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Improving diversity in global health governing boards

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

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

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

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

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

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

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

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

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

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Tranexamic acid for trauma in the USA: is prejudice a barrier to saving lives?

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The CRASH-2 clinical trial results were published in June, 2010.[1,2] Our global collaboration had randomly allocated 20 211 trauma patients from 274 hospitals in 40 countries to receive tranexamic acid, an antifibrinolytic agent to prevent or reduce bleeding, or placebo. Timely tranexamic acid treatment reduced bleeding deaths by nearly one third and without any side-effects.[1,2] We estimated that widespread use of tranexamic acid could prevent more than 120 000 trauma deaths each year worldwide, with 3500 deaths avoided each year in the USA.[3] Within weeks of publication in 2010, the British Army was using tranexamic acid for treatment of trauma on the battlefield. In 2010, the war in Afghanistan was at its worst with thousands of civilian deaths due to violence and injury. 2010 was also a disastrous year for the US Army in this war with 496 soldiers killed. But the US Army was slow to adopt tranexamic acid.

Perhaps they were reluctant to use tranexamic acid due to their bad experience with the use of recombinant factor VIIa**.** The US Army used recombinant factor VIIa for the treatment of combat injuries from 2003 to 2009.[4] However, systematic reviews in 2009 and 2010 showed no mortality reduction but more thrombotic side-effects, some leading to amputation.[5,6] In 2011, Novo Nordisk, the manufacturer of recombinant factor VIIa, agreed to pay the US Government US$25 million to resolve its liability arising from the illegal promotion of the drug.[7,8] It was only in September, 2011 that the US Committee on Tactical Combat Casualty Care approved use of tranexamic acid for treatment of combat injuries.[9] The decisive data were not from the CRASH-2 randomised trial but from the MATTERS study—a small cohort study in the Camp Bastion military base in Afghanistan—that showed casualties who got tranexamic acid were less likely to die, despite being more severely injured than those who did not get it.[10] Cohort studies are not the best way to assess treatment effects due to the risk of confounding, but the data were from US soldiers and this seemed to prove decisive for the Committee.

What makes clinical trial results trustworthy? Most drugs have moderate effects and, to detect these, trials must eliminate moderate bias, with proper randomisation and unbiased outcome assessment, and minimise random error, by enrolling enough patients. The CRASH-2 trial was randomised, with good allocation concealment, and it was placebo controlled and large.[1] The main criticism was not how the CRASH-2 trial was done but where.

Colombian hospitals recruited 2940 of the 20 211 patients in the CRASH-2 trial. According to a WHO report in 2000, Colombia then had the 22nd most efficient health-care system in the world, ahead of the USA and Australia.[11] However, the US Department of Defence Hemorrhage and Resuscitation Research and Development Steering Committee noted that the CRASH-2 trial was done "almost exclusively in the developing world" and that "just 1·4% of patients were from institutions in countries (none from the United States) where it was likely that trauma resuscitation and care with all therapies, including blood components, were consistently practiced".[12] Gruen and colleagues in Australia also questioned the efficacy of tranexamic acid in "patients treated to modern trauma care standards", commenting in an editorial that "fewer than 2% of the patients in CRASH-2 were treated in countries that routinely provide