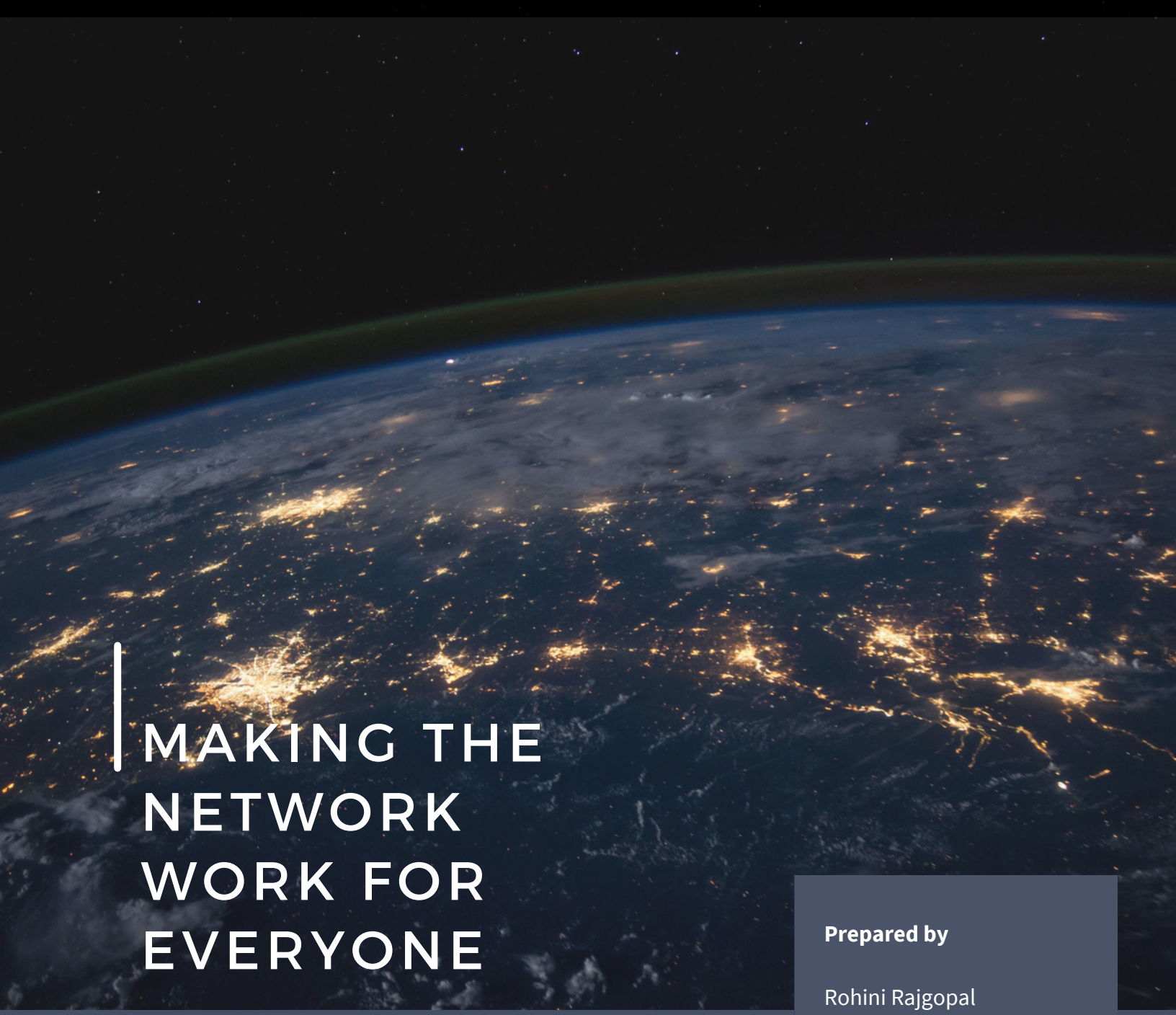

MAKING THE NETWORK WORK FOR EVERYONE

Assessing the Diversity, Equity and Inclusion within the Global Digital Health Network

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INTRODUCTION

Coming into their tenure in April 2020, the Global Digital Health Network (GDHN) Co-Chairs wanted a greater focus on Diversity, Equity and Inclusion (DEI) within the Network, to explore how the Network's governance, events, communications, and member recruitment and retention could be improved to better meet the needs of and be representative of the Network's membership. This focus was further propelled forward by the events in June 2020 protesting long standing racism and discrimination of the Black community in the United States. The state of racism and discrimination within the United States is just one example of why improving DEI within organizations and communities is so important to improving the state of our world.

The sector of global health is also at an inflection point where many who work in the space are acknowledging that many of the structures set up by the international development field are not sustainable and not always effective at attaining the improved outcomes we wish to garner through these efforts. Many believe that the colonialist history of foreign aid has had long-lasting influence and consequences for how international development work is carried out. Seeing as the Network serves a global membership with diverse assets, needs, perspectives, and skillsets, Network leadership felt it was an important moment to explore how the historical and systematic forces were at play within the Network so they could further address them.

In order to create a strategy to improve DEI within the Network, we needed to first understand the current state of affairs with regard to DEI. By conducting a survey of the GDHN membership, the Network would have a baseline assessment that would help identify gaps and shortcomings and would influence what strategy the Network should develop. This report presents the results and analysis of that survey. The objective of this report is not to provide guidance on a strategy development but rather to provide facts on DEI within the Network and possible recommendations from the perspectives of GDHN members.

METHODOLOGY

To create the DEI baseline survey, the assessment team adapted a survey from CultureAmp, the "provider of a popular employee feedback and analytics platform". CultureAmp had been recommended to us by representatives from a global health organization as a starting point for this analysis.

CultureAmp's survey focuses on seven constructs of DEI: fairness, opportunities & resources, decision making, voice, belonging, diversity and contribution to broader purpose. Questions about these constructs together with questions regarding one's engagement helped us learn how GDHN members experience the Network's culture. The assessment team adapted these constructs and the subsequent questions to be specific to the Network (e.g., "I see myself still working at Global Digital Health Network in two years' time" to "I see myself still being a part of the Global Digital Health Network in two years' time.")

Furthermore, the assessment team adapted a series of demographic questions focused on race, nationality, gender, and education level, among others, to understand the intersectional identities of our members. The survey was anonymous and members could choose to skip questions throughout the survey if they did not want to answer them. The co-chairs and student fellow were the first set of individuals to compile the survey adaptation, tailoring questions to the Network. The second round of review was completed by the GDHN Advisory Council and the final round of review was completed by the Network of Networks[1].

The survey was released at the end of July 2020 and originally allowed two weeks for responses. Given heavy workloads during this time of year, and a timeline that coincided with the abstract submission deadline for the Global Digital Health Forum 2020, a two week extension was provided to allow for more responses.

[1] The Network of Networks (NoN) is a collaboration of networks including the Global Digital Health Network (GDHN), Red Centroamericana de Informatica en Salud (RECAINSA), Pacific Health Information Network (PHIN), Africa Alliance of Digital Health Networks, Asia eHealth Information Network (AeHIN), Routine Health Information Network, African Center for eHealth Excellence (ACFEE) , BID Learning Network, Red Americana de Cooperación sobre Salud Electrónica (RACSEL), Red Latinoamericana y del Caribe para el Fortalecimiento de los Sistemas de Salud (RELACSIS), and Red IberoAmericana de Tecnologías Móviles en Salud (RITMOS). While each network is unique and has its own focus, we are linked by a common goal to share best practices and knowledge in order to increase digital health capacity within our members.

QUANTITATIVE RESULTS

OVERVIEW

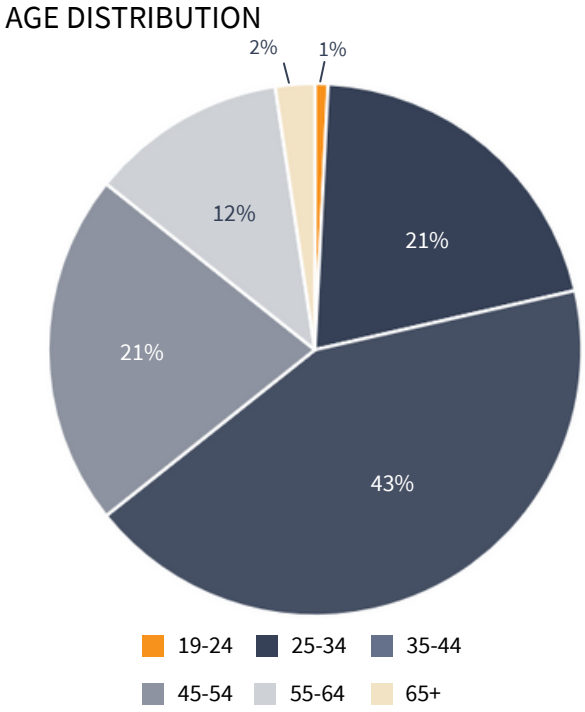
As of December 31, 2020, the GDHN membership consisted of 4042 members from 117 countries. The 3 most populous countries were United States, United Kingdom and Kenya. While the desired response rate was 10%, the GDHN DEI member survey had 131 respondents from 25 different countries, representing 3.2% of the membership. The 3 countries with the most respondents were the United States, Nigeria, Kenya and India (tie). This is different from the representation of the Network's overall membership and is important to keep in mind as context for the subsequent analysis.

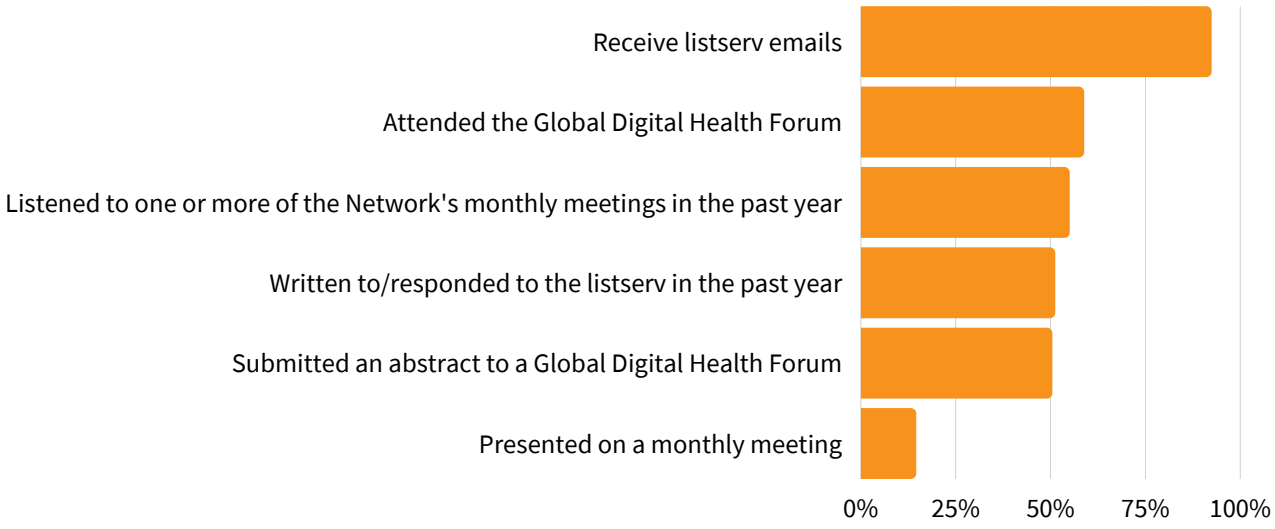
GDHN MEMBERSHIP

SURVEY RESPONDENTS

Of those that responded, 66% of the survey respondents identified as female and 34% identified as male. Furthermore, 85% of respondents fall between the ages of 25 - 54, with 43% of respondents falling between 35 - 44 years of age.

Of those that responded with their country of residence, a little more than half of respondents (57%) were from North America or Europe, 28% were from Africa or the Middle East, 11% were from Asia and 4% were from Latin or South America. The assessment team further categorized them based on the World Bank's Country Classification of Economies: high income (56%), upper middle income (10%), lower middle income (29%) and low income (5%).



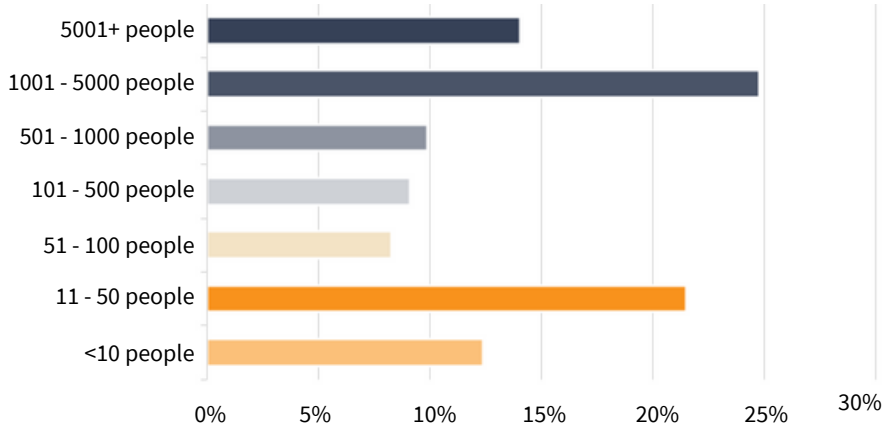


When looking at members' involvement and engagement within the Network, 92% indicated they receive listserv emails compared to 51% who indicated they have written to or responded to the listserv. About half of the survey respondents have submitted an abstract to a past Global Digital Health Forum event and 58% of survey respondents have attended the Global Digital Health Forum in the past. A little more than half (55%) of the respondents have attended one or more of the monthly meetings while only 15% have presented at one.

QUANTITATIVE RESULTS

Before administering the DEI survey, the Network had very little demographic data about its members. In addition to the demographic factors already mentioned, the assessment team found the survey respondents to be a highly educated group of individuals with 90% having completed a Master's level or Doctoral level degree.

There was a large gap in organization size that members belonged to, with around a third were "50 people or less" and slightly over a third (39%) were from organizations with "1000 people or more". GDHN members work in several areas of digital health from academia and research to developing tools and resources to implementing these tools and resources.



ANALYSIS PREPARATION

Prior to the analyses, the survey data was normalized by categorizing country data into regions and economic classifications, removing any missing or incomplete responses and ensuring accurate representation of race and nationality responses. Comprehensive categorical scores were created by averaging the values for individual questions within each of the seven constructs (fairness, opportunities & resources, decision making, voice, belonging, diversity, and contribution to broader purpose), ignoring questions that were skipped. For example, if a participant responded to 4 of the 5 Fairness construct questions with a Likert scale response (e.g., 4 - Agree) but left one question blank or responded with "not applicable" or "unsure", the four numerical scores were averaged, ignoring any blank or non-Likert scale response. Lastly, upon further review, one question was removed from the analysis due to its ambiguity and subsequent variation in responses. [2]

The average scores for each of the seven constructs are as follows (1 - Strongly Disagree, 5 - Strongly Agree):

- Engagement: 4.25
- Fairness: 3.54
- Opportunities & resources: 3.54
- Decision making: 3.51
- Voice: 3.75
- Belonging: 3.48
- Diversity: 3.75
- Contribution to broader purpose: 4.07

The assessment team felt these values overall were important to document as a baseline measure so that future assessments would be able to more accurately assess progress. However, any conclusions based on interpreting these scores may not hold statistical validity and should only be used to compare year over year measures, because the response rate was lower than anticipated and likely not representative of the Network's overall membership.

[2] The removed question - "Diversity is a barrier to participation at the Global Digital Health Network"

ANALYSES OF DEMOGRAPHIC VARIABLES & DEI CONSTRUCTS

The initial hypothesis for each of the subsequent demographic categories was that there would be a statistically significant difference in categorical scores across one or more of the variables. All tests were run at a 5% significance level and were peer reviewed by an Advisory Council representative to ensure accuracy in the analysis. The statistical analysis and subsequent results are outlined below.

ANALYSES OF DEMOGRAPHIC VARIABLES & DEI CONSTRUCTS

GENDER

The initial hypothesis for gender was that those who identified as female, on average, would have statistically significant lower scores across each of the 7 constructs and overall engagement than those who identified as male. If there were not enough responses to produce a statistically significant result in the analysis (e.g., any blank responses, those that did not identify as either male or female), they were removed from the analysis. A series of two-sample, one-tailed t-tests were run across each construct and overall engagement. The following constructs proved to have statistically significant results: voice (n = 124, T-stat = 1.716, df = 91, p value = 0.045), belonging (n = 124, T-stat = 2.501, df = 87, p value = 0.007) and diversity (n = 124, T-stat = 2.020, df = 83, p value = 0.023).

LANGUAGE

The initial hypothesis for language was that those who identified as non-native English speakers, on average, would have statistically significant lower scores across each of the 7 constructs and overall engagement than those who identified as native English speakers. The assessment team removed any blank responses, ran a series of two-sample, one-tailed t-tests across each construct and overall engagement and found no constructs that had statistically significant results.

REGION

The initial hypothesis for this variable was that there would be a difference between the coefficients of individuals in the North America/European region, individuals in the Asia region, individuals in the Latin/South America (LATAM) region and individuals in the Africa/Middle East region. The assessment team removed any blank "country of residence" responses and blank categorical scores and ran a series of regressions across each construct and overall engagement. Upon analysis, there were no regressions that had statistically significant results.

RACE

The initial hypothesis for this variable was that there would be a difference between the coefficients of individuals who identified as White, individuals who identified as Black, individuals who identified as Asian, individuals who identified as Hispanic/Latinx, individuals who identified as Multiracial, or individuals who identified as Native Hawaiian or Pacific Islander. The assessment team removed any blank "race" responses and blank categorical scores and ran a series of regressions across each construct and overall engagement. The assessment team found statistically significant results across the following regressions. Those who identified as Asian on average had lower overall engagement (Beta = -0.462, p value = 0.014) and voice scores than those who identified as white (Beta = -0.403, p value = 0.014).

CLASSIFICATION OF COUNTRIES BY ECONOMIC STATUS

The initial hypothesis for this variable was that there would be a difference between the coefficients of individuals in higher income countries, individuals in upper middle income countries, individuals in lower middle income countries and individuals in lower income countries. The assessment team removed any blank "country of residence" responses and blank categorical scores and ran a series of regressions across each construct and overall engagement. Upon analysis, there were no regressions that had statistically significant results.

QUALITATIVE RESULTS

OVERVIEW

The three questions asked in the survey which produced qualitative feedback were as follows:

- What is the most important thing that the Global Digital Health Network can do to create a more inclusive culture?
- Within the four domains of the Network listed below, what is the most important thing that the Global Digital Health Network can do to create a more inclusive culture?
    - Four Domains of the Global Digital Health Network:
        - 1. Events - monthly meetings, Global Digital Health Forum;
        - 2. Governance - composition of the Advisory Council and Board;
        - 3. Member Recruitment & Retention;
        - 4. Communications - social media, listserv etc.
- Is there anything else that you would like to share on this topic?

The objective of these questions was to provide a space for members to elaborate on their thoughts and opinions based on the previous Likert questions. The assessment team analyzed each individual response across the three questions, identifying key themes that arose across the three responses. “Themes” are defined as key areas the Network leadership can focus on to improve DEI. The student fellow went through the questions first, identifying themes and then an Advisory Council member provided a peer review to ensure the analysis was accurately represented.

While the themes were initially organized across the following domains (Events, Governance, Member Recruitment & Retention, and Communication), upon reading member’s responses, several themes were found to cut across these domains and so the assessment team decided to reorganize the findings as follows.

- Structural changes
- Diversification of participation & leadership
- Formal capacity building
- Transparency in membership and in decision making

STRUCTURAL CHANGES

Several responses indicated members wanting to see changes in how the Network is currently organized. This includes: greater regional digital health network representation and involvement, possibly creating working groups, re-evaluating criteria for Advisory Council membership, and creating spaces of exchange for non-native English speakers.

Greater regional digital health network representation and involvement: The Network partnered with representatives from the Network of Networks for the first time this year to help plan the annual Forum event but members want to see greater collaboration with regional digital health networks to ensure equitable representation, through joint events, for example. Strong linkages with the regional networks could facilitate the development of a more diverse, equitable, and inclusive culture.

Affinity groups: Establishing affinity groups could allow for stronger representation and leadership from LMICs or a more targeted approach on certain topics (e.g., create a D&I officer or team that rotates [among] regions/ background/ genders etc. or an inclusive council who will be tasked with advocating for inclusiveness in discussions). Forming small discussion groups of like people can also allow people to discuss issues and report experiences more easily.

Re-evaluating criteria for Advisory Council membership:[3] This was a topic of significant feedback. A large majority of members voiced the need to diversify leadership in terms of representation expanding beyond US based staff. Many members concurred that the leadership could use a lot more representation from a) the global south and b) smaller organizations outside of the typical IPs and should prioritize non DC consulting firm implementers as leaders in the space rather than more large USAID grantees.

Creating spaces of exchange for non-native English speakers: Many members were pleased to see more languages in this year's GDHF, but would like to see webinars in different languages or announcements in languages other than English as additional opportunities to break the language barrier.

"PRIORITIZE NON DC CONSULTING FIRM IMPLEMENTERS AS LEADERS IN THE SPACE RATHER THAN MORE LARGE USAID GRANTEES"

[3] Currently the Advisory Council is composed of representatives from several large international NGOs, all primarily US or UK based. These representatives have ongoing responsibilities regarding selecting content and speakers for monthly meetings, curating content, speakers, and abstracts for the Global Digital Health Forum and facilitating financial support from their organizations to the Network for operating expenses.

DIVERSIFICATION OF PARTICIPATION & LEADERSHIP

Another large theme was increasing the diversity of GDHN membership and leadership, by increasing opportunities for the following groups of people to get involved: younger individuals, women, those from the Global South and more individuals from non-international nongovernmental organizations (NGOs).

Some aggregated suggestions:

- The gender issue is complex as the ICT industry tends to be more male while global public health tends to be more female. There is room, though, to actively engage and improve the participation of women of all colors, origins, and gender identities.
- There is a lack of young people presenting on digital health topics. Engaging younger people from a more purposefully diverse set of backgrounds will allow the Network to hear young voices and provide them with more visibility as they are the future of digital health.
- The Network should do more to promote leadership, talent, and perspectives of people from LMICs. They should actually be the ones to present as they are the ones actually implementing projects in these countries.
- The network is dominated by the voices of the large international NGOs, but lacks representation from small to mid-sized organizations who are also doing wonderful work in digital health. Is there opportunity for non-US NGOs or independent tech folks to take on more of a leadership role rather than merely participating in the monthly events?
- People find out about the Network by word of mouth or referral from other colleagues. Oftentimes, this can leave out a lot of people who have never had access to such a professional network to begin with. Not only proactively recruiting diverse members, but also actively recruiting diverse members to actively participate would be helpful.

FORMAL CAPACITY BUILDING

Many members indicated they would like to see more capacity building opportunities within the Network, primarily training and mentorship opportunities. Valuable suggestions included:

- Providing trainings on how to recruit and retain more people of color, women, persons from global health in digital health leadership and digital health roles in countries Network members work in
- Having south-south mentorship in other languages
- Connecting newer members with older, more experienced members to provide mentorship, helping them find ways to get the most out of GDHN resources and to have their voices heard more. This will also increase exposure of the older, more experienced members to some newer voices, and contribute to reducing the feeling of the "old boys network".
- Working with universities in LMICs with public health/health informatics programs to create greater awareness and linkages to key people as the listserv can be a bit intimidating, sending out an email to thousands of people at a time.
- Building momentum around important and very topical issues that uniquely implicate global health (e.g. better and more equitable approaches to gaining informed consent in collecting personal health information)

TRANSPARENCY

The last large theme was regarding the lack of transparency in GDHN membership [who are the members?] and decision making [who's on the Advisory Council, what are the decision-making procedures?]. The Network needs to be transparent about its leadership roles and how they are selected. Several members commented they didn't know if the leadership is diverse or how any other functions work or much about the composition of the Advisory Council and Board, or how members are recruited. The lack of knowledge (don't know the current make-up of the board and don't know how decisions are made) indicates a need for greater transparency in the Network's actions, decision making and membership.

Additional comments:

- It is a mystery to member on how leadership is chosen and decisions are made. While many decisions may have been good, members have no idea who contributes and how.
- Members don't know as much as they would like about the group, having only attended remotely.
- There is an opportunity to make some of the activities more clear to new or peripheral members or to make it easier to introduce oneself to the group. Doing a spotlight on individual members, who they are, and what they do could allow others to get to know them a little better.

LIMITATIONS

As with any research endeavor, there are always limitations to the interpretation of data collected. First, the limited sample size of 131 survey respondents should be taken into account when extrapolating to draw conclusions about the larger GDHN membership. Secondly, respondent bias may have been present as those who have more polarized views of DEI, one way or another, may have been more likely to participate in the survey. Additionally, lack of accessibility could have been another barrier to survey participation as this survey was conducted via the Internet (specifically Google Forms) and was only presented in English. Lastly, since this survey allowed participants to leave questions blank when responding, this has further decreased the possible sample size for analysis as the analysis only reviewed respondents that had completed responses for the applicable constructs and demographic variables in consideration during analysis.

NEXT STEPS

As stated in the introduction, the objective of this report was to analyze and present the findings from the Global Digital Health Network DEI Member Survey completed in 2020. The results suggest several tangible steps GDHN leadership can take, as well as some key areas of consideration for areas for growth of Network programming, to make the Network a more, diverse, equitable, and inclusive environment for all. We hope this report will help guide the strategy development and subsequent strategy for addressing these concerns and issues.

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