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Original article

BARRIERS AND FACILITATORS TO WOMEN'S LEADERSHIP IN HEALTH IN ARGENTINA AND NIGERIA: SURVEY FINDINGS

GLENDA ERNST[1,2], MARÍA LOURDES GIL ULIARTE[1], MURIEL SUAREZ[1], MERCEDES RUMI[3], ISAAC OLUWAFEMI DIPEOLU[4], PABLO YOUNG[1].

[1]Departamento de Docencia e Investigación, Hospital Británico de Buenos Aires, Argentina, [2]Consejo Nacional de Investigaciones Científicas y Técnicas (CONICET), Buenos Aires, Argentina, [3]University of Oxford, United Kingdom, [4]University of Ibadan, Nigeria

Postal address Glenda Ernst, Hospital Británico de Buenos Aires, Perdriel 74, 1280 Buenos Aires, Argentina
E-mail: GErnst@hbritanico.com.ar
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Abstract

Introduction: Women represent a significant proportion of the healthcare workforce in low- and middle-income countries (LMICs); however, their participation in leadership positions remains disproportionately low. Our objective was to examine the perceived barriers and facilitators to leadership among women in LMICs.

Materials and methods: Cross-sectional study using a distributed online survey with open-ended questions. Purposive sampling was used to recruit women aged ≥18 years who held leadership positions in the health sector in LMICs. The responses were analysed using an inductive thematic content analysis approach using ATLAS.ti software.

Results: Sixty-two women in leadership positions in the health sector responded to the survey: 31 were from Argentina, and 31 from Nigeria. The most common barriers to reaching leadership positions included challenges in interpersonal management, professional development, and work-life balance. Others were managing limited resources, staff conflicts, and experiences of gender discrimination. Participants identified conflict resolution, promoting equity, and empowering team members as key leadership responsibilities. Reported facilitators included leadership training, coaching, inclusive organisational cultures, and institutional support as key factors in counteracting persistent gender barriers.

Conclusion: Women in health leadership positions in LMICs face barriers at individual, organisational, and structural levels that go beyond personal capabilities and reflect persistent inequities. The survey data highlight the importance of adopting systemic, forward-looking leadership approaches to advance gender equity in health leadership.

Key words: leadership, health sector, gender equity, low and middle-income countries

Resumen

Barreras y facilitadores para el liderazgo de las mujeres en el sector de la salud en Argentina y Nigeria: resultados de una encuesta

Introducción: Las mujeres representan una alta proporción en la fuerza laboral sanitaria en países de ingresos bajos y medios (LMICs, por sus siglas en inglés); pero su liderazgo sigue siendo desproporcionadamente bajo. El objetivo de este estudio fue examinar barreras y facilitadores en mujeres líderes del sector salud.

Materiales y métodos: Estudio transversal basado en una encuesta online, de preguntas abiertas, con muestreo intencional. Las respuestas se analizaron mediante un enfoque de análisis temático de contenido inductivo utilizando el software ATLAS.ti.

Resultados: Respondieron 62 mujeres: 31 de Argentina, y 31 de Nigeria. Las barreras más frecuentes para acceder a cargos de liderazgo incluyeron desafíos en la gestión interpersonal, desarrollo profesional y equilibrio entre la vida laboral y personal. Otras barreras

identificadas fueron la gestión de recursos limitados, conflictos con el personal y discriminación de género. Las participantes señalaron la resolución de conflictos, la promoción de la equidad y empoderamiento de los miembros del equipo como responsabilidades clave del liderazgo. Entre los principales facilitadores mencionados se encontraron la capacitación, el *coaching*, culturas organizacionales inclusivas y apoyo institucional como factores clave para contrarrestar las persistentes barreras de género.

Conclusión: Las mujeres que ocupan posiciones de liderazgo en el sector salud en los LMICs enfrentan barreras a nivel individual, organizacional y estructural que van más allá de las capacidades personales y reflejan inequidades persistentes. Los datos de la encuesta destacan la importancia de adoptar enfoques de liderazgo sistemático y orientados al futuro para promover la equidad de género en el liderazgo en salud.

Palabras clave: liderazgo, sector salud, equidad de género, países de ingresos bajos y medios

KEY POINTS

Current knowledge

- Women remain underrepresented in healthcare leadership in low- and middle-income countries due to persistent structural, organisational, and socio-cultural barriers.

Articles's contribution to current knowledge

- This study shows that women leaders identify systemic, forward-looking leadership approaches and institutional support as key facilitators for overcoming gender-based barriers and promoting equitable leadership.
- **Acknowledgements:** The authors wish to acknowledge the Women's Health Innovation Equity Forum (IEF) for facilitating the dissemination of the survey through its professional network. We also sincerely thank all women healthcare leaders who participated in the study and contributed their perspectives and insights.

Women comprise a significant portion of the health workforce in low- and middle-income countries (LMICs), yet they remain underrepresented in leadership positions[1, 2]. A 2021 Global Health 50/50 shows that while women represent 40% of the workforce in high-income countries, their representation in leadership roles in LMICs falls below 1%[3]. This gender disparity is reported to be shaped by a complex interplay of societal expectations, domestic responsibilities, and professional roles[4]. Studies looking at barriers to women's leadership in health systems report the following: limited access to career development opportunities, the dual burden of work and family responsibilities, and biased perceptions of leadership styles[1].

For instance, a 2023 survey of 75 women in leadership positions in Sudan revealed that psychological, personal, organisational, and social factors influence their career motivations and opportunities. The findings highlighted how stereotypes, prejudice and discrimination permeate different aspects of women's lives and highlighted the impact of social barriers on women's career development, performance and leadership trajectory[4].

Similarly, a systematic review identified work-life balance, lack of support, stereotypes, discriminatory behaviour and organisational culture as perceived barriers to women's advancement in healthcare leadership[5]. Together, these studies illustrate the multifaceted challenges women face in leadership roles in health systems[6].

In Argentina, despite the high participation of women in medical and healthcare personnel, their representation in senior management positions remains notably low, reflecting the persistence of institutional and professional barriers[7]. In Nigeria and the West African region more broadly, previous qualitative research has similarly identified gender-insensitive organisational cultures, implicit discriminatory practices, and persistent gender stereotypes as key barriers limiting women's advancement to leadership positions. These findings have been considered applicable across West Africa due to shared cultural values and social norms that shape organisational expectations, power dynamics, and career trajectories for women in healthcare and research institutions. Taken together, this evidence suggests that, although

contexts differ, women leaders in Argentina and Nigeria face comparable structural and cultural constraints, underscoring the importance of examining both common and context-specific barriers and facilitators across regions[8].

This study aimed to examine perceived barriers and facilitators to leadership among women in health leadership roles.

Materials and methods

Study design

This study adopts a survey-based approach to explore and understand the barriers and facilitators to women's leadership in health systems in Argentina and Nigeria. An open survey was distributed via Google Forms, targeting women in leadership positions in Argentina and Nigeria. The study was approved by the Ethics Committee of the British Hospital in Buenos Aires, Argentina. Participants gave their informed consent electronically, ensuring the confidentiality and anonymity of their responses.

Population

This study adopted a survey-based exploratory design. An open online survey was distributed via Google Forms through professional networks and direct contacts, targeting women in leadership positions in the health sector in Argentina and Nigeria. Purposive sampling was employed to recruit participants with relevant leadership experience, aiming to capture a range of perspectives rather than achieve statistical representativeness. Eligible participants were women aged 18 years or older currently occupying formal leadership roles, including directors, heads of units or departments, service chiefs, section or division managers, or equivalent positions within health organisations.

Data analysis

Open-ended responses were analysed using a qualitative content analysis approach with ATLAS.ti v25 software. Responses were reviewed to identify relevant concepts, and initial codes were assigned inductively. Codes were subsequently grouped into broader thematic categories based on conceptual similarities. The coding framework was refined iteratively through discussion and consensus with a co-investigator. All available responses were analysed in full.

Results

Sixty-two female health leaders responded to the survey. Of these 62 participants, n: 31 were from Argentina, and n: 31 from Nigeria. Participants included 18 managers, 22 department or unit heads, and 22 section, division, or subspecialty heads. There were no significant differences in age between the public and private sectors (42.7±9.7 vs. 41.3±9.7; p = 0.58, respectively) (Table 1).

As presented in Table 2, the analysis identified managing interpersonal skills, career development, and work-life balance as the most frequently reported challenges in achieving leadership positions. Moreover, other commonly reported difficulties include limited resource management, staff conflict resolution, and experiences of gender discrimination. Regarding key leadership responsibilities, most answers included conflict resolution, promoting equity, and empowering team members as essential to fostering teams.

The word cloud (Fig. 1) provides a visual representation of the most frequently mentioned words in open-ended survey responses, highlighting recurrent terms related to management of interpersonal skills, effective communication, and gender discrimination.

Discussion

The results of this study highlight the interaction between individual, social, and organisa-

Table 1 |Sociodemographic characteristics of the participants (Total:62)

Characteristic	n (%)
Current age (years)	Mean ± SD: 50.6 ± 12.3
Age at entry of leadership role (years)	Mean ± SD: 41.6 ± 9.8
Workplace	
Private	30 (48.4)
Public	27 (43.5)
Public and Private	5 (8.1)

Table 2 | Frequency of responding according to code groups (Total participants: 62)

What professional and personal challenges have you faced as a leader?	
Code grouping	**n (%)**
What professional and personal challenges have you faced as a leader?	28 (45.1)
Professional development	21 (31.8)
Balancing work and personal life	14 (22.5)
What do you find challenging about leading?	
Code grouping	**n (%)**
Managing limited resources	19 (30.6)
Staff conflict	18 (29.0)
Gender discrimination	16 (25.8)
Lack of autonomy in leadership	5 (8.0)
Briefly describe lessons learned from your leadership experience.	
Code grouping	**n (%)**
Developing interpersonal skills	25 (40.3)
Effective communication	21 (33.9)
Collaborative leadership	20 (32.2)
Describe what possible interventions would have an impact on the development of the next generation of leaders.	
Code grouping	**n (%)**
Coaching and leadership programs	15 (24.0)
Training in management and negotiation	13 (20.9)
Gender and inclusive leadership	11 (17.8)
In your opinion, what should be a leader's main role?	
Code grouping	**n (%)**
Conflict management	16 (25.8)
Promoting equity	15 (24.2)
Empowering others	10 (16.2)

Figure 1 | Visual representation of frequently occurring words in open-ended survey responses. Larger font sizes indicate a higher frequency of mention



tional factors that shape women's leadership in healthcare, reflecting how institutional cultures and broader socio-cultural norms influence competencies. Consistent with previous research conducted in low- and middle-income countries and diverse international settings[8,9], the women leaders who responded to the survey emphasised the importance of interpersonal skills, effective communication, and collaborative leadership approaches in fostering cohesive, diverse, and committed teams.

A study conducted across 13 public and private healthcare institutions in Iraq examined women's experiences, challenges, and opportunities related to leadership, identifying socio-cultural norms, work–life balance constraints, limited institutional support, and gender bias as key barriers[10]. These findings closely align with our results, suggesting that similar structural and cultural dynamics shape women's leadership trajectories across diverse LMIC contexts.

In line with this, a multicentre survey conducted in Greece concurred with our findings. Its results showed that the main obstacles to women's leadership are entrenched stereotypes, limited career paths, and the competing demands of work and personal life[11]. Our study extends this evidence to low- and middle-income country settings, indicating that similar organisational dynamics operate in Argentina and Nigeria, despite differences in institutional maturity and resource availability.

A qualitative exploratory study conducted in Pakistan examined the barriers and facilitators of leadership among 16 women in senior management positions in academic institutions and medical and dental clinics in different provinces[12]. Like our results, the authors identified gender bias, exclusion from decision-making processes, expectations about roles at work and in the family, and deeply entrenched socio-cultural norms as the main constraints to women's leadership in healthcare.

A Latin American analysis highlights particularly pronounced gender disparities in Argentina. Women represent only about 3% of the members of Argentine medical academies, one of the lowest proportions recorded in the Region[13]. This severe underrepresentation at the highest levels of academic and professional governance reinforces the idea that barriers to leadership not only operate at the individual or institutional level but are deeply rooted in national professional structures.

In terms of facilitators for advancing women's leadership in healthcare Negrotto et al.[13] identified in Latin America the following: structured mentoring programmes, leadership training tailored to female physicians, blind selection processes for leadership positions, and gender-sensitive organisational policies as high-impact strategies for reducing leadership gaps in medical societies, hospitals, and universities. These facilitators closely align with the opportunities identified by participants in our study, who emphasised the importance of coaching, leadership development programmes, and inclusive organisational support to counter gender-based constraints.

In 2020, a virtual programme was developed to promote women's leadership in global health through online events and peer support networks. Five global leaders shared their experiences with more than 1300 attendees from 44 countries. The programme highlighted the importance of seizing unexpected opportunities, building connections to promote diversity and inclusion, finding personal passion, and strengthening essential skills such as communication and self-awareness. In addition, a survey showed that most participants gained a better understanding of the challenges faced by women leaders and highlighted the importance of flexible, non-linear career paths, openness to unexpected opportunities, and continuous learning as key factors for leadership development[14]. These approaches align with our findings, in which adaptability, cross-functional skill acquisition, and exposure to diverse professional settings emerged as essential competencies for women in leadership roles in complex, resource-constrained healthcare systems.

Beyond structural and programmatic interventions, our findings also point to the relevance of leadership models that prioritise empathy, transparency and self-awareness as core competencies, rather than personal traits. Emerging evidence from leadership experiences worldwide suggests that humanised leadership approaches, characterised by openness to un-

certainty, recognition of personal and professional limits, and relational forms of authority, can enhance institutional trust, collective commitment, and long-term sustainability. In health systems characterised by complexity, crises, and resource constraints, these approaches can be particularly valuable, as they counteract hypercompetitive leadership norms and challenge expectations of constant availability that disproportionately harm women. Therefore, incorporating these principles into leadership development and organisational cultures can contribute not only to gender equity but also to more resilient and legitimate health systems.

Notably, the evaluation of this virtual leadership programme also offers practical insights into scalable institutional measures to strengthen women's leadership development in healthcare. The virtual format facilitated the participation of high-level global leaders whose involvement would have been difficult to coordinate through in-person events, while reaching a broad international audience. Furthermore, the emergence and rapid growth of spaces dedicated to peer-to-peer networking, such as online community platforms created at the request of participants, underscores the value of peer and quasi-peer connections as a complement to traditional mentor-mentee models. These platforms provided structured opportunities for reflection, relationship building, and professional advancement. These elements illustrate how network-based, institutionally supported leadership training models can translate leadership development into actionable and context-appropriate actions within health systems.

Despite progress in gender equality policies, systemic barriers persist, particularly in Argentina and Nigeria. Challenges such as work-life balance, gender bias, and limited access to leadership opportunities remain significant obstacles for women. Addressing these barriers through targeted interventions, such as coaching, leadership training, and organizational reforms, was highlighted as a potential pathway to enhance women's representation in senior healthcare roles[15]. These recommendations, derived directly from the study population, align with global calls for systemic change to promote gender equity in leadership.

The study also highlights the importance of adopting a systemic and forward-thinking leadership approach, sing skill development and leveraging team members' strengths. These strategies were identified as integral to addressing the barriers women face and fostering environments conducive to their success in leadership positions.

As a first small study, this research provides an important foundation for a more comprehensive exploration of women's leadership in healthcare in Argentina and Nigeria. Future studies will expand the sample to include a more diverse range of participants across professional roles, institutional settings, and geographic regions. They will incorporate data on socio-economic characteristics and key social determinants of health. This broader approach aims to elucidate the multifaceted influences on women's attainment of leadership positions and to identify evidence-based interventions and strategies that can promote gender equity in health leadership. By addressing these dimensions, future research can help develop actionable solutions to achieve equitable representation of women in leadership across healthcare.

Conflict of interest: None to declare

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