# Seeking To Understand, Aspiring to Teach: Exploring How Life Shapes Emotional and Personal Development in Global Health Leaders

***Video Material on Emotional-Intelligence Based Qualities***
***(Non-Identifiable Qualitative Secondary Analysis)***
***Follow-Up Interviews on Emotional and Personal Development***
***(Primary Data Collection and Qualitative Transcript Analysis)***

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Abstract

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*Background*: This study explored the formative experiences that influence a leader's attitudes and practices in the global health setting. Strong global health leadership is key to achieving the Millennium and Sustainable Development Goals per the World Health Organization (WHO). Lack of it is seen as part of the implementation gap. Hence, training of global health leaders is an important part of health systems strengthening and achievement of those goals. Emotional intelligence and leadership practices guided by it, are associated with greater patient satisfaction, program health outcomes and team effectiveness. Therefore, understanding how emotional intelligence – guided practices (EI-GP) develop in effective global health leaders can improve future health leadership training and coaching.

*Methods:* Thirteen established global health leaders were interviewed through hour-long qualitative, semi-structured interviews. They were a subset of the 66 interviewees from the *Everyday Leadership* website. Interviews were audio-recorded and manually transcribed. Atlas-Ti supported data analysis, as did a second-reader review and agreement.

*Results:* The global health leaders interviewed for this study described EI-GP as both emotional and behavioral practices that they engaged in. They found these EI-GP to be valued across cultures that they had worked in. The formative experiences they commonly reported upon were with parents and mentors and from general life experiences. The global health leaders interviewed reported becoming aware of valued EI-GP through reflection on those life experiences. This purposive sample of global health leaders demonstrated gender differences and fluidity in language, behavior and perception of EI-GP. For future health leadership training, they recommended audience-dependent framing and structuring of EI-focused objectives through experiential learning and mentorship.

*Implications:* A better understanding of how global health leaders may have developed EI, known to be important for strong leadership functioning, can guide future leadership training and curriculum development. More effective health leadership can directly and indirectly strengthen health service implementation through improved team functioning and patient outcomes, bringing us closer to achieving the WHO's Millennium and Sustainable Development Goals.

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As I moved towards crafting the how-to, Peter Polatin, Nancy Campbell and Jennifer Tee generously offered their time for me to pilot my semi-structured interviews, and provided suggestions for improving the questions and interview style. Their feedback enriched the quality of the interview data I eventually gathered. When the interviews were all completed, Rahul D'Silva determinedly rolled up his sleeves to type and transcribe the recorded interviews for hours, to provide me with transcripts that I could analyze. Sarah Frey patiently read through all of the transcripts, and my written report of the findings, to provide me with an outside opinion of how the raw material correlated with my reported results. And at the foundation of all this work that has come together stood my family and friends, who provided constant support and faith in my ability to complete this ambitious project.

**Table of Contents:**

**Frequently used abbreviations:**

CI – Cultural Intelligence
EI-GP – Emotional Intelligence – Guided Practices
EI – Emotional Intelligence
EL – *Everyday Leadership* (website)
EQ-i – *Emotional Quotient Inventory*
FE – Formative Experiences
GHL – Global Health Leaders
GHLP – Global Health Leadership Practice
HLT – Health Leadership Training
LPI – *Leadership Practices Inventory*
PA – Processing Awareness
PE – Pursued Experience
PPI – Personal – Professional Integration

# INTRODUCTION

*"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." - Maya Angelou*

Emotional intelligence (EI) has been found to be the single most important factor for superior performance from entry-level jobs to top executive positions, consolidated from extensive research in the business world.[1, 2] The specific and focused development of emotional intelligence (EI) in global health leaders (GHL) must become a priority in global health leadership training if we want to make critical strides towards global health systems strengthening.

Within health systems, as in other types of systems, strong positive leadership can translate into strong health systems, teams, and, by extension, patient outcomes. It can also lead to stronger inter-organization collaboration – a critical ability in global health. The World Health Organization (WHO) has emphasized the value of strong leadership and governance as the central component among the six building blocks of health system strengthening[3], key to reaching the Millennium Development Goals (MGD) and upcoming Sustainable Development Goals (SDG). Lack of strong global health leadership practice (GHLP) is seen as part of the implementation gap[4], and strong health leaders are a critical stepping stone in closing the gap between knowing how to do something and implementing it.[5] Management in Health Services (MHS) made an "urgent call" to develop GHLP.[6] GHLP training is, hence, a critical part of health systems strengthening, and training needs not only to be knowledge based, but also to be skills (behaviors) and attitudes (awareness) based.

The US Centers for Disease Control and Prevention (CDC) collaborated with the University of California (UC) to offer a Public Health Leadership Institute, the nation's first one year leadership development program serving senior public health leaders. A retrospective study

of participants from 1991 – 1999 reported a positive impact on the leadership skills and confidence at personal, organizational and community levels.[7] The study was based on self-report, and neither examined EI specifically, nor were they able to measure the impact of these trainings on health outcomes on the ground. The National Public Health Leadership Development Network (NLN) developed a Public Health Leadership Competency Framework in 2000 with CDC support. It specifies competency-based training, including the areas of visionary leadership and team-building.[8] However, how to teach these competencies is still unclear. Another long-standing program is the Afya Bora Global Health Leadership Fellowship, a collaboration focused on leadership and management training between four African countries and four US academic institutions. Nakanjako et al[9] reported on how the fellowship training improved critical thinking skills and participants' abilities to implement research studies in support of Ministry of Health efforts to strengthen health systems. However, teaching methods and measures of team-based and interpersonal skill development have not been reported as contributors to the impact of this fellowship. Showing the relationship between EI-development and health outcomes is clearly challenging. So why is this still an important leadership competency to include in health leadership training?

This study was based on the assumption that coordinated team-based efforts contribute to successful health programs on the ground. Strong health leaders guide stronger health service programs and increased employee and patient satisfaction.[10] Leaders who use EI are more effective in achieving workplace team-based outcomes.[11] Stubbs and Wolff found that a team leader's level of EI significantly related to the team's collective group EI, which then significantly related to team performance.[12] So teams led by leaders using EI-guided skills are

more effective in implementing those health programs. Therefore, GHL need training in EI-guided leadership skills as an important component of strengthening global health systems.

Health professions leadership report a desire to see more EI-guided leadership training. A study of chairpersons and faculty in allied health professions found that they believed that organizational outcomes of higher effectiveness and employee satisfaction depended on a transformational leader in charge,[13] a style of leadership known to be strongly rooted in EI. However, specific health leadership training on EI is seldom offered, nor measured for its impact on health outcomes. A recent systematic review of physician leadership development programs noted that most measured individual-level outcomes such as increased knowledge about leadership, but did not focus or promote greater self-awareness or system-level outcomes[14]. Advice for physician leadership development is to model other physician leaders[15], but it is not clear what specific qualities they should model.

Studying and understanding how effective leaders who are demonstrating high EI have developed it within themselves will help with teaching leadership. What qualities are essential in GHL or health leadership in general? And how are they shaped in effective leaders? Understanding that process might guide the training of future health leaders, resulting in improved employee satisfaction, overall organizational effectiveness, and, consequently, improved patient outcomes and health services. If there is a difference between leadership styles in men and women and across cultures, that would be important to understand for training, too, and for leading program implementation in the global arena.

The focus of this thesis research was on better understanding how emotional and personal development occurs in GHL in the hope that this understanding can guide EI-based leadership

training. The study further explored whether and how these health leaders saw a connection between personal growth and their professional development at work.

**Defining Leadership**

*"Leading well means enabling others to face challenges, achieve results, and create the positive future that people envision."*
*–An Urgent Call to Professionalize Leadership and Management in Health Care Worldwide*[6]

While leadership and management are closely related concepts, they require different skill sets. Many definitions of what constitutes strong leadership have emerged over the years. Peter Drucker, a well-known writer and management consultant, liked to say, "Leadership is doing the right thing. Management is doing it right."[16] Harvey Firestone, an American businessman and founder of the Firestone Tire and Rubber Company, added, "The growth and development of people is the highest calling of leadership." We recognize the end result, but what are the behaviors that enable good leadership and win support in communities and teams to work toward a common vision? People have tried to explain what constitutes great leadership for decades. Over time, the conversation has moved from a belief in inborn traits such as charisma[17] to support for learned behaviors such as transactional leadership – leading by rewarding for transactions and goals met- and on to the more current ideas of transformational leadership[18] – leading by winning over and transforming followers[19] [20] and authentic leadership[21]. Well into the 20th century, Western leadership theories based themselves on top-down, bureaucratic, in-born qualities of leaders that few were fortunate to have. For a long time, the "Great Man" theory remained prevalent – the idea that leaders came from the rich, upper, and usually fair-skinned classes, naturally born into and destined to lead the masses.[22] Theories focusing on leadership traits came next, emphasizing qualities such as eloquence, intelligence, and self-confidence. [22]

Either way, one had to be born with these capabilities, leaving the majority of people without a chance of being considered capable of leadership.

As we entered a more knowledge-oriented economy towards the latter part of the 20th century, leadership began to be recognized as shifting towards what Uhl-Bien et al[23] framed as Complexity Leadership Theory. Moving from the old administrative leadership styles, they described two other categories of leadership – enabling and adaptive styles. These styles are based on acquired skills and behaviors, implying that leadership can be learned and skills honed. The behavior-based styles dynamically interact between more rigid administrative functions of organizations, and emerging Complex Adaptive Systems[23] Other literature on leadership theory expanded upon these categories by describing styles such as autocratic vs. democratic vs. laissez-faire leadership,[24] production- vs. employee-oriented leadership,[25] and transactional leadership.[22] Eventually, scholars of leadership theory began to recognize the value and phenomena of situational or contingency-based leadership – the notion that leaders should shift their style of leadership and the skills used based on the context, which could include political environment and climate, organizational structure, and employee personality.[22] Theories on transformational, servant and integrated/ multifaceted leadership began to take hold in the later part of the 20th century and guide modern thinking[22]. They built on combined schools of thought on styles prior to this point, acknowledging in leaders a combination of in-born traits, circumstances of birth, contextual responsiveness, and learned behaviors and skills. Thought leaders included Robert Greenleaf (servant leadership – where a leader serves his/her followers),[26] James Burns (moral leadership – leaders guided by their morals),[27] and Parker Palmer (leadership development based on self-knowledge).[28] Finally, in the first decade of the 21st century, a new theory has been evolving – authentic leadership. It combines concepts of "being self-aware and acting in accord

with one's true self"[29], acting based on one's ethics and morals, being oriented toward interpersonal relationships, nurturing growth in followers, and integrating one's personal and professional self into a single personhood. Authentic leaders practice self-awareness, model positive behaviors, and regulate themselves emotionally[30]. We see through this overview a theoretical movement from born leaders to leaders who are developed and who balance tasks and relationships with their own inner ethics and morals.

The theories on transformational leadership onward have two things in common – they are guided by ethics, and the leaders use a higher level of EI to guide their own actions, decisions, and interaction with followers. In general, life experiences shape people, so how do life experiences shape leaders? Do they process their experiential memories differently from non-leaders, such that they consciously and sub-consciously draw more from them, perhaps through active reflection on their memories? If EI-guided leadership styles involve an integration of one's personal and professional selves, how can we better understand the benefits of that integration and how it occurs?

In a large mixed methods research study conducted in the business world by Bill George and Peter Sims[31], 125 leaders were interviewed, with a framework of exploring how they developed the qualities that helped them become leaders. All were leaders identified as highly effective by colleagues, academics engaged in leadership, and others. People saw them as true to themselves in all that they did. People also described them as people who integrated their personal with their professional lives – they maintained the same personhood in both spheres of life. The interviewed leaders added that they believed an important component of leadership development included self-discipline and nurturing connected relationships. The results from this study were presented in the book, *True North.*[31] Shamir and Eilam proposed that authentic

leaders developed by reflecting on their lives and developing a life-story[32]. The authors found that those who reflected on their life experiences and grew through self-reflection were better able to lead others and emotionally connect with teams. Some gender differences have also been noted within transformational or authentic leadership styles. Women tend to be more interactive, sharing power and information[33]. Eagly and colleagues found in a meta-analysis of literature on transformational, transactional and laissez-fare leadership styles that women tended to use a mix of the former two styles of leadership more than men did[34] and that these styles were associated with their overall effectiveness as leaders. Self-reflection on one's life experiences, gaining aspects of EI, and integrating one's personal and professional personhoods appear to be important for leadership in the knowledge-oriented economy and dynamic work environments of the 21st century.

**Emotional Intelligence**

It is common to study how to improve interventions in health service programs or systems, measuring health outcomes as markers of success; it is less common to consider how those in charge of leading and managing the programs impact their implementation. Improving leadership functionality among heads of teams, for instance, can impact the effectiveness of program and health outcomes. The transformational and authentic leadership literature discusses the development and use of EI as an essential component of leadership.[35, 30] In recent years, EI has come to be defined as "proficiencies in intrapersonal and interpersonal skills in the areas of self-awareness, self-regulation, self-motivation, social awareness, and social skills."[36]

EI can be measured through several validated instruments. One of the most well-known is the *Emotional Quotient Inventory* (*EQ-i*), developed by Bar-On[37, 38], a self-report measure of emotionally and socially intelligent behavior that provides an estimate of emotional-social

intelligence. It measures components of EI such as emotional self-awareness (intrapersonal), empathy (interpersonal), stress tolerance (stress management), flexibility (change management), and optimism (self-motivation). It also makes a distinction between the intrapersonal EI components as generally relating more to EI and the interpersonal components generally relating more to social intelligence. The *Hay 360 Emotional Competence Inventory* not only assesses workplace EI, but also helps to develop and build EI competencies in the workplace.[1] The *Mayer, Salovey, and Caruso Emotional Intelligence Test* (*MSCEIT*) measures four EI abilities – perceiving emotion, using emotion to facilitate thought, understanding emotion, and managing emotion.[39] Another validated instrument, the *Leadership Practices Inventory* (*LPI*)[40], has consolidated aspects of leadership practices into five components - Modeling the Way, Inspiring a Shared Vision, Challenging the Process, Enabling Others to Act, and Encouraging the Heart. Posner and Kouzes, the authors, identified 14 key concepts of EI, such as emotion management and impulse control, within these five leadership practices.[41] Of note, any descriptions of EI components tend to be action- or process-oriented and not inert qualities. Hence, in this study, the author refered to these components as EI-guided practices (EI-GP) – practices that come for exercising acquired EI.

The abilities to be emotionally self-aware and to empathize with others are considered central to having high EI.[42, 38] Skinner and Spurgeon[35] found that components of empathy (measured on an itemized scale of empathic concern), perspective taking (being able to assess a situation cognitively while being emotionally self-aware) , and empathic matching (reflecting what one senses in someone else's emotions) were strongly related to transformational leadership. High EI is also strongly correlated with high impetus towards self-actualization[43], striving to reach one's full potential. In general, older adults have greater EI than younger

adults.[38] EI is teachable and learnable[38] and can be increased with training. Sjolund and Gustaffson's Swedish study found that after an intensive workshop for experienced managers, not only did their overall EI scores increase, but also the two EI components that increased the most were emotional self-awareness and empathy.[44] Additionally, the ones with the lowest beginning EI scores improved the most.

Results on gender differences in measures of EI seem to vary in the literature. Using the EQ-i, Bar-On reported no overall differences in EI scores between men and women.[38] Yet Schutte et al found that women measured as having more EI overall than men on a scale consolidated from the *MSCEIT* items.[45] Bar-On did find that a few EI components had statistically significant gender differences. In their North American normative sample, Bar-On's group found that women had stronger interpersonal skills (such as empathy, maintaining satisfying interpersonal relationships and a greater sense of social responsibility) than men. Men however, had greater intrapersonal ability (self-regard, self-reliance), were better at managing emotions (stress tolerance), adaptability (flexibility), and were more optimistic than women. Cross-culturally, pattern of results for gender differences were maintained across population samples from different countries. In addition, different ethnic groups did not vary significantly in their EI scores.

Researchers in a United Kingdom-based study were interested in comparing how men and women differed in EI self-estimated scores versus measured scores.[46] Similar to Bar-On, they found that men and women did not measure differently on overall EI, using the *MSCEIT* items, except where women scored higher on the "social skills" component. However, they also compared self-estimates of EI by men and women to the actual measures of EI between genders. Men consistently self-estimated EI components higher than women did. Men's self-estimated

scores then correlated far more strongly with their measured EI scores than did women's estimates. They discussed their findings as indicating that either men displayed a self-enhancing bias or were accurate in their estimation of their EI compared to their measured scores. Women, on the other hand, displayed a self-derogatory bias, estimating their EI components as less than what they were actually measured. Gender differences in EI might even out at the top. Hopkins and Bilimoria[47] found that, among the most effective men and women at the top of the organizations that they were studying, EI competencies were equal. These men and women also equally demonstrated these competencies. However, in a 360 degree evaluation, the observers rated the women as being less successful than the men.

Why might being aware of gender differences in EI matter? Women may underestimate their EI, have less self-confidence in their ability to use these skills, and then underperform because of lowered self-expectations. This problem could be worsened if observers and colleagues around them see women as less successful even though they might be demonstrating equal EI competencies to men. It might indicate that in health leadership training and self-estimating measures, women need more prompting and encouragement to acknowledge the EI skills. It also would be valuable to use observer reporting such as 360 degree evaluations of EI competencies instead of simply self-report in order to provide women leaders with more accurate, positive feedback.

**Meta-Cognition and its Extension into Narrative and Emotional Processing**

Meta-cognition is the notion of being aware of what one knows and whether it's accurate. It is the process of thinking about one's thoughts and being aware of one's current actions and cognitive or emotional state.[48] In the world of psychotherapy, a similar process is noted in narrative therapy, or the narrating of one's life story.[49] In this process of reviewing one's life and

the turns it takes, the lessons learned, and the joys and pains experienced, one gleans meaning from it, clarifying for oneself what one values. People create self-identity by this process of attempting to understand their own lives. That process can provide direction for the future and clarity of vision, mission and purpose in life. Reviewing one's own life story can also help to process pain and nurture growth through difficult, dark memories. This might be termed *meta-narrative*. As discussed earlier, certain leadership styles are more strongly associated with higher EI, authentic leaders being one of them. Shamir and Eilam noted how authentic leaders seem to develop a life-story that clarifies their values and self-knowledge.[50] They suggested that this process develops authenticity. It also might be the way to develop EI. Similarly, Mirvis reported teaching executive leaders consciousness-raising techniques that increased their self-awareness and interpersonal relationship skills – both being components of EI.[51] Both these processes seem to correlate with the concept of meta-narration.

If methods to promote meta-cognition and meta-narration are ways in which EI can be developed in an individual, which we know to be a strong component of effective 21st century leadership, perhaps these methods can be incorporated into leadership training programs for health leaders. For future research, this prompts us to develop ways to measure systems-level outcomes of stronger leadership training and development. Growing stronger leaders in this manner could grow stronger health service programs and, in turn, improve health outcomes.

**Conceptual Framework**

***"****Self-awareness is no one-time project. No less essential than the initial assessment of one's strengths, weaknesses, values and worldview is the ongoing, everyday habit of self-reflection." – Chris Lowney,* Heroic Leadership*[52]*

Review of the literature provided an overview of leadership styles and their development over time and the concept of EI and its important role in these later styles of leadership. In

research on business leaders and authentic leadership, Bill George[31] and others[32] discovered that authentic leaders reflected on their lives in a way that shaped their leadership growth. These leaders did not present separate personalities at home or at work, but rather integrated them into one personhood. This literature review provided context on why developing EI in GHL is important for health systems strengthening and program effectiveness. Figure 1 illustrates a conceptual framework model tying together these concepts discussed to this point in a proposed hypothesis of how EI and EI-GP might develop in leaders, leading over time to personal and professional development of those leaders. It provides a frame that the study used to explore specific aims and guide questions in the qualitative research.

**Figure 1:**

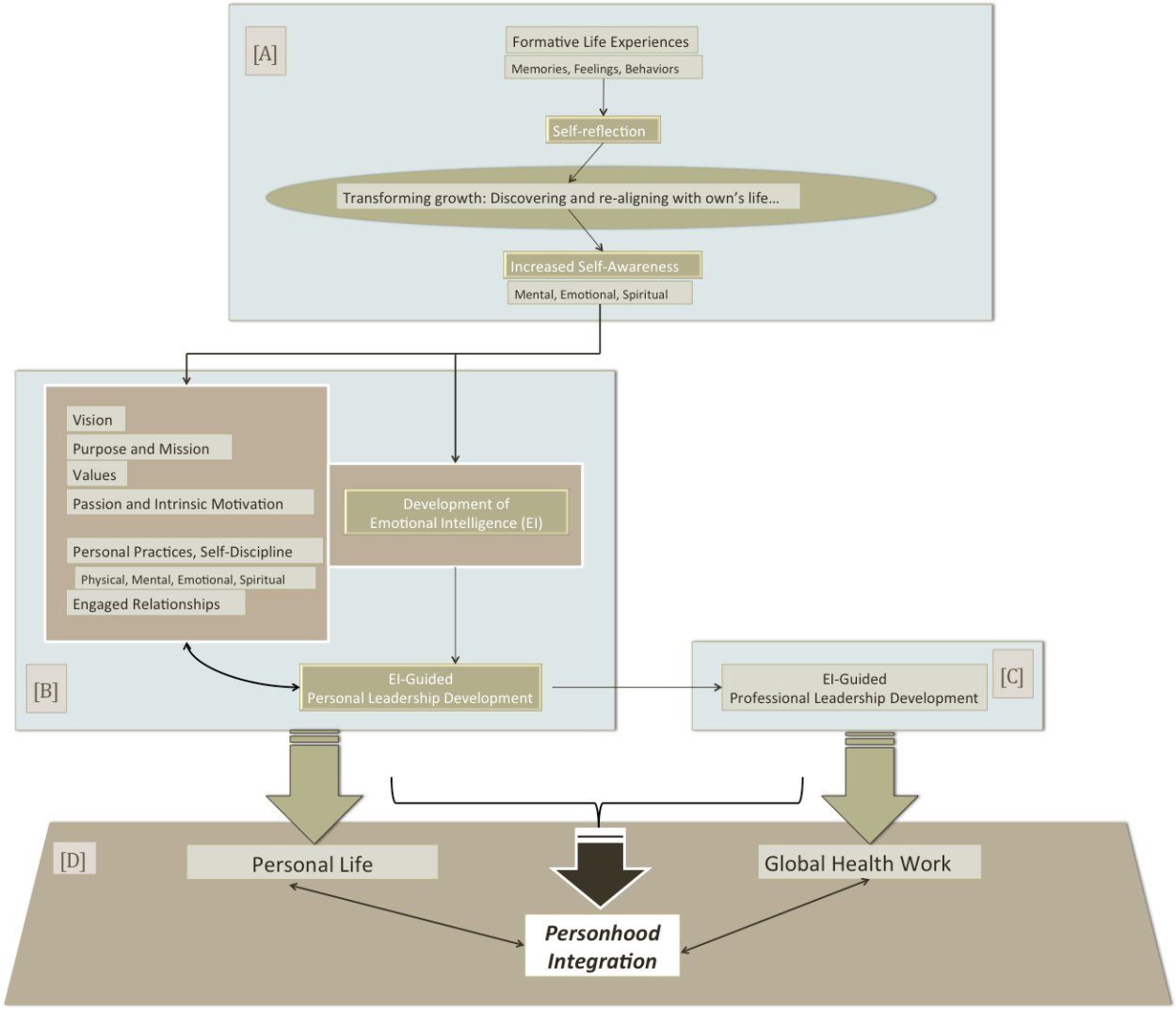


Figure 1 begins with acknowledging the presence of formative life experiences in everyone's lives [A]. Self-reflection on one's formative life experiences includes reflecting upon key influential figures in one's life and significant life turning points. The hypothesis in this study is that effective leaders who have developed EI have taken the time to self-reflect. As Figure 1 indicates, that self-reflection acts as a stepping stone or catalyst, to promote a process of transforming intrapersonal growth.

That inner growth then leads to increased self-awareness of who one is emotionally, mentally and spiritually. It necessitates acceptance of all of oneself, both faults and strengths. Only from that awareness and acceptance can one grow in areas that need improvement. This whole process [Figure 1-A] occurs within the self-reflective individual.

Learning to self-reflect in increasingly refined ways, and maintaining self-awareness moves the individual towards developing emotional intelligence inwardly and clarifying life direction and active self-development outwardly [Figure 1-B]. Open acceptance of what one has become self-aware of nurtures inner emotional development, aspects of which are measured by emotional intelligence scales. As the individual grows in emotional intelligence inwardly, he/ she concurrently uses that self- and emotional-awareness to clarify her/his vision, mission, purpose, passion and values. The person understands his/her own internal motivations for living a meaningful life and working professionally and begins or continues to cultivate regular personal practices that build self-discipline, as well as forging and strengthening rich interpersonal relationships. Those efforts come together to foster EI-guided personal leadership development. Through that personal growth and development one gains deeper communication skills and EI-guided professional leadership development [Figure 1-C].

The personal development sustains a rich personal life. The professional development sustains professional work life. As authentic leadership demonstrated in the literature, this thesis research study predicted that this entire process of growth and development as outlined in Figure 1 would come together for authentic personhood integration [Figure 1-D].

The focus of this research study was to better understand whether reflection on life experience fosters emotional and personal development in health leaders, in the hope that this understanding can guide EI-based leadership training for GHL trainees. Self-reflection can occur

through a meta-cognitive and meta-narrative process, as discussed earlier. This study explored the concept and process of what could be called *meta-emotionality* – being emotionally aware of one's one level of emotional development and how one grew to that level, predicting that this process would result in developing EI. The study further explored whether and how these health leaders measured a connection between personal growth and their professional development at work.

## METHODS

**Specific Aims:**

***- Primary Research Questions:***

i. How do global health leaders describe qualities and components of emotional intelligence that they believe are important for their leadership?

ii. How do formative life experiences shape emotional intelligence as an aspect of leadership in global health leaders? How do they gain an awareness of those emotional qualities?

iii. How do global health leaders suggest shaping training curriculum on emotion-based leadership skills, for the next generation of global health trainees?

***- Secondary Research Questions:***

iv. Do men and women describe EI and process its growth within themselves differently?

v. Through emotional and personal development, do leaders integrate their personal and professional selves? If so, how and to what benefit?

**Analytical Orientation and Positionality**

The research questions were approached with a more interpretive (open-ended, exploratory) than positivist (preconceived hypothesis to prove) perspective. The conceptual framework presented a proposed hypothesis, yet openness was maintained to changing that framework as themes arose during the research and analysis that guided an understanding of the responses to questions. From a positivist point of view, having reviewed several theories on leadership styles that discuss emotional development, the researcher framed an informed possibility on how a leader in global health may have come to that style of leadership. Yet from an interpretivist perspective, she maintained being open to the informants' perspectives that may not have been part of the literature on leadership or the researcher's personal view. While this research was conducted on a small scale with a concentration of established global health leaders, which offers a hermeneutic perspective, it was hoped that it would help fine-tune the proposed framework in a way that could be extended to general leadership skills training. Overall, the interviewees' responses seemed to closely correlate with the conceptual framework outlined in Figure 1.

In conducting this research, the position of the researcher was considered "in-group" for several reasons. She was a physician specialized in psychiatry and trained in a program that emphasized reflective, emotion-based therapeutic stance. Her medical and psychiatric training in underserved and ethnically diverse populations has sensitized her to the struggles of healthcare in ethnically and culturally diverse communities. In her personal and professional lives, she has pursued a self-reflective process to actively help her understand how these experiences have shaped her. She has also had training and work experience in leadership and management. This combination has helped to develop her own EI to a moderate-high degree (also measured

quantitatively). However, the lack of experience in global health leadership resulted in her out-group positionality, as well.

**Stages of the Research**

The researcher generated an a priori codebook using a list of EI-based qualities from two sources – the *Emotional Quotient Inventory* (*EQ-i*) composite scales and sub-scales[53], as well as the *Leadership Practices Inventory* (*LPI*) *14 Key Concepts of Emotional Quotient*.[41] Overlapping themes and constructs were eliminated to minimize repetition. The research was then conducted in two stages over a period of nine months.

***Stage 1: Review of Original Interviews from 2010, and Video Analysis***

Stage 1 consisted of a qualitative analysis of previously completed videotaped interviews with 66 global health leaders on a website called *Everyday Leadership*. The purpose of Stage 1 was to understand how these interviewees generally described the qualities of leadership. The original individual, in-depth, semi-structured interviews were conducted by the University of Washington (UW) International Training and Education Center for Health (I-TECH) global health program. GHL were selected from different types of health organizations, at various levels of the organizations, in both formal and informal leadership positions. Interviewees were selected using intensive purposeful sampling of senior leaders and managers. I-TECH country office leads developed a list of established, well-regarded health leaders from around the world who they had worked with for many years and considered GHL. Inclusion criteria for this list consisted of men and women GHL from diverse cultural and national identities (i.e., Ethiopia, India, Malawi, Namibia, and South Africa) who were considered to demonstrate strong leadership skills. These GHL had visible success in maintaining engaged interpersonal

relationships and being people who others enjoyed working and who successfully led and managed health programs. The original interview questions covered topics of leadership style, value systems, cultural differences, lessons learned, professionalism, and integrity. The researcher reviewed these videotaped interviews using the a priori codebook to select 44 potential Stage 2 study participants based upon whether they described EI qualities in their conversations.

***Stage 2: New Interviews in 2015-2016 and Transcript Analysis***

Stage 2 involved conducting a cross-sectional qualitative study of a subset of global health leaders from the original 2010 *Everyday Leadership* cohort. Individual, in-depth interviews explored the relationship between their formative life experiences and the development of their EI-based leadership skills. IRB authorization was approved under the "Expedited/ Minimal Risk" category [Appendix A]. Of the 66 participants from the initial interviews by I-TECH, 44 GHL who described EI-based qualities as important to their leadership style and global health work were invited to participate in Stage 2 of the study. Recruitment spanned five months. Inclusion criteria were the same as in Stage 1. The initial target sample size was seven men and seven women. Of the 44 invitees, 11 men and 11 women replied expressing interest in being interviewed. Six men and seven women completed the consent and interview process, at which point the study was closed. Informed consent forms assured confidentiality, essential in this study as public figures were being interviewed about their personal lives [Appendix B]. Participants could also opt to defer completing the study, or exit from it, if relating life stories became emotionally upsetting for them. None of the 13 needed to do so. Participants were interviewed in their home countries via Skype and audio-recorded for transcription. Semi-structured interview questions were constructed based on the study Research

Questions [Appendix D], using some question structures from George et al.[21] Pilot interviews helped focus the questions before beginning study interviews. After completing the first four interviews in the study, two additional questions on life experiences and health leadership training were added. These were sent by email to the people already interviewed to assure a complete record of responses. Interviews were transcribed verbatim. The a priori codebook from Stage 1 helped to begin data analysis of EI-based qualities, leaving open the generation of new codes, as needed. The rest of the material was thematically and analytically open coded. All coding was done with the help of Atlas-Ti Software to help organize themes and categories that emerged. At the end of the analysis, themes that contained less than five quotations were merged into others that they overlapped with, which helped assess frequency of arising themes. A second reader was used to compare the material from the 13 transcripts with the researcher's written results. Agreement through discussion was established on all themes presented in the results. IRB authorization was approved under the "Expedited/ Minimal Risk" category.

**Study Strengths and Limitations**

In general, the purposive sampling of GHL by I-TECH staff originally may have biased the sampling away from other leadership styles. Additionally, these leaders were already recommended by their colleagues as people demonstrating a higher level of emotion-based leadership skills. A more random sample of leaders may have presented different responses and themes. However, particularly in qualitative research that sometimes needs enriched sampling for data that is difficult to find or understand, intensive purposive sampling is a useful method to achieve that. Given that this sample is specifically of health leaders from around the world, it may not be generalizable to all leaders or to those with different leadership styles. Cultural

differences among leaders within the sample may have made it difficult to collect comparative information, or it may have affected what information they offered. Cultural differences in the interviewers (different interviewers were used in Stage 1 and 2) could also affect how and what responses were elicited. Since all interviews were conducted in English, it may have limited sample selection, as well as expressiveness by non-native English speakers.

The entirety of video material originally recorded for the EL website might have contained clips of some leaders describing EI-GP that were not included in the clips on them that were published in the online video clip database. Since leaders were invited based o EI-GP described in published clips on the EL site, some leaders may not have been invited when in actuality, their excluded clips may have contained material describing EI-GP. This was one limitation of the Stage 1 sample selection process. The research might have missed voice nuances or gestures in Stage 2 interviews that meant something to the original interviewer. Also, interpretation could be skewed when video material was reduced and taken out of context. However, these limitations were possibly mitigated by using Stage 1 to generate a consolidated codebook on EI-GP of value to GHL. That does not limit Stage 2, as the interview questions asked about emotional qualities anew. Audio-recording interviews might have introduced some hesitation in offering information, but likely provided more in-depth material to analyze via transcriptions.

Additionally, awareness of one's internal growth and the verbal expression of it might be more or less restricted in various cultures. One's cultural background may keep one from talking openly with a relative stranger about previous life difficulties, for instance. Similarly, the degree to which that awareness can be verbally expressed might be stronger in some cultures than in others. These could limit the information received in the Stage 2 interviews. A professional

transcriptionist transcribing the material can improve text accuracy, but could also result in lost information from pauses and conversational nuances. Transcription itself reduces some information, but is necessary as a method to condense, analyze and distill the data. Finally, in spite of reassurances about confidentiality, conducting these audio-recorded interviews with public, well-established figures in global health might limit their comfort in divulging more sensitive information about their life stories. Exploring participants' perspectives on their own EI-GP, behaviors and leadership skills could introduce reporting bias. A more expanded way to understand these categories of data in the future would be to gather the perspectives of colleagues working with these leaders. A combination of qualitative and quantitative data with a larger sample as a next research step would also provide more comparative data than a study sample of 13 participants, while this was a good number to begin exploratory research with. An in-person interview might also have helped with data quality, although Skype provided a fair visual interaction, which was better than the non-visual limitations of phone interviews. Regardless, the study, in combining Stages 1 and 2, had the strong advantage of constituting a cohesive whole – from analyzing the videos as background information and enabling a priori coding to returning for fuller interviews on questions of interest. By using a subset of the original sample of leaders, the researcher was able to gather more in-depth data in Stage 2 having had the context of interviews and perspectives by those leaders in the Stage 1 interviews. The comfort and familiarity of being interviewed in their home countries for most leaders likely induced a smoother interview than if done in unfamiliar settings. Demographically, the participants were all in the latter stages of their career trajectories. They had all successfully held multiple global leadership positions, both within and outside their home countries. Hence, their thoughts and opinions about EI-GP come from at least two decades of practical application and experience.

This enriched and diversified the study sample, providing rich content material for the questions this study sought to answer.

## RESULTS AND DISCUSSION

### Demographic Overview

Among the 44 global health leaders from the *Everyday Leadership* website who were invited to participate in the study [Appendix C], an equal number of men and women (11 each) responded via email accepting the invitation over the course of four months. Thirteen global health leaders eventually completed the consent process and interview (6 men and 7 women). The men's ages ranged from 57 to 78 years. Women ranged in age from 49 to 67 years. Although the invitation to participate included an even spread of people from around the globe, among the 13 who completed the consent process and interviewed, five participants reported being born in the US The remaining eight reported countries in the global south as their birth countries. Of the six men, one has lived outside his birth country for more than three years. Of the seven women, six have lived outside of their birth countries for more than three years, with three of them now calling another country their home. However, all 13 have travelled extensively globally and have lived outside of their birth countries for extended periods of time related to their global health work. At the time of these interviews, all participants except one woman had returned to living in their birth countries. Of note, none of the 13 interviewees responded to the question of gender identification, although two men described themselves as being "gay" or homosexual during their interviews. The participants' degrees ranged from Bachelor's level education to post-graduate (either Doctor of Medicine or Doctorate of Philosophy). With professional careers

spanning at least 2-3 decades, they all had- in the past and currently- continued to hold top leadership and administrative positions in their respective organizations. To protect participants' identities, participants are referred to as male or female (M or F) with numbers 1 through 6 for men and 1 through 7 for women. Given the source of this sample (a publicly available website), further demographic information with the quotations below might be too revealing of their identities.

**Overview of Results in Six Emergent Categories -**

Figure 2 [Appendix E] provides an overview of the six categories of themes that emerged through the semi-structured interview questions [Appendix D].

A. It became apparent early in the study that gender differences were prevalent in participants' responses to questions.
B. They listed EI-GP that they had used and considered important for leadership in their public global health work.
C. They narrated various formative experiences (FE), both personal and professional, that happened in the earlier parts of their lives. They also described their FEs as sources of where they learned to value the EI-GP that they considered important. When asked how they became aware of the connection between the FEs and their acquired EI-GP, the participants described processing this awareness (PA), either by reflecting on the experience or model figure in it, or by acting in certain ways in response to the experience and then reflecting on their own actions.

D. All participants found that they integrated who they were as individuals in their personal lives and professional roles (PPI) as they developed as leaders through their professional and personal trajectory. However, people moved through this integrative process differently.
E. Participants commented on how EI-GP translated across cultures between their home countries and global locations that they had worked in. They added thoughts about some nuanced differences in EI-GP within those broader similarities.
F. Finally, they offered ideas in shaping content and technique in teaching these EI-GP to global health trainees and future leaders through health leadership training programs.

In providing quotations from participants, identifying information has been removed or modified where necessary.

**Category A: Gender Differences and Fluidity as a Spectrum –**

For the purposes of distinguishing gender differences in the responses between men and women, the biological (genotypic) males were referred to as men and females as women. While acknowledging that the gender identity labels of 'man' and 'woman' are social constructs, these were used for the presentation and analysis of results. In reality, both men and women (males and females) expressed a blend of what society and culture consider masculine and feminine traits or behaviors, often moving back and forth across this spectrum of expression that is referred to as gender fluidity in this paper [Appendix E, Figure 3]. The gender differences and fluidity demonstrated in each of the categories below are presented and discussed as such. They are then summarized as a separate concept section further below.

**Category B: Emotional Intelligence – Guided Practices (EI-GP) –**

The EI-GP that leaders described separated into two overall groups – feelings and behaviors. The 61 themes became a spectrum ranging from sub-groups of purely feeling, feeling and doing simultaneously, and purely doing in the ways in which participants described using these feelings and behaviors in their leadership work [Appendix E, Figure 4]. While the lines between these sub-groups do blur, they have been loosely separated for the purposes of visualization. Also, the sub-groups and themes have been presented for two reasons as a clustered figure instead of consolidating the themes further.. Each of the themes arose at least five times (less frequent themes were consolidated), with 24 of them being described 11-20 times, nine of them being described 21-30 times, and two described more than 31 times among the 13 participants. Given the frequency of how often they arose and the differences between thematic sub-groups of feeling and doing, these subtleties of human experience and behavior would be lost if they were further consolidated. While it was not possible within this presentation to provide quotations of all themes, selected samples are offered below.

***Feeling qualities*** - These themes could be associated and used in combination with multiple themes in either of the other two sub-groups.

"I think 'Know thyself' is supposed to be what we're doing. And when you know yourself, you'll either enhance your weaknesses, or enhance your strengths, address your weaknesses. And become a better person," noted M1, as an example of the need to be *emotionally self-aware* ***within oneself*****,** a quality that leaders described as important 45 times, the highest frequency of any of the 61 themes in Figure 4.

Participants emphasized *social awareness* as the second most frequently described theme (39 times). This theme relates to an awareness and acknowledgement of the importance of relationships ***with other people***, be they team members or officers in positions of power in the

ministry of health in a country. “I think it’s important to look them in the eyes and use the same language. I talk with people at all levels, ministry of health or community worker. So talking with them at their own level, recognizing what they can do and their abilities. And even if there are problems, help them to look at the problems as an opportunity as a way of learning, so lessons learned from that thing, and keep moving.” (F1)

***‘Feeling and doing’ qualities*** – This sub-group involved feeling an emotion and doing an action concurrently.

This sub-group could be experienced only ***by oneself,*** such as through *self-actualization*, a notion of pursuing constant self-improvement, demonstrating an openness to learning through exploration, connecting and understanding, feeling humble that one does not know everything. “Innovation and contextualization are very important… I consider myself a lifelong student and always feel that I need to learn more.” (M5)

Some themes could be felt and done ***either with oneself and/or with other people.*** An example would be to *balance mental strategy* of leadership or management skills *with emotional awareness* of one’s own internal emotional state and/or that of others around one concurrently. “I like to know who I’m working with. Because I like to keep things professional but I like to also let people know they’re valued, I see you I know what you’re doing kind of thing. So to me it’s having empathy but it’s also being firm because we’re focused on some objective at any time. It’s trying to listen to people, and being accessible to them, but at the same time, not carrying it to too much of an extreme. I also like to have clear boundaries. So I like to be attentive to you and available to you, I support you and guide you, but I also have expectations because as my coworker and subordinate I also expect that I will get a certain amount of honesty from you. It hasn’t always worked but that’s the point from which I start. And the relationship might change

along the way but I'm fairly flexible with people who are my subordinates. Generally my thing is to be very respectful and caring because I recognize that I depend on them." (F4)

Other themes of feeling and doing together could only be done ***with other people,*** such as *expressing one's emotions* verbally to help someone else understand one's own emotional state, often as a reason for one's actions. "I get excited about things that I care about. You're right. I think of myself as a passionate person and a measured person. …to articulate [the feeling of] why it's important to heal or to go abroad." (M4)

Participants used the word "charisma" to describe an EI-GP of being self-aware of the effect of one's own presence in a room and using it to connect with people. "A skill that I use is listening to what people say and internalize that. Only recently have people really been talking to me about "When you come into a room, everything calms down, and everyone knows it's going to be okay when you're up there leading a discussion." So I've been listening more to that, and I don't think of myself in that way I just think this is how I do things, but they say 'No no, we're in some pretty tense discussions but when you're there you just calm us down.'" (M6) With a different intention behind it, they saw it as a way to model for and inspire others to act and feel empowered.

***'Doing' qualities*** – can do these without actively feeling emotions, although they are usually guided by deep-seated emotions and internal motivations.

One could do these ***through oneself***, such as by *persevering* in the pursuit of a goal. "I think time I spent at [left blank to protect identity - unique hire in a top organizational position]… and I had to deal with difficult people, difficult situations, very difficult issues. I felt very comfortable with technical issues, but not so much with personal situations, and that really pushed me to start reading about leadership, personal issues, leadership qualities, how to better

organize your time, communicate, how to convince people in 1 second, 3 seconds, etc. (F1) Another woman noted, "Not giving up on something. Trying to look at different avenues to solve a problem. Or to get to a point of view." (F7)

One could also do these behaviors ***between oneself and other people*** such as by being *assertive* in a non-offensive way. "As I grew into my leadership positions, I learned to say things like 'I see your point but I respectfully disagree.'" (M1)

Some leaders emphasized *building relationships between themselves and team members, or between team members*. Within building those relationships, they wove in strategies to help people *realize the value of each other*, and working together. "…would be convincing people that there is a lot that we can do and we can do it together." (F1) "I think it's easy for me to work with people and people find it easy to work with me, and that's why I'm such a collaborative leader because I value what each single individual brings above my own knowledge and experience, and I absolutely believe in collaborative leadership." (M5)

EI can be developed over time.[44, 38] This could happen when an individual grows through life experiences, or, more formally, pursues training that focuses on emotional development and then puts those learned ideas into practice.

**Notes on Gender Differences and Gender Fluidity**

On initial readings of the transcripts prior to more methodic analysis, men seemed to describe behaviors and skills as EI-GP important to their global health leadership work while women described an awareness of feelings and attitudes. However, on deeper reading and analysis, it became apparent to the researcher that men and women were simply using language differently. When telling stories about their life and leadership experiences, which is how we as human beings best relate in metaphors and something that is a complex combination of feelings,

thoughts and behaviors, men primarily listed EI-GP as behaviors. The researcher realized that if she looked for and allowed herself to become aware of the meaning beneath the stories told, there were always feelings being described as well, by both men and women. This analysis then required that she be self-aware in going beyond her own expectations about what men and women would be saying about EI-GP. Keeping this openness and subsequent need to change her own hypothesis about a clear demarcation between the EI-GP that each gender would be listing served as proof that she was no longer projecting her expectations on to these findings. She was then able to observe and understand the 'feeling' EI-GP demonstrated beneath the behaviors that men often described verbally, as well as notice the 'feeling' EI-GP in stories that the women told, in addition to the 'feeling' EI-GP that women were more able to verbally articulate. These observations can be summarized in three ways:

1. On the surface, men and women appeared to be verbally be different in the EI-GP they described as important to health leadership work.
2. Beneath the stories, men and women either demonstrated or described feeling EI-GP that ultimately were the same.
3. In coding for both verbal and demonstrated EI-GP, there was ultimately no difference or demarcation between feeling and doing EI-GP between men and women (i.e., they all used each type).

Men and women in this study described differently the EI-GP that they valued in their work as leaders. Men used more behavior-based language, while women used more feeling-based language. However, in the telling of their stories, men then demonstrated an awareness of the feeling EI-GP, and women described behaviors demonstrating the "doing" or behavior-based EI-GP. So, in this self-reported, cross-sectional, qualitative study of a selective emotionally-

developed sample, it would be hard to say whether true differences exist in what EI-GP men and women leaders use. The data here seems to suggest that, in reality, both men and women feel and do from a similar set of EI-GP. They simply use different language to describe it. Carless' 1998 study[54] supported this conclusion. She explored this apparent contradiction between men and women and writes about how superiors tended to rate women as transformational leaders (using more EI-GP) more than they rated men as such. Women said the same about themselves in comparison to men. However, on formal EI measurement, gender groups were found to behave similarly, and when subordinates were asked to rate the same men and women leaders, they rated bosses of both genders as equal in transformational leader behavior. Carless' results contradict Bar-On's,[43] who reported that although overall EI scores did not reveal differences between men and women, women did display higher interpersonal and social skills. Hopkins[47] reported that the EI gender differences between effective leaders at the top of their organizations evens out. It is possible that, given the enriched sample of this study are leaders at the top of their organizations, we hear them describe their EI-GP in similar ways. Another possibility, remembering that women in this study tended to use more "feeling" language around describing EI-GP and men more "doing" language, is that women tend to underreport and underestimate their EI skills.[46] This is another area of potential future research.

These differences in the language men and women used to describe EI-GP can be explored using various validated tools to examine EI. For instance, the EQ-i used in this study also had an EQ-360 version[55] that could provide more observer perspective to compare with the leader's perspective. One could also compare some of the feeling-based EI-GP listed as part of the EQ-i[53] against the behaviors that are part of the LPI. The LPI uses a 360 degree evaluation approach where leaders rate themselves, and observers (colleagues who work with them) rate

them on the same leadership skills inventory. Posner and Kouzes, who formulated the Five Practices of Exemplary Leadership that the LPI evaluates and rates an individual towards, have more recently formulated 14 key concepts of EI. They cross-mapped these 14 concepts against the Five LPI Practices.[41] Finally, it would be valuable to conduct mixed methods research, combining quantitative data from EI measures with qualitative data such as that found in this study.

In an interview posted online[56] (published study material from the Posner/ Kouzes group could not be found on this material), Posner stated that through their LPI database of over 7000 subjects, they have found that female and male leaders rated themselves significantly differently on certain leadership behaviors. Female observers rated their leaders, regardless of gender, with higher scores than their male observer counterparts. In reality, neither men nor women leaders were behaving any differently. This suggests that when it comes to reporting behaviors, or EI-GP in general, women describe themselves and others differently than men do. These results also correlated with the Petrides study on how women self-estimate their EI skills lower than men do.[46] The Posner group observed a similar gender difference at baseline in a four-year college student sample that they trained on leadership skills. The women rated themselves differently than the men in Year 1. Yet at the end of Year 4, women rated themselves in those same behaviors similar to men. Putting these observations together, it appears that training might improve some behaviors and emotional skills in either gender, and it improves the language women use to describe the skills they are using. Ultimately, the goal is to help leaders understand their strengths and weaknesses and help them improve the latter. A potential research question in the world of health systems is – does the use of different language by women leaders to describe the EI-GP they use (and perhaps down-playing those EI-GP in comparison to men) affect their

effectiveness as leaders, how they run their teams, and, eventually, the success of health programs and outcomes on the ground? Does self-perception get in the way of success?

**Category C: Formative Experiences (FE) and Processing Awareness (PA)**

One of the main aims of this research was to understand how formative life experiences, both personal and professional, might shape the use of EI-GP and personal development in leaders. The study also sought to understand how leaders might have become consciously aware that those experiences were significant in their lives and what methods they realized that they used to that glean those EI-GP from those experiences. If this process can be understood better, we might be able to mirror those methods in developing EI in future GHL.

Formative experiences from childhood to adulthood constantly shape how we see the world. We then continue to think, feel and behave in the world based on those formative experiences.[57] Some of us are more consciously aware than others of how those formative experiences have shaped us. In this study, leaders all described and demonstrated an awareness of what formative experiences the EI-GP that they valued and practiced came from. This was a combination of parents or parent figures, life in general, and/or mentors, similar to other studies.[58] In addition, they all described having reflected on those varied formative experiences in order to understand more consciously what EI-GP they valued.

Leaders described FEs that separated into three general sub-groups – an overall experience of the self in concert with life in general; parents or parent figures; and mentors or professional experiences. The 13 participants mentioned all three sub-groups with about equal frequency. When later asked to name one experience in life that they had actively pursued for personal or professional growth (PE), the participants described experiences that fell into the

latter two FE sub-groups. They also always described this PE as a significant formative event, through which they concurrently grew both personally and professionally. Janson's study in New Zealand reflected this phenomena, where senior leaders noted that the FE that had the most far-reaching effect on their leadership development was always the one they had actively pursued for self-development, as opposed to adverse events that happened to them.[58]

Interviewed leaders were asked how they thought they had become aware that the formative experiences (FE) they referred to as sources of learning the EI-GP that they valued carried that significance for them. How did they process this awareness (PA) about the experience? Their responses separated into two sub-groups [Appendix E, Figure 2-C].

Some leaders *reflected on the people* who played the key roles in their memories of their formative experiences. They then processed that memory by *introspecting on their own values* and what they found meaningful in the memory of that experience *in relation to the other person's actions*. Out of the 33 experiences that leaders related reflecting on other key people in their FEs, this theme of value introspection co-occurred 27 times. Whatever EI-GP they then noted as meaningful and in resonance with their own values, they consciously incorporated into their behaviors. "My father comes to mind. He's long dead now, but it's something that comes from the society you're brought up in. Because [country] when I was a child growing up, my father was a person who was very proper - wasn't perfect but he was proper. And respect for your elders was something that was sort of ingrained in you from the time you could interact on your own. Was always heavily emphasized in the home and the social environment. And I'm thinking of my father because it was a known expectation from him." (F4) In this FE, her father played a key role as a parent, setting a model example of the EI-GP of *respect*.

Other leaders *reflected on themselves* within FEs, where an experience had happened to him or her directly. They then processed that memory by *introspecting on their own actions and reactions* within that experience. Out of the 51 experiences that leaders related reflecting on their own actions in these remembered FEs, this theme of self-action introspection co-occurred 38 times. They were able to identify their own *strengths, values, feelings and weaknesses of emotional skills or behaviors* through this method of introspection. They then took action to continue to practice and reinforce strengths, feelings and values, or work on improving weaknesses when they became consciously aware of these,

"After working there for a few months, I discovered that the director was embezzling funds. I had no experience in dealing with anything remotely like that. I felt gutted cause I knew the implications would be big. Any organization that cannot track its money faces a serious downhill battle for its integrity, reputation, and survival, which we spend so much time and money to build up. So I approached him and he denied it, I did my own investigation and clearly found that he was lying, so then I shared the documents with the board, with others that I trusted …to hear my own voice and hear different angles, what's important is reflection, and then being able to sift through and find what's rising to the top… I'll be armed with the evidence, I'll know the facts, and then I have a soundboard and a mirror [in myself], I'll put it to others and see if there's a blindspot and see if that gets me to where we need to be, that strengthens where I'm at." (M5) By looking within himself at his own behavior, he used himself as the teacher of these EI-GP, of *assertiveness, emotional self-awareness,* and being *open and honest in dealings,* for example, that he values.

One can see leaders constructing a narrative around the event and making observations about how it unfolded while processing the memories of these experiences by reflecting on the

role of the other, or oneself. They expressed their own thoughts and feelings elicited in response to the memory occurring, and the conscious processing of it in re-telling the story. These leaders are demonstrating meta-narration and meta-emotionally, concepts discussed in the introduction.

Is it necessary to reflect on one's formative experiences and be consciously aware of what EI-GP one has gleaned from them, and why they are important to an individual in order to have a highly developed sense of emotion-based leadership skills? It would be hard to say whether a process of reflection on their formative experiences developed these skills more acutely as a result of being consciously aware of their value since this study included a selective sample of leaders who were already known to be exercising a high level of EI-GP. Would other leaders who may not have reflected on their formative experiences in the same manner equally develop these skills? What we do know is that a reflective process is associated with developing EI from FE.[50]

**Notes on Gender Differences and Gender Fluidity**

Men and women approached processing awareness of the EI-GP within a formative experience differently [Figure 2-C]. Women generally tended to process awareness of EI-GP that they valued and put into practice more by reflecting on FEs where a person other than themselves played a key role. Men tended to process awareness of EI-GP that they valued and put into practice more by reflecting on FEs where they themselves played a key role. Bar-On's observations that men's self-regard is often higher than women's[38] could be why they examined themselves to process awareness of EI-GP, while women examined others, being less self-confident in pointing to their own actions as sources of learning. Each gender group eventually appeared to have arrived at the same overall set of EI-GP regardless of method of PA. This might be reflective of Hopkins' work, noting that gender differences in EI-GP level off among

experienced, effective leaders often at the top of organizations (as are the leaders in this study).[47] These differences in PA might mean that we need to be offering different gender-based methods of processing life experiences to effectively glean EI-guided leadership development when formulating health leadership training for men and women.

Figure 5 [Appendix E] depicts how this generalization holds true for all seven women and five of the six men. While no women described FEs where they reflected on their own actions, two men described several FEs where they reflected on the actions of other people, to become aware of EI-GP of value to them, demonstrating some gender fluidity in this category.

**Category D: Personal – Professional Integration (PPI)**

All participants replied that in their overall personality and way of interacting with others, they saw themselves as essentially the same person in both personal and professional spheres of being [Figure 2-D]. The direction of integrating those two role spheres varied into two sub-groups.

Some leaders described who they were in their personal lives and how they then ***carried that same personal self or personhood core into who they were professionally.*** They described *feeling* the same way in both spheres as a result of that integration. "One and the same [person]. Because people in my professional life, they get pulled in very close to me, like family. So I don't see a line of demarcation." (F7) "I grew up in a Christian household, so we had a strong foundation, within that teaching that we are all God's creatures, those are the kind of values, respecting people and honoring people, do unto others as you would have done unto you, and I practice [those personally true values in my professional work]." (F5)

This direction of PPI from personal to professional spheres, maintaining the same personhood core, co-occurred with two related themes – the challenge of *being seen or treated too personally at work*, or of *desiring more personal connection at work*. "I can't take action on people. I find it very difficult to be forceful in punishment. These are things that are both personal and professional." (F3) Or, "The work part does have many complete challenges and demands. And it has a sustainability aspect to it, that doesn't allow me to spend as much time as I would like with people, to truly understand, to reach out to students and stuff. Especially as you move up there's too many people to do that as well as I'd like… So I think some of that part gets eroded by the demands of professional life." (F2)

Other leaders described who they were in their professional lives and how they then ***carried that same professional self into who they were in their personal lives.*** They described *using the same leadership behaviors* that they saw themselves as having developed professionally subsequently in both spheres as a result of that integration. "I think it matters now, I've got two 90-yr old parents, and listening to what they're saying, not just their words but what's behind their words, is a lot of what me and my siblings have to do." (M3) "Having learned all these things from our professional way… We learn how to be patient with other people, and our family members, and use our reasoning skill [from professional life]… Nowadays we don't get angry with anybody, with our children or our grandchildren. We are very very patient, listen to them carefully, we respond to them in many ways, and we also teach them not only the subject but also the life skills and other things. So definitely there is an overlap." (M2)

This direction of PPI from professional to personal spheres, carrying over leadership behaviors, co-occurred with two related themes. One was *an awareness to modify leadership*

*behaviors in different personal and professional settings*. "Being a leader of an organization is not too different from being a leader in your family situation and it's not too different from being a leader in your church situation or in your school engagement situation… and so that's where I think the leadership qualities that you develop in your professional environment carry over to other spheres. …Despite each environment having its own peculiarities… what you carry is your own set of leadership attitudes, and it's just important for you to temper the way you apply them in one environment vs. the other. But definitely, whatever your attitudes are that you've developed, refined, let's say in your professional capacity, I think that you bring the same attitudes perspectives, etc. in your professional relationships. It's just a matter of maturity to think of how to temper them." (F4)

The other co-occurring theme was when one *brought home too much of the leadership behaviors from the professional sphere*. A ***gender difference*** presented itself within this theme – family or friends of men leaders might ask to *see less of those behaviors at home*. "In the first [marriage], it was an irritant and a problem in the relationship, and that ended; in this [marriage], it's not only tolerated but it's a part of the grout in the relationship. Oh, I hope she agrees with that… The home suffers or benefits from the engagement and competition of the work life and the charismatic life [depending on the people at home and their own professional background]." (M4) Women leaders themselves *wanted to make an effort to bring home less of those leadership behaviors.* "As a human if you have a big problem at work, how you feel you are going to reflect it when you are at home. But in those cases I try to separate that, what I try to do is change that concern, not take it home, how should I solve it. It doesn't mean when I leave office I let it go, I try to solve issues so it doesn't affect my family." (F1)

Is PPI necessary for the development of EI and leadership practices that it guides? Leadership material on authentic leadership discusses this, for instance.[31] As all the participants in this study described an integrated personal-professional self, and we know them to have developed a strong sense of EI, PPI seems to go hand-in-hand with developing EI. A leader is then essentially the same person at home and at work. Who that integrated personhood is varies by gender.

**Notes on Gender Differences and Gender Fluidity**

Both gender groups described a definite overlap of being the same person between personal and professional spheres. They approached the integration of the two spheres from two different directions [Figure 2-D]. Women tended to integrate their personal-professional spheres of being by carrying more of their personhood core into their professional lives. Conversely, men tended to integrate their personal-professional spheres of being by carrying their leadership behaviors home. Figure 5 [Appendix E] depicts how this generalization holds true for all seven women, and four of the six men. However, three women also described integration of leadership behaviors into their home lives, and three men demonstrated some gender fluidity in this category, as well.

Women carried more of who they were personally into their professional lives. They sometimes wished for more emotional connection at work and sometimes worried about colleagues overstepping boundaries and becoming too emotionally attached to them. They struggled with how to define those boundaries. Men, on the other hand, did not seem to wrestle with this. They tended to bring more of their professional or work personalities home and did not struggle with that process unless family or friends around them expressed concern. In her ground-breaking work on moral and emotional development of women,[59] Carol Gilligan

discussed how women could be naturally psychologically different from men in bringing caring and a desire for relational connections to their work in the world. Men, she noted, may naturally bring a more linear, control-based, justice-oriented approach to their work in the world. That perspective could relate to this study's findings on PPI, with men leaders compartmentalizing the roles they lead more easily than women and women desiring more interpersonal connection at work. However, one could easily make the argument that, instead of the above developmental phenomena being natural, it is socially constructed from a very young age, with women being taught to the be nurturers of relationships and men more critical and cognitive by action. These expectations might be playing out in how men and women leaders described the direction of their PPI. Regardless of nature vs. nurture, do these separate conflicts indicate an area where GHL trainees could use help and guidance, shaped differently for each gender?

***Concept: Three Case Examples of EI-GP, FE/PA and PPI***

Participants shared stories of formative experiences and the EI-GP that they believed that they gleaned from those experiences. They then reflected or described, in the process of telling the story, how they became consciously aware of how those experiences taught them the EI-GP that they now value in their leadership work. Three examples follow.

***M6:***

"I remember being kind of present at death, which started very young for me with elderly aunties dying of old age, and me being a pallbearer at a very young age and carrying the casket and going to funerals and going to cheap nursing homes in [location] that were so awful, that I would find amusement in, like this is so horrible that I need to find something amusing within all this, like this woman who used to go "ohhhhhhhhhhhhh" down the hall, over and over again, so

every time she did it, and went "oohhhhh," I'd jump in "where the wind goes sweeping down the lane" and sing out, and I got this comfort with the end of life and how people were, and no one around me got that comfortable with it. I became okay to be there when people were dying. I was at dinner [at a restaurant a few years ago] and this woman came up to my table and said "I just need to thank you, you helped my father die, and that was about the best death anyone could ask for, and I'm eternally grateful for that." And I just did it my way, I didn't do anything special." He subsequently reflected on this story by noting that this is when he became comfortable with deep, intimate emotions.

In this physician participant's story, we see a formative experience that happened in his *personal life* during childhood. In telling that story, he demonstrates EI-GP of *a willingness to be vulnerable, resilience and adaptability, humor, comfort with emotions, being grounded in vision, meaning and optimism without being pulled into negativity,* and a sense of *social responsibility.* He processes an awareness of these EI-GP by reflecting on his own behavior and role in the childhood experience, as well as years later, when he uses those same qualities and comfort with death, as a physician helping a patient die.

***F2:***

"I grew up between the US and [home country]. When I was 4 my parents both moved from the US back to [home country], so I grew up every 4 years between the countries. I think maybe when I was 4 or 5 I had already decided that what they did was really worthwhile so I'd be a physician, which is also not very unique for [someone from that home country]. I thought that sounded like a good idea and I thought I would also want to go and work in an area that's underserved, I thought I might go back to [home country] or somewhere else. My grandfather

had founded a [specific disease-focused] mission so I thought that sounded good [to get involved with]."

In this physician participant's story, we see a formative experience that happened in her *personal life* during childhood and young adulthood. In telling that story, she demonstrates EI-GP such as *following a call to a deeper vision of meaning,* and *being aware of her own commitment to service and her values.* She processes an awareness of these EI-GP by reflecting on her parents' and grandfather's roles in those experiences and memories. Through that reflection, she realizes what she herself values and holds as meaningful.

***F7:***

"The way we try to practice medicine now is a lot more empathetic than when I was in medical school. At the time there was a lot of criticism of the type of medical training that was being given. One case study I can tell you, is a young woman who had a long history of stomach ache and had been ignored. Went into the operating theatre and had late stage ovarian cancer, classic story. The consultant or somebody had to tell her, but in those days nobody told people they had cancer. So she asked what did you find, and the consultant sort of mumbled and said we have to do more treatment, etc. without telling her she had cancer. Absolutely appalling. Anyway, after that I went and sat down with her. And she was crying. And she said I've got cancer haven't I? And I said yes you have got cancer. It's extraordinary how we collude in not saying how the world is. It's very [cultural to home country] actually, not telling people how the world is. In medicine we do a lot of stuff which is not necessarily in people's interests, and we could work in ways that would be more beneficial."

In this physician participant's story, we see a formative experience that happened in her *professional life*. In telling that story, she demonstrates EI-GP such as *assertiveness, earning*

*trust in relationships, emotional awareness of and resonance with the other person, integrity,* and *self regard.* She processes an awareness of these EI-GP by reflecting on her own behavior and role within that experience. In doing so, she becomes consciously aware of her own values, strengths as well as weaknesses of emotional behaviors and skills.

**Category E: Cultural Comparisons**

This category explored whether participants found that the EI-GP that they valued translated in their use across cultures. They compared the culture of the country they considered home (which for all except one woman was their country of birth) with the cultures that they had travelled and worked in (often living there for extended periods of time). Two sets of sub-categories emerged within this category.

Some leaders commented on how ***external behaviors might vary across cultures*** but ***an internal attunement to EI-GP remains universal across the globe***. Those internal EI-GP then guide one to modify their external behaviors in different cultures, to achieve the same emotion-based outcomes of leadership. Of note, all but one of the leaders who described this idea were women.

"Countries are different [in how they do things] but people and families are the same in terms of values." (M6) "I know that there are cultural differences in interacting with people. But basically I find that across all areas, it really makes a difference, regardless of who you are dealing with, to be really respectful and to really come across that, to demonstrate in the way you're speaking with them that they matter." (F4)

***Universal EI-GP***

The main EI-GP that leaders mentioned as common across all the varied cultures that they had worked in, whether within their home countries or outside of that, were: *assertiveness, authenticity, building and earning trust in interpersonal relationships,* ***emotional self-awareness, other awareness, resonance with others, and expression; empathy,*** *flexibility, genuine appreciation of another's value; humility, instilling faith in one's own abilities, integrity,* ***listening and reflecting back****,* ***openness to learning from others****;* ***openness to understand and connect;*** *to perceive, understand and accept differences between people; maintaining a personal connection and using personal influence;* ***respect****, self-regard,* ***social awareness and social responsibility****; and a willingness to be vulnerable.* The bolded themes came up most frequently. This idea of universal EI-GP is reflected in Bar-On's work as well.[38]

Within the idea of EI-GP that translated universally across cultural and national borders, leaders seemed to comment on ***non-home countries*** that they had travelled and lived in (so were familiar with culturally) versus their ***home countries of birth,*** and ***compared the two angles.*** Both men and women leaders made far more general comments about how the *EI-GP* that they considered valuable *were used similarly across countries that were <u>not</u> those of their birth.*

"I'm very convinced that most of the qualities are identical across different cultures… For example being technical, defining goals, communicating, I think that is across cultures. I went to an event with [neighboring countries], and they were identical. Listening, empathy, these are definitely common. Some have to put a little more effort when dealing with politicians, but I think I don't see much difference." (F3)

"Mentoring is very common not only in [home country] but in [all the other countries I have worked in]. (M2)

**Notes on Gender Differences by Perceptions of Culture**

Men and women verbally pointed out nuances about the use of EI-GP to demonstrate that *EI-GP may not be used in the same manner throughout the land of their home country.* These subtleties were verbally expressed by six of the seven women and none of the men.

"I tell my students if you just stay in your own country, you lose the opportunity to see how other people might see things or handle things. So I think the things that I learned outside [home country] had helped me also within [my home country]. Since I'm [from this country], I can adjust little things. So I would say the qualities help you globally, but in your own country you need to be a little bit different. Depending on where you are from, having been able to meet people from different countries, they've been very very helpful." (F1)

"In the [coast of my home country] I noticed a little bit more of that spirit than in [my home state of home country], yes." (F3)

***EI-GP Lacking in Comparison of Home to Non-Home Countries***

Leaders from the US and the UK commented more on *the comparison between their home countries and non-home countries* that they had worked/ lived in, and were familiar with. They pointed out ***certain EI-GP lacking within these particular home countries compared to the rest of the globe.*** Specifically, they described a ***lack of empathy, emotional self-awareness, listening and reflecting back****; openness to learning from others, understanding and connecting;* ***social awareness and social responsibility*** that are <u>country and white race-based</u>. The bolded themes came up more frequently.

"We're a very 'look at me' culture, very 'look at me' society, that doesn't think that anybody else can know what we know. The problem with us [United States] as a society, is we haven't traveled, we haven't seen what other people do, how they lead, how they work, how they live…if we did more of that, if we learned that in fact they have something to add, not just that

[we think we] are in front of everybody else." "To listen, to ask, to learn… people often know more about the US and global news than we know about [the rest of the world]. "What do you think about Maggie Thatcher?" [I've been asked]. I've never thought about Maggie Thatcher. They [people in countries I've worked in] are well versed in international events. NY Times is as far as we [people in the United States] get. We don't get to the Economist too often." (M1)

"I think [listening, empathy and learning] are valued [in the United States], but maybe not universally valued. By universal I mean every person in America. Think about values like freedom…if you were to ask all Americans if they believed in freedom, they'd say yes. I'm not sure there'd be that universality about listening, but I think in a lot of respect and parts of the culture, listening and learning and empathy are valued." (M3)

"We host something called the [communicable disease conference], and I represent [my university], and there's huge inequity in terms of power across the organization… I'm quite analytic in terms of emotions that are going around the table. I watch the power play. In these boards, sometimes you can get embarrassed because there's one white male from a northern country, and lots of non-white non-males from lots of smaller countries, and lots of people with dominant positions, very insensitive in engaging with other people, and I find that very cringing, because it's so imperialistic. So in an environment like that I'd try very hard to be very polite to different people." (F6)

We know EI-GP to be universally translatable across cultures and countries.[38] Maintaining cultural intelligence in how to express and manifest those EI-GP is always important[60] in spite of their universality. This notion that cultures in the US and UK, particularly linked to Caucasians, might be lacking certain EI-GP is an important perspective that needs

further investigation. When training GHL from these countries and races, it might mean focusing on strengthening these qualities in those lacking them.

***Concept: Gender Differences and Fluidity Across EI-GP, PA, PPI, and Perceptions of Culture***

One of the secondary aims for this exploratory study was to explore whether there would be a difference in responses between men and women. On first and second reading through the 13 transcripts, the qualitative material seemed to denote a clear separation between how men and women responded to questions on EI-GP, PA of EI-GP gleaned from FEs, and integrated their personal and professional selves. A meticulous analysis of the interview material via Atlas-Ti by thematic and analytic coding made it clear that beneath their different language around EI-GP, men and women were talking about the same skill sets. The researcher may have initially heard and expected differences, reflecting socially influenced, perceptual bias in her expectation of different responses between genders.

***Individual Level***

Men and women displayed different approaches and described different feelings and behaviors within these three sub-categories as to what society, culture and science might designate as masculine and feminine ways of feeling and doing [Figure 4]. All participants except two men displayed fluidity [Figure 3] along the gender behavior and feeling spectrum. That is, men and women described feeling and doing different things in different situations, which society, culture and science might deem as more masculine or feminine as a quality or behavior.

In Figure 5, looking across the rows at each participant, we notice that all the women demonstrate gender fluidity between the categories of PA and PPI, displaying a combination of

otherwise feminine and masculine traits. Fewer men demonstrated this same fluidity from masculine to otherwise feminine traits. Overall, these results suggest that these leaders innately adapt in their EI-GP, PA and PPI to what the situation calls for, although women seemed to display that fluidity more than men. These results correlate with Hopkins' findings that among the most effective leaders, usually those who have reached the top levels of leadership in organizations, gender differences in EI-GP level off.[47] Leaders may be using these practices and processes to their leadership advantage and moving fluidly across masculine and feminine ways of using EI. That ability helps them interact in an emotionally intelligent way, modified to fit the person or situation they are dealing with from moment to moment, increasing their leadership effectiveness.

This fluidity is similar to what leaders who use EI do n general to shift their leadership personalities as a whole to match that of others around them, regardless of gender. That ability to shift styles supports leadership success.[61] Could the same be said of mastering gender fluidity when it comes to the use of EI? As men seemed to be less gender fluid in this study than women – is that a true gender difference (i.e., a biological inability to be as fluid as women) or a result of social acculturation?[59, 62] This would be a point of future research as well.

Differences in how men and women describe EI-GP that they use (behavior vs. feeling), manner of processing awareness of experiences (reflect on self vs. reflect on other), and manner of integrating personal and professional selves (professional behavior base to personal feeling base or vice versa) respectively could indicate a sociocultural difference in what we teach women and men about how to perceive of themselves. Men have been noted to score higher on the EI self-regard component than women.[38] Perhaps society raises women to be more unsure of themselves and less confident and men to be more sure of themselves. As a society, we may

value external behaviors more than internal attunements of feeling, as the latter is less tangible. In response to what is socially valued, men in their confidence might describe these behaviors as part of what they do far more frequently than women do. This could contribute to EI-GP[46] and PA reporting differences, where women reported observing others from being less confident of their own behaviors. As a broader sociocultural construct, we expect women to be the nurturers and relationship-builders. This expectation might influence how women describe carrying their personal selves into work spaces for PPI, far more than men did in this sample.[59, 62] Koch et al found that when placed under negative emotional stress, women's brains tended to activate emotional areas (i.e., amygdala and orbitofrontal cortex) to maintain a verbal response and process the emotions in those situations.[63] Men's brains, on the other hand, activated cognitive areas (i.e., prefrontal and parietal cortex) to ensure more cognitive control of the situation. Perhaps women and men demonstrate the differences in EI-GP, PA and PPI found in this study because women tend to be more verbally expressive and more able to articulate their feelings from a neurodevelopmental perspective, and men are wired to switch to more cognitive control. These study results could have been influenced by how men and women are generally raised to respond to emotional situations. This comes to the classic nature vs. nurture question.

Does answering this question matter as far as leadership development? The Posner/ Kouzes team believes it does not. They found that gender differences in self-ratings of LPI evened out after four years of training and leadership experiences with a group of college students.[56] This suggests that expected outcomes of team leadership and health program outcomes would also be equal between men and women regardless of their ability to articulate what EI-GP they are using.

How men and women describe EI-GP, PA and PPI in this study might be real differences or simply an artifact of reporting and perceptual bias. One would need to evaluate and compare these factors for leaders between self-report and observer-based report, as the LPI, and EQ-360[55] do, to discern real difference from bias. Qualitative data to complement information from the scores would help. One would need to further evaluate outcomes as dependent variables of those reported measures by gender to see if reporting differences by gender affects health outcomes.

***Collective, Cultural Level***

Exploring how leaders shifted the EI-GP they used when working in different cultures revealed some interesting results. Women seemed better able to articulate the notion that across cultures the internal EI-GP remained consistently the same even if external behaviors might change between people. Men may have been aware of this difference, but less able to verbally express it.[62] This concept of shifting external behaviors when moving across cultures reflects cultural intelligence,[60] which was not explored further as it was not the purpose of this study.

Participants in this study may have been describing *a general collective level of emotional intelligence in various cultures* that they had worked in, while acknowledging that even within the same country, cultures, and thereby, expression of EI-GP can vary. They commented on collective culture-related EI in a more general fashion when talking about countries not of their birth. They were able to present a more nuanced view of how they would adjust the expression of the EI-guided leadership skills when working in their own countries of birth. This might simply be a matter of them knowing their own home culture better than other cultures. Once again, women articulated this awareness of within-home country differences far more than men.

We may be seeing a gender difference in reporting, because at a level of viewing EI from a broader, collective standpoint, women were either more verbally adept at describing EI differences (linguistic strength) or they were actually more aware of EI differences (perceptive awareness strength). If the latter, that could affect health program outcomes and team management on the ground, when men and women GHL are deployed to work in cultures other than their own home countries. The health leadership training that we would like to provide on EI might need to take this gender and cultural perception difference into account. This would be another area of potential research.

A notable finding that five leaders from the US and UK made was based on *home country and race*. The comments were not specifically prompted by the research interview questions. These leaders described a lack of emotional awareness, empathy, ability to listen and reflect back, social awareness and social responsibility, especially among Caucasians in these countries. It is striking that no one from other countries pointed out *an awareness of a cluster of EI-GP that were, in their experience, lacking*. While Bar-On's work demonstrated repeatedly no significant differences across race and ethnic groups in EI scores,[38] their sampling had a higher frequency of Caucasian participants to reflect the North American population distribution at the time. The study aims were also more focused on the presence of EI components than on the lack of them and, hence, may not have been powered to examine for these differences. The literature does reflect material on racially privileged groups lacking social awareness and social responsibility within predominantly white countries and ways in which those deficits can be addressed.[64,65]

Johnson's qualitative study of white teachers[64] found that using a narrative life-story approach helped them bring their learning to awareness.

They where better able to articulate how they gained social awareness and responsibility to go beyond their subconscious white privileged outlook. They reported realizing the value of being immersed in diverse environments that offered them insider perspectives into the experiences of other races. The immersion also helped them de-identify themselves from the predominant white class. They began to resonate their own personal values and beliefs through that exposure with that of the external environment of desiring equality and social justice. In this thesis research work, the number of leaders making these comments was small given the nature of this qualitative study. It still deserves further exploration. It would be important to keep these racial/cultural differences in mind to better fine-tune the design of health leadership training directed towards certain audiences.

**Category F: Global Health Leadership Training**

Participants were asked at the end of the interview for their thoughts on how they might teach these EI-GP to the next generation of global health leaders. Their responses separated into three sub-categories:

1. An overall sense of the value and challenges of providing such training;
2. Their ideas on how such training could be framed and offered; and
3. Their thoughts on how training future global health leaders might be similar or different from trainees specifically on a business school setting.

***F1. Value and challenges***

All leader-participants saw value in providing global health trainees with ***specific training in development around EI-guided leadership skills.***

"I think if we designed educational programs consciously with the notion of the importance of individual leadership, we would have an amazing evolution of generations." (M3). He talked about this in the context of nurturing a consciousness of empathy, social responsibility, social justice and equity. He emphasized the importance of helping trainees become aware of the need to support and nurture other people around them.

F2 emphasized how bringing this awareness and understanding of how other people operate helps a leader help the team better. "It gives you a better lens… to understand how this person is operating… It's a very important toolkit to be aware of… if you can consciously [fine-tune understanding someone] there's a lot you can leverage in terms of doing a better job. So to me it feels very efficient."

Several leaders also described ***challenges in providing leadership training for global health trainees.*** M3 discussed the challenges of funding and measuring effectiveness of such programs because that of the complex interaction between a leader's actions and his/her environment, both with colleagues and external situations. "One reason is the realities behind funding is that funders want short-term measurable results. And leadership training doesn't get you that… It's very difficult and expensive to measure the effects in a convincing way… So I think donors shy away in part because of that." (M3)

F2 noted the difficulty of convincing leaders on an individual level that emotion-based leadership training might actually be valuable to them. As a clinician herself, she noted that many clinicians assume they work well in teams because their professional training contains a lot of teamwork. "In health, my sense is that there's a lot of hubris and health has resisted feeling the need for this training, until later in the game at least. So especially with us clinicians… there isn't really a spirit of I need to figure this out and do this better… it's not apparent for other

people that it's a good use of time. So maybe we need to think about how do we get across the value of this." (F2) She later suggested that a way to help them see the value of such training would be to "show how much difference it makes." This returns to M3's point – how do we measure that both effectively and cost-effectively for donors and trainees?

### *F2. How to Set Up and Teach*

Leaders described that teaching and training environments to develop EI-GP can be through both formal training processes like workshops, as well as informal training like field experience. Their responses fell into four clusters of themes.

They first noted that, when putting together a training program around EI-GP (as perhaps with any training program), one must ***package the training based on the target audience*** (needs-assessment). What *experience and background* do they have as leaders and trainees in the field of global health? "… very dependent on one or two people in the group getting it and being willing to dive in. …it's maybe 20 or 30 percent that will actually kindle, so trying to get the right personalities together." (F2) "You would really have to find out how many of them are ready for these things, then involve them with others and other situations. I don't see any other way." (F3)

In addition, one must consider the *timing of the training* in their career trajectories. For example, F2 reflected that the leadership training she received had great impact upon her because she cared deeply about her leadership role and for her subordinates. She was motivated to be her best for the job and for the team. She noted that she may not have been as motivated at a different point in her life. "The thing about this [training] that really helped me was, I was a little blind to how much I assumed other people act the way they act, just inserting myself into them.

Until that point the differences in the way people processed things wasn't as clear to me as it should have been. I think I always kind of tacitly assumed people are like me, except if they're cranky [or some other reason in the moment]." (F2)

After assessing the needs of one's audience, *frame the training* to meet those needs and motivations. "The point is we're all different, we can use this [training] to get different outcomes. The way in which people are wired, would alter the ways in which you propose the benefits of this." (F2)

M5 combined those concepts well. "It's how do you teach it, who do you teach it to, and at what stage, and when do you get to teach it. It's how we package it, who packages it, and when we package it. You must remember, many activists from the developing world don't have education. So writing, reading, things we take for granted aren't possible for them. You have to keep in mind what people are exposed to, what backgrounds they have."

Second, craft and ***set up the training environment*** in a way that supports exploring, learning and becoming aware of EI-GP and skills in leadership. *Create a safe space* for reflecting and sharing life experiences and opinions. "In groups where there are levels of relationships and vulnerability, and that kind of promoting people who are afraid of ideas…sometimes it's just building safe places for people to start to get used to each other, so they can start learning from each other. You know, the chemistry of the different people within those groups really makes or breaks the groups." (F2)

Part of the challenge of successful emotion-based leadership training is having people who are *open to learning about it* and who see the value of it. "The qualities of leadership can be taught, and I believe that. But I also believe that they can only be taught if they're open to it." (M1) " (F5) "[Teach] not specific attributes but how to be open to new and different ideas. They

should have an open mind, so they're not [people stuck] in a rut." (F5) So having assessed background and needs (first step), create an environment that hooks those motivations and opens the desire to learn these skills.

For successful emotion-based training, one also *needs emotionally intelligent mentors to teach and model*, people who recognize the value of these skills themselves. "I think the way our trainings are structured [by the teachers] is specifically designed to open people's eyes to their and their colleagues' styles and strengths and limitations." (M3) "One of the most effective ways in which we teach is actually by demonstration. Through your immediate team you will teach by demonstration in the ways in which you work with them." (F4)

M5 described how strong women mentors in his life nurtured a collaborative style of leadership in him – "Most of my mentors are women… That has helped in a big way." (M5) F6 found that being coached and receiving feedback about her EI-guided skills was extremely helpful in her leadership development.

Third, leaders described ***skill- and attitude-based learning objectives*** for training settings. They suggested that activities based on these objectives could mirror how they had processed their own awareness of valued personal and professional EI-GP. Achieving these learning objectives would mean prompt an awareness and practice of valued EI-GP in GHL trainees.

Aiming to achieve these objectives provides content for the trainings. The following examples capture leaders emphasizing learning objective themes of skills like *examining oneself introspectively in the context of past experiences.* The same examples also display how leaders believed that using those skills would guide trainees to gain *an awareness of the relationality between oneself and another,* as well as *an awareness of the relationality among team members*. The two kinds of objectives are closely intertwined within the quotes.

"I think people need to be challenged to look internally, at the qualities they have of leadership. And [understand] where they are paralyzed, where they've led, and what their barriers are - impersonal, internal - for being a leader." He adds, "I think "Know thyself" is supposed to be what we're doing. And when you know yourself, you'll either enhance your weaknesses, or enhance your strengths, address your weaknesses. And become a better person." (M1)

"It's being conscious, that's a lot of what leadership is, on the individual level. It's being conscious of one's strengths and weaknesses, conscious of one's colleagues and their strengths and weaknesses, how they learn and they grow, that's probably one of the most important things," M3 notes, stating the value of being aware of one's "personal leadership status."

"Raising awareness, saying how would you feel if someone did this to you, is the best way of making them realize the situation, putting them in the situation… if we can make them feel and make them aware, and see how those things can be [potentially different] we can make them aware of what we want them to do better." (F1)

"Self-help books… examine your own ideas… I think these aren't really taught qualities. I think these are intrinsic qualities but you need to be made aware of them. You can bring out the part that is within them to look for this. Ask them what is standing in their way. Teach them to listen." (F3)

"Getting a relationship to the point where there's trust, where there's some sort of an academic competition, takes some people who are brave and secure and have been there, to make it work." (F2) She later also placed a distinction between leaders who connect well one-on-one with people, and how that is still a different skill set that what is needed in leading a team. There,

one has to understand personalities, and how the team fits together, to build those relationships, making it a joint effort towards success.

The trainee would become more consciously aware of EI-GP that are important within those relationships through an awareness of relationality.

Fourth, leaders suggested ***methods and modes*** of teaching EI-GP. They described teaching by *lectures with some experiential material.* "You could make those [lessons on EI-GP] into modules, or lectures, whatever. And I'm sure, if one thought about it, people could probably with YouTube and other things there's ample stuff out there, you could embellish those topics with examples, leaderly skills, whether it's articulateness or whatever" (M4) "Look for ways of teaching, ways of trying to read history of cultures to understand what has made the people like they are." (F5) "I really believe in everyday leadership as a website, and those vignettes and those stories. So when students are going global for the first time, I say go to this website and look at all the stories about cultural humility…think about women, think about power and hierarchy." (M6)

Many preferred to teach by *case-based learning and discussion.* "Active learning. If you haven't been involved in discussions, [EI-GP] aren't necessarily easily understood concepts. There is a terminology mode just to have those verbal tools. I think we've used role-play case studies for this reason. I think all of the tools for active learning, not lecture but active learning, help somebody build up their understanding and skills." (M3) "Case study method helps. Understand with examples of failure and success, both important. Relevant examples with public health, where you would use them, test the potential of various leaders, how you would examine them." (F3)

Participants also believed that, beyond a formalized training process, global health trainees should *pursue field experience* where mentors would also emphasize consciously and verbally teaching skills around EI-GP. *"*It is important for all of us to travel and be exposed to other cultures and ways of doing things, to become aware. That opens us up as leaders." (F5) "Mentors can work with mentees to actively cultivate that in their peer groups then that might be more effective than a course." (F2)

Leaders shared their thoughts on how best to nurture EI-GP to future global health trainees. Several of them pointed out that these are not skills that can be taught in a lecture; they are not knowledge-based. To create an awareness in trainees, an opening of attitude and practice skills-based learning, they recommended several stages of creating such training. One would need to take into account the audience experience, background and career timing. It suggests packaging and framing a training following needs assessment in order to tap into motivation for learning these skills. This advice sounds generally standard for crafting any kind of training or group activity, but the recommendations of interviewees shifted inward in focus as they came to talking about content and method of teaching.

Participants recommended practices they themselves had used to teach EI-guided leadership skills, including reflecting on one's own formative experiences, significant role models, and prior actions in order to understand one's own strengths, weaknesses and areas for growth. These are processes reflected in the literature as ways to develop EI.[50, 66, 51] They also recommended experiential learning and case study methods, whether through a formally designed training or informally by field experience. They mentioned the importance of mentors who were themselves self-aware and emotionally intelligent to model and teach these qualities to trainees, guiding trainees to their own process of awareness. This is a concept that Bennetts

found to be a strong factor in building intimacy between mentor and mentee, within which relationship the practice of EI unfolded.[67] Such ideas for developing EI-guided leadership skills can be integrated into training programs such as the CDC/ UC collaborative Public Health Leadership Institute[7] and the Afya Bora fellowship mentioned earlier.[68] If the gender and cultural differences in results discussed thus far are accurate, it would be important to consider shaping and modifying health leadership training based on the gender and cultural backgrounds of trainees.

Gender and cultural differences are another aspect to incorporate into GHL training. Adler argued for acknowledgement of global leadership theory development that goes beyond a mostly UW or Western point of view. She went on to say that within US leadership theory, feminine leadership qualities, such as many components of EI, have tended to imply weaker leadership authority. Women GHLs in the US have to push against US leadership cultural norms of perceived weakness of the womens' feeling-based EI skills and directionality of their PPI (personal into professional spheres). These women might then underestimate their EI skills[46] as they are not socially valued. Providing health leadership training for women GHLs in the US then becomes a double challenge – encouraging confidence in themselves and their intuitive ways of executing leadership while remaining aware that doing so is pushing against the status quo of US leadership culture. Adler argued that, on the contrary, these same highly effective feminine qualities are much needed in global leadership.[69]

***F3. Similarities or differences to health leadership training in business school***

Participants were also asked to ***compare leadership training in health, to that of trainees in business school***. They reflected on a few ***similarities*** between the two, as far as *general*

*training on leading and managing teams* and *managing finances* to keep an organization fiscally stable.

"My sense is that the intuitive abilities and the formally developed skill sets that make a good leader are not particularly linked to who is being led or in what profession or job or circumstance." "I can't imagine the ability to lead a pioneering clinic or provide leadership to an academic health center are terribly different in terms of leadership skills. There is surely a different knowledge base involving finance, personnel, etc. but the ability to get people to work together for common purpose and raise the arc of expectation does not strike me as different in one setting from another." (M4)

"I don't see any difference. Maybe the final objective of making money will be different. But more and more in public health, I see that only way of making public health sustainable is, thinking of business models that are based on reinvesting whatever, so that becomes social innovation, so in that sense I think the training should be exactly the same. What we should add is concepts of sustainability, for social innovation, for business models that could make public health more sustainable." (F1)

Overall, leaders believed that no matter what the field, whether health service or business, all leaders needed to have basic skills in leading and managing because running a health-based organization, is like running any other business.

Participants also pointed out several ***differences*** between leadership training in health versus business schools. One set of differences they identified was based on the idea that strong health leaders ***attend to the ongoing process of working together*** towards a common goal or achieving a health outcome more than simply focusing on the ultimate product. That ongoing process is comprised of complex human behavior interaction. During that unfolding process, a

health leader needs to keep track of *variables such as intra- and interpersonal human values, thoughts and agendas* that each as well as the external/ environmental situation. A health leader needs to *be adaptable to lead and manage human and situation variables* changing simultaneously.

"One of the things is the clarity that is available in this training. We are more focused on process rather than outcomes, and outcomes are more difficult to measure rather than in business or other fields. You have to define their goals in a different way. It's much more people-centered. Business is a combination of very different things. In health people's behavior is much less studied. We are dealing with variables which are much more complex. Dealing with staff who are much more technical or trained professionals who have their own goals and thought processes which have to be worked into our programs." (F3)

The other main difference in health leadership, according to several participants, is that the work goals are ***driven by a set of values*** and a desire to serve rather than a goal of creating a marketable product with monetary gain. "Leadership begins with this consciousness about yourself, and it's very difficult to be successful without that, regardless of what you do. You may never become a director or have one of those titles. But if you have this consciousness about yourself and your leadership qualities, you can be a leader anywhere, anyplace… Embedded in our training are notions of fairness and equity, and a priority on, "Will whatever we're doing improve the health of the community? You do role-plays and things come up about fairness and equity and equality in relationships and opportunity and giving people an opportunity to soar and spread their wings. So even though it starts with consciousness about one's individual qualities, that's the vehicle for empathy, for supporting other people, for nurturing other people's careers." (M3) "The importance of acting 'for others' sets health training apart in my estimation." (M1)

"The health leadership training taught more skills in communication, mentorship, attitudinal aspects, imparting ethics, [which we need to return to doing]." (M2)

When asked to compare health leadership training with what someone might receive in business school, leaders believed that general leadership and management skills, including training about financial management, would be similar. However, they emphasized that health leaders are motivated to do service-based work based on their own values, as opposed to business school trainees' motivations on profit and market product. While much has been written about public and global health leadership, not much is available on how to engage that interest and motivate a service-oriented GHL population towards leadership training or on how those motivations might be different than a corporate business leadership population.[70] Participants also thought it important that health leader trainees learned to focus on the unfolding process during the implementation of a program or project along with the target health outcome. They described this process as containing not only constantly shifting external situations, but also the human component – team members with their own interactive styles, agendas and perspectives. A health leader, they felt, needed to learn to emotionally and strategically adapt to and handle all of that. Even though participants made these distinctions between health and business leadership training, it is possible that the distinctions are purely perceptual. They perceive these differences because they belong within the health leadership group and have not directly experienced business leadership training or careers. The National Public Health Leadership Development Network put together an excellent framework for competency development in public health leadership in 2000.[8] Lachance and Oxendine[71] have crafted a proposal for how to bring public health leadership core competencies to graduate public health programs, encompassing ideas on making it experiential, process focused, and interdisciplinary.

Several leaders who commented on these differences also mused that, while they believed these differences to be inherent in the health field, they wished that the business world would inherently adopt these process- and value-based ways of leadership, too. The only true difference then, perhaps, is that in health, these differences are intuitively and naturally the first things that a training program can use to engage the interest of GHL trainees. These are differences that they believed should be tapped into, not only to incorporate them into health leadership training, but also to engage interest in the training itself.

Overall, they expressed a desire that, regardless of their perceived differences between health and business leaders, they wished for a world where many more leaders would exercise emotion-based leadership styles. Participants believed that this shift in leadership styles would be motivated more by service-based values and less by profit. Finally, given the challenges of engaging health leaders' interest in emotion-based leadership training, they advised connecting with the service-based values of trainees to engage their motivation in learning these important skills.

## SUMMARY AND FUTURE RECOMMENDATIONS

Strong team-based health leadership that uses EI would go a long way toward improving program effectiveness and achieving essential global health systems strengthening. The first and key step in promoting leadership in global health is to understand the process of the internal development of leaders as emotionally intelligent human beings, as exemplified by authentic, transformational leadership practice. We need to study the people who are doing it well. A better understanding of the differences between men and women leaders in their path to emotional

development would also help guide the training of future leaders. This qualitative research study sought to better understand how leaders who exercise a high level of EI-GP in their interactions with colleagues and team members might describe how they gained these skills. Their perspectives were further explored regarding how to nurture those practices in upcoming global health trainees through understanding their own process.

The study findings appeared consistent with the initial conceptual framework formulated to guide this research study. The participant interviews provided a better understanding of how these GHL, who were known to use EI well in their leadership work, may have developed an awareness and honed their EI-GP through meta-cognition, - narrative and –emotionality by processing significant formative experiences in their lives. This research offers ideas for focusing training on developing EI in GHL trainees.

We need to offer stronger health leadership training to global health trainees in order to help them develop emotionally in ways that would be beneficial for leadership in health programs. The results of this study suggest that we would need to design experiential and case-based curriculum that prompts a self- and life-reflective process in order to nurture an awareness of EI-GP that trainees value. Skilled mentorship would guide that process, as well as continued practice of those gained skills that consolidate EI-guided leadership growth. This approach to training might need to be modified based on audience, gender and cultural background. Training can be offered in formal and informal settings. Curricula could be aimed at teaching EI-GP in a way that ultimately improves teamwork and solidifies relationships to the benefit of health outcomes in health programs.

Men and women reported similar types of formative experiences that shaped their emotional and personal development. They may be using language differently to describe EI-GP,

their processes for reflecting and nurturing those qualities in themselves, and integrating a personal and professional self. Leaders also pointed to some cross-cultural differences in how these emotion-based skills were used. Cultural upbringing may also play a part in emotional sensitivity and expression. Therefore, it would be important to keep gender differences, a trainee's own culture and global cultural nuances in mind when designing and implementing health leadership training.

Gender fluidity seems to provide a leadership advantage, it being an ability that we see naturally happening at the top of leadership hierarchies.[47] Gender fluidity among this particular set of accomplished leaders may have smoothed some of the gender differences noted. This is an area needing further investigation. We can aspire to push the boundary of our expectations of how men and women will behave differently with regards to EI-GP, PA, PPI and Cultural perceptions within a socially-constructed lens. Widening those expectations could promote more gender fluidity. Teaching gender fluidity in using EI might be a valuable lesson in and of itself and should be incorporated into health leadership training.

We need to engage our target trainee audiences in value-based language to motivate them towards health leadership training on EI development.

Global public health environments act as moderating factors in the relationship between successful training on EI, improved team functioning and health outcomes on the ground. These environments are constantly shifting situations. That makes it difficult and expensive to track the effectiveness of EI-focused leadership training outcomes, leading to challenges in finding sustainable funding for such programs.

These results can help build a foundation for further research in EI-guided leadership development work in health education. An initial research question might be to understand better

what kinds of processes are needed for emotional development. This study indicated an internal reflective process. We need additional research to investigate approaches to developing EI other than processing formative experiences. Two-source data gathering (self-report and observer-report) will be helpful to understand EI-GP that leaders demonstrate both in feeling and behavior for distinguishing between perceived and real differences in these qualities and skills, as well as potential gender differences. Validated inventories like the EQ-I, EQ-360, Hay 360 Emotional Competence Inventory and LPI could be cross-mapped in future research to understand what combination of feeling and behavior-based EI-GP leaders were developing and demonstrating. Prospective research can examine whether health leadership training results in improved health outcomes through mediating factors like team relationship building.

Target outcomes can include measures of team satisfaction, collaborative efforts, and health program patient outcomes. Research and monitoring and evaluation in health leadership training programs can track outcomes to demonstrate the value of such training in developing emotional intelligence in global health leaders. This would help guide continued improvement in training, secure sustained funding by engaging interest in supporting these programs, and convince trainees that this is a worthwhile investment of their time. Ultimately, such training programs will develop more emotionally intelligent global health leaders who make even greater strides in effecting change at every level of global public health programs and health systems.

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# APPENDICES

## A: IRB Approval:-

UNIVERSITY of WASHINGTON
HUMAN SUBJECTS DIVISION

October 13, 2015

PI: Sahana D'Silva
Student / Senior Fellow
Global Health / Psychiatry

RE: HSD study #50583
"Seeking to Understand, Aspiring to Teach: Exploring How Life Shapes Emotional and Personal Development in Global Health Leaders"

Dear Dr. D'Silva:

The University of Washington Human Subjects Division (HSD) has determined that your research qualifies for exempt status in accordance with the federal regulations under 45 CFR 46.101/ 21 CFR 56.104. Details of this determination are as follows:

Exempt category determination: Category 2

Determination period: October 13, 2015 – October 12, 2020

Although research that qualifies for exempt status is not governed by federal requirements for research involving human subjects, investigators still have a responsibility to protect the rights and welfare of their subjects, and are expected to conduct their research in accordance with the ethical principles of *Justice, Beneficence* and *Respect for Persons*, as described in the Belmont Report, as well as with state and local institutional policy.

**Determination Period:** An exempt determination is valid for five years from the date of the determination, as long as the nature of the research activity remains the same. If there is any substantive change to the activity that has determined to be exempt, one that alters the overall design, procedures, or risk/benefit ratio to subjects, the exempt determination will no longer be valid. Exempt determinations expire automatically at the end of the five-year period. If you complete your project before the end of the determination period, it is not necessary to make a formal request that your study be closed. Should you need to continue your research activity beyond the five-year determination period, you will need to submit a new *Exempt Status Request* form for review and determination *prior to expiration*.

**Revisions:** Only modifications that are deemed "minor" are allowable, in other words, modifications that do not change the nature of the research and therefore do not affect the validity of the exempt determination. **Please refer to the Guidance document for more information about what are considered minor changes.** If changes that are considered to be "substantive" occur to the research, that is, changes that alter the nature of the research and therefore affect the validity of the exempt determination, a new *Exempt Status Request* must be submitted to HSD for review and determination *prior to implementation*.

**Problems:** If issues should arise during the conduct of the research, such as unanticipated problems, adverse events or any problem that may increase the risk to the human subjects and change the category of review, notify HSD promptly. Any complaints from subjects pertaining to the risk and benefits of the research must be reported to HSD.

Please use the HSD study number listed above on any forms submitted which relate to this research, or on any correspondence with the HSD office.

Good luck in your research. If we can be of further assistance, please contact us at (206) 543-0098 or via email at hsdinfo@uw.edu. Thank you for your cooperation.

Sincerely,

Kristen Wittmann
Review Administrator
Committee J
(206) 221-2093
kmw89@uw.edu

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# B: Informed Consent Form:-

**UNIVERSITY OF WASHINGTON**
**CONSENT FORM**
**Qualitative Research Study – MPH Thesis**

**Seeking To Understand, Aspiring to Teach: Exploring How Life Shapes Emotional and Personal Development in Global Health Leaders**

***Follow-Up Interviews on Emotional and Personal Development***


Researchers:

PI/ Contact person for Subjects: Sahana D'Silva, M.D., M.S. - MPH Student (Global Health)/ Senior Fellow (Psychiatry and Behavioral Sciences)

Ph: 646-670-1654

Email: sahanadsilva@gmail.com, sdsilva7@uw.edu

Faculty advisor/ committee chair for MPH Thesis: Ann Downer, Ed. D. - Director (International Training and Education Center for Health (I-TECH))

Ph: 206-685-6841


**Researchers' statement**

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to be in the study or not. This process is called "informed consent." We will give you a copy of this form for your records.

**PURPOSE OF THE STUDY**

[Provide a brief background and describe the purpose of the activity in lay-language. For drug studies, state how many people will be in the study. This number should be the same as the number that has been approved by the IRB.]

*Background:* The World Health Organization (WHO) sees **health leadership as central** of the six building blocks of health system strengthening. Lack of strong global health leadership (GHLp) is seen as part of the **gap in implementing health programs. Training future global health leaders** needs to be not only knowledge based, but also skills and attitudes based. Understanding what qualities make for a successful global health leader, and how that can be incorporated into training programs, has the potential to **improve health services**, patient and employee **satisfaction**, and overall **organizational effectiveness**.

Towards this end, I combine an understanding of transformational and **authentic leadership theory**, which emphasizes emotional development in leaders; with an understanding of components of **emotional intelligence** as background for this research study. I would like to understand from successful global health leaders what they consider important emotional qualities that have helped them exercise strong leadership in their global health work. I will then explore their thoughts on how they developed those skills, and how that emotional development continues to help them in their present work.

*Purpose:* The purpose of understanding this process of emotional development among successful global health leaders, is to then be able to incorporate components of what successful leaders have done, into **training future global health leaders** to improve their own emotional development. In addition, as men and women tend to exercise leadership and emotional qualities differently, I will be observing for **gender differences** in my research study as well.

**STUDY PROCEDURES**

I am conducting a **cross-sectional qualitative** study of a **subset of 16 global health leaders** from the original cohort of 66 leaders interviewed for the Everyday Leadership website. I would like to interview them in-depth, individually to explore the **relationship between their formative life experiences and the development of their perceived emotional intelligence-based leadership skills.**

In doing this study, I recognize that **confidentiality** is essential, as I am interviewing relatively public figures about their personal lives. This consent form aims to assure and achieve that.

***Procedures Involved, Should You Choose to Participate:***

1. *Demographic questions:* Eight questions that gather information on age, gender, education level, nationality, position and organization.
   *Time to complete:* Less than 5 minutes.
2. *Qualitative interview:* In-depth individual interview that I will conduct via Skype or in-person at a pre-arranged appointment time. Questions and content discussed will cover topics of emotional qualities important for global health leadership, and how your life might have shaped your process of emotional development. The *most sensitive* portions of the conversation might include reflecting on difficult periods of your life, challenges, and lessons learned. These interviews will be audio-recorded for transcription – see below for how data and privacy will be protected.
   *Time for interview:* 1 hour.

*Total Time Commitment:* 1.5 hours – includes time for email correspondence to set up interview appointment.

You may refuse to answer any question or item in the questionnaire, or interview, at any time.

*Timeframe:*
October and November 2015 – Study Participant Recruitment (after IRB approval)
November and early December 2015 – Gathering questionnaires, conducting interviews
January to April 2016 – Analysis and writing up results for publication

**RISKS, STRESS, OR DISCOMFORT**

Given the focus of this study's topic on emotional development towards leadership, through life events, participation in the study carries a minimal risk of the following:

1. *Emotional response:* Relating difficult moments in one's life story can be emotionally upsetting. If this happens, you may choose to complete the interview at another time, or exit from the study.
2. *Personal stories:* You may find yourself remembering and relating stories that feel personal and private. If this happens, you may choose to decline answering a question.
3. *Concerns about working relationship with I-TECH/ Dr. Downer:* As Dr. Ann Downer will be the initial liaison connecting me (Sahana D'Silva) with you during recruitment for the study, you may have concerns that participation and providing data for the study may influence her views about you. Beyond initial contact for recruitment purposes, she will not have access to knowledge about who chose to participate (or decline), and will not have access to data or any identifying information about participants.
4. *Breach of confidentiality:* Every study, in spite of the best efforts to maintain confidentiality, carries a minimal risk of the breach of it. My efforts to protect your privacy and maintain confidentiality of the data are further described below.

**BENEFITS OF THE STUDY**

Although there are no direct benefits from participating in this study, you may experience the following indirect benefits:

- Reviewing one's life story has been shown to have emotional benefits, in seeing the progress and development that one has made. Offering advice to future trainees also has emotional benefits of generativity (being able to share one's accumulated and earned wisdom with the next generation).

- Understanding the processes that successful leaders have used to develop their emotional skills, which are an important part of effective leadership, can then be incorporated into global health leadership training programs. Nurturing effective global health leaders is a core component of health system strengthening around the world that will improve health service program outcomes, patient and employee satisfaction, and organizational effectiveness.

**SOURCE OF FUNDING**


The "Psychiatry in Primary Care" fellowship at the University of Washington receives financial support as part of a training grant, from the United States' National Institutes of Health (NIH). This supports my (Sahana D'Silva) research time.


**CONFIDENTIALITY OF RESEARCH INFORMATION**

*Protected linking list of identifying information:* Names of participants and their position, organization and nationality will be saved with a unique study ID number, as a separate linking list. This link will help maintain background context of identity for my reference only, towards a stronger data analysis, given my research topic of individual emotional development in leadership. The list will be a password-protected electronic document on a further password-protected office computer that I am the sole user of, within the UW computer network, which has its own level of electronic security maintained.

*Non-identifying data:* Demographic data of age, gender and education level, and interview recordings and transcriptions will be maintained separately using only the participant's assigned unique ID number, to protect against identity disclosure. These will be stored on password-protected computers, in password-protected documents.

*Duration of retaining data and linking list:* I will retain the linking list of names and ID numbers until after the data entry, analysis, and manuscript preparation are complete. This will be necessary in the event that I need to reconcile errors. After the project is complete, I will destroy the link and all identifying information. I anticipate that this will be approximately 3 years after the project begins.

*Access to data:* On the research team, only I will have access to the data, with the exception of the transcriptionist who will have access to the interview recordings (which will have no recorded identifiers). Government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

*Use of data:* Upon analysis and consolidation, I will be using the data generated to publish 1-2 academic research papers. I will not name any participant in any publication or report, and will not publish any identifiable data.

**OTHER INFORMATION**

You may refuse to participate and you are free to withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled.

**RESEARCH-RELATED INJURY**

*MINIMAL RISK STUDIES*

If you are experiencing an emotional response to reviewing life events that you believe you will need help processing, contact:
Sahana D'Silva (primary researcher) at 646-670-1654 or sdsilva7@uw.edu.

Although I cannot provide long-term treatment myself, I can provide guidance in determining the next best steps after assessing the situation.

Sahana D'Silva 11/9/15

Printed name of study staff obtaining consent | Signature | Date

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, or if I have been harmed by participating in this study, I can contact one of the researchers listed on the first page of this consent form. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098. I will receive a copy of this consent form.

Printed name of subject | Signature of subject | Date

Copies to: Researcher
Subject
Subject's Medical Record (if applicable)

## C: Participant Invitation Email:-

**MPH Global Health Thesis:**
***Seeking To Understand, Aspiring to Teach: Exploring How Life Shapes Emotional and Personal Development in Global Health Leaders***

**Follow-Up Interviews on Emotional and Personal Development (Primary Data Collection and Qualitative Analysis) with select *Everyday Leadership* project participants**

Initial email contacting a potential participant will be sent from Dr. Ann Downer as follows:

*Greetings. I would like to introduce you to Sahana D'Silva, MD, MS, a second year student in our Global Health MPH program at the University of Washington. She is also a Senior Research Fellow in the Department of Psychiatry here at UW. She will be pursuing her master's thesis research on emotional intelligence and how life experiences shape its development in global health leaders. She is inviting some interviewees such as yourself from the Everyday Leadership website to to participate in her study, having noticed that you mentioned several important emotional qualities during your own interview. Further information about Dr. D'Silva's study is found attached. Please reply to her directly with any questions you might have and with your availability or lack of availability to participate in her study. Please do not cc me on the email in order to maintain the privacy of your decision. Thank you for your consideration of this request.*

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**D: Semi- Structured Interview Questions:-**

**Guide to In-depth Individual Interview – Semi-Structured Questions**

**Opener:**

1. Tell me about your work/ journey in Global Health? What do you remember of your first global health experience, and what did you learn from it?

**Emotional qualities:**

2. In what way do you think emotional or internal qualities are important for leadership in global health work?
3. Culture: Within your culture, do these emotional qualities, or relationships have value or importance in leadership? How have you found those qualities to translate across cultures?
4. What are values that are important to you personally and professionally?

**Reflection:**

5. Tell me about:
    a. An experience when you learned the value of that emotional quality in your life?
    b. A turning point in your life when you learned the value of that emotional quality in your life?
    c. A person in your life who stands out as someone from whom you learned the value of that emotional quality in your life?
6. How did you come to understand or realize that this quality is something you value from those experiences/ person/ turning point, enough to want to continue to use it in your work?

**Personal and professional growth and development:**

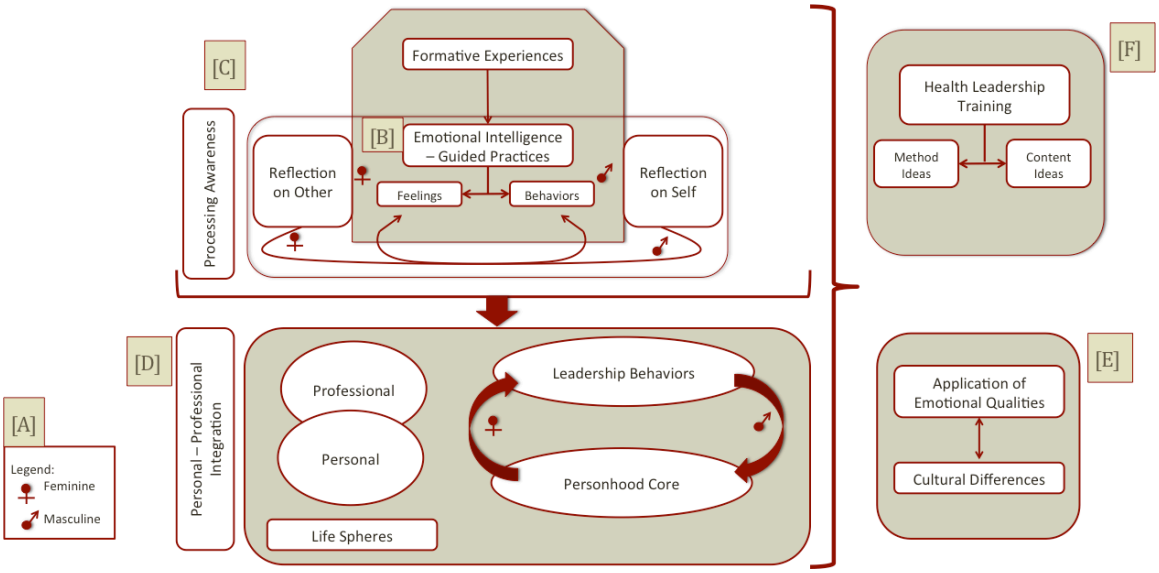
7. In what way you developed personally, in using these qualities? How about professionally?
8. What is the single most important thing that you did for yourself personally/ in your personal life, that shaped your leadership growth? Why does that memory stand out?

**Integration and teaching forward:**

9. Is there an overlap between who you are as a person in your personal life versus your professional life? If so, how did that occur, given your life experiences? How did that integration help in your personal life? In your professional life? Has it made things difficult personally or professionally? How did you handle that?
10. How would you suggest teaching some of these important emotional leadership qualities to the rising global health trainee workforce? What kinds of experiences might be important for their emotional development and awareness of it?
11. How is health leadership training (content or skills that need to be taught) different from other professions/ schools of leadership training?

## E: Results:- Figures 2 to 5

## Figure 2: Overview of Results in 6 Emergent Categories




## Figure 3: Gender Fluidity Spectrum

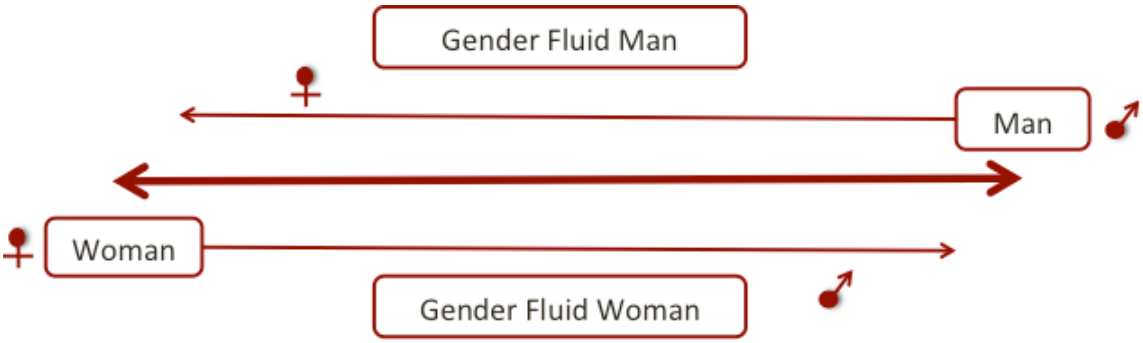


**Figure 4: Emotional-Intelligence Guided Practices (EI-GP)**

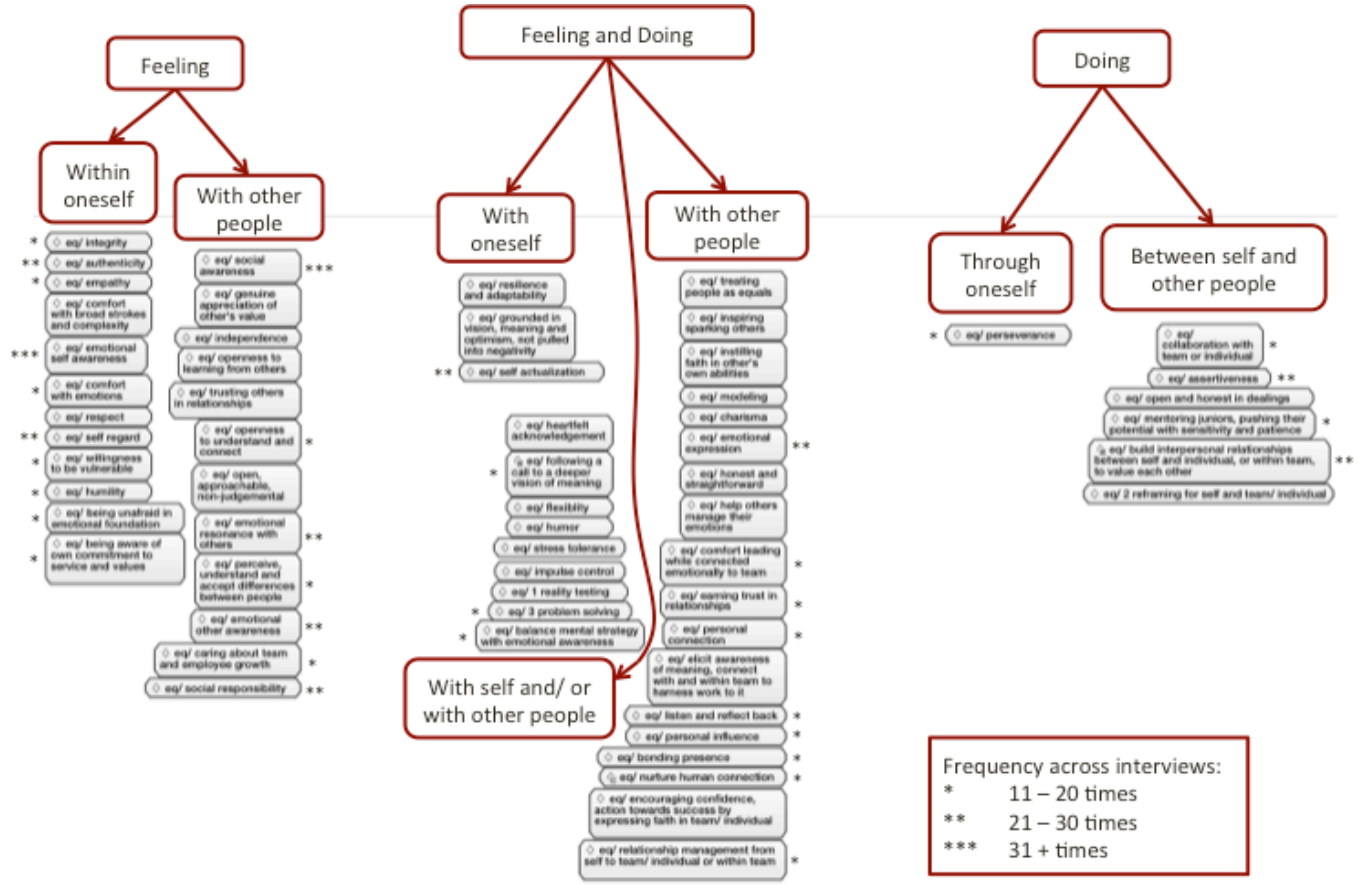


**Figure 5: Gender Fluidity Across Ways of Processing Awareness and Personal – Professional Integration**

| Subject | Processing Awareness | | | | | Personal – Professional Integration | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Reflect on Other | | Reflect on Self | | | Personal to Professional | | Professional to Personal | |
| | *W* | *GFM* | *GFW* | *M* | | *W* | *GFM* | *GFW* | *M* |
| *F1* | X | | X | | | X | | | |
| *F2* | X | | X | | | X | | | |
| *F3* | X | | X | | | X | | | |
| *F4* | X | | X | | | X | | X | |
| *F5* | X | | | | | X | | X | |
| *F6* | X | | X | | | X | | X | |
| *F7* | X | | X | | | X | | | |
| *M1* | | | | X | | | X | | |
| *M2* | | | | | | | | | X |
| *M3* | | | | X | | | X | | X |
| *M4* | | X | | X | | | | | X |
| *M5* | | X | | X | | | X | | |
| *M6* | | | | X | | | | | X |

Key:

| | |
|---|---|
| W | Woman |
| GFM | Gender Fluid Man |
| GFW | Gender Fluid Woman |
| M | Man |