Comparing barriers and enablers of women's health leadership in India with East Africa and North America

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Summary

Background Women are estimated to hold between 70 and 75% of global health positions worldwide yet persistent inequities in power and leadership remain. There is little information on specific enablers and barriers that women working in public health face in India and how those compare with other regions.

Methods We collected and analyzed information from women working in public health in India and East Africa (Kenya, Rwanda, and Uganda) and in global health (Canada and United States), to understand and document the specific enablers and barriers women face in India, compared with other regions.

Findings Several universal themes emerged around factors enabling (mentors, professional networks, leadership based in empathy and team building) or impeding (obvert bias and family responsibilities) women across all contexts. Within this, there are nuances in how women's leadership growth factors and obstacles play out in India differently than in other contexts.

Interpretation There are important similarities in the enablers and barriers faced by women in India and other geographies and important ways these differs in for women in India. By designing programs and policies at institutional levels to address these factors, we can create a professional ecosystem that works for women in health and beyond.

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Keywords: Women's leadership; Global health; Public health

Introduction

Women are estimated to hold between 70 and 75% of global health positions worldwide, yet persistent inequities in power and leadership remain. The Global Health 50/50 2022 report found that while the number of women's positions of power on boards of the world's governing health bodies is slowly growing, those positions were primarily held by women from the Global North. Women from low- and middle-income countries held only 1% and 8% of the total board seats, respectively, while women from the Global North held 31%.[1] This follows from their earlier finding that more than 70% of global health leaders were men, 80% were nationals of high-income countries, and 90% were educated in high-income countries.[2] Downs et al. documented the difficulties female global health faculty face when managing leadership and reproductive timelines, the challenges of demanding global travel

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Research in context

Evidence before this study

The authors began research in January 2020 to better understand enablers and barriers to women's global health leadership to inform the WomenLift Health leadership program. This consisted of systematic searches of Google Scholar, Georgetown and Johns Hopkins University library databases to conduct our search. We also did a review of references that these searches yielded. The search terms we used were:

- Women + Health + Leadership
- Women + Health + Leadership + International
- Women + Health + Leadership + Africa
- Women + Health + Leadership + Asia
- Women + Health + Leadership + Measurement
- Women + Health + Leadership + Evaluation
- Women + Global + Health + Leadership
- Women + Global + Health + Leadership + Africa
- Women + Global + Health + Leadership + Asia
- Women + Global + Health + Leadership + Measurement
- Women + Global + Health + Leadership + Evaluation

We also included sources from a similar review conducted with Google search engine to include non-peer reviewed sources. We included articles, blogs and reports published within the last 15 years and while we did not specify that publications had to be in English, we did not find anything specific in our search in other languages. This research revealed relatively little in-depth information in our specific countries of interest in the global health field specifically, or comparative analyses across our regions of interest.

Added value of this study

Our findings build on the knowledge base in several key ways. First, by focusing on the global health field and exploring how gender bias and patriarchal systems affected women's leadership a specific context, we added to an area where there is little qualitative work. Second, by comparing the experiences of the women respondents in India with those of similar women in East Africa and North America we developed a comparative exploration of the nuances of women's experiences in three different regions. Third, by utilizing the specific lens of leadership, we added a wider scope to the current body of research that generally focused on workforce retention, pay equity, and work-family balance.

Implications of all the available evidence

Three programmatic implications for India from our research include the necessity for networks of women leaders in global health in order to foster connections, the need for safe spaces to build female networks, and access to mentors to promote women's leadership. In keeping with findings from other sectors, public health workplaces can promote women's career progression through family leave, flexible hours, and the ability to work from home—which have shown to help women better balance work and family. Workplaces, leadership programs, and supervisors/mentors should focus on building empathy and vision in women leaders.

requirements, and the balance needed to manage family and globally based assignments.[3] A global study, drawn from participants at the 2017 Women Leaders in Global Health conference, found the lack of mentorship, challenges of balancing work and home, gender bias, and lack of assertiveness/confidence were major barriers to women's leadership.[4]

Researcher have documented the global issues women face with the lack of female role models and mentors,[5] sexual harassment,[6] reproductive demands and related discrimination,[7,8] and the conscious and unconscious bias against women in terms of promotions, salary, grant funding, publications, and positions.[9–11] While the overall global situation of women's leadership is worrying, country specific information about the barriers to women's leadership in the health sector in low- and middle-income countries in general, and India specifically, is limited.[12]

Outside the health sector, research in the Indian information technology industry found that individual factors such as self-confidence, ambition, and perceived competency were enablers for women in gaining leadership positions.[13] Budhwar et al. observed that women circa 2005 experienced a number of factors affecting their ability to gain leadership positions, such as cultural deterrence, family/motherhood, women's exclusion from informal male networks, limited opportunities to prove themselves, and a need for more flexibility in the workplace.[14] Another study on women's leadership in India found women faced family pressure to marry rather than pursue a career, had the added burden of caste stereotypes, and experienced an overall lack of networking opportunities.[15] Other researchers found a lack of gender sensitive employer policies and the need for more flexible work locations[8] (which may have improved since the onset of COVID—but no research is published yet). In Africa, women workers reported enduring sexual harassment, a work culture that discourages pregnancy, and encountering difficulty being promoted if they are perceived as outspoken.[6,16]

WomenLift Health,[17] a non-profit organization supported by the Bill and Melinda Gates Foundation (BMGF), undertook a study of mid-career and senior women in the health sector. The geographic scope of this research is focused on the WomenLift Health's programmatic hubs in India, East Africa (for the

purpose of this study limited to Kenya, Rwanda, and Uganda), and North America (United States and Canada). This study builds on ongoing research, including WomenLift Health's Leadership Journey program evaluations, a longitudinal study of women participating in the program cohorts, and a forthcoming global stakeholder analysis.

The purpose of this research is to understand and document the specific enablers and barriers faced by Indian women in public health. Specifically, we sought to understand the leadership qualities women in public health India find most important, how their experience compares with similar women in other regions, and how barriers could be addressed to improve women's ability to attain leadership positions in India. A secondary objective of the research was to understand the nuances between what curriculum would be most appropriate in an Indian women's health leadership program vs. what might be needed in other geographies.

This research, begun in 2021, builds on the current knowledge base in several key areas. By focusing on the global health field and exploring how gender bias and patriarchal systems affect women's leadership in this specific context, we add to an area with limited qualitative research. Likewise, we developed a comparative analysis of the nuances of women's experiences in three different regions, comparing women respondents in India with similar women in East Africa and North America, and thereby contributing to a better understanding of how these variables play out differently in different parts of the world. Additionally, by employing the specific lens of leadership, we added a wider scope to the current body of research—adding a dimension to the current research focused on pay equity, workforce participation, and work-family balance.

Methods

The researchers collected information through 79 individual interviews and 153 surveys of women working in public health in India and East Africa (for the purpose of this study limited to Kenya, Rwanda, and Uganda) and in global health in North America (limited to the United States and Canada). Mid-career women, with approximately 10–20 years of experience, working in public health or global health in the focus countries were targeted for interviews. This demographic is the focus of WomenLift Health's leadership development programs and as such, their experience can best inform our understanding of the facilitators and hinderers along their leadership path and specific training needs for the India, East Africa, and North America cohorts. To compare the survey sample with a broader range of experience, women at all career stages working in public health or global health in the focus countries were targeted for the survey.

Women outside of the focus countries were excluded from both the interview and the survey. Women outside of the mid-career experience level, less than 10 years or greater than 20 years of experience were excluded from the interviews. Additionally, women outside of the public or global health sector were not included. As this study investigated the experiences of women, men were not included in this study.

This combination of interviews and survey data was selected to provide nuanced documentation of the personal experience of women through interviews and to validate the findings with quantitative survey data. The interviews and surveys focused on women's leadership aspirations, the challenges they face, the leadership qualities they value, and the capabilities they would like to grow. Interviews and surveys were conducted concurrently during the period of September 2021 through January 2022.

Survey questions were developed based on the WomenLift Health learning objectives—to understand women's leadership enablers, barriers, views on leadership, and what they would want out of a leadership program. The survey design drew on the both the Center for Creative Leadership's leadership research[18,19] and internal leadership metrics and on WomenLift Health's program evaluation research[20] which involves ongoing data collection and leadership research. Open ended interview questions, informed by this research and aligned with the objectives, were created for the qualitative research. A pilot study for the interview and survey tools, to confirm question validity and time burden for participants, was conducted with a representative sample of women. The survey was distributed and collected through the Qualtrics online platform.

In addition to career status, participants were selected to represent six countries (India, Kenya, Rwanda, Uganda, Canada, and the United States), different types of organizations (government, academic, philanthropic, international and national non-profit, multilateral, private), and underrepresented groups. Participants for the sample were identified through the following approaches:

- Direct outreach to our networks: we reached out to women who we and our wider circle of colleagues knew in the target demographic to ask them to participate or to recommend others.
- LinkedIn searches. We searched for women within our target demographic on LinkedIn and contacted them directly to request interviews.
- Cold outreach to organizations: we identified organizations in the global health landscape and reached out to their points of contact or searched their staff directories for people in our target demographic. We especially targeted organizations and types of organizations that were not well-represented by our networks.
- Snowball sampling[21,22]: To recruit additional women in the public/global health sector, at the conclusion

of the interview women were asked to recommend others that we should speak to. This method was used to expand participants beyond those reached through the network and organization outreach.

These methods were used for both the survey and the interviews. Initially, women who met the inclusion criteria were invited to participate in interviews first, until the interviews reached saturation. In total, we reached out to 286 women, resulting in 79 interviews and 153 survey responses (the response rate was lower than the total of the two numbers suggest; many of the survey responses came from women forwarding the link to their networks directly). Table 1 shows the sample size disaggregated by geography. We reached saturation in the qualitative interviews and saw strong agreement in the quantitative results.

We analyzed the qualitative data through a multi-stage coding process. The lead researcher created a codebook based on a review of interview notes and trained the data analysts. The lead researcher and data analysts then conducted an inter-rater reliability exercise, each coding the same set of notes from three interviews using the codebook and then debriefing to surface any variance in understanding or needed codebook edits. The team then revised the codebook based on this debrief and conducted thematic coding using Atlas.ti.

The team analyzed the survey data in Stata, disaggregating results by geography, sector, and career stage (early, mid, or late) to test for statistically significant differences between groups and to report on frequencies by geography. This paper focuses on similarities and differences found between regions.

Role of the funding source

This research was funded by WomenLift Health, which is funded by the Bill and Melinda Gates Foundation. Representatives from WomenLift Health, listed as authors, participated in the conceptualization of the research to define objectives and core questions, provided commentary and revision to improve the manuscript, and supervised the progress of the research.

Results

While contexts do influence leadership, the findings identified several universal themes in enabling or impeding women's leadership in health. Women in all geographies identified the universal enablers of female mentors, professional networks, and leadership based on empathy and team building. Likewise, the overt and implicit biases in patriarchal culture emerged as universal barriers across all regions. Within the wider universal categories, there are nuances in how women's leadership growth and obstacles play out in India differently compared to other contexts.

Region	Key informant interviews	Survey
India	23	46
East Africa	31	64
North America	25	43
Total	79	153

Table 1: Sample size.

Mentors

Women most frequently cited informal mentors as a key enabler in their career growth and often described themselves "lucky" to have had a good mentor. In India, respondents described how specifically having female mentors was especially important to them, noting that women supervisors have more empathy with their life experiences which enabled a deeper connection, bridging the personal and the professional. One respondent summarized,

> *"Having a mentor is really helpful. Frankly, having a female supervisor is more helpful than a male supervisor because they've gone through similar situations. Personal life is something that we women are going through constantly, whether it's getting married, children, taking time off because you're menstruating. I had a male supervisor once, he was fine, but my female supervisors took that level of empathy to another level. . .. Having a mentor who can advise you in a personal life as well is the biggest blessing."*

Women described their mentors as not just giving them advice, but also pushing them forward and making space for them to thrive. They contrasted this with the patriarchal, hierarchical system in which they worked. One woman explained,

> *"My previous manager would make an effort to make space for me. She would never position me under her, as a junior person—she would credit me in public, say I'm leading something even if that's not 100% true, a public declaration that she trusts this person, so others view me more positively and then it's up to me to prove her right. When it comes to government engagement, I've seen where the boss cuts you out of the conversation."*

Women in East Africa and North America also highlighted how critical mentors were to their professional growth. Similar to women in India, women in East Africa saw female mentors as important, senior people who shared their experiences and could relate to them. *"There were women leaders—mostly doctors—you would feel comfortable because they were all women. And you could look up to them. They understand when your child is sick, and they are flexible. Having women leaders, you can relate to them and talk on the same wavelength."*

In North America, in contrast, respondents mentioned male and female mentors in similar proportions. While women in India and East Africa almost always mentioned supervisors or other senior leaders as their mentors, women in North America also talked about informal mentorship from peers as well. One said, *"I love mentorship even if it's not formal. Especially women who are open and willing to share—where they're open to sharing resources, learning, etc., vested interest in you succeeding."*

The survey asked about barriers to women's leadership in public or global health. Despite women in all regions emphasizing the importance of mentors, nearly a third (32%) of women in East Africa said that a lack of female mentors or role models was one of their top three barriers at work, as illustrated in Fig. 1a. A fifth (20.5%) of respondents from India also reported this as one of their top three barriers. It was uncommon for respondents from North America (8.3%) to name this as a barrier, suggesting that lack of female role models or mentors was more salient in low- and middle-income countries.

Professional networks

Women in India frequently identified their professional networks as an enabler to their career growth. They described networking as part of their official job descriptions, at conferences and events, and for professional or organizational development. Though their networks had value in linking them to job opportunities and technical knowledge, women most commonly described the value of their networks in terms of their connections with communities of other women:

> *"One of the important things is to have a community. The one thing that would stand out for me—to have that space to share and learn from each other. There are skills that you can do a course on, but there are others that you need to hear and learn from others. Also having that safe space is really important for talking about workplace challenges with people who will listen to you and identify with you."*

In contrast, women in North America—while they did also mention peer support networks—emphasized the role of their professional networks in seeking new opportunities. They gave examples of building networks through their jobs and using these networks to expand their opportunities and build technical knowledge.

Women in East Africa rarely mentioned their peer networks. Instead, as described above, they placed the most value on having a more senior mentor or sponsor to whom they could turn.

Leadership qualities

In all three regions, women most commonly named empathy as a top leadership quality. They described the importance of leaders demonstrating care for their teams through listening and acknowledging the pressures that arise in life outside of work. A woman in India noted,

> *"Empathy is something that's not valued, but it is essential, especially in these last two years [during the COVID-19 pandemic]. You don't have to do much besides acknowledging people are going through a hardship. It's not traditionally seen as a very masculine trait. It's seen as something that makes you seem vulnerable and therefore weak. It doesn't align with the typical hypermasculine view of leadership."*

As this comment exemplifies, while women saw empathy as critical to high quality leadership, they also saw it as being associated with traditionally feminine qualities, and, therefore, undervalued. Women discussed the importance of empathy in very similar terms across all three geographies.

In a similar vein, across all three geographies women commonly described strong leaders as those who promote their team's professional growth. Many shared

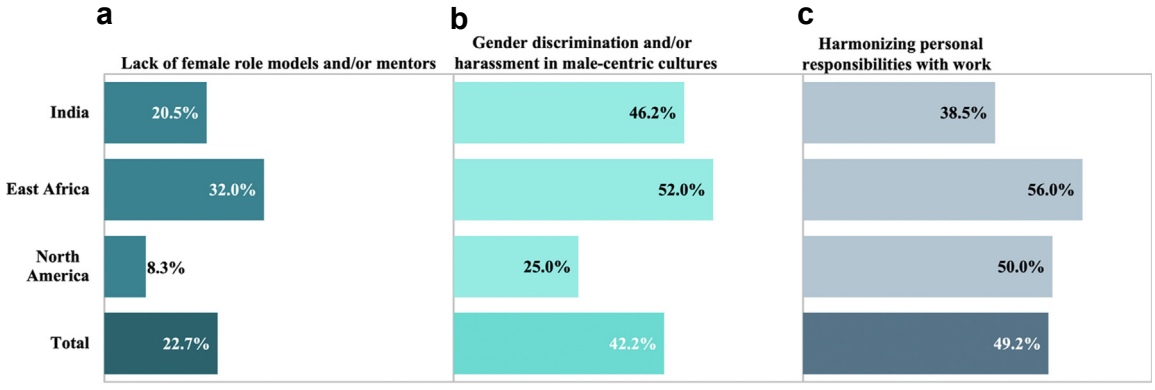

Fig. 1: **Top three barriers to work for women in public or global health in India, East Africa, and North America.**

examples of leaders/mentors who helped them develop by building on their strengths, developing areas of weakness, and providing opportunities that helped them stretch or gain exposure in their field. One woman in India explained how her manager helped her to grow:

> *"Your manager plays a big role from the perspective of having your back . . . [and] identifying where you need support. I had a great manager . . . she consciously thought about my growth. I wouldn't have had the opportunities I had without this. I was shy, self-conscious, introverted. It doesn't come to me to put myself out there and that has changed with my manager."*

Promoting the team's professional growth, while described in a way distinct from empathy and emotional intelligence, stems from a similar focus on the team rather than the individual, a promotion of others rather than the self. In both instances, women placed a premium on leaders who genuinely cared about them and their teams.

The final most common leadership quality women in India described was the importance of having a clear vision. Several respondents shared anecdotes of leaders they worked with who were able to see the big picture, effectively communicate it to others, and be unflappable in its pursuit. For example, one woman said,

> *"They didn't care about what others thought. They knew what they wanted, and they knew that so clearly that others' opinions couldn't shake it. They had a vision. They were willing to overcome the challenges . . . they decided the priority, and nothing could stop them. They were confident even alone. They had the ability to influence a whole group of people [who could] support them. They had the power to make a lot of people see their ways."*

While this was a theme amongst interviewees in India, it did not commonly come up in the same way in North America or East Africa. In North America, women discussed the importance of self-awareness and understanding in the context of humility—knowing one's strengths and weaknesses. One woman in North America explained,

> *"Strength and humility, paired together to be effective. Strength is needed to imbue confidence, to lead clearly and decisively. But this needs to be tempered with humility and the awareness that you don't know what you don't know. Humility is a treatment of other humans kindly. Humble leaders can milk their employees in a way that authoritative leaders can't. You bring them beside you, working towards a common vision."*

Patriarchal culture

Women in India frequently described facing casual, routine sexism in their jobs, 46.2% selected this as a top barrier in the survey (Fig. 1b). Frequently, women gave examples that emphasized not having their voices valued compared to their male colleagues. One woman described her experience of not being able to express her opinion:

> *"Senior women get clubbed down. They're not allowed to fly. A much more junior male would be brought in with me to see what his views are. It happened quite often, a man put there and told to provide his views where woman is clubbed with someone else."*

Women in India also linked these biases to ageism. Being a woman meant one's opinion was devalued, but being a young woman was a double hurdle, especially in government:

> *"I also felt I was [the] youngest in the room and wouldn't be taken seriously. . .. It's a bigger challenge for us to be taken seriously in this [government] space. I do think it is changing and working with a private NGO is much better . . . Leadership in government is structured like that."*

Respondents attributed this to a combination of systemic patriarchy—senior positions are occupied by older men who, explicitly or implicitly, do not see women's opinions as valuable, and these same men are much more willing to sponsor and promote more junior men who are part of a "male-bonding group."

In East Africa, approximately half of women in the survey also saw gender discrimination as one of their top three barriers at work. In interviews, they often made some version of the observation, "Men do not like taking orders from women." Women in management or technical leadership positions described how their male team members, both peers and those more junior, said that they struggled with resistance to anything they proposed at work because men did not want to (or did not want to be seen) following a woman's direction. Instead, they resorted to communicating individually with each male prior to group meetings to build buy-in and make the men feel respected. As a corollary, women often mentioned being asked to get tea, take notes, or lead prayers when in key meetings with their peers.

In North America, women described implicit rather than explicit bias, and only a quarter chose it as one of their top three barriers at work. They connected gender bias to racial and other kinds of discrimination, talking about how, although on the surface their work environments seem equitable, they still note a lack of women and people of color in top leadership positions in their organizations. They felt like women "have to work 2–3 times harder" to be given the same opportunities as their male colleagues. Women also drew the line at the need for an "intentional decision" to hire women and "make the business case for diversity" in order to truly see change at the highest levels.

Family responsibilities

In the survey, 38.9% of women in India identified harmonizing personal responsibilities with work as one of their top three professional barriers, Interviews respondents highlighted this as family obligations that made it harder to prioritize work. Women in India noted that because they are expected to be the primary caretakers for their families, this divides their attention:

> *"The burden of caregiving and childcare and making sure the home functions smoothly is disproportionally on women. Women who are working full time and are ambitious but have this additional burden of fulfilling these expectations or this guilt at the back of their mind."*

In India, women also described the pressure to get married and have children, and the disruptive effect of this pressure on careers. This included needing to move for a husband's job, not being able to move their families for an opportunity they had, and not taking jobs because of children:

> *"I've been a working mother and raising a son. . .. The biological clock of a woman is really funny. Once we are past post-grad, our parents say, "Get married." I'm from a Muslim family. When we get married, now [the] next thing is the child. The transitions—I got a good job on a [multilateral agency] project, but I couldn't accept it because I was in an advanced stage of pregnancy. I had wanted to join that agency for a long time, but I couldn't. We want to advance our careers at the same time as there's pressure all around us to have children."*

Family responsibilities was the most frequently chosen professional barrier in East Africa (56%) and North America (50%), Fig. 1c. Similar to women in India, women in East Africa and North America saw family responsibilities as something they had to "juggle" with work, rather than giving their careers their undivided attention. In all three regions, family responsibilities made traveling for work—a common expectation—more challenging.

In North America, some women framed marriage as a decision between focusing on their careers or deciding to have a family:

> *"I'm at the age where I have to decide if I want a family and those personal aspirations or do I commit all in with work. I'm pretty sure if I go all in, I could get there really quickly; I'd have more flexibility. I'm interested in the fragile areas, but if you go all in, you won't have a personal life since you have to work all hours."*

Discussion

The study data demonstrated similarities between India and other geographies in important ways: the importance of mentors and professional networks to women's professional growth, the overt bias women must confront in the workplace, and the effect of women's family responsibilities on career focus. Women across all three geographies also emphasized the importance of leadership based on empathy and team building.

Amidst these similarities, there are nuances in how women's leadership growth and obstacles play out differently in India compared to other contexts. The overt bias that Indian women face in the workplace—in contrast to the implicit bias that women in North America reported—underlies many of our other findings. When women work in overtly patriarchal institutions, it likely becomes more important that women seek support and understanding through specifically female mentors. They emphasize the role of their peer support networks in giving them not only professional opportunities, but also in creating a safe space to discuss and connect with other women. In a context of overt bias, it also makes sense that women perceive a need to advocate for themselves so that their colleagues will make space for them, and a need to demonstrate their strength and professional qualities to garner buy-in to a vision.

Several issues were particularly acute in India. One was the pressure on women to get married early in their careers, which was not a theme in East Africa or North America. Studies of women information technology professionals in India, who are similar to our target demographic (e.g., highly educated, high-pressure careers, and odd working hours), also found that family strongly influences women's career and marriage choices, and that women struggle to balance work and family responsibilities.[21] Other research found that among highly educated women in India, workforce participation is lower than expected due to family influence and social norms.[22]

The intersection of ageism and sexism was also shown to be more prominent in India than other geographies—being both young and female exacerbated women's experience of not being taken seriously at work. While ageism was frequently noted among our respondents, most of the existing literature focused on discrimination against older women rather than workplace discrimination against younger women. The data from our research contribute towards better understanding and awareness in this area.

Three programmatic implications for India from our research include the necessity of networks of women leaders in global health to foster crucial connections, the need for safe spaces to build female networks,[23] and the access to mentors to promote women's leadership.[24] In keeping with findings from other sectors, public health workplaces can promote women's career progression through family leave, flexible hours, and the ability to work from home—which have been shown to help

women better balance work and family.[25,26] Workplaces, leadership programs, and supervisors/mentors should focus on building empathy and vision in women leaders.

Our findings, consistent with existing literature, build on the knowledge base in several key ways. First, by focusing on the global health field and exploring how gender bias and patriarchal systems affected women's leadership in a specific context, we added to an area where there is little qualitative work. Second, by comparing the experiences of the women respondents in India with those of similar women in East Africa and North America, we developed a comparative exploration of the nuances of women's experiences in three different regions. Third, by utilizing the specific lens of leadership, we added a wider scope to the current body of research that generally focused on workforce retention, pay equity, and work-family balance.

Overall, the study shows that while context matters, many of the barriers women face are also universal in nature. By looking globally at women's leadership in this comparative context, we can identify ways in which we can design future programs and policies at the institutional level to lift women's voices, talents, and vision in order to create a professional ecosystem that works for them and takes into account their specific needs.

Contributors

S.S.: Conceptualization, writing-review and editing and supervision. J.L.: Methodology, formal analysis, investigation, writing-original draft and project administration. S.B.: Conceptualization. K.B.: Methodology, writing-original draft and supervision. G.P.: Formal analysis and investigation. C.R.: Writing-review and editing and visualization. N.O.: Conceptualization. A.B.: Conceptualization.

Data sharing statement

Quantitative individual participant data from the survey will be available, after de-identification, to researchers who provide a methodologically sound proposal. Proposals should be directed to the corresponding author at jade.lamb@bixal.com.

Declaration of interests

WomenLift Health, which is funded by the Bill and Melinda Gates Foundation, commissioned Bixal to conduct this research. G.P. is an independent consultant and was subcontracted by Bixal for this research project.

None of the authors have competing interests.

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