

# AAMRI GENDER EQUITY DIVERSITY AND INCLUSION STRATEGY AND ACTION PLAN



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# FOREWORD FROM PROFESSOR MAXINE MORAND

I am delighted to be introducing the first gender equity, diversity and inclusion (GEDI) strategy and action plan for the Association of Australian Medical Research Institutes (AAMRI).

AAMRI's GEDI Strategy and action plan promotes diverse workforces consisting of people with different backgrounds and perspectives who bring a broad array of insights, ideas, and solutions and are better able to drive innovation.

Like many other sectors, the medical research workforce is affected by systematic biases resulting in gender imbalance and inequities and these are compounded by intersectional factors such as sexuality, race, ethnicity, age, caring responsibilities, social class, culture, religion, disability, and physical appearance.

The goal of the strategy and action plan is to create a stronger and enhanced MRI sector by working together to drive the cultural and structural change that will address these biases and create a fairer and more equitable workplace for all.

AAMRI and the GEDI Committee have been working with the membership and key stakeholders to develop the strategy and action plan, which builds on activities already underway at member medical research institutes (MRIs) to advance GEDI in the sector. In this document, we present four priority areas for action, outlining the vision and objectives in each area and the actions we need to take to get us there.

I look forward to working with AAMRI, its member institutes and the broader sector as we take the next steps together and build a thriving, inclusive and supportive environment for diverse and talented health and medical research workforce.



**Professor Maxine Morand**

Chair, GEDI Committee

Association of Australian Medical Research Institutes (AAMRI)

AAMRI Board Director, Board Chair of the Peter MacCallum Cancer Centre

ON AVERAGE  
**ONLY 17%** of senior academics in Australian universities and research institutes are women



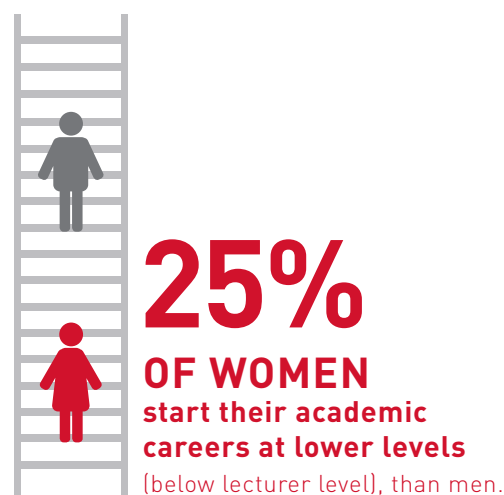
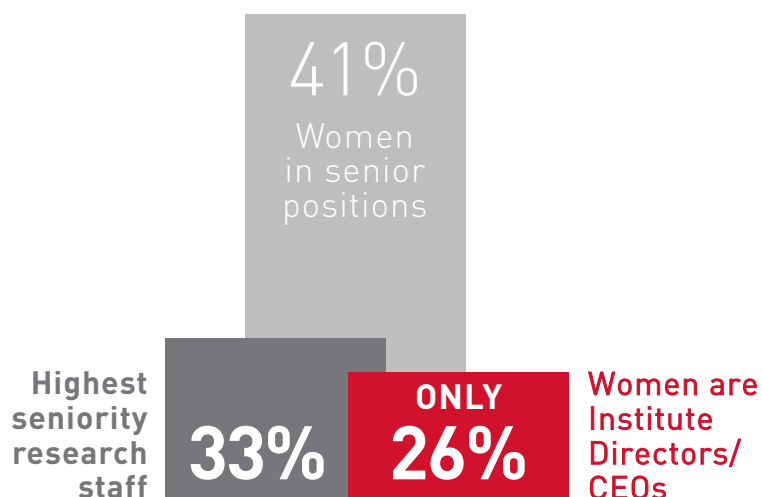
**WOMEN REMAIN LESS LIKELY** than men to

- PUBLISH
- RECEIVE AUTHORSHIP CREDIT
- BE AN INVITED SPEAKER
- RECEIVE GRANT FUNDING
- OR HOLD LEADERSHIP POSITIONS

BETWEEN 2018 AND 2020 **OVER 60%** of the **MRI workforce were women** but **ONLY 41%** of **senior positions** at MRIs were held by women

Gender inequity in academic settings has been extensively examined and parallels can be drawn with the MRI sector

**DISPARITIES** are not due to differences in ability but rather **DUE TO BIAS AGAINST WOMEN**



**WOMEN DISPROPORTIONATELY** LEAVE A RESEARCH CAREER DUE TO:

- |                     |                      |                          |
|---------------------|----------------------|--------------------------|
| Isolation           | Ineffective Feedback | Insensitive Interactions |
| Lack of Role Models | Lack of Mentors      | Lack of Sponsors         |

Experiences and career trajectories of **TRANS WOMEN AS WELL AS TRANS AND GENDER DIVERSE PEOPLE** will often be further impacted by transphobia.

**ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN** face unique barriers related to the impacts of colonisation as well as additional cultural biases.

# INTRODUCTION

The medical research workforce is affected by systematic biases resulting in gender imbalance and inequities. Factors contributing towards gender inequity are compounded by intersectional factors such as sexuality, race, ethnicity, age, caring responsibilities, social class, culture, religion, disability, and physical appearance.<sup>1</sup>

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**Women disproportionately leave research due to isolation, ineffective feedback, insensitive interactions, sexual harassment, and a lack of role models, mentors, and sponsors.<sup>2</sup>**

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These existing inequities have been further exacerbated by the COVID-19 pandemic. Ongoing restrictions continue to impact the workforce and their productivity, with women having to bear the brunt of increasing domestic and caring responsibilities.<sup>3</sup> The pandemic is likely to have more long-term negative implications for women than men due to the compounding effect of career breaks and gender-based discrimination on career progression.<sup>4</sup>

Evidence demonstrates the benefits of diverse research workforces.

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**Workforces consisting of people with different backgrounds and perspectives are better able to drive innovation due to the ability to generate an array of insights, ideas, and solutions.<sup>5</sup>**

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There is a need to shift organisational culture and climate so that workplaces become more inclusive and diverse. To be effective, strategies should include legislation, allyship, leadership by scientific societies, professional development of core competencies in gender equity, diversity, and inclusion (GEDI) principles, and inclusive leadership.

In 2020 AAMRI conducted a survey to better understand the activities in progress to advance GEDI at member medical research institutes (MRIs). Responses to the survey helped identify the most urgent areas for action in the MRI sector and informed the development of AAMRI's 5-year GEDI Strategy and Action Plan. The four priority areas, along with the associated vision, objectives and action are summarised in this document.

In 2020, many workplaces, including MRIs, adopted new policies to address the impacts of COVID-19. This response demonstrated that adaptations and change are possible within a rapid timeframe. With a strategic approach, the positive practices established can be maintained and we can strive for more changes to address and mitigate existing inequities to create a health and medical research sector that is inclusive, flexible, and responsive to the needs of its diverse workforce.

While the initial focus within this strategy is on gender equity, the overall objective is to be intersectional, inclusive and provide fairer career paths for everyone within the medical research workforce. AAMRI and the GEDI Committee will now work in close collaboration with different stakeholders and experts to take forward the identified actions to help achieve better gender equity, diversity, and inclusion outcomes in the MRI sector.

# GENDER INEQUITY IN MEDICAL RESEARCH

## UNDERREPRESENTATION OF WOMEN IN SENIOR POSITIONS

While women now outnumber men at university, men still outnumber women in leadership roles in nearly all areas of professional workplaces. On average, only 17% of senior academics in Australian universities and research institutes are women.<sup>4</sup> Although more women are entering science, technology, engineering, mathematics, and medicine (STEMM) fields, women remain less likely than men to publish and receive authorship credit, be an invited speaker, receive grant funding, or hold leadership positions.<sup>7</sup> Women from diverse backgrounds and other under-represented groups face additional barriers to entry, retention, and progression.<sup>8</sup>

As the peak body for Australian medical research institutes (MRIs), the Association of Australian Medical Research Institutes (AAMRI) had been conducting biennial surveys since 2011 to capture snapshots of its members' activities. In 2018, AAMRI started collecting data on gender balance in the MRI workforce. The 2018 report found that while more than 60% of the member MRI workforce were women, only 40% of senior positions, that is highest seniority researchers, executive staff, and directors, were held by women.<sup>9</sup> These figures remained largely unchanged in 2020; over 60% of the MRI workforce were women but only 41% of senior positions at MRIs were held by women. Of these only 26% of Institute Directors and 33% of highest seniority research staff were women.<sup>10</sup> It was found that member MRIs were cognisant of this issue and were actively working towards achieving gender equity.

## ISSUES CONTRIBUTING TO ONGOING GENDER INEQUITY

Gender inequity in academic settings has been extensively examined and parallels can be drawn with the MRI sector. Women disproportionately leave a research career due to isolation, ineffective feedback, insensitive interactions, and a lack of role models, mentors, and sponsors.<sup>11</sup> Frequently women in leadership roles have negotiated with and navigated gendered leadership cultures at the cost of expending considerable energy to fit in. This leaky pipeline was reflected in the National Health and Medical Research Council (NHMRC) Fellowship and Investigator grant schemes, where far fewer women applied for the senior fellowship levels compared to men, even though the majority of applicants at the junior levels were women. The low representation of women at more senior levels of NHMRC's Fellowship and Investigator grant schemes suggested disproportionate attrition of women from the research sector as they progressed through their careers.

Research has shown that disparities in STEMM fields are not due to differences in ability but rather due to bias against women.<sup>12, 13</sup> Implicit societal views about gendered

roles and capabilities harm women in research, deprive future generations of role models, and artificially limit progress and innovation. Studies have found that around 25% of women start their academic careers at lower levels, that is below lecturer level, than men.<sup>14</sup> Women may be reticent to push forward as quickly as men and less women tend to seek promotions compared to men.<sup>15</sup> Achievements by women are often valued and evaluated differently to men in academia.<sup>16</sup> Thus, younger academic women often considered, and then dismissed, for leadership careers in academia.<sup>17</sup> Trans women's experiences are likely to be different to cis women's.<sup>18</sup> This is because trans women's as well as trans and gender diverse people's experiences and career trajectories will often be further impacted by transphobia.<sup>19</sup>

These decisions and outcomes contributing towards gender inequity are also compounded by intersectional factors including but not limited to sexuality, race, ethnicity, age, caring responsibilities, social class, culture, religion, disability and physical appearance.<sup>20</sup> Aboriginal and Torres Strait Islander women face unique barriers related to the impacts of colonisation as well as additional cultural biases. The role of Indigenous knowledges and the inherent publication biases that exist serves as additional impediments to the progression of Aboriginal and Torres Strait Islander women.<sup>21</sup>

## A NATIONAL PRIORITY

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**This gender imbalance has been recognised as a national problem.**

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In 2014, the Science in Australia Gender Equity (SAGE) pilot, based on the principles of the UK's Athena SWAN Charter, was launched by the Australian Academy of Science (AAS) and the Australian Academy of Technology and Engineering (ATSE). In 2020, this pilot program transitioned to an independent not-for-profit entity, allowing it to continue its work to accredit and grant awards to Higher Education and Research (HER) institutions for gender equity, diversity, and inclusion programs.

In 2018, the Australian Government requested that AAS and ATSE develop a Women in STEM Decadal Plan. AAMRI's submission to the consultation for the Decadal Plan included recommendations that address the underlying barriers that prevent retention and promotion of women in medical research. AAMRI's stated long-term goal was to achieve equal representation of women in senior medical research positions and leadership roles. The Women in STEM Decadal Plan was launched in April 2019.<sup>22</sup> AAMRI's activities in this area are, and will be, largely guided by this plan.

## GENDER INEQUITY IN MEDICAL RESEARCH (CONTINUED)

### COVID-19 IMPACTS

In 2020, the COVID-19 pandemic changed the way we all work and live. For researchers, key activities that contributed to their track record such as data collection and research outputs have been impacted by COVID-19 restrictions such as the closure of research facilities, laboratories and offices and international travel restrictions.<sup>23</sup> Researchers reported increased administrative and teaching workload, higher stress and anxiety levels and other mental health impacts.<sup>24</sup> Disruptions to grant processes meant researchers may be left with a gap between research projects, leading to a loss of income and an interruption to their careers.

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**Critically, the pandemic exposed and exacerbated existing inequities in the workforce.<sup>25</sup>**

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Early evidence suggests women face disproportionate increases in caring responsibilities and disruptions to working hours, job security and paid work capacity.<sup>26</sup> A study of publishing patterns found that women submitted proportionally fewer manuscripts than men during the early months of the pandemic.<sup>27</sup> Most early and mid-career researchers are women, thus they are often more likely to be in precarious employment reliant on short-term grant funding.<sup>28</sup>

Given the compounding effect of career breaks and gender-based discrimination on career progression, the pandemic is likely to have more long-term negative implications for women than men.<sup>29</sup> Evidence demonstrates the benefits of diverse research workforces and the risks of homogenous research workforces.<sup>30</sup> Gains in gender equity are at risk, especially if employers do not closely monitor and mitigate the impact of their decisions on their workforce.



# DEVELOPING AN AAMRI STRATEGY AND ACTION PLAN

## AAMRI GEDI COMMITTEE AND GEDI SURVEY

Initiatives that focus on women as being the problem, and which assume a masculine heteronormative view of the world only exacerbate the inequity.<sup>31</sup> Women have previously been expected to adapt to and achieve a set of behaviours and measures that have been defined, determined, and continue to be measured by systems that are inherently biased against them.

**Strategies to shift organisational culture and climate are required such as legislation, allyship, leadership by scientific societies, professional development of core competencies in GEDI principles, and inclusive leadership.**

This confluence of factors led to the establishment of the GEDI Committee by AAMRI in July 2020. Working with members the Committee identified four priority areas for action and undertook a survey of members to better understand the activities in progress at member medical research institutes (MRIs) to advance GEDI matters, and to understand how COVID-19 had impacted them.

## AAMRI STRATEGY AND ACTION PLAN – SUMMARY

In response to the survey and further sector engagement the GEDI Committee has developed a strategy and action plan. The details of the plan are explored in the remaining sections of the document and summarised in the following table.

| PRIORITY AREA  | VISION  | OBJECTIVES  |
|--|---|---|
| 1. Redefining measures of success/merit for medical research                 | 1. A system that acknowledges and values the individual qualities and ambitions of medical researchers and enable the diversification of career paths.  | 1.1 Pursue a sector wide approach to redefine measures of success and merit and ensure sufficient value, including cultural significance, is placed across the whole research career pipeline.  |
| 2. Enabling mechanisms for equity and inclusion in advancement and promotion | 2. A health and medical research sector that systematically addresses biases and barriers for women, trans and gender diverse people and under-represented groups to enable equitable career advancement. | 2.1 Determine current best practice toward eliminating bias in organisational policies and practices.<br>2.2 Support the career development and advancement of women, trans and gender diverse people and other under-represented groups.<br>2.3 Advocate for equity in the funding system. |
| 3. Addressing sexual harassment and promoting safe workplaces                | 3. Safe workplaces within the health and medical research sector, where career prospects, health, well-being and relationships are not hampered by experiencing sexual harassment.                        | 3.1 Develop a sector-based, intersectional and culturally safe approach to address the prevention and response to sexism and sexual harassment.   |
| 4. Addressing inequities in health and medical research design               | 4. Equity in medical and health research design and practice resulting in improved health outcomes for the community.   | 4.1 Champion best practice in policy and process in health and medical research design.<br>4.2 Advocate for change in research, funding and publication requirements.   |

While the initial focus of the strategy has been on achieving gender equity in medical research, the AAMRI GEDI Strategy and Action Plan sought to incorporate intersectionality and apply a COVID-19 lens to all four priority areas. AAMRI and the GEDI Committee will seek advice, consult, and collaborate closely with different stakeholders to address gaps in knowledge and expertise.

The long-term aim is to build upon the learnings and outcomes from this initial work to foster the creation of a more diverse and inclusive MRI sector. AAMRI acknowledges that unique barriers exist for Aboriginal and Torres Strait Islander women and as such will be aiming to address these challenges more comprehensively in a separate piece of work via an expert working group in collaboration with relevant experts in field.

# PRIORITY AREA 1

## REDEFINING MEASURES OF SUCCESS/MERIT FOR MEDICAL RESEARCH

### BACKGROUND

#### Where we are now

Within the medical research sector, there is an expectation that a candidate seeking career advancement and grant success must be excellent across a multitude of assessment criteria that are unfortunately very narrowly scoped. The current system largely rewards quantity over quality and places a strong emphasis on retrospective metrics such as funding success and number of publications. This contributes to the disparities observed between men's and women's representation in senior positions, publication rates, citations, recognition, and salary. These disparities are not due to differences in ability but rather due to systemic gendered and intersectional barriers impeding the productivity of women and trans and gender diverse researchers. These barriers include the structure of career absences, the peer review process, resource and grant allocation, implicit biases around gender, sexuality, race, ethnicity, age, caring responsibilities, social class, culture, religion, disability and physical appearance, stereotypes, work environment and culture.<sup>32</sup> Women and trans and gender diverse people are placed in a pervasive culture where they may find their achievements very differently valued and evaluated from those of men.<sup>33</sup>

There is an inherent inflexibility in the existing system as it does not consider the heterogeneity of the medical research workforce. Less value is placed on important research outputs such as the generation of data, reagents, and software; intellectual property; and the training of the next generation of scientists. It also neglects critical attributes such as teamwork and mentoring, and discourages risk-taking, multi-disciplinary research and diverse career pathways. The system often ignores the different strengths and weaknesses, context-dependent criteria, or a candidate's potential to develop and grow, in some cases forcing researchers to leave the medical research sector. It is one of many factors contributing to the leaky career pipeline, particularly at the mid-career stage.

Evidence from a broad range of fields shows that a diverse workforce and leadership produces better organisational outcomes.<sup>34</sup> While some grant programs have taken steps in the right direction, a culture of assessing success using diverse measures is far from mainstream practice.

For example, the NHMRC Relative to Opportunity (RTO) policy seeks to address the uneven playing field by requiring the assessment process to consider matters such as an applicant's track record and associated productivity relative to stage of career, any career disruptions, fair access to funding and career diversity.<sup>35</sup> However, it does not acknowledge or address the different forms of leadership or success criteria that can result from a non-traditional research/academic career. As such, candidates are often still ranked in a simple linear order based on past achievements using the existing narrow range of assessment criteria.

#### Where we want to be

Overall, there is a need to shift from these compliance and programmatically driven policies to more strategic and integrated initiatives that actively challenge traditional measures of success and address different models of leadership.<sup>36</sup>

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**The Australian medical research sector should, and can, work with our stakeholders to broaden the measures of success in research and academia to be more inclusive and better recognise and reward different models of success.**

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This will likely involve expansion beyond traditional and quantitative metrics such as funding and publication records so that diverse and qualitative metrics are also included. For example, these diverse metrics could be:

- Contributions to the field, for example, intellectual property (including techniques, methods) generation, industry collaborations, research translation, influence on policy and practice, patient care;
- Academic leadership e.g., lectureship, supervisorship, and training;
- Successful mentorship of junior staff and students;
- Collaboration, teamwork (team performances) and open science.

# VISION

A system that acknowledges and values the individual qualities and ambitions of medical researchers and enable the diversification of career paths.<sup>37</sup>

## OBJECTIVE

1.1

Pursue a sector wide approach to redefine measures of success and merit and ensure sufficient value, including cultural significance, is placed across the whole research career pipeline.

## ACTION

- 1.1 Encourage institutes and fellowship schemes, such as the NHMRC, to value (1) leadership in research governance and administration as well as (2) mentoring in gender and diversity more highly among assessment criteria or key performance indicators (KPIs) for reappointment and promotion;
- 1.2 Examine how career breaks, career stage and individual factors impact ability to achieve 'success'.
  - 1.2.1 Develop policies that address precarious employment in the sector and recognise the disproportionate impact on people who have career interruptions due to caring responsibilities;
  - 1.2.2 Work with the sector on how success is defined and rewarded (where appropriate consider the outcomes of the Australian Academy of Science Reboot STEMM think tank which recently considered this issue);<sup>38</sup>
- 1.3 Promote the development of gold-standard national Relative to Opportunity (RTO) guidelines for grant/promotion for applicants and reviewers, including a marking matrix.

# PRIORITY AREA 2

## ENABLING MECHANISMS FOR EQUITY AND INCLUSION IN ADVANCEMENT AND PROMOTION

### BACKGROUND

#### Where we are now

Two major systemic factors contributing to the leaky pipeline and lower representation of women at the highest seniority level are organisational policies and decision-making processes that contain inherent biases and discrimination.

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**Unconscious biases such as stereotyping (men are more competent than women), affinity bias (being more attracted to people who are more like us, hence men promoting more men), anchoring (particularly to salaries) and confirmatory biases all result in shifting standards between candidates.<sup>40</sup>**

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These biases are usually activated by an organisation's emphasis on merit. The emphasis on merit results in evaluators being less likely to view their behaviour as biased and less likely to think that others will judge their actions to be prejudiced.<sup>40</sup>

Organisational policies and procedures that do not apply a gender lens can also impact and affect people of different genders in different ways. Organisational systems, including policies, plans, programs, services, and communication, can result in discriminatory effects and inequity in access, or inadvertently reinforce harmful gender stereotypes. A key example is around parental leave. Parental leave supports gender equity by allowing partners to share caring responsibilities.<sup>41</sup> Despite Australian men being increasingly interested in being active and engaged fathers, uptake by fathers and partners remain low due to barriers relating to income, organisational stigmas and traditional gender norms. Existing research finds that Australian men are less likely than women to have or to request access to parental leave, and they are more likely to be refused or penalised when they do.<sup>42</sup> Applying a gender lens in the workplace helps to create gender equity and inclusion by ensuring that any differences in the way processes, policies or structures are likely to impact unfairly on different genders are anticipated. It also means that decisions are made that take account of and are responsive to gender.<sup>43</sup>

#### Where we want to be

Audits, as recommended by the Workplace Gender Equality Agency (WGEA), can assist organisations in identifying gaps. The identification of gaps can lead to the review of systems and processes for potential biases, particularly around advancement and promotion including appraisals, moderation committees and salary reviews. Reviews may result in the redesign of the systems and processes to minimise bias, including improvements in the analyses and organisation of the data considered and discussions of the data as well as the development of clear guidelines for members of any committees involved in the advancement and promotion process.

Standing in the way of advancement and promotion for women in medical research has been the lower success rates and lower levels of funding awarded to women through major granting programs. Career advancement in medical research is still intricately linked to grant funding success, and until there are more equal outcomes from funding programs it will be difficult to achieve gender equity in medical research. The NHMRC has led the way in taking strategic action in recent years to address unequal funding outcomes. This has helped reduce the gap in success rates, especially at the early career stage. However, the funding gaps at senior levels remain, and overall women are awarded less funding than men.

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**The medical research sector needs to commit to achieving equal funding outcomes for men and women.**

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Given the current disparity in funding outcomes, particular at mid- and senior-career levels this will take time to achieve, and how equal funding outcomes are defined will need to be considered. However, as an important starting point, AAMRI will take a policy position of advocating for equal funding outcomes to be achieved in all major funding programs, including the NHMRC, MRFF and the ARC, by 2031.

# VISION

A health and medical research sector that systematically addresses biases and barriers for women, trans and gender diverse people and under-represented groups to enable equitable career advancement.

## OBJECTIVE

2.1

Pursue a sector wide approach to redefine measures of success and merit and ensure sufficient value, including cultural significance, is placed across the whole research career pipeline.

2.2

Support the career development and advancement of women, trans and gender diverse people and other under-represented groups.

2.3

Advocate for equity in the funding system.

## ACTION

- 2.1 Determine current best practice toward eliminating bias in organisational policies, decision-making processes and recruitment and promotion practices;
  - 2.1.1 Disseminate to AAMRI member institutes to accelerate progress towards equity, as well as a more diverse and inclusive workplace;
  - 2.1.2 Advocate for member MRIs to dedicate sufficient resources, including committed staff, to progress GEDI initiatives and activities;
  - 2.1.3 Recommend KPIs on GEDI outcomes be attached to leadership positions in MRIs;
- 2.2 Work with member MRIs to track and monitor COVID-19 impacts through data collection and analysis;
- 2.3 Work with member MRIs to develop a standardised national reporting system that allows for benchmarking across the sector;
- 2.4 Establishment of an AAMRI member panel pledge for internal and external events;
- 2.5 Advocate for member MRIs to achieve equal representation of men and women on MRI Boards, decision making committees and senior management by 2030;
- 2.6 Advocate for medical research funders to provide incentives for institutes to implement best practice and hit GEDI targets, such as through the provision of additional funding;
- 2.7 Investigate existing leadership development and mentoring programs to determine whether a leadership and mentoring program specific to the medical research sector would be beneficial;
- 2.8 Recommend strategies for Directors and other senior leaders in MRIs to hear from emerging leaders and understand barriers and opportunities for advancement;
- 2.9 To assist parents and carers, develop tools and share ways to minimise the impact of career breaks and leaves of absence, for example:
  - 2.9.1 Communications plans to ensure that returning parents are kept informed of all the supports to which they may be entitled;
  - 2.9.2 Models of parental/carers leave that are more flexible, such as both parents taking part-time leave, stretching this beyond the first year after birth etc;
  - 2.9.3 Models to provide support for research to continue while researchers are on periods of extended absence;
- 2.10 Analyse and report to AAMRI members on the gender breakdown of all major government grant funding programs;
- 2.11 Advocate for equal funding outcomes for men and women across NHMRC/ MRFF/ARC and other major funding programs by 2031;
- 2.12 Advocate to relevant Ministers and work with NHMRC/ARC/MRFF leadership to find solutions which better address bias and equity in the funding, and consequently promotion, system;
  - 2.12.1 Set targets that improve outcomes for early to mid-career researchers, particularly women, trans and gender diverse people and under-represented groups;
  - 2.12.2 Seek adoption of a diversity statement on research applications to enable the tracking of intersectional diversity;
  - 2.12.3 Implementation of non-subjective and clear criteria to debias grant assessment, in particular, within RTO sections and with consideration for impacts of COVID-related career disruptions (linked to action 1.3);
  - 2.12.4 Broaden eligibility for carers in early-mid career fellowship schemes, such as two years given to primary carer after each birth or adoption.

# PRIORITY AREA 3

## ADDRESSING SEXUAL HARASSMENT AND PROMOTING SAFE WORKPLACES

### BACKGROUND

#### Where we are now

Sexual harassment can include behaviours such as sexual coercion and unwanted sexual attention, as defined by the *Sex Discrimination Act 1984* (Cth).<sup>44</sup> It can also include more commonplace but usually dismissed verbal and nonverbal behaviours that are not aimed at sexual cooperation but convey insulting, hostile, and degrading attitudes.<sup>45</sup> Sexual harassment is shown to be gendered and intersectional in nature, with non-binary people experiencing higher rates of abuse.<sup>46</sup>

While successive Sex Discrimination Commissioners have identified the elimination of workplace sexual harassment as a key priority since 1984, Australia trails other countries in preventing and responding to sexual harassment. The Australian Human Rights Commission's (AHRC) Fourth National Survey on Sexual Harassment in Australian Workplaces in 2018 showed that one in three people experienced sexual harassment at work in the past five years.<sup>47</sup> In the past five years, almost two in five women (39%) and just over one in four men (26%) have experienced sexual harassment in the workplace. Aboriginal and Torres Strait Islander people were more likely to have experienced workplace sexual harassment than people who are non-Indigenous (53% and 32% respectively) due to cultural biases and racism.

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**Past surveys of working women have suggested that approximately 50% of women will be harassed at some point during their academic or working lives.<sup>48</sup>**

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The medical research sector can be a fertile environment for harassment, as it has many parallels to academia such as hierarchies and blurred lines between personal and professional lives. The AHRC found prevalence of workplace sexual harassment in the professional, scientific and technical services sector to be 18%; for the education and training sector, prevalence of workplace sexual harassment is 39% (above the national prevalence rate of 33%).

Studies have shown that sexual harassment negatively impacts mental and physical health; targets of harassment report long term depressive symptoms, anger and self-doubt.<sup>49</sup> It not only affects immediate work outcomes (reduced job satisfaction, increased absenteeism and work withdrawal, deteriorating relationships with co-workers), but will likely also influence the target's future employment experience. Research has also shown that reporting sexual harassment can negatively impact career progression.<sup>50</sup>

#### Where we want to be

In recent years there has been a significant national effort to shift to a prevention-based approach to addressing sexual harassment in the workplace.

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**The AHRC led a comprehensive National Inquiry into Sexual Harassment in Australian Workplaces and released their report, *Respect@Work*, in March 2020.<sup>51</sup>**

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The report recommended a new model that improves the coordination, consistency and clarity between the anti-discrimination, employment and work health and safety legislative schemes.<sup>52</sup> In particular, the recommendations from the Report set out a new framework that is focussed on creating a culture of prevention and a network of support for victims in all levels of the organisation.

The Australian Government responded to the AHRC's *Respect@Work* report in April 2021. The response agreed to (in full, in-principle, or in-part) 46 of the 55 recommendations in the Report, with the remaining nine noted for further consideration.<sup>53</sup> In September 2021, the Sex Discrimination and Fair Work (Respect at Work) Amendment Bill 2021 was passed, bringing into law six of the twelve recommendations for specific legislative reform put forward in the *Respect@Work* Report.<sup>54</sup>

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**The Sex Discrimination Commissioner's call for each industry to lead their own response to the *Respect@Work* report was strongly endorsed by the Government,**

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with calls to engage with the recently established *Respect@Work* Council. AAMRI aims to work with its members, the wider medical research community and the Council to develop a sector-led response that would be fit for purpose in the medical research sector.

# VISION

Safe workplaces within the health and medical research sector, where career prospects, health, well-being and relationships are not hampered by experiencing sexual harassment.

## OBJECTIVE

3.1

Develop a sector-based, intersectional and culturally safe approach to address the prevention and response to sexism and sexual harassment.

## ACTION

- 3.1 Develop a sector-based framework, community of practice and practical resources (already in progress);
  - 3.1.1 Action leverages AAMRI's national member base and expertise from WiSP<sup>35</sup>, a grassroots-driven Australian not-for-profit organisation committed to improving workplaces and increasing diversity of leadership in medical research;
- 3.2 Seek leadership commitment from all AAMRI members on addressing sexism and sexual harassment;
- 3.3 Recommend reporting of sexual harassment to the Boards of all AAMRI members;

# PRIORITY AREA 4

## ADDRESSING INEQUITIES IN HEALTH AND MEDICAL RESEARCH DESIGN

### BACKGROUND

#### Where we are now

Gender inequity impacts health through differential exposures, health-related behaviours, and access to care.<sup>66</sup> Gender-biased health research and health-care systems reinforce and reproduce gender inequities, especially along racial and socioeconomic lines, with serious implications for health.

There are some research studies in which reaching gender equity is not applicable, for example when the burden of disease mainly or wholly impacts one sex and/or gender.<sup>67</sup> However, it was estimated that only 39% of trials, on conditions unspecific to sex, included approximately equal numbers of men and women.<sup>68</sup>

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#### **In clinical research, women have been underrepresented for much of the modern medical era,**

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which may explain why women have more frequent and more severe drug reactions compared to men.<sup>69</sup> In preclinical research, single-sex studies with male animals dominate most biological fields, even when the studied disease mainly affects women.<sup>60</sup> Trans and gender diverse people are further excluded from health and medical research due to lack of understanding and awareness.<sup>61</sup>

Combined analyses can obscure the true and sex-specific effects of treatment on men and women, for example, naltrexone.<sup>62</sup> Unfortunately, only a handful of clinical trials report outcomes by sex and fewer formally test for sex or gender effects on safety and efficacy.<sup>63</sup> <sup>64</sup> AAMRI's 2020 survey of its member medical research institutes found that only 23% had a requirement to consider sex and/or gender in study design as part of their research governance and internal funding processes.<sup>65</sup> Lack of awareness of the issue and the high cost of funding sex- and gender-specific research may be barriers to changes in policy.<sup>66</sup>

Cultural backgrounds and normative contexts impact the way in which research is funded, conducted, and applied. Research in areas that specifically affect women and trans and gender diverse people are often vastly underfunded compared to research on conditions that affect men.

The imbalance impacts research advances on diagnosis, treatments, prevention, and risk factors in women and trans and gender diverse people. Unspoken assumptions about associations between gender and disease also create critical gaps in knowledge.<sup>67</sup> These gaps and assumptions are reinforced along racial and socioeconomic lines. Unconscious biases influence how specific test variables or populations are chosen, defined, and measured, thus limiting our ability to understand the health issue and implement appropriate solutions. Thus, in addition to considerations around sex and/or gender, the incorporation of considerations around racial diversity in health and medical research design is critical.

#### Where we want to be

A growing number of countries, including the United States, Canada, Ireland, and Germany, have introduced policies and practices that require the integration of sex and gender analysis in competitive research grants and publications in journals. However, only a minority of Australian institutions such as publishers, funders, and research institutions, have similar policies and practices in place.<sup>68</sup>

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#### **Policy change and guidance from larger organisations may facilitate change within and across organisations and promote a culture and commitment to research which is more representative of and relevant to the Australian population and diverse communities.**

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# VISION

Equity in medical and health research design and practice resulting in improved health outcomes for the community.

## OBJECTIVE

4.1

Champion best practice in policy and process in health and medical research design.

4.2

Advocate for change in research, funding and publication requirements.

## ACTION

- 4.1 Work with members to implement a coordinated, sector-wide strategy to raise awareness of sex and/or gender-biased health research, including:
  - 4.1.1 Considerations for people who identify as trans and gender diverse;
  - 4.1.2 Advocacy for the integration of sex and gender analysis in research for studies in which there are possible sex and gender-related differences;
  - 4.1.3 Usage of appropriate contemporary standards for the reporting of sex and gender;<sup>69</sup>
- 4.2 Explore collaborations with groups working in this area such as the Sex and Gender Sensitive Research Call to Action Group,<sup>70</sup> National Women's Health Research, Translation and Impact Network (WHRTN) and the Australian Clinical Trials Alliance<sup>71</sup> as well as the National Indigenous Research and Knowledges Network (NIRAKN), and The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINAM) to develop frameworks and policies in this area;
- 4.3 Work with health and medical research funders to develop a framework for the integration of race, ethnicity, sex and gender analysis in health and medical research, for appropriate studies;
- 4.4 Encourage Australian-based, peer-reviewed journal editors to:
  - 4.4.1 Develop and monitor the implementation of unified policies to ensure researchers report on how they addressed race, ethnicity, sex and gender in their research, if it is applicable, and challenge submitted manuscripts that do not address this;
  - 4.4.2 Promote uptake of the above into reporting guidelines, for example via the EQUATOR network.<sup>72</sup>


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