

## TITLE PAGE

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Nidhi Gupta: Conceptualization, data curation, formal analysis, investigation, methodology, project administration, software, visualization, writing – original draft.

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**Title:** Navigating Gender-Based Microaggressions, Incivility, and Bullying: Experiences of Women Leaders in Global Health in India.

**Short title:** Gender-Based Behaviours in Global Health in India.

**Key message:** A critical examination of the firsthand experiences of eight women leaders in the global health sector in the Indian context revealed encounters with microaggressions, incivility, and workplace bullying, offering nuanced insights into these pervasive issues that impact professional settings.

**Key findings:**

- This study explored instances of workplace microaggressions, incivility, and bullying by conducting in-depth interviews with eight women global health leaders based in India.
- Participants mentioned overt sexual harassment committed towards them, as well such unsolicited behaviour perpetrated towards others.
- They also reported specific experiences of microaggressions, bullying, and incivility toward them that manifest in nuanced, context-specific ways; participants recounted their strategies for addressing these behaviours.
- Despite these distressing behaviours, participants stated being encouraged by the impact of their work on communities, the health sector, and their mentees.
- We offer recommendations to identify and address these negative behaviours in the global health sector.

**Key implications**

- This study deepens our understanding of challenges faced by women leaders in global health. Creating multifaceted systems to address these behaviours will likely have systemic long-term positive impacts on the global health workforce.

**Abstract (216 words)**

Women constitute a significant majority of health and social care workers worldwide, yet they are underrepresented in leadership positions within these fields. In addition to overt stereotypes and a lack of opportunities for women in global health, there are other subtler behaviours, such as gendered microaggressions, incivility, and bullying that women face. This qualitative study using an interpretive phenomenological approach explores specific experiences of women leaders in India's global health sector regarding gender-based microaggressions, incivility, and bullying. It aims to uncover how these leaders perceive, encounter, and manage such discriminatory behaviours within their professional environments. We utilized an interpretive phenomenological approach to grounded analysis; in-depth, semi-structured interviews were conducted with eight women leaders. We found instances of explicit sexual harassment and gender-based microaggressions contributing to the psychological toll on women leaders. Participants reported these behaviours manifesting in subtle and nuanced, culture-specific ways. Participants shared the institutional and internalised dimensions of these behaviours, as well as those related to gendered stereotypes, and shared some tactics they use to address them. The study contextualizes microaggressions, incivility, and bullying using an intersectional framework. We provide recommendations, including implementing comprehensive diversity and inclusion training, establishing clear policies against workplace aggression, fostering supportive mentorship programs, cultivating an inclusive organizational culture, and advocating for intersectional approaches to address biases across professional domains.

#### **Figures, tables, and photos embedded in the manuscript**

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## **INTRODUCTION**

Women comprise almost 70% of health and social care workers globally,<sup>1,2</sup> and nearly 90% of the nursing and midwifery workforce;<sup>3</sup> yet they hold only around 25% of health-related leadership roles.<sup>4</sup> Many studies have looked at factors impacting the representation of women in global health. While India boasts of close to a million women frontline health workers (ASHA workers), the proportion of women in senior roles in the health sector is small.<sup>5</sup> The reasons for this conspicuous lack of women's leadership are long-standing biases, stigma, structural inequities in the workplace, and a lack of enabling environments and conditions to support women in decision-making roles.<sup>6,7</sup>

Other studies have also explored the nuances of women's representation in global health. A phenomenological study that explored the lived experiences of five women in higher levels of public health in Europe, Africa, South Asia, and the Americas revealed themes of health equity, challenging the status quo, “leading by listening”, and the critical importance of social support to build “confidence and credibility”.<sup>8</sup> A multi-country study conducted in an academic setting in Haiti, Tanzania, India, and the USA revealed three main themes that impact women in public health: entrenched assumptions regarding women and their capabilities, power imbalances on an institutional level, and restricted agency.<sup>9</sup> Another study that interviewed mid-career women in India, East Africa, and North America revealed the critical role of women mentors and professional networks in career development.<sup>9</sup> Lastly, a scoping review that focused on India and Kenya described many gender-based impediments and called for a gender transformative leadership model.<sup>10</sup>

The benefits of women in leadership roles are many: women wielding decision-making power can directly lead to the realization of a better workforce required to achieve universal health coverage and sustainable development goals.<sup>11</sup> A recent scoping review revealed that women's leadership has positive influences on areas such as innovation, engagement, organisational outcomes, and how it inspires other women's career aspirations.<sup>12</sup> Indeed, seeing women leaders in prominent leadership roles paves the way for the younger generation, as they see this as a possible career option for them too.<sup>13</sup> The recent COVID-19 pandemic also uncovered the role of women's leadership in times of national emergency - a study exploring data from 35 countries found that governments led by women were effective in crisis management in the face of pandemic-related restrictions and displayed a stronger sense of equality.<sup>14</sup>

In addition to broader issues and overt discrimination mentioned by others,<sup>8,9</sup> women also face subtle, nuanced forms of discrimination. For example, microaggressions are defined as “a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group, such as a racial minority”.<sup>15</sup> Microaggressions can be classified as microassaults, microinsults, and microinvalidations, and include discriminatory verbal abuse, insensitive and disparaging comments, and dismissive and exclusive practices (Glossary of terms provided in Table 2).<sup>16</sup> Microaggressions go unreported for a variety of reasons – women fear retaliation if they speak up, fear that reporting such behaviour will negatively impact their careers, and that no action will be taken.<sup>17</sup> A survey of women in corporate India revealed that women from ethnic minority groups and lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual (LGBTQIA+) were more likely to be patronized, undermined, and face condescending comments by coworkers.<sup>17</sup> Women facing microaggressions report feeling dissatisfied and unsafe; in extreme scenarios, repeated microaggressions can also be associated with anxiety, depression, and a lack of confidence in their abilities.<sup>18</sup> A study done in the United States found a high prevalence of microaggressions in racial and ethnic-minority women physicians in the fields of anaesthesiology and surgery that contributed to physician burnout.<sup>19</sup> A qualitative study done in Lebanon on women in Science, Technology, Engineering, and Math (STEM) fields showed that gendered microaggressions are common and can damage the individual’s mental health and reinforce oppressive societal stereotypes.<sup>20</sup> This paper revealed that women face these behaviours through four strategies: adaptation (considering microaggressions as facing a “lost battle”), confrontation (strategically challenging microaggressions), negotiations (embracing their visibility to gain agency), and ‘beyond bodies’ (supporting other women by mentoring and educating them).<sup>20</sup>

How women leaders in India in the global health space perceive, address, and challenge microaggressions is not fully understood. For example, Javadi et al. report women leaders feeling “unwelcome and unheard in leadership spheres,”<sup>3</sup> and Sabarwal et al. report women leaders facing “casual, routine sexism” and experiencing the intersection of ageism and sexism in their professional journeys.<sup>9</sup> Riche et al describe “cultural bias and institutionalised gender bias” that may impact women advancing and retaining leadership positions.<sup>8</sup> In the rapidly evolving landscape of women’s

leadership in India,<sup>21</sup> our paper explores specific and nuanced behaviours that women leaders in global health in India face. The current study adds to these previous studies by understanding the personal journeys of women leaders in global health in India, specifically as they relate to behaviours of gendered microaggressions, incivility, and bullying.<sup>3,8,9</sup>

## **METHODS**

**Positionality of authors:** All authors identify as women and are originally from India, with experience in professional settings in the Indian global health context. Author 1 is currently based in the United States and is a scientist and creative aging expert with experience in the Indian palliative care research fields.<sup>22,23</sup> All other authors are based in India - Author 2 is a public health researcher with two decades of experience in health systems strengthening, policy advisory, capacity building, research, and organizational development, and population ageing.<sup>24</sup> Author 3 is a global health consultant and supports policy and advocacy efforts to advance leadership in women to build gender equity in health.<sup>25</sup> Author 4 has extensive experience in health system strengthening and expertise in shaping evidence-based policy planning and development within the Indian healthcare ecosystems.

**Ethics:** This study involved qualitative, in-depth interviews with adult women leaders working in the Indian health and global health ecosystem. The study did not include any clinical procedures, collection of sensitive personal health information, or access to patient records. As per the Indian Council of Medical Research (ICMR) National Ethical Guidelines for Biomedical and Health Research Involving Human Participants,<sup>26</sup> qualitative social and behavioural research that poses minimal risk, does not involve vulnerable populations, and focuses on professional experiences may be conducted without formal ethics committee review. Hence, this study did not require formal ethics committee approval. All participants were adults and were approached through professional networks. Before the interviews, participants received an information sheet outlining the purpose of the study, the voluntary nature of participation, and the interview guide (Table 1). Informed consent was obtained electronically from all participants. To ensure anonymity and privacy, identifying details were removed during transcription, and only anonymised data were used for analysis. All procedures

adhered to established ethical principles for qualitative research, including respect, autonomy, confidentiality, and protection from harm.

A study from 2016 utilized phenomenological inquiry to describe the successes and challenges of five “health leaders”.<sup>3</sup> In phenomenological studies, “key themes” are extracted into “meaning units” which are used to identify a “grounding theme”.<sup>27</sup> In this study, qualitative, semi-structured, in-depth interviews were used to allow participants to provide detailed explanations and opinions to understand the lived experiences of successful women leaders in the global health sector in the Indian setting.<sup>28,29</sup> In our study, all participants mentioned microaggressions, bullying, and incivility perpetrated towards them, and this emerged as a “grounding theme” (the “key element that is necessary for the experience being reflected upon to take place”)<sup>3</sup>, and the focus of this paper.<sup>30</sup> Similar to the 2016 paper, we took a phenomenological approach to grounded analysis.<sup>30</sup> Specifically, the intention of the paper was informed by the positionality of the authors in global health; hence, an interpretative phenomenological approach was used.

The sampling frame consisted of research participants who were identified by preparing a list of ten key women leaders in health in India through a consultative process and ensuring the representation of health leaders from a multitude of sectors. These individuals were approached for their availability and willingness to participate in the study. Six women leaders were available and agreed to participate in the study, and later connected us with two more women leaders who also agreed to participate. Eight women health leaders from diverse domains (academia, non-government organizations, international organizations, health insurance, and global health systems) were interviewed – participants had varied (4-30 years) experience in global health leadership.

Primary data analysis was performed in parallel with data collection to identify theoretical saturation and guide us to stop further data collection. Theoretical sampling (based on grounded theory) was used to guide the sample size, to capture experiences related to microaggressions, bullying, and incivility in Indian global health spaces.<sup>29</sup> Data was collected by conducting qualitative interviews guided by an interview guide (Table 1). Interviews were conducted online in January and February of 2022. An interview guide was shared with the research participants beforehand to enable them to reflect on their journey as women leaders. Anonymity, privacy, and confidentiality of

the data collected were ensured in all phases of data collection as well as analysis. Interviews lasted between 45 and 90 minutes.

Table 1: Interview guide

<p>A. Informed consent</p> <p>B. Background information of the research participant</p> <ul style="list-style-type: none"><li>a. Educational background</li><li>b. Training (in global and/or public health)</li><li>c. Formal leadership training - type of training, duration of formal leadership training</li><li>d. Leadership position</li><li>e. Duration of leadership</li><li>f. Number of years in the current leadership role</li></ul> <p>C. Exploration of how gender affects career path</p> <ul style="list-style-type: none"><li>a. In what ways do you think that gender has affected your career path?</li><li>b. Does it continue to affect how you lead in your current position?</li></ul> <p>D. What contexts or situations have typically influenced or affected your experiences as a woman in a leadership position?</p> <ul style="list-style-type: none"><li>a. What have been some of your motivating factors from the start of your career to now?</li><li>b. What enabling factors do you think were the most significant in getting you to where you are?</li><li>c. What barriers did you have to overcome?</li><li>d. Do you credit any individual, institution, or program with supporting you on your path to leadership?</li><li>e. What are some of the biggest crises or critical events you've had to handle?<ul style="list-style-type: none"><li>• How did you resolve these events with outcomes that you were happy with?</li></ul></li></ul> <p>E. What are your recommendations and key strategies for young women in the health sector in India to unlock their potential and become health leaders?</p> <p>F. What is it that you feel should change from a policy perspective at the national level that will enable and encourage more women to take up such roles?</p>
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Interviews were conducted in English and were recorded with the consent of the research participants. Interviews were then transcribed, and transcripts were organized under themes as described in the Glossary (Table 2). The authors spent at least an hour after each interview discussing and analysing transcripts and convening on emergent themes, and additional time while developing this manuscript. Hence, an iterative approach to data analysis was adopted, and computer-aided manual coding using Microsoft Excel was used to identify common themes and sub-themes in the transcripts.<sup>22</sup> Bracketing was done using analytical memos written and maintained by each author during the entire process from creating the interview guide (Table 1), conducting the interviews, and analysing transcripts. The authors referred to these notes multiple times over the course of the study to reflect on assumptions and biases. Transcripts were thematically color-coded into descriptive first-level codes and analytic second-level codes. All sub-themes under the themes were reorganized, and the findings were presented, substantiated by verbatim/ quotes from interviews. Authors 1 and 2 independently verified and cross-validated that all the points during the interviews were reflected in the transcription and thematic coding. A set of recommendations was then detailed based on the synthesis of findings and connecting them with the context of the health sector in India.

Table 2: Glossary of terms used <sup>15,16,31-35</sup>

<ul style="list-style-type: none"> <li>• <u>Bullying</u>: “Negative, repetitive, aggressive, and intentional behaviours that may involve personal attacks, belittlement, threats, intimidation, exclusion, isolation, or humiliation”<sup>33</sup></li> <li>• <u>Environmental microaggression</u>: Microassaults, microinsults, and microinvalidations “becoming institutionalised in the overall culture of the workplace environment”<sup>35</sup></li> <li>• <u>Incivility</u>: “Low-intensity deviant behaviour by the perpetrator with the ambiguous intent to harm the victim and destroy mutual respect in the workplace” <sup>31,32</sup></li> <li>• <u>Intersectionality</u>: “A theoretical framework that posits that multiple social categories intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level”<sup>34</sup></li> </ul>
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- Microaggressions: “A comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group, such as a racial minority”<sup>15</sup>
- Microassaults: “Conscious biases or discriminatory verbal abuse or behaviours”<sup>16</sup>
- Microinsults: “Unconscious messages that are insensitive and disparaging to a person's racial identity or background”<sup>16</sup>
- Microinvalidation: “Behaviours and statements that are meant to exclude, negate, and dismiss one's personal feelings, thoughts, and experiences”<sup>16</sup>

## RESULTS

### A. Participant profiles

At the time of the interviews, participants had spent varying times working in the field of global or public health, and the amount of time in leadership roles (Table 3). A common theme in their education was that they undertook specialized courses after post-graduation to better perform the specific responsibilities in niche areas. One participant had formal and exclusive leadership training; for the remaining participants, leadership training was experiential as they learned “on the job”. All participants mentioned the role of the privilege they enjoyed due to their standing in society (class/caste/socioeconomic status), training (e.g., medical training), experience in urban vs. rural settings, educational institutions attended, and access to mentors and role models. Regional differences were also discussed, suggesting that leadership journeys cannot be studied in silos.

Table 3: Profile of participants

ID #	Educational background	Formal global or public health training	Formal leadership training	Total number of years of work	Total number of years of work in a leadership position	Total number of years of work in the current role
ID 1	Postgraduate followed by direct recruitment at an	None	Management Development Programs	14	8 (Health Insurance Company);	8 (Health Insurance Company)

	insurance company in a management/ operations role		sponsored by the employee, Management training programs from the London School of Direct Marketing		3 (Senior Consultant at World Bank)	3 (Senior Consultant at World Bank)
ID 2	MBBS, MD	MD (Community Medicine)	None	10	4	4
ID 3	MBBS, Health economics, M Phil	MD (Community Medicine)	Global Health Leadership Award	19	7-8	4
ID 4	Master's, PhD	MHA (master's in healthcare education); PH	Stephen Covey's "Seven Habits of Highly Effective People" training; Harvard fellowship (executive, structured, experiential)	20	15	10
ID 5	Bachelor's and master's degrees in speech- language pathology; PhD; post-doctoral fellowship in neurosciences	DBT Wellcome India fellowship in clinical and public health (5 years)	None	8	6	2
ID 6	Social Work Master's, Jamia Media Islamia in 1998.	Masters & PhD- University of Cape Town	None	24	3	3

	Master's and PhD- University of Cape Town					
ID 7	Ph.D. in human nutrition	None	4 months	28	16	16
ID8	Bachelor's, Master's, and PhD. in a specific field of pharmacy	None	Course in management that focuses on capacity building for women in higher positions; a Week-long course on mentoring offered by the Government of India	More than 30	More than 30	13

Interviews revealed several themes that are outlined in the sections below. Section B outlines experienced or witnessed) overt sexual harassment; Section C describes microaggressions, incivility, and bullying, and the subtle ways in which these manifest; and Section D highlights institutional and internalised dimensions of these behaviours, as well as those related to related to gendered stereotypes. Participants also shared some of how they have been addressing such behaviours, and what keeps them motivated despite these distressing experiences (Section E).

*B. Participants mentioned overt sexual harassment committed towards them, and unsolicited behaviour perpetrated towards others.*

All participants mentioned being harassed sexually, cornered, and harassed by male colleagues as a specific barrier they face because of their gender. Participants were sometimes also witnesses to sexual harassment; in these instances, they mentioned the importance of support from the organization and the team. For one participant (ID2), witnessing a sexual harassment incident encouraged her to start a wider conversation, which she recounted as such: *“Initially, I panicked and*

*went into crisis, but later, as I came out of it, I started having conversations with people in the institute. There were a lot of people seemingly in agreement (with me), but in the end, really nothing happened. The incident reiterated the hollowness of language.”*

Speaking about such instances perpetrated on others, one participant (ID2) mentioned: *“Many times, health workers are put in this situation that they feel unsafe. It's difficult to say whether they are unsafe or not, but all women need to work with the feeling in their mind that she is safe.”* Women mentioned standing up for other women put in this situation, but that this comes at a certain expense as well, as such (participant ID5): *“I had to stand up for myself, my student, and to stop this behaviour bordering on harassment. I did speak up, but the dynamics changed. Now we no longer go out for coffee, chat, and talk about things that I would have previously done. Now, we do not share jokes on WhatsApp. That said, I am willing to make that sacrifice because this was something that I had to put a stop to.”* In some situations, senior professionals addressed sexual harassment with the help of supportive superiors, as such (participant ID8): *“There was a lot of pressure on me. I was threatened as well, but I didn't yield because I knew I was in the right. Ultimately, I stood my ground, and the director supported me, but it was very stressful for a couple of weeks. After this incident, though, relationships changed. Even friends started behaving a little odd, so that disturbed me.”* One participant mentioned the role of exposure to professional settings in other geographical locations (in her case, to the Global North) in combating sexual harassment. During her training, the participant (ID5) recalls: *“The women were able to do exactly what men did, and they were able to voice their opinions in the same way. Once I came back, a lot of these things became more evident, and I started challenging these things.”*

*C. Microaggressions, bullying, and incivility toward women are rampant in global health and manifest in nuanced, context-specific ways.*

In addition to explicit sexual harassment, participants stated they routinely experienced nuanced and subtle behaviours such as microaggressions and bullying. In the words of one woman (ID5), *“These things have not made me come home crying, but there are a lot of subtle things. In a culture like ours, it is considered ok. People wonder why I am making a big deal out of it.”*

Participants mentioned occasions where people in a meeting would respond to a man but blatantly

ignore a woman saying the same thing. In the words of one respondent (ID2), *“When (men) discuss things, your point of view is not considered, and you are given literally a minute. Other than that, you are largely invisible.”* The mindset that leads to these behaviours is also associated with perceptions of limitations as to the kinds of work women can do. Participants mentioned sexual and reproductive rights as something women are thought fit to work in, but not occupational health, or working in communities. Other work-related contextual issues were those that hinder women from getting into roles that are perceived to require forceful personalities, such as dealing with the government, and difficulties in traveling to communities. One participant (ID2) recounted the impact of the intersection with marital status: *“I was told that rural communities are not places where women doctors should be working. I saw it as a challenge, and that helped me a bit. But I was viewed very weirdly during my training because of my status as a single woman...my Master’s training was a very lonely space”*. The need to travel to different locations was recounted as a challenge based on gender, with some participants being discouraged from taking leadership roles due to the need to travel. Women expressed their expertise being questioned, their opinions being second-guessed, and their success being seen as accidental tokenism. One woman (ID3) mentioned overhearing *“Oh, she got it easy, she got (to this role) as a result of a lateral entry.”* When one participant (ID8) shared her ambition with colleagues, she was met with quizzical responses such as *“It is a challenge - do you think you’ll be able to handle it?”* The same participant (ID8) mentioned being sidelined, people *“ganging up against them and pulling the carpet from underfoot.”* On the futility of speaking up, participant ID8 said: *“You are kept out of decisions that need to be taken by you. Somebody else makes those decisions, and it keeps happening. One must understand that when you are in a setup. And beyond the point, questioning doesn’t help because it’s not going to solve the problem. It’s only going to create acrimony.”*

These behaviours manifest in communication styles as well; instead of being direct, participants felt they had to be overly congenial and polite in communicating with higher-ups in the organization. They mentioned the instinct to over-apologize in written communication, a behaviour they found difficult to unlearn even after many years. One participant (ID6) mentioned: *“Even after so many years, this is something I am having to work towards; this is how we have been socialized.”* Participants mentioned always questioning themselves as to how their (written or verbal) tone would

be perceived by others, as *“there is a lot of background noise going on in my head. (ID2)”* Women also mentioned having to use indirect, roundabout ways of communication so that they don't hurt the men in the department and perhaps even senior women who may not be aware of current communicative trends. One participant (ID5) received an email addressed to her as “Dear Sir” for many years and finally spoke up about the proper honorific. In her words, *“In the current times where people have choices beyond 'man' and 'woman', you cannot afford to write something like this.”*

Even after achieving roles in leadership, women may struggle to gain acceptance and recognition from the broader workplace; they may fail to get the respect they deserve from all levels of the staff unless they are identified by a certain dress code or some other form of identity, such as a “badge”. According to one participant (ID5), *“It does not matter if my male colleague wears a badge or not.”* This gendered experience is further complicated when considering age; as one woman said, *“In a country like India, I see many young people - especially young women - being undermined. I want to wear a sari to work because people don't take me seriously. There are some days I wear formal clothes, wear heels, and look a little taller and a little older than my age.”*

*D. Dimensions of microaggressions, bullying, and incivility can be institutional, internalised, or related to gendered stereotypes.*

Institutional dimensions: The lack of role models to show how such behaviours can be combated was brought up as an institutional issue, as was the role of men in the professional workspace. Speaking about the role of peer groups and mentors, one participant (ID2) said, *“There is a lack of spaces where you can share these experiences, be comforted, and be advised by others who have gone through similar experiences.”* One woman acknowledged her mentor as someone very comfortable letting her speak and never stopping her from expressing her viewpoints. According to one participant (ID5), the goal should be as such: *“My goal is that if I am in a room full of men, I should be able to stand up and make my point without pulling the woman's card.”* While many participants had the support of a mentor at some point in their professional career, two mentioned the difficulty of finding a mentor and professional networks within the organization, and they shared: *“I see women like me who struggle to fit into these existing structures in big organizations. One of the ways I have been able to navigate and find my way along is through some*

social networks.” (ID2), and “We don't have a lot of role models who opt out of the normative models. Because you've made some personal sacrifices and/or made some personal decisions, you feel isolated” (ID7).

Internalised dimensions: Deeply ingrained and innate beliefs were reported to amplify such behaviours. One woman noted that these biases are subconscious and that this instinct of questioning a woman's ability comes very naturally (to most men and perhaps to women as well). Speaking about the lack of experience that men have working with a woman superior, one participant (ID7) said, “A lot of men do not have the experience or the conditioning of working under a woman leader.” Participants observed that women themselves often harbour biases about their abilities; they may believe that their professional ambitions are secondary to their family or any family-oriented ambitions. One participant (ID8) mentioned the role of social conditioning as such: “Often, women allow difficult circumstances to rule them instead of trying to find a solution. Once women start getting into that mode, it's very difficult to pull them out.” These biases are also apparent in the attitudes of women toward other women, where, unintentionally, women themselves may contribute to the gender divide.

Dimension of gendered stereotypes: Participants discussed that due to stereotypes, global health is often classified as social work in India, which makes it difficult to communicate the importance of this work. Another misconception is that fields such as social work and global health are thought of as “female” work. Women are believed to be better at tasks that involve soft skills, such as managing human resources, capacity building, and maintaining rosters, whereas men are better in profiles involving money and numbers, such as finances, decision-making, and leadership positions. In the words of one participant (ID5): “They don't think of me as the first person for a leadership role because they don't think I will be able to organize and handle finances.”

#### *E. Staying motivated in the face of microaggressions, bullying, and incivility.*

Participants mentioned that finding value in their work and its impact keeps them energized in the face of such experiencing behaviours. One participant mentioned how she enjoys working with the community, especially women and children, and that the tragedies that her (chosen) community encounters daily continue to motivate her. Another participant mentioned that working in the field of

rights and justice was a motivator. Participants shared that any success they achieve encourages them to become more aspirational, aim for technical excellence, and find ways of giving back to the younger generation.

Speaking broadly on their leadership journeys, several participants cited the impact of positive attitude, grit, perseverance, and readiness to accept opportunities. Speaking of their unflinching, positive attitude, all participants saw an opportunity in every challenge they came across, such as *“storms are not always to destroy; sometimes they just clear your path”* (ID3). One participant mentioned that being authentic, being positive and resilient, and looking at life a bit lighter and with laughter are some characteristics that have motivated her. Most participants mentioned actively challenging themselves in every situation, using *“obstacles as stepping stones”* (ID3), as they did not want family, friends, or colleagues to think or feel they couldn't perform a task because of their gender. They identified areas in which they were competent, made progress, and mentioned that certain roles, such as welcoming guests at organizational events and being the front face of the organization, can be seen as ways to build connections. To combat negative stereotypes and biases, participants mentioned how (in retrospect) they could have been better prepared. One participant mentioned that her mental makeup was not tuned to leadership positions early on in her career and that she could have had a better idea of what this work entailed if she had sought out and listened to other women in similar lines of work. Skills that were cited to combat (or being prepared to face) biases and stereotypes were financial literacy, public speaking, and self-care to help maintain a healthy life. Continued support and cooperation from families were cited as instrumental in participants' journeys. Support in the form of childcare and paid help for household chores was also mentioned. The fact that the leadership journeys of women (and men) are often sustained by the informal labour of women was observed by all.

Speaking to the transformative power of mentorship, participants stated that they were mentors themselves and expressed joy in guiding the younger generation. Being contacted by junior professionals when they are contemplating career changes and using the participant as a sounding board is something that motivates one participant (ID1). In her words: *“I love interacting with junior professionals, looking at the issues from their perspective and helping them build careers while doing*

*this*". Participants also mentioned mentorship as a responsibility and talked about the role of mentors in checking their thinking, adjusting as needed, and calling out bias whenever they see it.

Despite successes in their professional journeys, participants admitted to experiencing intense exhaustion, with one participant mentioning "no breaks in her professional life except for two maternity breaks in 19 years."

## **DISCUSSION**

This study employed an interpretive phenomenological approach to grounded theory to understand experiences of microaggression, bullying, and incivility from the point of view of women leaders in global health in India. All women shared that these experiences took place quite often in subtle and nuanced ways. They noted that relationships and friendships got redefined when they called out these behaviours. Others have studied microaggressions and similar behaviours in other sectors. For example, our findings align with those found in a study of gender-based microaggressions conducted in India in the corporate sector. This study, done by WomenLead, showed that microaggressions play out in the following ways: women getting feedback on personality rather than on technical skills, being perceived as too forceful or too soft; hesitation felt by women while negotiating salary for fear of being perceived as pushy, and critical conversations happening in after-hours parties that they may be unable to attend.<sup>36</sup> In the recent past, microaggressions in all their forms have been studied in greater detail, revealing that organizational tolerance, a siloed workplace that hinders productive mingling, gender bias, and hierarchical structures between coworkers contribute to microaggressions<sup>35</sup>

Our findings can be contextualized given the Microaggressions Triangle Model<sup>37</sup> and an intersectional framework.<sup>34</sup> The Microaggressions Triangle Model encourages viewing microaggressions from the points of view of the "source" (perpetrator), "recipient", and the "bystander".<sup>37</sup> The "source" of the microaggression should acknowledge their bias, seek honest feedback, and apologize to the recipient of the microaggression. The "recipient" is suggested to ask clarifying questions, discuss the impact of the microaggression, and be aware of their thoughts and feelings about the incident. Lastly, the "bystander" also has a role, in that they should stay aware, respond with empathy, inquire, educate, and engage.<sup>37</sup> Individuals in all sectors, including global

health, can use this framework to actively address microaggressions in the workplace. On the role of intersectionality, all participants mentioned the role of intersectionality in their professional careers. Indeed, studies have also reported the intersection of microaggressions with gender, ethnicity, and race in the healthcare setting.<sup>35</sup> For example, studies have shown that being witness to derogatory words or images directed to women may be normalized as innocuous, but are quite common and harmful.<sup>35</sup> We suggest that the inclusion of lived experiences of women leaders (described in this and other works) into existing frameworks will be essential for capturing and measuring intersectionality over time.<sup>38</sup>

While not explicitly included in the questionnaire, the experience of exhaustion among women leaders is a global phenomenon and was organically recapitulated in our study.<sup>39</sup> Some reasons for this are that women either volunteer to (or are volunteered by others) to promote equity initiatives that are perhaps not considered in productivity quotas, microaggressions such as being interrupted, their professional judgment questioned, and a lack of support from male colleagues.<sup>39</sup> Indeed, a study suggested microaggressions as being linked to psychologically unsafe environments that can lead to (physician) burnout.<sup>35</sup> Persistent microaggressions are associated with a lack of psychological safety.<sup>35</sup> The concept of psychological safety is important not only for individuals to learn, contribute, and question the status quo without fear of retaliation, but it is also important for thriving teams, which in turn impacts the recipients of care.<sup>35</sup> Long-term, daily microaggressions have been linked to emotional exhaustion, negative affect, and a cascading effect leading to decreased engagement with work.<sup>40</sup> Given the many negative impacts of microaggression and related behaviours in global health, systemic efforts to identify and address microaggressions, incivility, and bullying will likely lead to productive and equitable workplaces, and many positive implications in the field of global health. In the recent past, the concept of “belonging” has emerged in the professional context. Belonging is “an employee’s sense that their uniqueness is accepted and even treasured by their organization and colleagues.”<sup>41</sup> While a seemingly abstract notion that can be hard to quantify, reducing microaggressions in the workplace can directly lead to a greater feeling of belonging, greater satisfaction, and reduced turnover.<sup>42</sup>

Based on the experiences of interviewed women leaders and published literature,<sup>43-46</sup> we offer some recommendations to address these negative behaviours in the global health sector.

- Promote intersectional approaches: Recognize and address the intersectionality of identities (e.g., gender, race, caste, socioeconomic status) that contribute to experiences of microaggressions. Interventions should be tailored to acknowledge and support diverse experiences. Given the nuanced nature of these behaviours, efforts to understand and acknowledge the positionality and privilege of those in power will be essential to actualize this recommendation. Learnings from anti-oppressive and decolonizing movements should be incorporated.<sup>45,46</sup>
- Implement awareness and training programs: Develop and implement mandatory training programs on diversity, inclusion, and respectful workplace behaviours. These training programs should also include modules on recognizing and addressing microaggressions, bullying, and incivility. The Microaggressions Triangle Model described earlier can be used to highlight the role of all parties – the source, the recipient, and the bystander.<sup>37</sup>
- Promote mentorship and support networks: Encourage mentorship programs that pair senior leaders with mid-career and junior professionals, focusing on women and underrepresented groups. Foster supportive networks where individuals can seek guidance and share experiences.
- Establish clear policies and reporting mechanisms: Create clear policies against microaggressions, incivility, and bullying, and ensure they are communicated effectively to all employees. Establish confidential reporting mechanisms and ensure swift and fair investigations of reported incidents.
- Address organizational culture and leadership accountability: Foster an inclusive organizational culture from the top down. Hold leaders and managers accountable for promoting respectful behaviours and addressing any instances of microaggressions or bullying within their teams.
- Monitor and evaluate progress: Establish metrics to monitor progress in reducing microaggressions and improving workplace inclusivity. Regularly evaluate the effectiveness of interventions and adjust strategies as needed based on feedback and outcomes.

### ***Conclusions, Limitations, and Future Directions***

Overall, this research deepens our understanding of the challenges faced by women leaders in global health and underscores the urgent need for proactive measures to mitigate these challenges. It calls for organizational policies and cultural shifts that foster inclusivity, respect, and support for diverse perspectives, ultimately aiming to create healthier and more productive work environments for all professionals. By documenting these experiences, the study highlights the broader implications of such behaviours on professional relationships and organizational culture. It reveals how addressing microaggressions, incivility, and bullying is not merely about interpersonal dynamics but also about promoting a more equitable and respectful workplace environment. The study highlights the complexities of navigating hierarchical structures and entrenched biases within the global health sector in India, shedding light on regional variations that influence gender norms and workplace dynamics.

Participants in our study were recruited based on personal/ professional contacts and recommendations; it is possible that a follow-up study on more participants representing a wider section of the global health sector in India might give a complete and more nuanced look into the behaviours described, and how women navigate their professional journeys. Participants occupying more peripheral and diverse roles within the health sector would also have offered varied voices. A targeted study aimed at studying microaggressions specifically (and exploring microassaults, microinsults, and microinvalidations separately) would also potentially lead to deeper insights. Repeating the study with a larger and more varied group of individuals, employing mixed-methods and longitudinal study designs, could help us comprehensively capture the evolving nature of workplace dynamics in India, as well as evaluate the efficacy of the described recommendations. Systematic studies on how age, caste, and marital status intersect with gender, as well as mapping different types of microaggressions to intersectional positions, could make for fruitful areas of study.

In conclusion, the study explores specific ways in which behaviours like microaggressions, bullying, and incivility towards women leaders play out in global health settings in India and provides recommendations on addressing these behaviours.

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