Exploring the Opportunities and Challenges of Female Health Leaders in Three Regional States of Ethiopia: A Phenomenological Study

Sualiha Abdulkader Muktar
JSI Research & Training Institute, Inc. in Ethiopia
Binyam Fekadu Desta
JSI Research & Training Institute, Inc. in Ethiopia
Heran Demissie
JSI Research & Training Institute, Inc. in Ethiopia
Wubishet Kebede Heyi
JSI Research & Training Institute, Inc. in Ethiopia
Elias Mamo Gurmamo
JSI Research & Training Institute, Inc. in Ethiopia
Melkamu Getu Abebe
JSI Research & Training Institute, Inc. in Ethiopia
Mestawot Getachew Mesele
JSI Research & Training Institute, Inc. in Ethiopia
Mesele Damte Argaw (mdamte5@gmail.com)
JSI Research & Training Institute, Inc. in Ethiopia

Research Article

Keywords: gender, leadership, female leaders in health, opportunities and challenges, phenomenological study, Ethiopia

Posted Date: October 6th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-910350/v1

Abstract

Background: Gender equity involves fairness in all aspects of life for women and men and is usually determined by social, political, economic, and cultural contexts. The proportion of female leaders in healthcare within the health sector is low. The aim of this study was to explore and describe the experiences, opportunities, and challenges faced by women in their path towards becoming leaders within the health sector.

Methods: This study was conducted using the phenomenological method of qualitative inquiry. A purposive sampling technique was used to identify six women leaders. Semi-structured interviews were conducted through telephone by the investigators. The qualitative data analysis was conducted parallel with data collection using steps of thematic analysis.

Results: This study identified individual, societal, and organizational level opportunities and challenges that had an influence on the career paths of female health leaders in Ethiopia. The leadership positions were an opportunity in the career development of women who had long-term goals, were known for their empathy, and exercised wise use of resources. In addition, women who had the support of close family members and their peers are more likely to compete and rise to leadership positions. Furthermore, women who received organizational support in the form of affirmative action, training, development, and recognition also tended to rise to leadership positions. However, women who assumed leadership positions but whose day-to-day decision-making was influenced by their supervisors, those who had experienced sexual harassment, and those under the influence of societal norms were less likely to attain leadership positions.

Conclusion: This study explored the opportunities and challenges of women leaders in the health sector in a low-income country. The findings highlight individual, social, organizational, and societal factors influencing the career development of women leaders. Therefore, enhancing the leadership capacity of women, and improving social and organizational support is recommended. In addition, addressing the low level of self-image among women and patriarchal societal norms at the community level is recommended.

Background

Leadership and governance (stewardship) is one of the critical elements of conceptual framework of the World Health Organization (WHO) proposed to strengthen the health systems [1][2]. The skills and competenecies of leadership and governance improve the effectiveness and efficiencies of remaining five components including service delivery; health workforce; health information; medical products, vaccines and technologies, and financing [1]. Globally, slightly lower than three fourth of the health and social sector workforce are assumed by women [3]. However, the number of women in healthcare leadership and management positions is disproportionally low [4].

Gender equity involves fairness in all aspects of life for women and men and is usually determined by social, political, economic, and cultural contexts [5]. Despite gender equity showing improvements in recent years, several reasons are cited for the low proportion of women leaders in the health sector. Some studies confer that the societal norms in favor of men are deep-rooted in the community and influence women's self-image and aspirations from childhood to adulthood [6][7]. In addition, this unfavorable environment has become a challenge to women's career development and is demonstrated by fewer representations of women in senior professional and leadership positions. Although many countries acknowledge that the existence of gender norms in leadership positions favor men rather than women, there is little evidence of efforts and investments being applied to change the situation [8]-[10].

USAID funds the six-year (2017 – 2022) USAID Transform: Primary Health Care project, implemented by a consortium of international and local development partners led by Pathfinder International along with JSI Research & Training Institute, Inc., (JSI), Abt Associates Inc., Malaria Consortium, EnCompass, and Ethiopian Midwives Association. The project began by providing technical support to contribute to the prevention of maternal, neonatal and child deaths in 300 *woredas* (districts) in Ethiopia which has been expanded to 434 districts located in Amhara, Oromia, Sidama, Southern, Nation, Nationalities and Peoples', and Tigray regions during the fifth year of the project's implementation period [11].

Since 2017, the project has extended leadership, management, and governance (LMG) capacity enhancement to primary healthcare workers using a mixed cohort approach and a combination of male and female participants by offering an equal opportunity for participation through predefined invitation criteria for both sexes. However, after two years of implementation of the LMG intervention, the actual number of women participants was found as only one-sixth (15%; 402/2682) of participants [12]. Hence, the project prepared and conducted a women only LMG trainings cohorts. However, the opinion and experiences of women health leaders was nor explored. Therefore, this study aims to explore and describe the experiences, opportunities, and challenges faced by women in their path towards becoming leaders within the health sector in three regional states of Ethiopia.

Materials And Methods

Study design

For this study, the phenomenological method of qualitative inquiry was used [13]. This approach was chosen for its merits to narratively explore and describe the lived stories and shared experiences of women leaders in healthcare during the data collection procedure [13]. The individual, social, societal, and organizational level factors affecting a woman on the path towards becoming a leader in health can be delved into through the use of the phenomenological inquiry [13]. The data were collected from March – July 2021.

Study setting

The USAID Transform: Primary Health Care project provides LMG training and interventions in five regional states of Ethiopia, namely: Amhara, Oromia, Sidama, SNNP and Tigray. During the last four years of the project's implementation period (2017 - 2020), a total of 2,682 health workers, recruited from 644 primary healthcare entities were capacitated on LMG competencies. Of the trained health workers, 15% were women leaders in health, managers, or staff from primary healthcare units. In addition, three 'only women' LMG cohorts were formed and 78 female health workers were trained in Amhara, Oromia, and SNNP regions. Within the cohorts of LMG trained health workers, 18 were promoted to senior leadership positions within the primary healthcare system [12].

Intervetnion

In 2019, a 'women-only' leadership and governance training and coaching program was conceptualized and administered for 78 participants (23 in Amhara, 24 in Oromia, and 31 in SNNP regions). The national was used, projects were designed, and coachings were conducted.Using the nationally endorsed LMG standard guideline, trainees were given a six-day block course, practically exercises the desired competencies and skills on six to nine month long leadership projects, coaching sessions conducted using a tool call observe, sk, listen, feedback, and agree (OALFA)technique every 30 to 45 days, and continuous phone follow up and/or support through zone level technical assistants of the project [12].

Population and sampling

The target population for this study was health leaders that are women, working at primary healthcare entities. A purposive sampling technique was employed to identify the targeted participants, with a pre-defined criterion that selected women healthcare leaders that are working within the various primary health system levels in three regional states of Ethiopia. Participants of this study were identified through consultation between field staff of the USAID Transform: Primary Health Care project, trainers, and certified coaches within the study areas.

Data collection

Data were collected using the iterative process of in-depth individual interviews. In-depth interview guides were developed in the English language and then translated into Amharic and Afan Oromo languages. To maintain the consistency of the tools it was translated back to English by the investigators. The interviews were conducted using local official languages of the study area, i.e. Amharic and Afan Oromo,. Semi-structured telephone interviews were conducted by the female investigators which also captured the participants' socio-demographic information [5]. The two main question were: '(1) what have you experienced as a woman on your path towards health leadership?', and '(2) what contexts or situations have typically influenced or affected your experiences as a woman in a leadership position?'. These questions were helpful to explore the phenomenon and experiences of women in the contexts of assuming leadership positions. Probing questions were applied and were used to uncover the individual, household, organizational, economic, and political opportunities and challenges faced by women leaders in healthcare (additional file1). On average, each in-depth interview lasted about 60 minutes. Digital

recorders and handwritten notes were used to capture the information gathered from the in-depth interviews. The data collection process was concluded after reaching a redundancy of information.

Data analysis

The data analysis was conducted using the convergent parallel approach to data collection [14]. The audio recorded data were transcribed verbatim on the same day by the investigators and were reappraised with the interviewees for accuracy. The transcripts were then translated from local languages into English by the interviewers. Four independent investigators read and re-read each transcript and became familiar with the data. A woman's unique experience in the journey towards achieving a leadership position in health was identified and the investigators looked for common themes across stories. Quotes were extracted and collected under identified codes. The investigators held consensus discussions on the codes and examined the meaning of equal values. Once the codes were defined, the data analysis was continued until all themes and categories were identified. Since this study follows a phenomenological inquiry, the research participants were engaged at all stages of the research activities. Hence, participants reviewed transcripts, provided their comments on the preliminary findings, codes, categories, themes, and approved highlighted quotations and descriptions [15].

Inclusion criteria

- LMG trained female leaders in health that consented to participate in this study and,
- are familiar with the different components of the primary healthcare system.

Measures to ensure trustworthiness

This study was led by LMG experts with experiences in qualitative inquiry. The data collection guides were piloted. The lived stories, shared experiences, and perceptions of the female leaders in healthcare were narratively collected. The trustworthiness of this study was ensured through maintaining four criteria, namely: credibility, transferability, dependability, and confirmability [16]. The credibility of this study was maintained through the prolonged engagement of investigators, and reviewing of transcripts by respondents during the data collection process, analysis, and interpretation. The transferability of this study was ensured through the dense description of the research methods, particular phenomena, and the contexts of this research activity [15]. The dependability of this study was maintained through an in-depth description of the steps employed for the adopted research method. Finally, the confirmability of this research's findings were ensured through the active participation of respondents in the processes of data collection, analysis, and interpretation [17].

Ethical considerations

This study protocol was carried out in accordance with the Declaration of Helsinki and ethical clearance was obtained from John Snow Inc institution review board (IRB) with certificate ref no IRB #21-06E. Before starting data collection, permission and support letters were collected from regional state health

bureaus. After providing a brief orientation on the purpose of the study, an informed written consent was obtained from each participant. All participants were adults (greater or equal to 18 years) and had the right to discontinue or refuse to participate in the study at any time. Data collectors were trained on ethical principles and methods of acquiring data. Privacy, anonymity, and confidentiality was maintained throughout the data collection, analysis and report writing activities.

Operational definitions

Woman:

According to the Oxford dictionary, woman means an adult female human being and a female person associated with a particular place, activity, or occupation.

Leadership, management, and governance training:

Leadership, management, and governance (LMG) training is a result-oriented, participatory leadership development process that enables teams to address their self-identified challenges and move towards results through developed action plans and experiential learning [18]. In this study, LMG means a structured process in which LMG core teams recruited from primary healthcare facilities learn and apply leading, managing, and governing practices to address the main challenges they face in their health units while receiving feedback and support from facilitators. Together the team members create a shared vision, select their desired results, and decide how they will work to achieve the results [18].

Women only' LMG:

In this study 'women only' LMG means standard LMG trainings provided to female participants recruited from different primary healthcare units and that are supported through intensive coaching sessions, telephone follow up, and project development and applications.

Training:

The Oxford dictionary defines training as practical education in any profession, art, or craft. Similarly, Armstrong (2009) defines training as the use of systematic and planned instruction activities to promote learning [19]. Training is a key business process used to increase the skills and knowledge of employees to improve overall performance.

Results

Participant characteristics

This qualitative phenomenological study was conducted through in-depth telephone interviews with six female leaders in health in three regional states of Ethiopia. The educational background of all

participants were linked to bachelors of sciences in health studies. The average overall services tenured by the participates was nine years. However, the participants had been in leadership positions for about two years (table 1).

The qualitative data analysis revealed four themes and thirteen categories (Table 2).

Theme 1: Individual behavior

This theme emerged from four categories of the data analysis results. The participants of this study described individual behaviors such as being a visionary person, an empathetic listener and honest, and applying wise use of limited resources as making a woman an ideal candidate for a leadership position within primary health facilities. In addition, the participants described the importance of having experience in leadership for achieving better results in work-family life.

Category 1.1: Visionary

The research participants explained that a leader with a clear vision has the potential to achieve better results and they tend to self-initiate their rise to leadership positions in their organization. The following extract which is verbatim, illustrates the commitment of one visionary woman on her path towards a leadership position in health.

I want to be successful in my educational career and business too. It is my dream to be a successful healthcare leader. I am sure one day I will serve as a role model for young girls in my vicinity. Participant #1

Another female health leader expresses her vision to lead beyond her organization by saying:

I am a strong woman and the best health leader among all primary healthcare unit directors in the [name] zone. I believe in myself and I am capable of leading beyond the primary healthcare unit level . Participant #4

Category 1.2: Empathy and honesty

Participants of this study stated that female leaders in health spent a lot more time on listening to their staff than men. This behavior is an opportunity for women to progress in their path towards leadership and management positions. The participants also described their efforts towards building a culture of honesty in the Ethiopian health system. Participant #1 and participant #3 explainid:

As a female leader, I used to listen my subordinates and try to solve their problems. In addition, I was known by staff for being transparent and an effective communicator in the health center. Participant #1

I am faithful and honest with my staff and organization. I am sure that there is no corruption in the health center. Therefore, I am among a few effective health leaders. That is why I survived holding the leadership position even in difficult times. Participant #3

Category 1.3: Wise use of resources

Participants perceived that women are known for their wise use of health facility resources. This behavior made women the preferred health system leaders. Participant #5 and #6 described how their behavior in this regard assisted them to rise to leadership positions.

…. women are known for preventing malpractices and corruption in the management of health facilities and for encouraging subordinates to perform well in accordance with health system standards. Participant #6

Almost all women have experience in managing and leading their households. A woman can easily identify the needs of her child and can properly address it in the best way.. … having such household management practices and experiences capacitate women leaders to use available resources efficiently in health facilities too. Participant #5

Category 1.4: Leadership experience

In this study, participants stated that women who had experiences on leadership skills, were more likely to volunteer to hold leadership positions in their organizations. Three participants illustrate their shared experiences on leadership.

I was inspired by the leadership skills of my grandmother. When she faced a challenge, she considered it as part of life. I took a lot from her problem-solving skills. Participant #1

When I was a college student, I was serving as a student council president and facing many challenges because of my courage to correct malpractices observed inside the college compound. I believe this experience built my leadership capacity and became a springboard for engaging in higher level roles and responsibilities. Participant #3

I was a health extension worker supervisor, students' representative at university and undertook leadership training; all of which have enriched my experiences. I am a strong woman by nature. Growing up in a rural area with a lot of problems helped me become resilient and cope with challenges easily. By using my experience I manage my day-to-day activities very well and my health center's performance is very good. Participant #4

However, there were challenges which influenced the women's ascension to leadership positions at primary health care entities in Ethiopia. In this study, participants described their lived stories of delegation of leadership positions combined with micromanagement by supervisors. In addition, experiences of workplace sexual harassment was expressed as a challenge for the women in their rise to leadership positions. A woman leader describes this challenges as follows:

Previously, officials used to give authority to female leaders but would be deeply involved in the execusion of their responsibilities. Because I was having these discouraging experiences, I would often

avoid putting myself up for leadership positions. Participants #2

I know cases of sexual harassment that occurred among female leaders. It not only affects their work, but can also impact their private family life. I have missed few opportunities because I was afraid of going through similar ordeals. Participants #2

Theme 2:- Social support

Participants frequently described the positive effects of support from spouses, grandparents, and colleagues in their paths towards leadership positions. The theme social support was identified from close family and peer support categories.

Category 2.1: Close family support

Almost all participants of this study mentioned that women who had received support from their spouse and close family members continue to advanceme in leadership positions. Participant #4 and #6 describe the support of close family members a follows:

My mother encourages and supports me by taking care of my children. This enables me to fully focus on my office work. Participant #4

My husband encourages and supports me in my leadership career development. I had discussed the leadership opportunity at my organization with my spouse and got his input before I decided to compete for the position. Participant #6

Similarly, some participants of this study frequently stated that women who had the burden of household chores and who do not have support of close family members would avoid assuming leadership positions. A female leader recalls her experience of avoiding leadership positions due to lack of family support by saying:

After I had two children, my mother and my mother-in-law advised me to leave my job and concentrate on household chores. I was responsible to taking care of my children, cooking meals, and feeding them, washing clothes, and managing all other aspects of family life. …. For a woman like me, leaving children with their father or other family members for a long periods of time was not possible and therefore, I declined to take opportunities. Participant #5

Category 2.2.: Peer support

In this study, participants linked their preparedness for leadership roles to the support they received from their supervisors which were expressed as trainings, mentorship, coaching, and feedback. Participants # 3 and #5 expressed their peer support positive experiences as follow:

Since I am known for my commitment, courage, confidence, and being fearless about public speaking, my supervisor has great trust in me handling and managing things in his absence. Participant #3

…. when I was a family health department coordinator, [a colleague] supported me to build my confidence in handling more than my current responsibilities. Before I assumed my current post, I discussed it with my best friend and it is because of her encouragement that I took on the leadership position. Participant #5

Participants attributed lack of peer support as the main reason for women avoiding leadership positions. Participant #1 explains that lack of peer support negatively influenced her career development decisions saying:

My colleagues laughed at my decision to assume a leadership position while having children who need my full-time care, and they discouraged me to continue my career development. Participant #1

Another woman leader expresses her decision to decline a leadership position due to lack of support from her supervisors:

My supervisor was not understanding. When I would request permission to seek medical care for my child, he refused to give me permission. Because of the lack of support from my supervisor, I decided to decline a leadership position. Participant #5

Theme 3:- Organizational support

Leadership development is a process of capacitating health workforces by adhering to principles and guidelines of an organization. The theme organizational support emerged from four categories, namely: principles and guidelines, training and mentoring, succession planning, and development partners' support.

Category 3.1: Affirmative action

All participants identified and explained the importance of adherence to principles and guidelines in increasing female leaders in health organizations. Clear principles and guidelines from health leaders solve complaints from staff and simplify future activities. Participants #1 and #5 illustrates the importance of adherence with guidelines as follow:

The human resources manager follows pre-defined guidelines in the processes of selecting the best candidates for advertised posts. Though some candidates raised issues of fairness on the selection processes, the core process owner was able to check for consistency and reliability on the points given to each participant.. Participant #1

The affirmative action taken by the government is an important action to increase women leaders. Participant #5

Category 3.2: Training and mentoring

In this study all participants attested to feeling more capable following the leadership training and mentoring sessions. The following three participats stated the benefit of the leadership training incapacitating women health leadersby saying:

The leadership training in which I took part benefited me a lot. It helped me prepare myself to cope with any challenges I faced. Furthermore, while I was implementing my project, the coaching sessions helped me adapt some revisions that had been made on leadership, management and governance practices, experience sharing and developing do-able actions. Participant #1

....the leadership training enhanced my presentation and communication skills and facilitated my promotion to a leadership position. Participant #5

Arranging continuous training and development activities on leadership, facilitate the experience sharing events or shadowing of junior staff with experienced once and sharing the stories of successful women leaders could help us to develop the capacity and capabilities as we are among the next generation health care leaders. Participant #1

Category 3.3: Succession planning

In this study, participants explained that women who were identified as future leaders by their immediate supervisors and got prepared to face new challenges before assuming leadership positions were successful in their career development. Participants #1 and #5 describe the benefits of engaging and preparing women for leadership positions in advance, as follows:

Women are busy both in the household and with work related activities. We are not always eager to take on additional responsibilities in the workplace. But with proper succession planning, one can be familiar with the principles, guidelines, and workload of a role and be adequately prepared to be a future leader in the health system. Participant #1

In my current organization, my immediate supervisor encourages me to build my confidence and courage, and practice my leadership and management skills. He always delegates me when he has other commitments outside. This has a huge impact on my self improvement and in helping others achieve better results. I am also really motivated to work towards leadership when my supervisor delegates me, and the support from my colleagues (especially women) helps me recognize my shortcomings and enables me to work on them. Participant #3

Category 3.4: Recognition

To encourage more women to assume leadership positions, the health system should recognize and motivate the role models in the health system. In this study, participant #2 and #4 explain the importance of exercising recognition for best performing women in increasing leaders.

Recognizing current leaders will encourage more women to take on senior leadership positions. I was encouraged and motivated by a model female leader in my zone's health department. Participant #4

……to attractwomen to leadership positions, there should incentives and recognition like offering continuous education... Participant #2

Category 3.5: Development partners' support

All participants stated that their leadership capacity, competencies, and capabilities were enhanced with the support of development partners. The verbatims of participant #1and #6 shows the role of development partners on women leadership development,

I thank [name] for their support. I took leadership training which prepared me for my day-to-day activities in leadership. Participant #6

As a result of the leadership training of [name], I now understand the importance of moving from a gender neutral environment to a gender transformation one in any organization. This motivates me to face gender inequalities in access to power and opportunities. Participant #1

Theme 4.: Gender stereotype

Gender stereotypes are the generalized views of the community about the roles played by men and women and can affect how women assume leadership positions. Gender stereotyping was identified from two categories i.e. status quos (norms) and self-image.

Category 4.1: Status quos and norms

All six participants stated societal norms hinder women from assuming leadership positions. The following are verbatims from participants #1, #3, and #6 which summarize the opinions of the rest of the respondents.

In my district, the social norms favor men and there is limited support for women to progress in their career development. Women are expected to manage all household matters and are perceived as weak in leading organizations. Participant #1

As a felame leader, I have not been particularly affected by the problem, but the community gives priority to male leaders. There is a preconception in the community that the leadership skill of a woman is lower than that of a man in nature, and even those who are empowered to lead an organization are seen as exhibiting male traits. Participants #4

…community members including trained professionals think of women as too weak to lead complex organizations. The workload of a leadership position, a busy home life, and the expectation of staff can sometimes create frustration …. Participant #6

Category 4.2: Self image

In this study, four out of six participants explain that lack of self-image and confidence are among reasons for women being hindered in their leadership career development. Participants #4 and #5 state that lack of confidence and self-image are barriers to assuming leadership positions.

[Women] lack confidence in our leadership capacity. We think that we cannot overcome the work-life/home burden and avoid taking on leadership positions. Participants #4

… I consider myself as weak and someone who cannot handle a lot of responsibilities…this is why I declined leadership positions three to four times - because of the fear of failure. Participants #5

Discussion

Many studies have documented the significant contributions of female leaders in high performing organizations. Recognizing this positive influence, the Ministry of Health has committed to ensure the gender balance of leadership positions for the second health sector strategic plan (2020 – 2025) [20]. However, currently, only a few women are in leadership positions. This phenomenological qualitative inquiry explored and described the lived stories and shared experiences of six female leaders in health in three regional states of Ethiopia. The qualitative data analysis identified individual, social, organizational, and societal related opportunities and challenges of female leaders in health. The findings of this study influence policy makers, program managers, development partners, and health workers in the future in improving efforts towards increasing female leaders and managers in health.

According to the participants, the individual behavior of women held both opportunities and challenges in their career development towards leadership. A woman who has long term goals, is empathetic and a good listner, is wise in the use of resources, and is honest to subordinates is more likely rise to a leadership position. This finding was in line with the arguments of Bass (1999), where personal characteristics which improve team engagement, confidence, and build trust among staff are exhibited among women transformational leaders [21]. In addition, leadership experiences which were acquired through direct engagement in executing assignments or through lessons from colleagues, family members, and elders assist women to be competent in leadership positions. This finding was in line with the argument of Jyoti and Dev (2015) that leadership skills and competencies were improved through orientation and experience sharing activities [22].

However, women who had negative leadership experiences like those who were micromanaged by their supervisors tend to decline taking on leadership positions. In addition, women who are afraid of experiencing sexual harassment also avoid leadership positions. This challenge for women leaders was documented in three western countries by Folke et al. (2020), where the high risk of sexual harassment reported among lower and mid-level women leaders obstructed their journey to leadership positions [23].

In a developing country like Ethiopia, the burden of household chores is heavy on women. This study's findings indicated that women who had the support of their spouse, grandparents and peers are more likely assume the roles and responsibilities of senior health leadership positions. Similarly, women that are burdened with household chores and lack social support found it challenging to continue to advance their career development towards leadership. This finding was in line with Bahiru and Mengistu (2018) who confer that women who lack personal and social support from family members were forced to leave their leadership positions due to work overload [24].

The lived stories and shared experiences of participants showed that women that received organizational support are well prepared to be leaders in the health system. Some of the organizational support identified by the participants are affirmative actions and recognition. Ely et al. (2011) attest that recognition and affirmation strengthens one's leadership identity which fuels the search for growth [25].

In a low-income country, like Ethiopia, the role of development partners in providing technical, financial, and other resource support is invaluable. Leadership training and mentoring sessions, facilitated with the support of partners build the leadership capacity and competencies of women, and prepare them to be competent for leadership dispensation. This finding aligns with that of Desta et al (2020) and Argaw et al. (2021) where facilitating leadership training and coaching activities were found to be effective in building the desired competencies [26] - [28].

In the Ethiopian health system, almost all leadership positions are assumed by men. In this study, the culture and norms of society was indicated as favouring men in terms of their rise to leadership positions. This prevented women from rising to leadership positions. Similarly, because of deep-rooted gender stereotypes held by the community, women have a poor sense of self-image when it comes to managing complex organizations and therefore avoid assuming leadership positions. This finding is supported by Akhtar (2008) and Bahiru and Mengistu, (2018) that show that social stereotypes and the institutionalized norms of linking leadership position to men had an influence on the professional career development of women [8] [24].

Strength and limitations

The historic legacy of inequality and discrimination by gender results in more suffering among women in Ethiopia. Acknowledging the problem leads to the revision of policies, proclamations, and directives [29]. Empowering women and reducing the inequalities will benefit families, communities, and the country. This study explored and described the opportunities and challenges faced among six women health profesionals in their journey to rise in leadership positions. The study includes women leaders from three agrarian regions and ensure diversity in decentralized political leadership. The indepth interviews were conductd by an experienced female public health and social science professtionals. In addition, to control the investigators bias all interviews were actively participated in data transcription, coding and analysis. Furthermore, the data were analyzed by all investigators.The study has some limitations. Since the study participants are leadership and governance-trained women working at primary health care entities, the result lacks the opinions and experiences of un-trained women leaders. In addition, the study was

conducted only in three agrarian regions of Ethiopia, and the experience of women health leaders in ministry of health, general and referral hospitals, private sector, and pastoralist regions were not included. Therefore, the investigator described the context as useful for the interpretation and generalizability of the result of this study.

Conclusions

This study delved into participants' experiences in the path to leadership positions. The identified opportunities and challenges are related to individual behavior, and social, organizational, and societal related factors. The leadership positions were an opportunity in the career development of women who had long-term goals, are known for their empathy and listening skills, and displayed a wise use of resources. In addition, women with positive leadership experiences through delegation and engagement in focusing, inspiring, planning, organizing, directing, and controlling activities were capacitated to assume senior leadership and management positions. Women who has the support of close family members and peers are more likely to compete for and accept leadership positions. Furthermore, women who had received organizational support in the form of affirmative action, training, development, and recognition also tend to take on leadership positions. However, women who had been influenced in their day-to day decision making by their supervisors, experienced sexual harassment, and were under the influence of societal norms that favor men are more likely decline leadership positions. Therefore, enhancing the leadership capacity of women, and improving social and organizational support is recommended. In addition, addressing the poor self-image among women and men dominated societal norms at community level is recommended.

Abbreviations

LMG: leadership, management, and governance; OALFA: observe, ask, listen, feedback and agree; SNNP: Southern Nations and Nationalities of Peoples'; USAID: United States Agency for International Development; WHO: World Health Organization.

Declarations

Acknowledgements

The investigators are indebted to all six participants for their opinion, time, and cooperation during data collection, analysis and interpretation.

Funding

Transform: Primary Health Care is a United States Agency for International Development (USAID) funded health program under cooperative agreement number of AID-663-A-17-00002. The program is implemented by a consortium of organizations which includes Pathfinder International, JSI Research & Training Institute, Inc., EnCompass, Malaria Consortium, Abt Associates Inc., and Ethiopian Midwives

Association in collaboration with local Government and non-government partners. This phenomenological study report is made possible by the generous support of the American people through USAID. The authors' views expressed in this technical report do not necessarily reflect the views of USAID or the United States Government.

Availability of data and materials

All relevant data are within the paper.

Authors' contribution

The authors of this manuscript are SAM, BFD, HD, WKH, EMG, MGA, MG, and MDA. All authors equally contributed to the conception and design of the study, fieldwork, data cleaning, analysis, and drafting the manuscript. All authors have read and approved the final document. MDA: the corresponding author submitted the manuscript for publication.

Ethics approval and consent to participate

This study protocol was carried out in accordance with the Declaration of Helsinki and ethical clearance was obtained from John Snow Inc institution review board (IRB) with certificate ref no IRB #21-06E. The IRB determined that this research activity is exempted from human subjects oversight. Written informed consent was obtained from all research participants. In precaution to COVID-19, the data were collected telephonic interviewees.The study has no known risk and no payment was made to participants.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

Authors' information

SAM: MPH, Leadership, Management, and Governance Advisor at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

BFD: Ph.D., Deputy Chief of Party at USAID Transform: Primary Health Care, JSI Research &Training Institute, Inc., Addis Ababa, Ethiopia.

HD: BA, Knowledge Management Advisor at USAID Transform: Primary Health Care, JSI Research &Training Institute, Inc., Addis Ababa, Ethiopia.

WKH: MPH, Health Systems Strengthening Officer at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

EMG: MPH, , Health Systems Strengthening Officer at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

MGA: MPH, Health Systems Strengthening Officer at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

MGM: MPH, Health Systems Strengthening Officer at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

MDA: Ph.D., Senior Health Systems Strengthening Advisor at USAID Transform: Primary Health Care, JSI Research & Training Institute Inc., Addis Ababa, Ethiopia.

References

1. World Health Organization. Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, WHO, 2007.
2. Shung-King M, Gilson L, Mbachu C, Molyneux S, Muraya KW, Uguru N, Govender V. Leadership experiences and practices of South African health managers: what is the influence of gender?-a qualitative, exploratory study. International journal for equity in health. 2018 Dec;17(1):1-2.
3. Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender equity in the health workforce: analysis of 104 countries. World Health Organization; 2019.
4. McDonagh KJ, Bobrowski P, Hoss MA, Paris NM, Schulte M. The leadership gap: Ensuring effective healthcare leadership requires inclusion of women at the top. Open Journal of Leadership. 2014 May 22;2014.
5. Javadi D, Vega J, Etienne C, Wandira S, Doyle Y, Nishtar S. Women who lead: successes and challenges of five health leaders. Health Systems & Reform. 2016 Jul 2;2(3):229-40.
6. 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 Nov 1;5(11): e009384. .
7. Bayeh E. The role of empowering women and achieving gender equality to the sustainable development of Ethiopia. Pacific Science Review B: Humanities and Social Sciences. 2016 Jan 1;2(1):37-42.
8. Akhtar M. Female and Gender Leadership: Under Representation of Female Leaders, 2008.
9. Vong S, Ros B, Morgan R, Theobald S. Why are fewer women rising to the top? A life history gender analysis of Cambodia's health workforce. BMC health services research. 2019 Dec;19(1):1-9.
10. Tlaiss HA. Women in healthcare: barriers and enablers from a developing country perspective. International journal of health policy and management. 2013 Jun;1(1):23.
11. United States of Agency for International Development: Transform Primary Health Care. Cooperative Agreement. USAID Ethiopia, 2017.

12. United States of Agency for International Development: Transform Primary Health Care. performance report of the year 2020. Addis Ababa, Ethiopia; 2021.
13. Moustakas C. Phenomenological research methods. Sage publications; 1994 Jul 27.
14. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. American journal of evaluation. 2006 Jun;27(2):237-46.
15. Tolley EE, Ulin PR, Mack N, Robinson ET, Succop SM. Qualitative methods in public health: a field guide for applied research. John Wiley & Sons; 2016 May 9.
16. Guba EG, Lincoln YS. Fourth generation evaluation. Sage Publications, Inc.; 1989.
17. Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. Eur J Gen Pract. 2018 Dec;24(1):120-124. doi: 10.1080/13814788.2017.1375092. Epub 2017 Dec 5. PMID: 29202616.
18. Federal Ministry of Health (FMOH). Leadership, management and governance in-service training manual for health managers at hospitals and health centers. Addis Ababa: FMOH; 2017.
19. Armstrong M. *Armstrong's handbook of human resource management practice.11th edition. KOGAN PAGE: London and Philadelphia, 2009.*
20. Federal Ministry of Health of Ethiopia. Health Sector Transformation Plan. Addis Ababa: FMOH; 2021.
21. Bass BM. Two Decades of Research and Development in Transformational Leadership. European Journal of Work and Organizational Psychology.1999; 8: 9-32. http://dx.doi.org/10.1080/135943299398410
22. Jyoti J, Dev M. The impact of transformational leadership on employee creativity: the role of learning orientation. Journal of Asia Business Studies. 2015 Jan 5.
23. Folke O, Rickne J, Tanaka S, Tateishi Y. Sexual harassment of women leaders. Daedalus. 2020 Jan 1;149(1):180-97.
24. Bahiru B, Mengistu AB. The challenges of women leaders of business organizations in Addis Ababa, Ethiopia, in balancing work-family responsibilities. Journal of International Women's Studies. 2018; 19(2), 140-158.
25. Ely RJ, Ibarra H, Kolb DM. Taking gender into account: Theory and design for women's leadership development programs. Academy of Management Learning & Education. 2011 Sep;10(3):474-93.
26. Argaw MD, Desta BF, Muktar SA, Tewfik N, Tefera BB, Abera WS, Bele TA, Buseir SS, Rogers D, Eifler K. Effectiveness of Leadership, Management, and Governance Competencies for Performance Improvements at Primary Health Care Entities in Ethiopia: A Before and After Study. Journal of Human Resource and Sustainability Studies. 2021 Apr 23;9(2):250-75.
27. Argaw MD., Desta BF, Muktar SA et al. Comparison of maternal and child health service performances following a leadership, management, and governance intervention in Ethiopia: a propensity score matched analysis. BMC Health Serv Res 21, 862 (2021).

28. Desta BF, Abitew A, Beshir IA, Argaw MD, Abdlkader S. Leadership, governance, and management for improving district capacity and performance: the case of USAID transform: primary health care. BMC Fam Pract. 2020;21(1):252.
29. Bayeh E. The role of empowering women and achieving gender equality to the sustainable development of Ethiopia. Pacific Science Review B: Humanities and Social Sciences. 2016 Jan 1;2(1):37-

Tables

Table 1: Participant descriptions

Study participant ID	Leadership position	Age	Overall work experience in years	Years in leadership position	Educational background	Leadership training
ID1	Clinical services auditor	29	Four	One	BSc in public health	Yes, off-site six-day classroom basic LMG training followed by coaching for nine months.
ID2	Head of health center	39	Nineteen	One	BSc in midwifery	Yes, off-site six-day classroom basic LMG training followed by coaching for nine months.
ID3	Pharmacy head	28	Six	Two	BPharm	Yes, off-site six-day classroom basic LMG training followed by coaching for nine months.
ID4	Primary health care unit director	31	Six	One	BSc in public health	Yes, six-day classroom basic LMG training and nine months' practical on-the-job experience.
ID5	Deputy head of district health office	31	Eleven	Three	BSc in public health	Yes, off-site six-day classroom basic LMG training followed by coaching for nine months.
1D6	Head of district health office	27	Eight	Four	BSc nurse	Yes, off-site six-day classroom basic LMG training followed by post training coaching and support for nine months. She also received leadership training for a month while on the leadership position.

Table 2: Themes and categories

Themes	Categories
1. Individual behavior	1.1. Visionary
	1.2. Empathy and honesty
	1.3. Wise use of resources
	1.4. Leadership experience
2. Social support	2.1. Family support
	2.2. Peer support
3. Organizational support	3.1. Affirmative actions
	3.2.Training and mentoring
	3.3. Succession planning
	3.4. Recognition
	3.5. Development partners' support
4. Gender stereotype (cultural norms/ societal factors)	4.1. Status quos and norms
	4.2. Self-image

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