustainable development thinking in gender equality objectives in EU and MS was found suffering from inconsistencies and misplaced priorities.

Conclusion: The gendered barriers are multiple, manifest themselves in chorus and with a varying degree of prevalence across sectors and are greatly influenced by country's specificity. Evidence informed gendered policies respecting national priorities may need to be revisited by policy actors to deliver the promised egalitarian social orderand sustainable future for the EU citizens.

Keywords: gendered barriers, gender equality, women's leadership, barriers thematic map, European Union gender policy.

Introduction

Progress towards achieving gender equality in the European Union context is reported slow, fragmented and uneven. Arguably, the centrality of gender equality in EU's legal and policy commitments has not yet been translated in adequate gender equality outcomes across Member States, although some achievements have been made (1). For example, employment rates have reached historically the highest levels in the EU and more women are in leading positions than ever, whereas the gender gap in education is being closed and even reversed in some disciplines. Yet, women participate in labor market at about 11,5% less than men, are paid at an average 16% lower than men and they hardly reach an equal share on the highest decision-making echelons assuming only 6,3% of CEO positions in major companies across EU (2). Hence, many indicators on gender equality are stagnating, while others are worsened in several Member States (3).

Scholarship on gender equality and women's leadership is productive in dispelling myths and facts about several forms of gender inequalities, yet shedding light in a scattered and fragmented way on gendered barriers. The manifestation of barriers within an organization or a sector on a comprehensive and prevalence basis has received scant attention so far. For example, stereotypes, gender pay gap, bias, sexual harassment have been explored on a one to one basis, but rarely through the big picture perspective and how each barrier contributes to shape this picture (4-6). This study aspires to highlight the big picture of all (in) visible gendered barriers, the context within which they are developed, the underlying mechanisms that feed the durability and transferability of each barrier within socio-cultural and economic reality and which may be the missing link between policy and practice. Thereby, understanding the barriers that make up the labyrinth of women's leadership (7) may provide deeper insights on how to address effectively the complexities of gender equality challenges at both social and economy level. Furthermore, it may make it easier to understand how to dismantle and de-power deeply rooted gendered perceptions, and to develop effective and gender responsive policies.

Thereby, this study aims *firstly*, to identify the gendered barriers and their prevalence across sectors, such as healthcare, academia and business on the grounds that these sectors cover a big part of society and economy, and, *secondly*, to gain deeper insights on how a persisting and central policy problem at the EU and Member States level remained poorly addressed for over two decades (8,9). To have a clearer focus and gain deeper insights on gendered barriers, current research concentrated on healthcare sector for three reasons: *firstly*, women are significantly underrepresented in leading positions across healthcare although the sector being women populated and their added value is widely acknowledged; *secondly*, healthcare sector is currently considered one of the major employers, encompassing several domains, such as academic, clinical and medical, and job categories; and, *thirdly*, healthcare is of critical importance to health systems' sustainability; health workforce is a key component to health systems, whereas the gender balanced health workforce is linked to health systems' improved performance (10,11). These features are considered to offer ample ground to gain deeper insights on the research question. Thereby, the research is developed at the intersection of gendered barriers in the healthcare sector within country's socio-cultural and economic contexts.

Methods

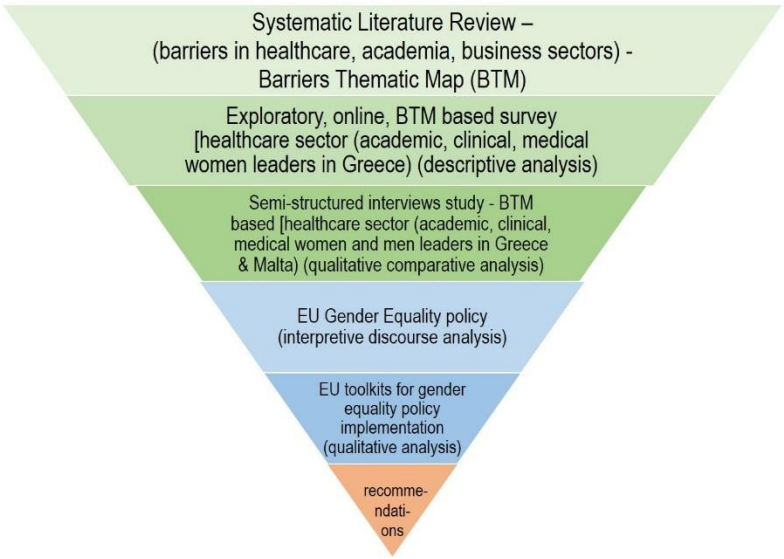
This study applied a qualitative research methodology built on a profound concern to understand the explored phenomenon and offer an interpretation of informed and sophisticated knowledge reconstructions (12). Adopting the social constructionism paradigm and on the grounds that some methods are more suited than others for conducting research on human construction of social realities (13), this study applied a mixed methods qualitative approach to ensure the quality criteria of trustworthiness, authenticity and triangulation incongruence of experiential and practical knowing (12).

In alignment with the qualitative research commitments, the research included obtaining and analyzing textual data, such as comments on a questionnaire and interviews' transcripts and data generated from the interaction between researchers and participants. Reflexivity relied on critical subjectivity; transparency as the study progresses, contextual understanding of particular social processes and application of qualitative research findings to other situations were also included in methodology considerations (14). Qualitative research was supplemented by the fundamental tenet of feminist research on the centrality of women aiming to "put the social construction of gender at the center of one's enquiries" (15) and interpret the experiences through immersion in the data (16).

Study design and methods

A mixed methods qualitative approach was applied to collect a variety of enriched data on the barriers to women's leadership and gender equality, validate the findings and triangulate the results (17). Following progressive analysis and comparison of collected data, an explanatory theory was formulated on addressing effectively the explored phenomenon and be plausibly applied and tested in other contexts (18). The study was supplemented by qualitative findings on EU gender equality policy and implementation to deduce conclusions on potential policy inconsistencies and ways of improvement. The study was grouped into three parts (Figure 1).

Figure 1. Study design and methods



I)*Problem statement and hypothesis:* A systematic literature review was undertaken aiming a) to uncover gendered barriers across healthcare, academy and business sectors, b) to contrast the differences in gendered barriers across sectors and c) to develop the gendered Barriers Thematic Map (BTM)with quantitative logic and a prevalence chart. The geographical target of the study was Europe with the time range for publications from 2000 to 2015 (19).

II) *Hypothesis testing:* the hypothesis testing on BTM and barriers' prevalence was focused on healthcare sector within two EU countries' socio-cultural and economic contexts: Greece and Malta. It was deployed in two sub-studies: one exploratory study conducted within one country's healthcare sector and one comparative study realized in two countries' healthcare sector (academic, clinical and medical facets):

The exploratory study was set out aiming to forage for the most and the least important barriers to women's leadership based on BTM. The study was drawn upon perceptions of women healthcare leaders in Greece in relation to gendered barriers; interest stemmed from country's poor performance on gender equality index and current economic turbulence (20).
The semi-structured interviews, comparative study was conducted aiming to assess empirically gendered barriers to women's leadership in healthcare through the lens of national socio-cultural and economic contexts. Study focused on Greece and Malta; interest was drawn from countries' poor performance in the gender employment gap and the rapid socio-cultural and economic changes occurring in the European Mediterranean region (21),

and

III)*EU policy and implementation level: An interpretive discourse analysis* was followed to gain deeper insights of the sustainable development thinking in gender equality policy agenda adopted by EU and in relation to its relevance to interests and challenges faced by Member States' citizens. In particular, the relevance of EU SDG5 themes and indicators and the prioritization of policy objectives to actual social reality across Member States was considered.
A qualitative analysis of organizational change was used to explore the transformative capacity of the developed EU gender mainstreaming toolkits aiming to unpack the complexity among toolkits, organizational culture, climate and outcomes and to gain nuances on potential room for improvement.

Data collection
To ensure the trustworthiness of the findings, qualitative and quantitative data was harvested from primary and secondary sources (12).
Primary data:

- Primary data on barriers to women's leadership and their prevalence was harvested applying a systematic literature review method (19).
- Primary data of an online questionnaire harvested by 30 purposively invited women healthcare Greek leaders (20).
- Primary data was collected from 36 semi-structured interviews with healthcare leaders, including women and men in Greece and Malta (21).

Secondary data:

- A content analysis of ten websites of key organizations, such as European Parliament, European Institute for

Gender Equality, Standing Committee of European Doctors, The World Bank, McKinsley Global Institute.
- EU evaluation reports and policy documents, communications, minutes of high level
- A narrative literature search in Google Scholar, PubMed, Web of Science and on dedicated websites discussing the implications of economic crisis on gender equality and on healthcare sector.
- A narrative literature search on interpretive discourse analysis of EU gender equality policy and the adoption of EU sustainable development goals (SDGs).
- A narrative literature review on theory of organizational and social change and on implementation sciences.

Ethical approval

Ethical approval was received from Ethics Committees from Maastricht University (No METC 16–4-266, January 19, 2017), National and Kapodistrian University of Athens (Medical School) (February3, 2017) and from the University of Malta (March 10, 2017).

Theoretical and conceptual considerations

The explored topic involves several aspects and thus requires an all-encompassing approach which may not fall easily into a single theoretical framework. The study applies theories of gender equality, women's leadership, gender equality policy and implementation at EU and Member States level.

Gender equality

In this study the concept of gender is approached as a cross-cutting socio-cultural and economic variable (22, 23). Gender is understood as "the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for women and men" (24) in contrast to "sex" referring to "the different biological and physiological characteristics of males and females such as reproductive organs, chromosomes, hormones, etc." (25). These characteristics tend to differentiate humans as men and women, whereas gender refers to a socially acquired identity connected to "being male or female in a given society at a given time and as a member of a specific community within that society" (26, 27). Hence, gender identity prescribes what is expected, allowed or valued in a woman or a man within a given context (22, 23).

Gender equality refers to "equal visibility, empowerment, responsibility and participation of women and men in all spheres of public and private life. It also means an equal access to and distribution of resources between women and men and valuing them equally" (28). Also known as "equality of opportunity" (29), it implies that women's and men's interest, needs and priorities are taken into consideration irrelevant to their gender. Thus, it is recognized that gender equality is not a women's issue but should interest and fully engage men and women in the sense of supporting women's capacity to make life choices in a context where this capacity was previously denied to them (27,28).

Gender equality policy in the EU context

European Union anchored firmly the concept of gender equality in the European Treaties and expressed its commitment with policies on economic development, social cohesion and democratic societies (30). The milestones of the trajectory of gender equality policy agendas arrayed from the Treaty of Rome (1957, Art 141) focusing on "equal pay

for equal work" to the Treaty of Amsterdam (1997, Art 3.2) "to eliminate inequalities and to promote equality between men and women" in all EU activities (31-33). Later, in the Treaty of Lisbon (2009) (34) EU broadened its binding commitment to observe gender equality principle and pursuit gender equality objectives. In 2015 EU committed to fully integrate the UN sustainable development goal towards achieving gender equality and women's empowerment (SDG5) in EU policy framework under the concept of social and economic development.

Gender equality and women's leadership

Women's leadership has been perceived as central component towards achieving gender equality and women's empowerment objectives within EU sustainable development policy framework (33). In particular, the target of women's leadership advancement was embedded directly to the theme of "leadership positions", but was also related indirectly to themes of "education" and "employment" (35). Hence, women's leadership advancement was approached to a certain extent by EU policy agenda as a driver to equal opportunities for full and effective participation to leading positions at all levels of decision making, in all employment areas and in all societal spheres (2).

Women's leadership in the healthcare sector

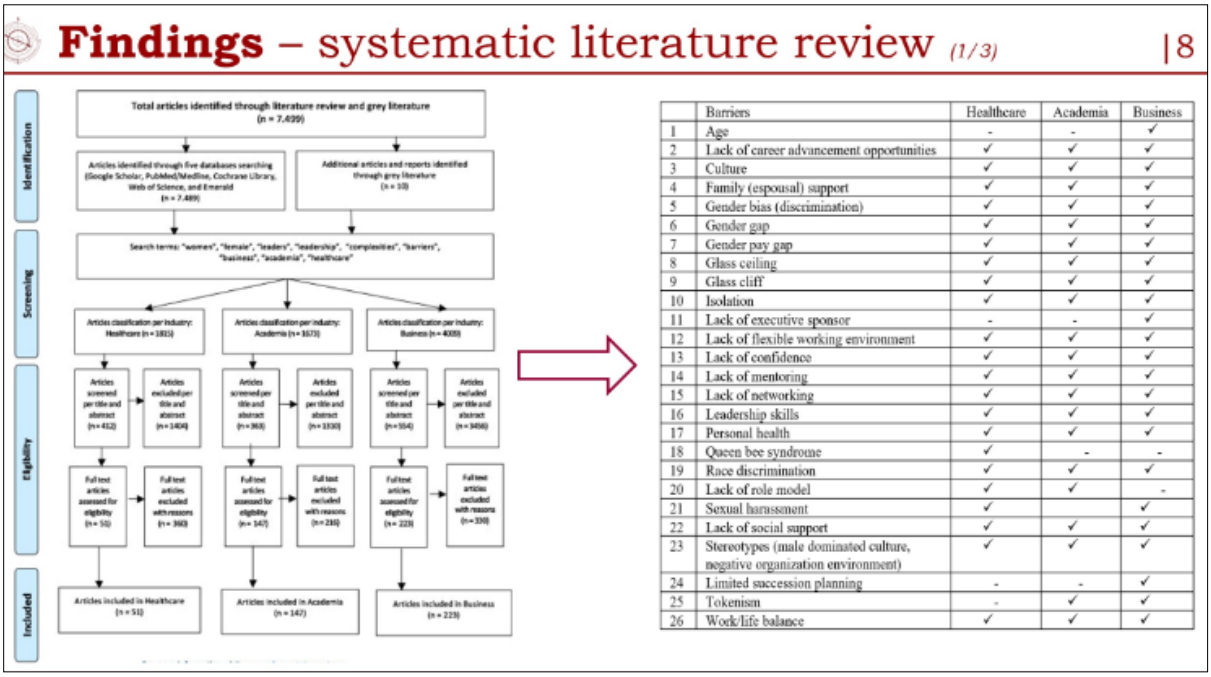
Healthcare is populated mainly by women; 74% of health workforce are women but only 14% assume high level positions in decision making (10). The healthcare sector is regarded as an investment driver across European Union (36,37) and, thereby, is considered a key component for health systems' sustainability. It also enjoys a prominent position among the biggest employers in EU (35). However, health systems miss female talent and perspectives, especially in higher echelons and turn weaker, underperformed since the women who deliver them do not have an equal say in the management and leadership of the systems, they know best (38). Hence, a substantial share of talents pool remains untapped, whereas the deficit for transformative leaders in healthcare grows bigger.

Findings

The undertaken qualitative study produced the following findings:

Part I explored the barriers to women's leadership and gender equality across three vital sectors, healthcare, academia and business in EU context. A comprehensive map of barriers to women's leadership was devised. The Barriers Thematic Map (BTM)included twenty-six barriers with quantitative logic and varying degree of prevalence. The BTM uncovered gendered inequalities across sectors and drew attention to under-studied barriers' prevalence across sectors (Figure 2, Figure 3, Figure 4) (19).

Figure 2. Gendered barriers across healthcare, academy and business sectors – systematic literature review findings



	Barriers	Healthcare	Academia	Business
1	Age	-	-	✓
2	Lack of career advancement opportunities	✓	✓	✓
3	Culture	✓	✓	✓
4	Family (espousal) support	✓	✓	✓
5	Gender bias (discrimination)	✓	✓	✓
6	Gender gap	✓	✓	✓
7	Gender pay gap	✓	✓	✓
8	Glass ceiling	✓	✓	✓
9	Glass cliff	✓	✓	✓
10	Isolation	✓	✓	✓
11	Lack of executive sponsor	-	-	✓
12	Lack of flexible working environment	✓	✓	✓
13	Lack of confidence	✓	✓	✓
14	Lack of mentoring	✓	✓	✓
15	Lack of networking	✓	✓	✓
16	Leadership skills	✓	✓	✓
17	Personal health	✓	✓	✓
18	Queen bee syndrome	✓	-	-
19	Race discrimination	✓	✓	✓
20	Lack of role model	✓	✓	-
21	Sexual harassment	✓		✓
22	Lack of social support	✓	✓	✓
23	Stereotypes (male dominated culture, negative organization environment)	✓	✓	✓
24	Limited succession planning	-	-	✓
25	Tokenism	-	✓	✓
26	Work/life balance	✓	✓	✓

Figure 3. Gendered barriers in business (%), academia (%) and in healthcare (%)

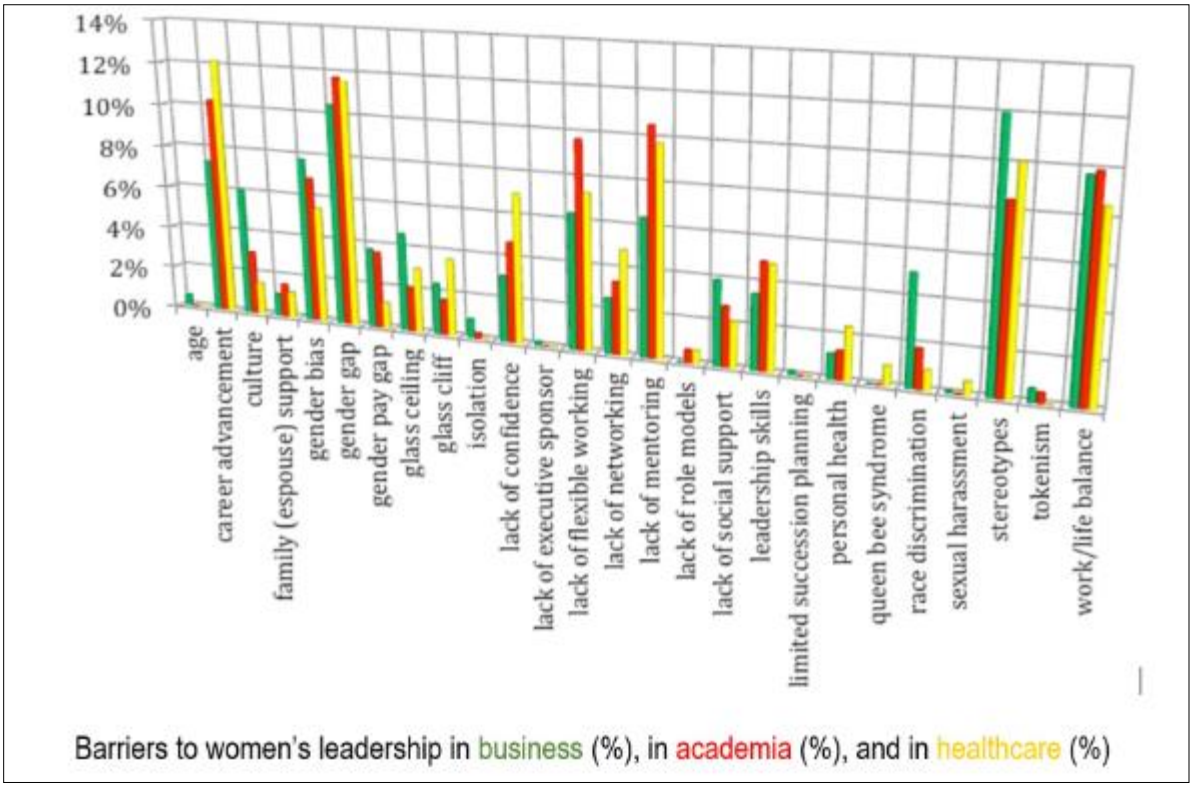
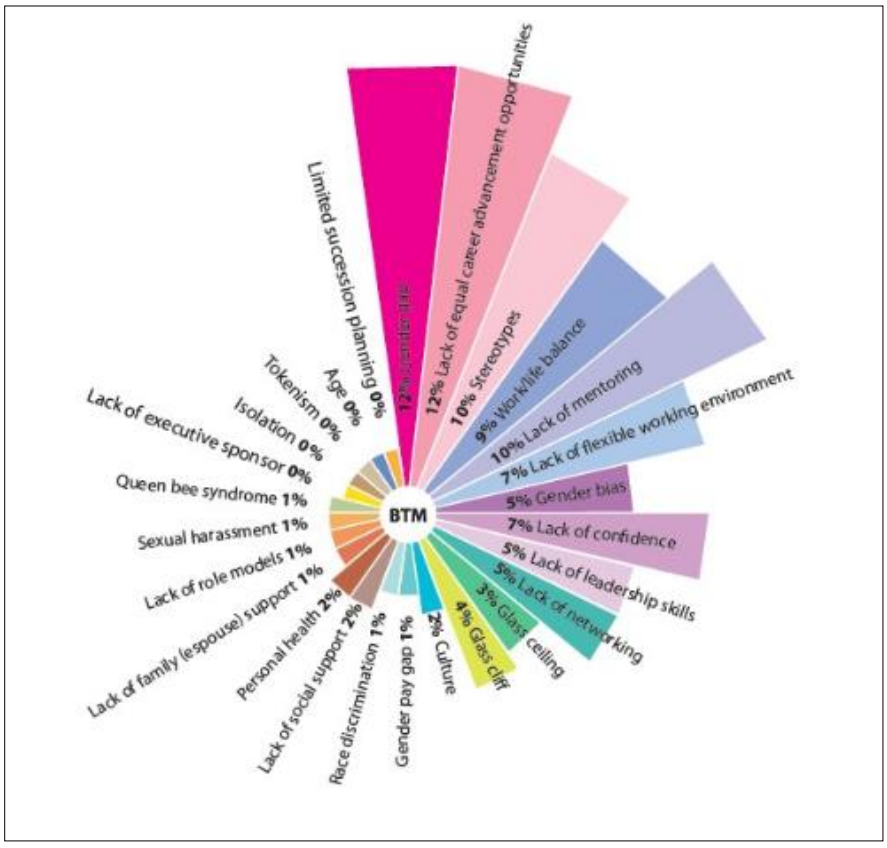


Figure 4. Barriers Thematic Map (BTM) to gender equality

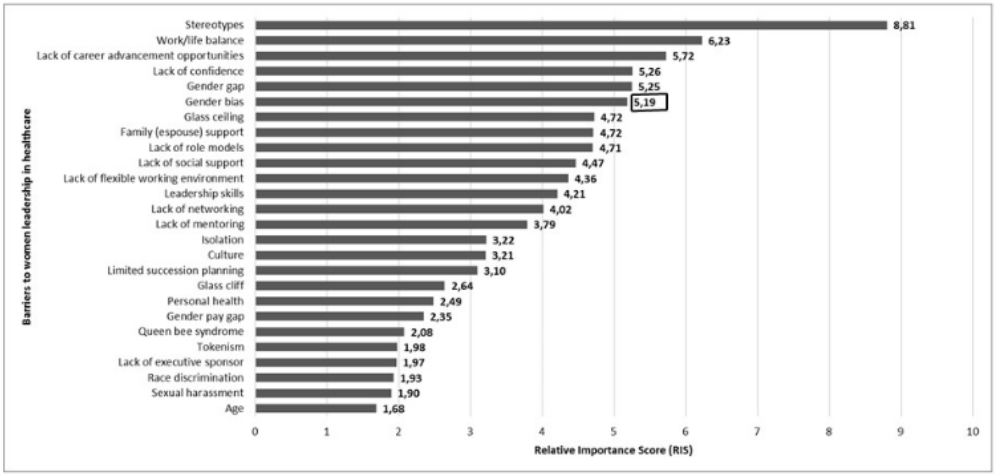


Part II focused on hypothesis testing by investigating the BTM within social reality, contextualizing and interpreting the findings and gaining in depth insights in relation to research hypothesis on healthcare sector within the context of two, comparable countries, Greece and Malta.

Firstly, empirical findings (online survey) on perceptions of Greek women healthcare leaders on barriers to career advancement identified the twenty-six barriers included in BTM (Figure 5) (20). Six barriers (stereotypes, work/life balance, lack of equal career advancement, lack of confidence, gender gap, and gender bias) prevailed in women leaders' perceptions in constraining opportunities for pursuing leading positions in Greek healthcare setting, whereas all twenty-six barriers presented varying degree of prevalence. Secondly, qualitative research findings (semi-structured interviews) identified twenty and twenty-one barriers to women's leadership within the Greek and Maltese healthcare settings, respectively (Figure 6) (21). In both research settings prevailing barriers included work/life balance, lack of family (spousal) support, culture, stereotypes, gender bias and lack of social support, yet countries' similarities and differences in prevalence of the identified barriers were observed. Notably, cultural tightness was found to be experienced against socio-cultural transformation in Maltese context; the recent economic crisis was found to be responsible for a backlash in previously achieved gender equality objectives in Greece. Thus, research findings unveiled underlying interactions

among gender, leadership and countries' socio-cultural and economic contexts elucidating the varying degree of strength of norms and barriers embedded in a society's egalitarian practice.

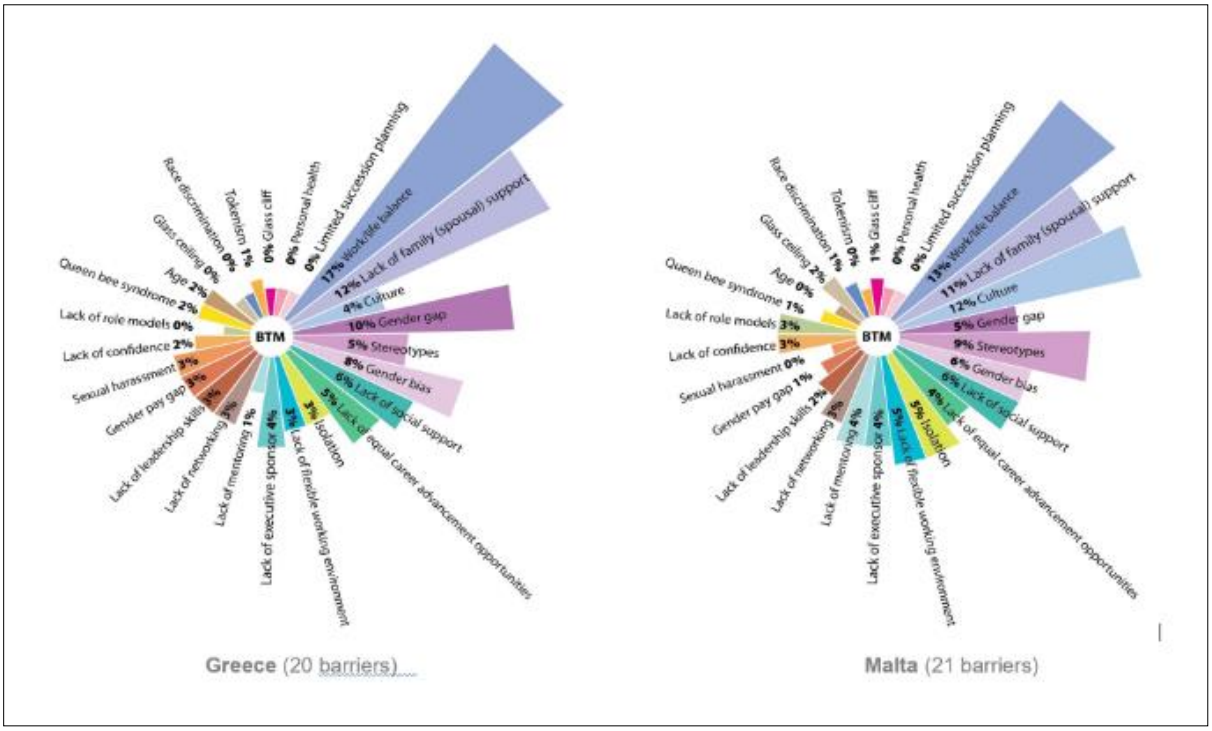
Figure 5. A BTM-based Best-Worst Scaling (BWS) assessment on gendered barriers across Greek women healthcare leaders



Part III turned to gender equality policy agenda at the EU level. The chapter considered the sustainable development thinking in gender equality policy objectives in EU pertaining to its relevance to challenges faced by Member States' citizens. In particular, the chapter explored the relevance of EU SDG5 themes and indicators and the prioritization of policy objectives to actual social reality across Member States. Findings identified inconsistencies in application of gender equality related articles binding for both EU and MS (Treaty of Lisbon, Art 2, Art 3.3, Art 6.1, and Art 9), posing thus questions about the prioritization of gendered challenges from EU and national policy actors and stakeholders. The translation of SDG5 into national achievable targets was discussed under the perspective of persistent and uneven gender inequalities across MS. The study argued for EU's proactive leadership, underpinned by academia and civil society contributions to optimize support to the MS to revisit their national policies and develop evidence-informed policies; thus, the sustainable development efforts may be strengthened to align with the gendered priorities and challenges at MS level.

Moving to the policy implementation realms, the study identified that the inherent duality of toolkits (gender and governance) may be held responsible for their suboptimal transformative capacity within organizational context; furthermore, the under-developed qualitative elements of the toolkits, such as the SESAME features (simple, easy, specific, affordable, measurable and efficient) and the lack of gender expertise at policy and decision makers level may also need to be further developed to facilitate effectively the organizational change processes

Figure 6. A BTM-based semi-structured interviews study on gendered barriers across women and men healthcare leaders in Greece and Malta



Discussion

European Union's high level legal and political commitment towards achieving gender equality objectives has produced suboptimal outcomes. The gendered priorities misplaced by policy makers and the inconsistent commitment across EU bodies and agencies fostered the persistence of gendered barriers and equal representation in economy and society, undermining thus the undertaken efforts. The policy intentions and policy implementation have not been sufficiently bridged; the suboptimal transferring of the academic knowledge to policy practice servants and the lack of gender disaggregated data feeding bottom up, customized policies at both country and EU level may be hold responsible, amongst others, for shortcomings in policy prioritization and effective implementation (3,9,39,40).

Inconsistent commitment and lack of collective action

Gender scholars argue that EU gender policies are the battleground for EU institutions underpinned by shifts in power relations (41). The way gender (in)equality is framed, engages differently the different actors across the EU policy making arena which results in fading away the centrality of the policy problem; hence, the gender equality policy objective is placed as the "side dish" of the actual EU policy making goals (42). For example, the European Commission framed gender equality policies through gender mainstreaming in all policies undertaken by actors normally involved in policy making (40,41,43); yet it ended up to bureaucrats with a rather technical than political conceptualization of

gender equality principle shaping accordingly the policy agenda (44,45). On that note, inconsistencies in funding and budgeting may conflict directly with the EU's full legal and political commitment (Art 2, Art 3.3, Art 6.1, Art 9; Treaty of Lisbon, 2007) (34) and, then, result to limited positive impact on gender equality issues, such as gendered unemployment (41,46).

Lack of gender disaggregated data

Putting evidence into practice is complicated and context dependent; yet, it remains a dynamic process with a continuous interaction between academic research and policy makers which may identify priorities and evaluate the level of responsiveness to key audiences. Almost none of the EU gender related policies incorporate a systematic and consistent mechanism, such as disaggregated data collection, to evaluate whether the policy has successfully responded to its objectives and the potential room for improvement (3,47). The critical gap of a gender disaggregated data pool enhanced the fuzzy evaluation of the gender equality policies, in particular at Member States implementation level (47). Robust evidence generated by academic knowledge may fill in the gaps in the policy cycle and contribute in developing evidence informed gendered policies, responsive to gendered barriers faced within country's specific socio-cultural and economic contexts.

Gendered barriers: The case of healthcare sector

The interest of scholars, civil society, European and international agencies on the persisting underrepresentation of women in leading positions and the implications to health systems, economy and society has been growing rapidly during the latest years. For example, a growing interest on gender inequalities in health and healthcare from civil society actors has been observed in recent years. Non-Governmental Organizations (NGOs) (e.g., Women in Global Health Research Initiative) and associations (e.g. European Health Management Association) advocate gender equality in health workforce from several perspectives, such as equal opportunities to career advancement and equal pay. In the same line, European and international agencies keep a close eye to EU region and discussed intensively in recent years the women's underrepresentation in healthcare. In particular, Dr Tedros, Director General of WHO, re-stated the necessity for gender transformative action in health (38) and launched the WHO Global Health Workforce Equity Hub in 2017 (48).

Arguably, the considerable, multi-disciplinary effort to unpack the complexity of barriers to gender equality demonstrates scholarship's unanimous voice on achieving gender equality objectives and, thereby, on addressing the gendered barriers in a feasible and effective way. However, although all involved actors argue for the importance and urgency of gendered challenges in healthcare and established the relevance of gender equality in health workforce to sustainable transformation and governance of health systems, the results remain poor. Health workforce is the beating heart of healthcare and health systems which are mainly populated by women. Thereby, maybe the extra mile towards achieving a gender balance workforce may need to be undertaken by academia with the main aim to detail the health workforce's capacity as a change agent towards achieving gender equality objectives within work and social contexts and project the gender balanced health workforce as a paradigm to society and economy.

Implications

The study introduces the feature of comprehensiveness and prevalence of gendered barriers; nonetheless, there is ample room for further research, which would be extremely informative and would maximize the impact of the findings at hand. Additional study on the twenty-six identified barriers through a multi-disciplinary lens would be of added value to the field; in particular, the barriers' contextuality in terms of their durability and transferability might have also been recognized and assessed differently through the lens of several academic disciplines, such as sociology, psychology, political science, management and organizational behavior science, gender science, feminism; similarly, gendered barriers manifestation across various sectors (e.g. NGOs, agriculture) would offer interesting insights to the explored phenomenon' prism.

On the grounds of the provided evidence-informed insights on the context sensitive and country specific gendered barriers, policy actors and decision makers are invited to follow the "think globally – act locally" strategy in gender equality policies and practices in their efforts to close the gap between policy and reality. Furthermore, the findings of this research may serve to raise awareness to policy and social actors on the gender asymmetries' influence in terms of power and authority within a country's social and cultural context. Policy and social stakeholders are invited to revisit the level of responsiveness of adopted policies to social audiences and to re-evaluate the dynamic dialogue among societal culture, leadership and gender in enabling social and cultural change.

At the author's best knowledge, this study is one of the first to develop a Barriers Thematic Map (BTM) with a prevalence feature. The BTM may be developed to a digital tool for self-awareness and a reality check on gendered challenges at organizational level. Applying the BTM, a snapshot of the gendered barriers' manifestation and prevalence within organizations may be generated. Providing data anonymization, the tool may offer the room to unveil both apparent and implicit barriers experienced by all genders bypassing, thus, potential power relations within organizations. This evidence-based overview may disclose policy gaps and be linked to organizational practices for improvement. The yielded evidence-based information will also contribute to effective use of resources, which may be channeled to fulfil customized needs and, therefore, improve organization's change capabilities and performance.

Conclusions

The study demonstrated that the gendered barriers are numerous, manifest themselves in chorus and with a varying degree of prevalence across and within sectors and are greatly influenced by country's socio-cultural and economic contexts. Hence, in contrast to published literature, the findings support that barriers to gender equality need to be addressed comprehensively, not on a one to one basis, aiming to capture the wholeness of the problem and, thus, design and implement effective strategies, policies and practices to address the actual priorities and challenges across sectors and within countries' specificity. The lack of consistent and collective commitment on gender equality objectives at both EU and Member States level, may have put forward misplaced gendered priorities and compromise the progress dynamics. Thereby, policy and decision makers may find fertile avenues for efficient implementation of gender sensitive policies turning to evidence informed agenda and work hand

by hand with academia and social actors towards achieving the promised egalitarian social order, social cohesion and sustainable future for the EU citizens and the generations to come.

References

1. European Commission. European Social Fund. Gender – An issue of equality. 2019a. Available at: https://ec.europa.eu/esf/transnationality/content/gender-issue-equality (Accessed: February 9, 2019).
2. European Commission. She Figures. 2019b. Available at: https://ec.europa.eu/info/publications/shefigures-2018_en (Accessed: April 12th, 2019).
3. European Institute for Gender Equality. Gender Equality Index Report 2017. Available at: https://eige.europa.eu/publications/gender-equality-index-2017-measuring-gender-equality-european-union-2005-2015-report (Accessed: February 13th, 2019).
4. Bismark M, Morris J, Thomas L, Loh E, Phelps G, Dickinson H. Reasons and remedies for under-representation of women in medical leadership roles: a qualitative study from Australia. BMJ Open 2015;5:e009384.
5. Linkova M. Academic excellence and gender bias in the practices and perceptions of scientists in leadership and decision-making positions. Gend Res 2017;18:42-66.
6. McLaughlin H, Silvester J, Bilimoria D, Jané S, Sealy R, Peters K, et al. Women in power: Contributing factors that impact on women in organizations and politics; psychological research and bets practice. Organ Dyn 2017. doi.org/10.1016/j.orgdyn.2017.09.001.
7. Eagly AH, Carli LL. Through the Labyrinth: The Truth About How Women Become Leaders. Harvard Business Press; 2007.
8. Jacquot S. A Policy in Crisis. The Dismantling of the EU Gender Equality Policy. In: Gender and the Economic Crisis in Europe. Palgrave Macmillan, Cham; 2007:27-48.
9. European Parliament. Gender mainstreaming in the EU: State of Play. 2019a. Available at: http://www.europarl.europa.eu/RegData/etudes/ATAG/2019/630359/EPRS_ATA(2019)630359_EN.pdf (Accessed: February 8th, 2019).
10. OECD. Gender Equality. Available at: http://www.oecd.org/gender/data/women-make-up-most-of-the-healthsector-workers-but-they-are-under-represented-in-high-skilled-jobs.html (Accessed: September 27, 2018).
11. Acker J. Inequality regimes: Gender, class, and race in organizations. Gend Soc 2006;20:441-64.
12. Guba EG, Lincoln YS. Competing paradigms in qualitative research. In: Denzin NK, Lincoln YS (Eds.). Handbook of qualitative research. Thousand Oaks, CA: Sage; 2000:105-117.
13. Lincoln YS, Guba EG. Naturalistic Inquiry. Thousand Oaks, CA, US: Sage Publications, Inc.; 1985:75.
14. Avis M. Is there an epistemology for qualitative research. In: Holloway I. Qualitative research in health care. McGraw-Hill Education (UK); 2005:3-16.

15. Lather P. Feminist perspectives on empowering research methodologies. In: Women's studies international forum. Pergamon 1988;11:569-81.
16. Kralik D. Engaging feminist thought in qualitative research. A participatory approach. In: Holloway I. Qualitative research in health care. McGraw-Hill Education (UK); 2005:270-87.
17. Collins KM, Onwuegbuzie AJ, Jiao QG. A mixed methods investigation of mixed methods sampling designs in social and health science research. J Mix Methods Res 2007;1:267-94.
18. Holloway I. Qualitative research in health care. McGraw-Hill Education (UK), 2005:101.
19. Kalaitzi S, Czabanowska K, Fowler-Davis S, Brand H. Women leadership barriers in healthcare, academia and business. Equal Divers Incl Int J 2017;36:457-74. doi: 10.1108.EDI-03-2017-0058.
20. Kalaitzi S, Cheung KL, Hiligsmann M, Babich S, Czabanowska K. Exploring Women Healthcare Leaders' Perceptions on Barriers to Leadership in Greek Context. Front Public Health 2019;7. doi/org/10.3389/fpubh.2019.00068.
21. Kalaitzi S, Czabanowska K, Azzopardi-Muscat N, Cuschieri L, Petelos E, Papadakaki M, et al. Women, healthcare leadership and societal culture: a qualitative study. Journal Healthc Leadersh 2019;11:43. 2019b. doi/org/10.2147/JHL.S194733.
22. Parsons T. Evolutionary universals in society. Am Sociol Rev 1964:339-57.
23. Helman CG. Culture, health and illness. CRC press; 2007
24. Council of Europe. Convention on preventing and combating violence against women and domestic violence. Istanbul, 11.V. 2011. Available at: https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168008482e (Accessed: January 4th, 2019).
25. World Health Organization. Glossary of terms and tools. 2019a. Available at: https://www.who.int/gender-equityrights/knowledge/glossary/en/ (Accessed: February 2nd, 2019).
26. European Institute for Gender Equality. Gender Equality Glossary and Thesaurus. 2019. Available at: https://eige.europa.eu/thesaurus/browse (Accessed: December 4th, 2018).
27. Mediterranean Institute of Gender Studies (MIGS). Glossary of Gender related terms. Available at: https://www.medinstgenderstudies.org/glossary-on-gender/ (Accessed: February 12th, 2019).
28. Council of Europe. Equality between women and men. Available at: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168064f51b (Accessed: January 4th, 2019).
29. Booth C, Bennett C. Gender mainstreaming in the European Union: towards a new conception and practice of equal opportunities? Eur J Women's Stud 2002;9:430-46.
30. European Commission. Communication from the commission to the European Parliament, the council, the European Economic and Social Committee and the Committee of the Regions. An initiative to support

work-life balance for working parents and carers. 2017. Available at: https://eur-lex.europa.eu/legal content/EN/TXT/?uri=COM%3A2017%3A252%3AFIN (Accessed: June 25th, 2018).
31. EUR-lex. Access to European Union Law. The Treaty of Rome. 2019a. Available at: https://eur-lex.europa.eu/legalcontent/EN/TXT/?uri=CELEX:11957E/TXT (Accessed: February 12, 2019).
32. EUR-lex. Access to European Union Law. The Treaty of Amsterdam. 2019b. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:11997D/TXT (Accessed: February 12, 2019).
33. European Commission. Report on equality between women and men in the EU. 2018 Brussels. Available at: https://publications.europa.eu/en/publication-detail/-/publication/950dce57-6222-11e8-ab9c-01aa75ed71a1 (Accessed: February 12th, 2019).
34. EUR-lex. Access to European Union Law. The Treaty of Lisbon. 2019c. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12007L%2FTXT (Accessed: February 12th, 2019).
35. Eurostat. Sustainable Development in the European Union. Monitoring Report on Progress towards the SDGs in an EU Context. 2018. Available at: https://ec.europa.eu/eurostat/web/products-statistical-books/-/KS-01-18-656 (Accessed: February 12th, 2019).
36. Mossialos E, Allin S, Davaki K. Analyzing the Greek health system: a tale of fragmentation and inertia. Health Econ 2005;14:S151-68.
37. Economou C, Kaitelidou D, Kentikelenis A, Maresso A, Sissouras A. The impact of the crisis on the health system and health in Greece. In Economic crisis, health systems and health in Europe: Country experience [Internet]. European Observatory on Health Systems and Policies; 2015.
38. World Health Organization. Female health workers drive global health. 2019b. Available at: https://www.who.int/news-room/commentaries/detail/female-health-workers-drive-global-health (Accessed: March 30th, 2019).
39. European Commission. Strategic Engagement for Gender Equality 2016-2018. 2019c. Available at:https://ec.europa.eu/anti-trafficking/sites/antitrafficking/files/strategic_engagement_for_gender_equality_en.pdf (Accessed: November 19th, 2018).
40. Cavaghan R. Making gender equality happen: Knowledge, change and resistance in EU gender mainstreaming. Routledge; 2017.
41. Kantola J, Lombardo E. EU gender equality policies. In: Eds. Gender and the economic crisis in Europe: Politics, institutions and intersectionality. Springer; 2017:331-49.
42. Verloo M, Van der Vleuten A. The discursive logic of ranking and benchmarking: Understanding gender equality measures in the European Union. In: The Discursive Politics of Gender Equality. Routledge; 2005:189-205.
43. Ahrens P, van der Vleuten A. EU Gender Equality Policies and Politics–New Modes of Governance.

Gender and Diversity Studies in European Perspectives; 2017.
44. Meier P, Celis K. Sowing the seeds of its own failure: Implementing the concept of gender mainstreaming. Soc Politics 2011;18:469-89.
45. Kantola J. Gender and the European Union. Macmillan International Higher Education; 2010:128.
46. European Parliament. Gender responsive EU Budgeting. Update of the study 'The EU Budget for Gender Equality' and review of its conclusions and recommendations. 2019b. Available at: http://www.europarl.europa.eu/thinktank/en/document.html?reference=IPOL_STU(2019)621801 (Accessed: March 15th, 2019).
47. European Parliament. 2021-2027 multiannual financial framework and new own resources. Analysis of the Commission's proposal. 2019c. Available at: http://www.europarl.europa.eu/RegData/etudes/IDAN/2018/625148/EPRS_IDA (2018)625148_EN.pdf (Accessed: February 9th, 2019).
48. World Health Organization. Gender Equity Hub. 2019c. Available at: https://www.who.int/hrh/network/GEH2018-overview.pdf?ua=1 (Accessed: March 6th, 2019).