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Factors associated with the under-representation of women in medical leadership in Nairobi County Kenya: a mixed method study.

Obino, Lilian Nyabonyi
Strathmore Business School
Strathmore University

FACTORS ASSOCIATED WITH THE UNDER-REPRESENTATION OF WOMEN IN MEDICAL LEADERSHIP IN NAIROBI COUNTY KENYA: A MIXED METHOD STUDY

LILIAN NYABONYI OBINO

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Strathmore University Business School
Strathmore University
Nairobi, Kenya

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DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made in the dissertation itself.

Name of Candidate: Lilian Nyabonyi Obino

Approval

The dissertation of Lilian Nyabonyi Obino was reviewed and approved by the following:

Dr. Jackline Aridi
Strathmore University Business School
Strathmore University

Dr. Tecla Kivuli
Strathmore University Business School
Strathmore University

Dr. Caesar Mwangi
Executive Dean
Strathmore University Business School

Dr. Benard Shibwabo
Director, Office of Graduate Studies

ABSTRACT

Effective healthcare systems in low- and middle-income countries require patient-centered service delivery, and the role of gender in healthcare leadership in these countries is a significant concern. Despite the increasing number of women enrolling in professional degrees, their representation in higher-level medical leadership positions remains low. To address this issue, a mixed-method study was conducted in Nairobi County, Kenya, involving surveys and interviews with medical professionals in executive leadership and management positions. The study found that women met the one-third representation threshold in executive management committees of selected hospitals but faced several barriers in their career progression journey. After adjusting for significant covariates, women with higher levels of education were associated with less likelihood of ascending to leadership ($\beta = -4.60$; 95%CI: -9.15 - -0.051; $p = 0.048$). On average, women were found to report higher barriers to career progression than men (Mean difference= 1.133; p-value = 0.000; 95% CI: 0.539- 1.728). Women were also found to perceive a greater lack of executive sponsors compared to men (Mead difference=0.683; p-value =0.043; 95% CI :0.022- 1.345).

The qualitative interviews revealed barriers such as challenges in work-life balance, limited opportunities for career development, poor communication and negotiation skills, organizational challenges such as limited succession planning, unconscious gender bias, politicization of roles within the organizations, dismissive attitude towards women leaders and lack of mentorship. Other barriers included lack of support from fellow women and patriarchal structures within the society. To promote gender equity in medical leadership, efforts should focus on challenging gender stereotypes, promoting diversity and inclusion, and creating more equitable career advancement opportunities. Future research should explore additional strategies to overcome these barriers and further enhance gender representation in healthcare leadership.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

ERC: Ethics and Research Committee

IRB: Institutional Review Board

KMA: Kenya Medical Association

KMPDU: Kenya Medical Practitioners, Pharmacist, and Dentist Union

KMTC: Kenya Medical Training College

KNH: Kenyatta National Hospital

LMIC: Low and middle-income countries

NACOSTI: National Commission on Science Technology and Innovation

OECD: Organization for Economic Co-operation and Development

SDG: Sustainable Development Goal

UHC: Universal Health Coverage

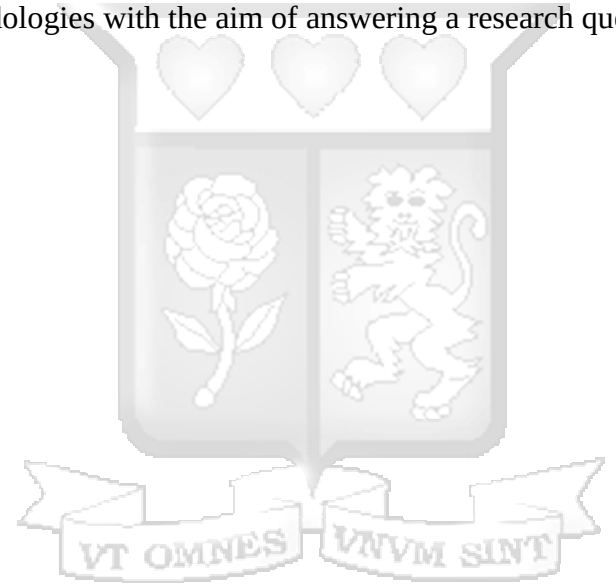
WHO: World Health Organization

OPERATIONAL DEFINITION OF TERMS

Medical Leadership: Medical leadership refers to the concept of clinical healthcare personnel, primarily at hospitals undertaking the roles of executive leadership and using their management skills and experience in decision-making and influencing the people within their institutions to ensure the services are delivered.

Underrepresentation: Insufficiently represented as compared to the proportion in the category of all relevant positions.

Mixed-Method Study: Refers to the combination of quantitative and qualitative research methodologies with the aim of answering a research question.



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DEDICATION

This work is dedicated to my dear parents, Mr. Henry Mackdonald Obino and Mrs. Emily Moige Obino, who have been my number one pillars of strength and motivators to pursue my academic goals. I also dedicate it to my dear husband, Mr. Reuben Manyiza, and lovely children, Liora Kwamboka and Aidan Louis, who have always given me a reason to keep going. Lastly, to my siblings Maureen, Eric, and Louis John.

Chapter 1. Introduction

1.1. Introduction

Chapter One presents an overview of the topic from the global, national, and local contexts. The Background of the study is covered in section 1.2. The problem statement, highlighting the issue for investigation, is covered in section 1.3. Research gap, scope, justification, objective, questions, and significance are also explored in this chapter.

1.2. Background

Strong and effective leadership and management are crucial, especially in low- and middle-income countries (LMIC), where health systems face various challenges like scarcity of resources and high disease burdens (Daire, Gilson, & Cleary, 2014). It has been found that placing medical practitioners in leadership roles is important for strong and effective healthcare systems and, more particularly, for achieving goals like Universal Healthcare Coverage (UHC) and Sustainable Development Goals (SDGs) (Ayeleke et al., 2018). The role of gender in healthcare leadership in LMICs has remained a great concern for quite some time. A study conducted by Downs, Reif, Hokororo, & Fitzgerald (2014) reported that most health organizations globally, regionally, and at a country level neglect the concern of gender equality in their leadership roles despite the significant role inclusion would play.

Gender-balanced leadership can enhance decision-making by bringing diverse perspectives, experiences, and expertise, resulting in more inclusive and comprehensive healthcare policies and programs (Zeinali et al., 2021). Women in medical leadership positions can address specific health needs that require attention, such as reproductive health, maternal care, and gender-based violence. Their presence ensures that these needs are adequately addressed in healthcare policies, programs, and service delivery, thereby reducing gender disparities in access to healthcare and improving overall health outcomes. The inclusion of women into medical leadership not only contributes to SDG's goal of ending gender inequality and promotes other goals like achieving good health and well-being, which is also an objective of any UHC program (WHO, 2020).

Fortunately, women represent a large proportion of the global health workforce today, which would create a basis for achieving gender equality and good health outcomes for the global population. According to Karelaia & Guillen (2012), there has been a rise in the number of women who enroll in professional degrees in law and medicine from under 25% in the 1970s to more than 50% worldwide. The World Health Organization (2019) reports that women are mostly over-represented in entry level positions like nursing, community health workers, laboratory technicians, nutritionists, among similar level jobs. Zeinali et al. (2021) note that up to 70 percent of the entire health care workforce comprises women. Their representation, however, decreases with higher professional positions like managerial and decision-making positions.

However, details within the leadership and management positions differ from the overall representation within the medical sector. According to a Lancet report published in 2016, women account for 16 percent of executive positions in the medical field globally (Boniol et al., 2019). The study was analyzed from 104 countries (Boniol et al., 2019). The 16 percent representation falls short of the expected representation as the world pushes toward gender equality. The same trend was illustrated in Africa. A 2017 study by the African Development Bank noted that poor data collection in Africa made it hard to collect accurate data. It estimated that women's representation in medical leadership and management accounted for 17-30 percent (African Development Bank, 2019). This brings out the aspect that women are still underrepresented in senior management and leadership positions. In Kenya, there is no precise data reporting on the representation of women in senior roles within the medical field. However, women underrepresentation remains an issue of concern in many sectors (State Department for Gender, 2020). The underrepresentation, resulting from various underlying issues that have prevented women from progressing to senior leadership and management positions, could negatively impact the delivery of health care services, particularly towards UHC and SDGs.

The underrepresentation of women in senior medical leadership and management positions limits the diversity of perspectives and experiences in decision-making processes, hindering the development of comprehensive and inclusive healthcare policies and programs (Heilman et al., 2004). It can also result in women's specific health needs being overlooked or inadequately addressed, perpetuating gender disparities in healthcare

and limiting improvements in women's health outcomes. In addition to that, the absence of women in leadership positions hinders the promotion of gender-sensitive healthcare services and the provision of culturally appropriate care. The practice can contribute equally to perpetuating traditional gender roles and stereotypes, inhibiting progress towards a more inclusive and gender-equal society. There have been deliberate efforts to increase women's representation to address some of the concerns resulting from underrepresentation.

The Kenyan Constitution specifically states the two-thirds women representation rule in reference to gender representation in the appointment and election of leadership (Kenya Law: The Constitution of Kenya, 2013). However, achieving the two-thirds gender rule, or as usually called the one-third gender rule, has been a challenge in many institutions. The gender rule was included to address the problem of female underrepresentation in leadership positions. Up to 2010, the ratio of women elected and appointed to leadership positions was less than 15 percent, and the clause aimed to increase that number (Jfrant, 2018). However, the same gender rule would apply to other leadership positions outside politics, including health care leadership. The gender rule states that no gender should have more than two third representation at any institution, board, or group whose purpose is to manage or run an entity (Makau, 2019). The rule is primarily required to absorb more women at least to acquire a one-third ratio in the group leading or managing any organization. Adherence to the gender rule has been a challenge in Kenya and not many organizations have succeeded in implementing it, as evidenced in Kiambu County (Reche, 2019).

Several research studies have identified structural, organizational, cultural, and personal factors as the barriers that hinder women from taking medical leadership roles. For instance, a study conducted in Lebanon by Tlaiss (2013) to explore the barriers and enablers of women's career progression in health in a middle-income country indicated that cultural values, gendered social roles and expectations hindered the career advancement of women. The study also highlighted that the women's agency acted as an enabler to navigate the barriers to move into management positions. On the other hand, appointing women to leadership positions are also affected by the perception that women have more emotive and reactive leadership style by men and even by positive

discrimination policies (Bismark et al., 2015). Evidence suggests that strong female representation in leadership and management positions is associated with better organizational performance (Tlaiss, 2013). Unfair representation of women in senior roles may result in ideological differences between clinicians and those in leadership roles (Boylan, Dacre, & Gordon, 2019).

This study used mixed methods to establish the factors influencing the underrepresentation of women in medical leadership within the Nairobi County public hospital system. It focused on interviewing the executive leadership team- which consisted of the positions of chief executive officers of hospitals and their hospital management teams to assess gender equality. The results will inform policy makers to ensure that gender equality strategies are enacted and medical leadership is equitably constituted, including well-qualified female medical leaders.

1.3. Problem Statement

In most OECD countries, the healthcare sector is a good source of employment, with most women represented among the specialized health workforce (OECD, 2016). Although women comprise more than 50% of the global healthcare workforce in most countries, less than 20% hold leadership positions (Kalaitzi, Cheung, Hiligsmann, Babich, & Czabanowska, 2019). Newman (2014) reports that women leaders in healthcare positions represent only 14% of healthcare boards of directors and 18% of hospital CEOs, and 15.9% in clinical leadership positions worldwide. This is despite the potential gains of gender inclusion.

Leadership and management are pivotal in driving the agenda of health care policies and related programs like Universal Health Coverage (UHC) and Sustainable Development Goals. The principles of gender equity and social inclusion are crucial for the success of any health-related program (Yakerson, 2019). Effective leadership and management provide strategic direction, coordination, and oversight to healthcare systems, ensuring that resources are allocated efficiently, services are accessible, and quality care is delivered. However, achieving UHC and SDGs goes beyond mere coverage; it necessitates addressing underlying inequalities and barriers to healthcare access (Langer et al., 2019). Integrating gender equity and social inclusion in the UHC and SDG agenda

recognizes all individuals' diverse needs and experiences, irrespective of their gender, socio-economic status, or marginalized identity. While prioritizing positive health outcomes is important, prioritizing gender equity will play an integral role in the overall success of UHC and SDG.

Underrepresentation remains a major issue across low- and middle-income countries (Zeinali et al., 2021). According to Zeinali et al. (2021), up to 70 percent of the health workforce comprises women, but the same is not reflected in higher leadership and management positions, where men dominate. Kenya is among the low- and middle-income countries struggling to resolve the issue of gender inequality (State Department for Gender, 2020). This is particularly reflected in elected leadership, where a study conducted in 2020 showed that women account for 22 percent and 18 percent of appointive positions (Gender Equality and Female Empowerment Fact Sheet, 2020). Women also account for 34 percent of political leaders at the county level, indicating they are underrepresented in the political class (Gender Equality and Female Empowerment Fact Sheet, 2020). Considering the advantages of gender equality and diversity in the workplace, most countries would want accelerated progress toward affirmative measures toward gender equity. Affirmative action was passed in the 2010 Kenyan Constitution, requiring all appointments to have at least a third of members from the opposite gender. To boost the number of women in various fields, the Kenyan government initiated an affirmative action in 2009 that required institutions of higher learning to admit ladies with fewer points to various education programs (Buchere, 2009). As a result, the number of women enrolling in medical courses has increased. In ten years between 2005 and 2015, the percentage of females enrolled in medical courses increased from 30 percent to around 50 percent (Kenya: Gender gap narrows for medical degrees, 2017). Despite the increase in the entry of women into medicine in Kenya and the introduction of equal opportunity policies in healthcare, women still seem to be under-represented in high-level formal medical leadership positions (State Department for Gender, 2020), a factor which makes it important to focus on women in this study.

Under-representation of women in medical leadership suggests gender inequality and a lack of inclusivity (Kimani & Jefferson, 2020). Gender underrepresentation may also hinder the diversity of opinions, perspectives, and experiences when it comes to decision-

making in healthcare (Zeinali et al., 2021). This problem is particularly critical for Nairobi County-, Kenya's capital City which traditionally attracts more highly educated persons and should reflect gender equity in leadership positions. Nairobi as a city has received most of the beneficiaries of affirmative action. Despite all these changes, there is still a high underrepresentation of female leadership in Nairobi County (Nyadera, 2020). That would attract closer scrutiny and failure to achieve global targets on implementing affirmative measures to increase the number of women in leadership, including medical leadership positions

Including women in medical leadership positions would bring many benefits, and that would serve as a bargaining tool to push their ratio to increase in leadership positions (Kimani & Jefferson, 2020). The inclusion of women will bring diversity to the leadership of the organization. Diversity allows generating new ideas, perspectives, and experiences that can improve health care outcomes (Kimani & Jefferson, 2020). The potential is high if women are allowed to serve in leadership positions. Women can bring leadership values and techniques unique to the needs of women, which are oven overlooked by men (Boniol et al., 2019). These values can benefit the organizations that they serve. Whether it is the feminine and motherly instincts or the cultural shifts from what men have made as their culture, each has the potential to improve health care outcomes. Including women in leadership can address other social challenges, like the gender pay gap or the representation of women's needs in various agencies (Muraya et al., 2019). In any case, increasing the number of women in leadership will make the society more equal and result in positive outcomes in health care and the society overall.

In light of all these findings, further research is needed to understand the reasons behind the low representation of women in healthcare leadership positions, despite their majority presence in the workforce. This research should investigate the specific barriers and biases that hinder women's progression, including gender bias in promotions, limited career development opportunities, and work-life balance challenges. Additionally, studying the specific context of public hospitals in Nairobi County, Kenya, can provide insights into the underrepresentation of women in medical leadership, despite affirmative action efforts, and the implications for achieving global gender equity targets. This research will contribute to addressing gender inequality and promoting diversity in healthcare systems.

1.4. Overall Objective

To establish the factors associated with the underrepresentation of women in medical leadership of selected higher levels public hospitals in Nairobi, Kenya.

1.4.1. Specific Objectives

1. To examine the representation status of women in executive medical leadership in selected higher level public hospitals in Nairobi, Kenya.
2. To explore factors associated with representation of women in executive medical leadership in Nairobi County.
3. To gather insights on the workplace experiences of male and female medical leaders in public hospitals in Nairobi County regarding their journey towards attaining executive leadership positions within medical institutions.
4. To determine the role of gender in enabling women's representation in executive medical leadership in Nairobi County, Kenya.

1.5. Research Questions

1. What is the representation status of women in executive medical leadership in selected higher level public hospitals in Nairobi, Kenya?
2. What are the factors associated with representation of women in executive medical leadership in Nairobi County?
3. What are the workplace experiences of male and female medical leaders in public hospitals in Nairobi County regarding their journey towards attaining executive leadership positions within medical institutions?
4. What is the role of gender in enabling women's representation in executive medical leadership in Nairobi County, Kenya?

1.6. Scope of the study

The study examined the representation status of women in leadership positions within public medical institutions across Nairobi County, Kenya. The study focused on those in hospital leadership positions from various public medical institutions of level four hospitals and above, which included two national referral hospitals, two county referral level 5 hospitals, and one level 4 referral hospital within Nairobi, as these hospitals have high-level medical practitioners offering specialized care to patients with a range of illness

including those in critical conditions from all over the country hence decisions about their management including service delivery impacts on the health outcomes of a large proportion of patients in the country. The national referral hospitals also serve as learning institutions offering teaching and research services; hence decisions affecting the operations of the facilities affect the quality of specialists training there and, consequently, the quality of service delivered by these specialists directly impacting the health outcomes of the country's general population. Those in executive leadership positions included members of the hospital management committee who participate in decision-making in matters affecting service delivery within the hospitals. The representation status of women in medical leadership positions was established, and the factors influencing the representation of women in medical leadership positions within Nairobi County were looked into. The insights from male and female medical leaders serving in medical leadership positions were also examined. The specific hospitals from where these medical leaders were drawn included Kenyatta National Hospital, Mathari National Teaching and Referral Hospital, Mbagathi County Referral Hospital, Mama Lucy Kibaki Hospital, and Pumwani Maternity Hospital.

1.7. Significance of the Study

Understanding the factors that lead to the underrepresentation of women in medical leadership roles will help inform policies around women's leadership and gender balance. It will also promote diversity and effective leadership. With diversity within the medical leadership teams, better decisions concerning service delivery will be made and consequently stimulate growth in the health sector. The study's findings can be used to guide policy makers in finding sustainable remedies for ensuring women are well-represented in leadership positions. Qualified women who experience challenges in their career progression can have a positive impact on the organization. This can be made possible once they are given opportunities based on merit to demonstrate their capabilities and bring all the benefits of diversity.

Chapter 2. Literature review

2.1. Introduction

This chapter will cover the theoretical framework, which describes the theory that explains the existence of the research problem being studied (Abend, 2008). Existing literature on the representation of women in medical leadership will be reviewed, and the gaps will be highlighted. This chapter will also cover the conceptual framework illustrating the different variables within the study and how they interrelate.

2.2. Theoretical Framework

This study was focused on women's underrepresentation in senior medical leadership positions. It was anchored on three theories, the Glass Ceiling theory, the organizational culture theory, and the implicit bias theory. The "glass ceiling" is a metaphor representing an unseen barrier that prohibits specific individuals from reaching high-level roles within an organization or an industry (Duquesne University School of Nursing, 2020). This theory specifically provides the background to understand how women in several organizational settings fail to grow professionally and undertake leadership positions within organizations, mostly due to discrimination based on their gender. Organizational culture theory provides an overview of the prevailing organizational values that can promote or undermine gender equality in the workplace. Implicit bias provides the biases within the medical leadership and their impact on women's career progression. Each theory is examined in detail below.

2.2.1. Glass Ceiling Theory

The glass ceiling refers to the discriminatory nature at workplaces preventing persons with the relevant qualifications from progressing in their organizations, barring them from decision-making positions. More often than not, the discriminatory practices are perceived to be against women creating barriers impeding their vertical growth. These barriers are often persistent and invisible hence termed the glass ceiling. Based on several other studies, the glass ceiling includes the barriers and obstacles that prevent women's progress, usually underpinned by multiple discriminatory myths against women. Conscious and

unconscious actions, attitudes, gender myths, and misconceptions create a glass ceiling (Babic & Hansez, 2021).

The glass ceiling theory posits that in many instances, qualified persons are stopped from advancing beyond a certain point, termed as the ceiling, due to discrimination and organizational attitudes. In the case of gender, women fail to rise beyond a certain management or leadership level not because they are less qualified but because of gender discrimination. The glass ceiling affects women in many setups, with most having to remain in middle-level positions for long years, even after their male counterparts have progressed to the next level.

With modern laws prohibiting open discrimination, noticing the barriers that facilitate the glass ceiling becomes challenging. However, the barriers can be observed through existing stereotypes, attitudes, actions, and many other biases that hinder the ascension of women from one position to the other, promoting gender discrimination (Tanrısevdi et al., 2019). There are also invisible barriers at the workplace, and their impact in hindering women's advancement in careers cannot be underestimated.

The glass ceiling has a diachronic perception (Babic & Hansez, 2021). It talks about women's career advancement and promotions and is not interested in the number of women at the top of management (Babic & Hansez, 2021). It would thus provide a basis for deliberating on the barriers created, consciously or unconsciously, to prevent the rise of women into senior positions in organizations and companies. Through this study, several factors that impact and act as barriers towards the ascent of women into medical leadership roles were explored through an understanding of the experiences and insights of male and female medical leaders with regards to ascending into their leadership positions and determining the role of gender in enabling and deterring women representation in medical leadership.

2.2.2. Organizational Culture Theory

Organizational culture theory provides valuable insights into the systemic factors contributing to women's underrepresentation in health care. Organizational culture refers to the shared values, beliefs, norms, and practices that shape the behavior and interactions within an organization (Olejniczak & Yasuyuki, 2019). Organizations can have values,

beliefs, norms, and practices that promote women's representation at all levels of their leadership. Similarly, some organizations can have values, beliefs, norms, and practices undermining women's growth and representation in their organizational structure. That implies organizational culture can explain women's representation in the health care leadership structure.

While there are organizational cultures that promote balanced gender representation, there are specific norms, beliefs, and practices that undermine balanced gender representation (Olejniczak & Yasuyuki, 2019). Gender bias and stereotypes often undermine women's representation in leadership positions. Organizations whose norms, beliefs, and practices accommodate gender bias and stereotypes undermine women's growth within the leadership structure (Olejniczak & Yasuyuki, 2019). Organizations with proper mentorship and development programs that take account of women's representation promote balanced representation. In contrast, those with no mentorship or development programs miss an important organizational culture aspect that can result in balanced women's representation.

An organizational culture lacking diversity and inclusion may perpetuate biased recruitment and promotion practices (Gabriel, 2021). Both conscious and unconscious biases can influence decision-making processes, resulting in the underrepresentation of women in leadership positions. There are many more organizational cultural issues that would explain representation of either gender, and the few highlighted impact women more adversely.

2.2.3. Implicit Bias Theory

The theory of implicit bias explores unconscious attitudes, beliefs, and stereotypes that individuals hold towards certain social groups (Hall et al., 2015). These biases can shape perceptions, judgments, and behaviors without conscious awareness or control. Implicit bias can have implications in various aspects, including the prospect of allowing people to assume roles within organizations (Hall et al., 2015). Even though implicit biases are at the individual level, they can impact systematic factors within the organizations. For instance, implicit bias can impact the hiring and recruitment, promotion policies, and other cultural aspects. Implicit bias has the potential to frustrate efforts to create an inclusive

and diverse team that embraces gender parity within health care institutions (Hall et al., 2015).

2.3. Application of Theories to Women's Underrepresentation in Medical Leadership

The glass ceiling theory, organizational culture theory, and implicit bias theory, offer valuable insights into the underrepresentation of women in medical leadership. These theories are not mutually exclusive and often intersect and influence each other to provide insights into the gender balance in medical leadership. The glass ceiling theory focuses on the invisible barriers that prevent qualified individuals, particularly women, from advancing to higher positions within an organization (Sabharwal, 2015). In contrast, organizational culture theory explores how gender biases, stereotypes, and cultural norms within healthcare organizations can influence women's access to leadership positions (Gabriel, 2021). With this study aims to understand factors associated with women's underrepresentation, the organizational culture theory would provide sufficient insights into the factors. On the glass ceiling theory, the study aims to determine women's career progression, and the study would identify the often invisible systematic barriers and limitations that prevent women from going beyond certain levels in the medical sector.

Implicit bias examines the biases within the medical sector and their impact on gender equality in medical leadership positions (Hall et al., 2015). This theory would assist in understanding implicit personal biases that impact gender balance. For instance, associating leadership traits with men would harm women's promotions. The study can develop a more holistic understanding of the complex factors contributing to the issue by examining the interplay and intersection between structural barriers, organizational culture, and implicit biases. These three theories can assist in creating a framework for understanding gender underrepresentation. Equally, the theory creates a basis for hypothesizing the possible variables that explain the gender inequality in medical leadership. The theories also enrich the discussions, creating a basis for understanding the findings.

2.4. Empirical Review

The underrepresentation of women in medical leadership positions is a global concern, with specific factors acting as common barriers worldwide. Discriminatory cultural values, gendered roles, stereotypes, work-life balance challenges, and gender bias are key obstacles faced by women in their pursuit of leadership roles (Gabriel, 2021). This section explores these barriers and sheds light on their impact on women's career progression in medical fields. Additionally, it examines the status of women's representation in medical leadership in, Kenya, highlighting the challenges faced and the factors contributing to their underrepresentation. The section also addresses issues related to women's empowerment and discusses discrimination, stereotypical perceptions, and the implementation of affirmative action as critical factors influencing women's representation in senior management positions.

2.4.1. Barriers to Women's Medical Leadership

Women's underrepresentation in medical leadership is a global concern. There are specific factors that seem to be common barriers across the globe. Tlaiss (2013), in a study that assessed barriers and enablers in women's leadership across developing countries, notes that discriminatory cultural values are a major reason behind women's underrepresentation in leadership positions across the globe. This study indicates that gender is still a major issue in women’s shift from entry and middle management positions, where they are absorbed at the same rate as men, to leadership positions in medical fields. The effect is that women will dissolve in middle-level positions, where most are stuck until retirement age.

Gendered roles worldwide have also been identified as influencing women's rise into leadership. Tlaiss (2013) studied barriers and enablers of women's leadership across developing countries and found that despite developed countries recording high levels of equality, the level of gendered roles remained relatively high- implying that when a situation arises where the husband and wife have equal leadership opportunities but one is needed to take family roles, it is the woman who is more likely to assume family duties and leave the man to pursue leadership positions. This is the case even in developed countries that have made significant steps towards equality. Since these gendered roles

are likely to occur in any society, more and more women continue to resume traditionally considered feminine roles, leaving men to take over traditionally considered masculine roles. In Tlaiss's (2013) findings, cultural perceptions and gendered roles substantially impact women's underrepresentation in medical leadership across the world.

2.4.2. Medical Leadership Representation Status of Women in Nairobi

Like the rest of the world, women comprise the bulk of healthcare employees but are usually underrepresented at the top (Muraya et al., 2019). Using anecdotal data, I have observed from print media and websites that women are underrepresented in management and leadership positions across public hospitals. In this case, underrepresentation means less than one-third of women in medical leadership in hospitals across the county, consistent with the constitutional requirements. While there are no specific studies exploring female medical leadership in Nairobi County, multiple lessons can be gathered on women's representation in the health care sector across the region. Studies have noted that there are other factors hampering women's career progression. Kalaitzi et al. (2019) found that stereotypes, work-life balance, lack of equal career opportunities, and gender bias all contributed to the slowed lateral progression of women's careers. This study was done in Greece but encompassed a global worldview. The stereotypical perception that women cannot handle some roles within medical leadership contributed to their underrepresentation. Balancing work and life is an extreme task for most people. Women agreed that establishing a balance as responsibilities continue to grow at home and work remains a serious hurdle, and some would forgo additional roles at the workplace. This is a global concern for women looking forward to career progression but challenging to meet family or social expectations against leadership expectations. This finding is also consistent with Tlaiss (2013), who discovered that cultural perceptions influence women's career progression. The stereotypes that pressure women to prioritize family over work when faced with work-life balance issues are largely a concept of cultural perceptions. Considering most people who dominate panels that employ or appoint leaders in institutions are men, concerns of gender bias exist and can explain the low number of women in top leadership positions (Rincón et al., 2017). Gender bias at the top gives

preferences to people who have close networks with appointive figures, who, for some reason, tend to be men in most cases.

In Africa, almost every barrier that women face globally, especially in developed countries, exists in even larger proportions. Tiedeu et al. (2019) found that in Africa, women are outnumbered by men in most scientific institutions. The proportion of women in African scientific institutions was far less than developed countries, pointing to higher and more severe barriers. Tiedeu et al. (2019) note that cultural practices and perceptions across the continent discouraged women from undertaking scientific leadership roles. That, coupled with the continent's fewer people advancing past basic learning, made it hard for women to rise to the top. Work-life balance was also another contributor to women missing top leadership positions. Like prior studies that have demonstrated women's preference to choose family before additional responsibilities at the workplace, in Africa, expectations for that are even higher. Muraya et al. (2019) found that gendered factors like child bearing, rearing, and societal expectations contributed substantially to women's underrepresentation in medical leadership in Kenya. This is happening amidst increased enrollment of women into medical institutions over the past decade. The increased enrolments are also reflected in registration data for various fields. For instance, the number of registered nurses entering the labor force increased by 68 percent between 2006 and 2015 (*Kenya Health Workforce Report*, 2015). The same trend was observed in the number of registered clinical officers, pharmaceutical technologists, and pharmacists (*Kenya Health Workforce Report*, 2015). The evidence from these changes in the number of registered health care workers also indicates bridging the gender gap, moving from less than 30 percent female healthcare workforce to almost 50 percent by 2015. That shows female representation has been moving towards parity, however the representation at higher levels of executive leadership in medical institutions seems to lag.

2.4.3. Existing Issues on Women Empowerment

Career progression is an ambition of every person. Despite this, women face numerous challenges that can explain their underrepresentation in senior management positions across the healthcare industry. Understanding the barriers women face in career progression is critical in initiating measures to address them. There is little understanding

of why men dominate most senior roles in Kenya. Exploring these factors can create a foundation to provide solutions that can assist the region in moving towards gender balance, an important step in delivering health services and improving the economy. Understanding the problem of underrepresentation requires different approaches.

Discrimination in the workplace is among the top reasons that can explain women's underrepresentation (Joshi, 2019). Discrimination is the unjust and prejudicial treatment of people of different categories, and in this case, based on gender. Discriminative tendencies in Kenya towards women seeking senior positions in the private sector and government continue to affect efforts for gender equality (*Status of Equality and Inclusion in Kenya*, 2016). It is interesting to note that even when the law exists to address the issue of discrimination, in many cases, it is hardly implemented, considering people who are in a position to implement the affirmative clauses are men (Foley & Williamson, 2019). This is similar to the gender affirmative action in Kenya, which has experienced hiccups in its implementation, failing to be passed on by parliament. The study reviewed the impact of discrimination as one of the potential factors serving as a barrier to women's empowerment across the healthcare sector in Kenya.

Stereotypical perceptions are also a major concern for women across the world (Zafar, 2019). This is a problem even in developed countries where women are often viewed as incapable of holding major positions in various organizations due to their attitude, nature, and other factors. Zafar (2019) notes that negative stereotypes that women are judged with are also associated with underperformance and indecisiveness, among other factors that make it hard for the management, largely dominated by men, to appoint them into senior management positions. There are even some stereotypes that serve women better in some factors but affect their rise in the workplace. For instance, the perception that young and middle-aged women should be at home taking care of families rather than taking roles that shall keep them out of their homes for long (Baxter, 2017). Perhaps these and many other stereotypes may have led to fewer women in management and leadership positions.

The study also utilized some theories to understand women's efforts toward career progression. Maslow’s hierarchy of beings details the stages people undergo as they seek needs from the most basic to self-actualization at the top (Zvavahera & Tandi, 2019).

Examining where women stall and whether conditions at a single stage contribute to that is important. For instance, belongingness and love are the third stages. Studies have noted that women give up their career ambitions for families that can be categorized as love. Giving up career progression for families prevents women from achieving esteem and self-actualization needs in career progression.

Many countries have introduced affirmative action in the law to address women's empowerment. Kenya passed the Constitution in 2010 that no government body should have more than 2/3rds of its members as one gender. This guaranteed that at least a third of the members of any appointive body should be women, considering they were the ones that were underrepresented (Kaimenyi, Kinya, & Chege, 2013). Implementation of this requirement has not been easy, even within the government. The study examines the inroads the law has made and its impact on women's empowerment. Even though the law is created for government entities, there has been pressure to implement it in the private sector. However, implementation in the private sector has continued to experience challenges due to a lack of enforcement mechanisms.

Understanding the perceptions of medical leaders in executive positions would give an insight into women's representation in medical leadership in Nairobi County. Questions were designed to inquire from executive medical leaders across Nairobi county about the reasons why women are underrepresented and how they thought the problem could be addressed.

2.5. Literature Gap

The literature review provides insights into barriers to women's leadership under different contexts. Discriminatory cultural values and gendered social roles are providing the collective reasons for women's underrepresentation. Discriminatory cultural values, stereotypes, poor work-life balance, and gender bias account for slow career progression into leadership roles. The empirical analysis illustrates the existence of these discriminatory factors and thus creates a gap to review if the same exists within Nairobi County. Bismarck et al. (2015) found that significant barriers restrict the entry of women into formal, high-level leadership positions. The interviewees recognized the dominance of men in formal, high-level positions in Australia., serving as a barrier to women's career

growth to senior leadership roles. Some specific barriers that interviewees mentioned include negative perceptions of capability, capacity, and credibility. Tlaiss (2013) affirmed the findings from Bismark et al. (2015) in illustrating barriers to women's career growth. The gendered social roles and expectations impact the prospect of women's career growth. Tlaiss (2013) noted that the spillover effect of societal expectations finds its way into the organizational realm, resulting in structural barriers for women. Rincon et al. (2017) found that most barriers to women's career growth in senior management and leadership positions were related to gender stereotypes. Gender social roles, child bearing, domestic responsibilities, and overall cultural expectations inhibit their rise to senior leadership positions. However, most of the research reviewed describes experiences within a global context. There is a need to provide evidence on why women are underrepresented in medical leadership in local contexts, such as within a City like Nairobi in Kenya. Previous research has explored women's leadership in healthcare in Nairobi County, in line with the working patterns, institutional processes, styles, roles, governance flaws, and sector insufficiencies (Kabira & Kimani, 2012). The study concluded that institutional bureaucracies, governance flaws, and other sectoral inadequacies contribute to women's underrepresentation.

Muraya et al. (2020), a study focusing on two counties in Kenya's coastal region, identifies child bearing and nurturing, social expectations, and domestic responsibilities as main domestic inhibitors to women's career progression. It also identifies policies favoring women as positively influencing their selection into leadership roles while perceptions towards their leadership styles as inhibitors to their rise to leadership positions. However, limited studies are focusing on other settings across Kenya. Nairobi City is the capital city and serves as a major hub for the country's financial, medical, political, and social functions. The city is global and interacts with the world both socially and economically. as a global destination for various forums, including on women's leadership, it would be important that the city leads as an example in embracing gender equality. In addition to the referral hospitals within Nairobi city, it is a host to the two national referral hospitals in the country, which offer specialist care to patients from all over the country with highly specialized clinicians and hence decisions about their management translates into health outcomes for a good majority of patients hence important study the representation status

of women in executive medical leadership positions in these facilities. According to World Health Organization (2020), unlocking the full potential of women at work helps in achieving the United Nations Sustainable Development Goal 5 (SDG 5.5) which aims to ensure that the full and effective participation for women and their equal opportunities for leadership at all levels of decision-making is attained (World Health Organization, 2020).

Despite this, the level of evidence existing about the city's leadership structure and gender equity in the medical sector remains limited, creating an opportunity for exploration of the gap to inform stakeholders on policy formulation to promote not just gender equity in medical leadership, but also in other areas of women representation in leadership.

However, little attention has been paid to the perceptions of other successful medical leaders- both male and female on what barriers constrain the representation of women in executive medical leadership roles. This study thus aims to go an extra mile and explore the barriers and constraints that result in women underrepresentation in leadership positions as perceived by those already in executive leadership positions.

2.6. Summary of Gap Analysis

Several studies have been carried out around underrepresentation of women in medical leadership. Evidence suggests that the underrepresentation is a factor of multiple facets in life, education, training and even organizational structural concerns (Tlais, 2013; Bismarck, et al., 2015). However, most of the studies have perspectives that apply in different contexts, mostly global. Most of the studies have been done based on other global contexts, whose cultural and socioeconomic status differ from the local context, hence the need to conduct another study based on local context. Some of the studies done in the local contexts focusing on developing nations relied on secondary data from review of other existing literature as opposed to primary data from firsthand questionnaires and interviews as will be the case in this study. There is also insufficient knowledge on the local policies and training that serve as enablers and barriers of women empowerment to take up roles in executive leadership in medical fields. In addition, the composition of the executive committees that form the leadership of national and referral hospitals, which play a vital role in the referral process has not been previously explored in Kenya. This study is therefore important because it will examine both male and female medical leaders

currently serving in these positions and get their perspective of how they overcame the barriers.

The knowledge gaps from the studies on women medical leadership underrepresentation are shown in Table 1.1A, Table1.1B and Table 1.1C below where the A, B and C represent a continuous table.

Table 2.1A: A table showing the knowledge gaps from studies on women medical leadership underrepresentation

	Study Title, Author	Objectives	Findings	Gaps Identified
1.	Women in healthcare: Barriers and enablers from a developing country perspective. International Journal of Health Policy and Management. Tlaiss, H. A. (2013)	To understand barriers and enablers in women leadership across developing countries.	Discriminatory cultural values and gendered social roles and expectations inhibit women's career progression in leadership.	The study focused on barriers to women leadership from the perspective of societal and cultural factors and did not assess institutional factors that may be barriers and enablers to women leadership.
2.	Increasing Women in leadership in global health. Downs, J. A., Reif, L. K., Hokororo, A., & Fitzgerald, D. W. (2014).	To explore options available to increase female leadership in healthcare across the world.	There is a shortage of women in leadership. Women face various issues that inhibit their rise to leadership.	The study only looked at ways to increase women representation in healthcare leadership and did not examine the causes of the underrepresentation status of women in leadership positions.
3.	Women and Top Leadership Positions: Towards an Institutional Analysis. Cook, A., & Glass, C. (2013)	Analysis of women leadership and what drives it, a literature review.	Diversity plays an important role in women's progression to top leadership. Diversity also improves women's tenure regardless of performance.	The study relied on secondary data from review of other existing literature. The current study will collect primary data from interviews and questionnaires and give a perspective from a developing country.

Table 2.1B: A table showing the knowledge gaps from studies on women medical leadership underrepresentation

	Study Title, Author	Objectives	Findings	Gaps Identified
4.	Exploring women healthcare leaders' perceptions on barriers to leadership in Greek context. Kalaitzi, S., Cheung, K. L., Hiligsmann, M., Babich, S., & Czabanowska, K. (2019).	Explore the perceptions of women healthcare leaders within the Greek context.	Key inhibiting factors to career progression include stereotypes, work/life balance, lack of equal career advancement, lack of confidence, gender gap and gender bias. The study identified 20 more barriers.	The study was done in a Greek healthcare context giving a global perspective. There is a need to understand the perception of healthcare leaders in the local context to give insights to formulating policies that address the career progression issues that women in developing countries can relate with.
5.	Addressing women's under-representation in medical leadership. Boylan, J., Dacre, J., & Gordon, H. (2019).	To explore reasons for women underrepresentation in medical leadership within the United States.	Women face practical issues like child care needs, social barriers like culture, and insufficient resilience due to inadequate role modeling, mentorship and support.	The study did not elaborate on proactive policies, eliminating social barriers, and introducing sufficient measures to enhance resilience to improve women's chances of increasing representation in medical leadership.
6.	Understanding Intersecting Gender Inequities in Academic Scientific Research Career Progression in Sub-Saharan Africa. Liani, M. L., Nyamongo, I. K., & Tolhurst, R. (2020).	Examining intersecting factors that lead to gender inequalities in Sub Saharan Africa.	Women underrepresentation results from intersections between gender roles and social power within families and institutions.	Specifically, creating gender roles encouraging women to take up leadership roles from a young age.
7.	"Gender is not even a side issue…it's a non-issue": career trajectories and experiences from the perspective of male and female healthcare managers in Kenya. Muraya, K. W., Govender, V., Mbachu, C., Uguru, N. P., & Molyneux, S. (2019).	To understand career trajectories based on gender from the perspective of healthcare managers in Kenya.	Women's role as child bearers and gendered societal expectations such as child nurturing and other domestic responsibilities can influence their ability to take up leadership opportunities, their selection and appointment as leaders.	Affirmative action favoring women can improve their representation for top leadership positions.

Table 2.1C: A table showing the knowledge gaps from studies on women medical leadership underrepresentation.

	Study Title, Author	Objectives	Findings	Gaps Identified
8.	Time to address gender discrimination and inequality in the health workforce Newman, C. (2014,).	Examine gender disparity and the need to address them.	The paper appreciates the existence of gender disparity affecting women. There have been limited efforts to address the issue.	Acknowledging gender factors that affect women's rise to leadership positions would be an important step toward addressing the problem.
9.	Leveraging women's leadership talent in healthcare. Hauser, M. C. (2014).	Exploring women talent and how it can be leveraged to improve leadership within the healthcare sector.	Women make less than 20% of senior healthcare leaders in the United States. The career paths most women pursue plays a role in their progression to leadership positions.	The study does not illustrate the role of training and development in enhancing women's progression in leadership roles.
10.	Gender bias in hospital leadership: a qualitative study on the experiences of women CEOs Soklaridis, S., Kuper, A., Whitehead, C. R., Ferguson, G., Taylor, V. H., & Zahn, C. (2017).	To examine the experiences of female CEOs in Ontario Canada and their gender perceptions regarding leadership.	The study examined the perceptions of female CEOs in healthcare. Even women leaders find it challenging to identify and address gender bias. That affects their ability to address issues that may affect women's progression.	The study fails to draw on quantitative aspects of common gender experiences that affect gender representation.
11.	Gender Equity in Medical Leadership. Chandra, L., Downey, C. L., Svavarsdottir, H. S., Skinner, H., & Young, A. L. (2020).	Exploring the state of gender equity in healthcare across the world.	This study notes that 44% of executive leaders in the UK are women, an improvement from the global average. Women play an important role in medical leadership. The study notes that diversity leads to effective leadership, efficient management among other benefits.	The study fails to illustrate the impact of gender diversity in medical leadership.

2.7. Conceptual Framework

A highlight of the literature review provides a conceptual model that provides an overview of women progression in healthcare leadership across the world. The conceptual framework provides a comprehensive overview of the topic under study. There are several factors that serve as inhibiting factors to women whose aspirations are to progress to leadership positions. The glass ceiling theory details factors that often serve as barriers to women career progression, a key research objective in this paper. Additional factors are highlighted by the organizational culture theory. The specific factors cut across cultural influences, gender influences, policy and regulatory frameworks. These barriers and limitations identified by the glass ceiling and organizational culture theory will be considered as independent variables in this study. The dependent variable is underrepresentation of women in medical leadership. Sociodemographic variables such as age, gender, marital status, education level, years of work experience, role in the workplace, tenure at workplace could have an impact on the effect component of the cause-effect relationship between the dependent and independent variables hence termed moderating variables in this study. The conceptual framework is illustrated in Figure 2.1.

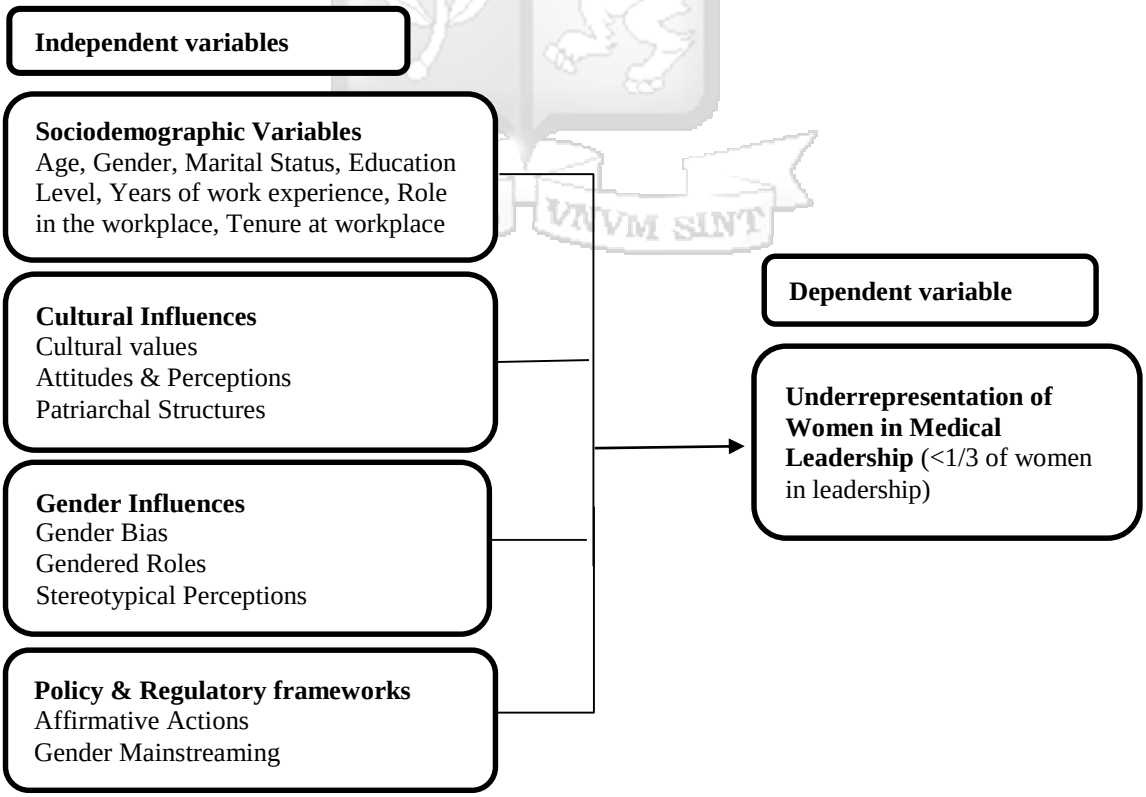

Figure 2.1: Conceptual Framework

2.8. Operationalization of Variables

Operationalization of variables helps enhance a research study's reliability and replicability. Given this is a mixed study, it is important to operationalize variables to provide a clear basis of the study objectives. The study variables are operationalized and presented in Table 2.2.

2.8.1. Dependent Variables

Women's representation (dependent variable), measures the number of women that are representative in various medical leadership roles within the healthcare sector. In this case, the medical leadership team of selected hospitals whose female leaders are less than a third of the total leaders in the management committee would denote that women are underrepresented. If women's proportion on any leadership team exceeds the one third that is constitutionally mandated, then the team would be well represented, anything else will denote underrepresentation.

2.8.2. Independent Variable

The independent variables are the factors that may inhibit women's progression into medical leadership positions. They include women's sociodemographic variables, cultural influences, gender influences, policy and regulatory frameworks.

Table 2.2: Operationalization Table

Objective	Variable	Indicator	Scale	Analysis
To examine the representation status of women in executive medical leadership in selected higher level public hospitals in Nairobi, Kenya.	Gender representation	Proportion of women in executive hospital management committees.	Ratio	Descriptive statistics- percentages
To explore factors associated with representation of women in executive medical leadership in Nairobi County.	Predictor variables	Social demographic variables Other personal and systems factors such as attitude and perception, Organizational and cultural challenges Barriers and challenges	Ordinal Ordinal Ordinal	Descriptive statistics- Frequencies and percentages. Spearman's Rho Association, Linear Regression models
To gather insights on the workplace experiences of male and female medical leaders in public hospitals in Nairobi County regarding their journey towards attaining executive leadership positions within medical institutions.	Policy and regulatory frameworks	Affirmative action Gender mainstreaming		Qualitative - Thematic analysis
To determine the role of gender in enabling women's representation in executive medical leadership in Nairobi County, Kenya.	Gender influences	Gender bias Gendered roles Stereotypical perceptions		Qualitative - Thematic analysis

Chapter 3. Research Methodology

3.1. Introduction

This chapter presents the methodological approaches used to carry out the study, including the research; design, sample population, sample size and sampling procedure. Data collection tools, validity and reliability, analytical approaches and ethical considerations are also highlighted in this chapter

3.2. Research design

Research design refers to the overall strategy or approach selected with different components to facilitate the completion of the research study (Van den Berg, & Struwig, 2017). This study employed a mixed methods research approach to collect relevant data on representation of women in medical leadership within Nairobi County. A mixed methods research design was used concurrently with both qualitative and quantitative methods. Mixed research collects rich and comprehensive data, something hardly available when different research designs are used. Mixed research design removes many limitations that would hinder the study using either qualitative or quantitative design (Lowe, 2019).

The justification for selecting a mixed method approach was to combine both an inductive and deductive approach in a complementary manner to answer the research questions. An inductive approach allowed exploration of the perceptions and experiences of the interviewees to understand the research question. The deductive approach with the survey questionnaire allowed an empirical analysis of the factors influencing the dependent variable of underrepresentation of women in management committees in medical leadership. These complemented each other and allowed a deeper understanding and insights into the research question under study.

The qualitative study was an exploratory study that used semi-structured interviews with Hospital based leaders in executive medical leadership roles. The qualitative study was used to answer the two latter research questions looking into the perceptions and experience of the hospital management committee members and the role of gender in enabling and deterring representation in medical leadership in Nairobi County Kenya.

To obtain quantitative data, a survey methodology was employed. Questionnaires were used with specific questions that were answered by the respondents serving in executive medical leadership positions (See Appendix III). The questionnaire's objective was to obtain specific information that complemented the qualitative data collected through interviews.

3.3. Population and sampling

3.3.1. Study population

The study was conducted in public hospitals; two national level six hospitals, two level five hospitals and one level four hospital within Nairobi County. The purposively selected institutions were: Kenyatta National Teaching and Referral Hospital, Mathari National Teaching and Referral Hospital, Mbagathi County Referral Hospital, Mama Lucy Kibaki Hospital and Pumwani Maternity Hospital. The main rationale for selecting the hospitals was their size, catchment population and the number of patients who seek healthcare services. All these hospitals are within Nairobi, not necessarily under Nairobi County, and were selected based on their classification of level four, five or six within Nairobi. The study focused on interviewing men and women in medical leadership positions who are members of hospital executive management committees in the institutions.

Both male and female members of the hospital management committees from the aforementioned public hospitals who agreed to participate by giving informed consent and agreed to be audio recorded during the interview were included in the study. Members of the hospital executive management committees who did not give consent or who did not agree to be audio recorded during the interview were excluded from the study.

3.3.2. Sampling

The study employed purposive sampling, focusing on convenience sampling. Purposive sampling is a form of non-probability sampling, which is subjective since the researcher relies on their judgment (Sharma, 2017). It allowed the researcher to focus on a group of people who gave in-depth information needed since they met the criteria that the researcher set. Convenience sampling, also a non-probability sampling technique that

involves drawing a close or easy-to-access sample (Luciani, et al., 2019) was also used. It was also a justified sampling method considering the target population was small. In sampling, both methods were applied concurrently, selecting people who met the criteria and were readily available to undertake the planned interviews.

In most cases, the researcher would embrace convenience in selecting participants with the intent of achieving a snowballing effect. The actual sample was purposely drawn from selecting both male and female persons in medical leadership positions from the sample of hospitals and professional organizations using purposive and convenience sampling. A total of 36 participants agreed to take part in the study.

3.4. Data collection tools

The following tools were used to collect data in this study:

3.4.1. Researcher designed questionnaire

This was used to obtain information on sociodemographic characteristics of the participants and representation status of women in medical leadership in public hospitals in Nairobi County. The questionnaire, designed by the researcher, also had questions on a five-point Likert scale to determine the level of agreement by the hospital leaders on the factors that influence the representation status of women in medical leadership in Nairobi County. (See Appendix V).

3.4.2. Interview guide

The interview guide (See Appendix VI) had qualitative questions designed by the researcher that explored the factors that influenced the representation status of women in medical leadership in executive management committee in public hospitals (level 4 and above) in Nairobi County. It was used to explore the experiences of male and female leaders regarding ascending into medical leadership positions in Nairobi County and the role of gender in enabling and deterring women representation in medical leadership in Nairobi County.

3.5. Study procedure

The principal investigator collected data. Upon obtaining clearance to carry out the research from the relevant authority, the researcher proceeded to the hospital administrator of the various facilities to inform them about the study and asked for their support through referral and linkage to members of the various hospital management committees. The researcher also requested the various hospital administrators for permission to access a quiet room within the hospital where the participants were engaged. The potential participants were then approached to establish whether they would participate in the study. They were assured of the confidentiality of the information they gave. Those willing were informed about the purpose of the study and what was expected of them and those who agreed to participate were asked to sign an informed consent form. Personal identifiers were issued to maintain anonymity of the various respondents. The researcher designed questionnaire was issued first then the participants were interviewed once they finished filling in the questionnaire. The researcher assisted the participants by reading out the questions to the participants and filled out the responses whenever such kind of help was needed. Upon completion, the researcher thanked each participant for their participation and asked them if they could refer the principal investigator to the next potential participant. At the end of the day, the questionnaires used were transferred to a central place and stored in a secure cabinet under lock and key, only accessible to the researcher. The audio recordings obtained were saved and transferred to a computer and stored in a password protected database only accessible to the researcher.

3.6. Data Analysis

Data analysis is the process of cleaning, transforming and modeling data to discover insights and useful information that would be important for key decision making processes (Richards, K. A. R., & Hemphill, 2018). This study utilized both quantitative and qualitative data. Qualitative data makes it possible to provide descriptive details of the data that has been collected. Quantitative data can also provide numerical descriptions that can make it easy to understand the data that has been collected.

A descriptive analysis was conducted on the quantitative data to identify key trends. The quantitative data was analyzed using Statistical Package for Social Sciences version

28.0(SPSS 28.0) This included establishing the representation status of women in medical leadership in Nairobi county. The number of executive leadership positions in each facility was determined and the proportion of women in the executive management committees in each facility from which respondents were drawn was established to determine the representation status of women in the selected facilities. The total executive positions and the total number of women in leadership positions were summed. The proportion of women in medical leadership in executive management committees was calculated and presented as a percentage using a pie chart. A linear regression analysis was conducted to determine the relationship between the respondents' sociodemographic characteristics and women's representation. For the second objective, reliability statistics, Cronbach's Alpha for the three scales which include attitude and perceptions, respondent's perception on organizational culture and barriers and challenges was done. A spearman's rho correlation analysis was conducted to bring out the association between the dependent and independent variables and strength of the relationship if present and the findings were presented in tables.

The correlation coefficient value was used to determine the strength and direction of the relationship between the variables. The correlation coefficient ranges from -1 to +1 where -1 indicates a perfect negative relationship, implying that as one variable increases, the other variable consistently decreases. Conversely, a correlation coefficient of +1 represents a perfect positive relationship, indicating that as one variable increases, the other variable consistently increases. A correlation coefficient of 0 indicates no relationship, implying that the variables are not consistently related (Gravetter & Wallnau, 2017).

The qualitative interviews were transcribed and analyzed using thematic analysis, often applied to texts and related data, particularly interviews and open-ended questions (Maguire, & Delahunt, 2017). The analysis was centered on Objectives 3 and 4 that intend to understand the workplace experiences and the role of gender in women's representation status in medical leadership. The audio-recorded interviews were transcribed verbatim. The data obtained was examined to identify meaningful and important concepts within the data. The meaningful data was then coded, and the codes were grouped based on similarity

of the patterns to develop meaningful and important themes. The themes were then analyzed and interpreted to develop a report on the important findings.

3.7. Validity and Reliability

Assessing the research instruments provides an overview of how good the data collected is, giving the entire study credence to be generalized. Reliability is the degree to which research methods produce stable and consistent results (Hayashi Jr, Abib, & Hoppen, 2019). To ensure the study tools were reliable, the objectives were examined against the tools to determine if the data collection tools were appropriate in finding the expected data. In addition to this, pretesting of the researcher designed questionnaire and interview guide was done to ensure face and content validity. Content validity was by use of Cronbach's alpha which is a measure of internal consistency reliability used to assess the reliability or consistency of a scale or questionnaire. It measures the extent to which all items in a scale or instrument are measuring the same construct (Streiner et al., 2015). Values of Cronbach's alpha above 0.7 are generally considered acceptable, suggesting good internal consistency or reliability of the scale (Pallant, 2020).

During the interview process, reliability was ensured by repeating some questions to see if the participants gave a similar answer, following which the data collected was deemed to be reliable. To ensure participants were trustworthy in giving their responses, they were assured that the data collected would be confidential and their responses would remain anonymous. Authenticity of the data obtained was ensured by collecting data in a private and quiet room from one participant at a time so as to make sure that every person who participated in the study gave original views. Field notes were also collected and compared to the transcribed digital files to ensure credibility of the interpreted results. This also ensured reliability and validity of the study instruments and the data collected.

3.8. Ethical considerations

Permission to carry out the study was obtained from Strathmore University school of Graduate Studies, Institutional Review Board (IRB). A permit from the National Commission on Science Technology and Innovation (NACOSTI) was also obtained. The researcher sought ethical approval from the ethics committees of the various institutions

where participants were drawn from, including the KNH-UON ethics committee, the Mathari National Teaching and Referral Hospital ethics committee, Pumwani Maternity hospital ethics committee, Mama Lucy Kibaki hospital ethics committee and Mbagathi County Referral Hospital ethics committee.

After obtaining the relevant ethical clearance, permission to conduct the study from the various hospital administrations was obtained. The study participants were also informed about the reason for the study and objectives, that their participation was voluntary, and that they could opt out at any point. They were also informed that the interview would be recorded. Still, anonymity would be ensured then those who agreed to participate and also agreed to be recorded during the interview were asked to sign an informed consent form that authorized the researcher to collect the data. The participants were informed that no monetary benefits would be given for participating in the study and there would be no harmful physical effects on the participants because the study was non-invasive. Strict confidentiality of the data collected was ensured.

Chapter 4. Results

4.1. Introduction

This chapter outlines the findings of this study obtained from the analysis of both the quantitative and qualitative data collected. Section 4.2 outlines the sociodemographic profile of the respondents who were executive medical leaders in selected higher level public hospitals within Nairobi County. Women's representation status in the executive management committees of the various hospitals is outlined in section 4.3. Findings from the descriptive and linear regression analysis of the perspective of the hospital leaders on factors associated with women underrepresentation in executive medical leadership is outlined in section 4.4. Section 4.5 and 4.6 outlines the findings of the thematic analysis of data obtained from the qualitative interviews.

4.2. Socio-Demographic data of the respondents

Table 4.1: Sociodemographic data of respondents

Variable		n(Frequency) N=36	% (Percent) ** / 100%
Gender	Male	15	41.7
	Female	21	58.3
Education	Bachelor's degree	12	33.3
	Master's degree	20	55.6
	Doctorate	4	11.1
Religion	Protestant	24	66.7
	Catholic	9	25.0
	Muslim	1	2.8
	None	2	5.6
Marital status	Married	33	91.7
	Single	3	8.3
Age	30-34	3	8.3
	35-39	13	36.1
	40 and above	20	55.6

The total number of respondents from the five hospitals was 36. Males who participated in the study were 15, accounting for roughly 42% of the total respondents, with females, 21, accounting for 58% of the total respondents. Four respondents had obtained a doctorate, 20 a master's degree, and 12 a bachelor's degree. The majority of the respondents (24) were protestant, Catholics were the second highest, with nine participating in the study, there was only one Muslim, and two respondents were not affiliated with any religion. Most respondents were married at 92% and the highest age category was forty years and above with about 20% reporting. All participants were given codes to maintain Anonymity. The codes started with the abbreviation "HL" to denote "Hospital Leader" followed by a number assigned sequentially to the hospital leaders who participated in the study.

Table 4.2: Socio-demographic variables of respondents by specific hospitals

Variable		**Hospital A n(%)**	**Hospital B n(%)**	**Hospital C n(%)**	**Hospital D n(%)**	**Hospital E n(%)**
Gender	Male	3(37.5%)	4(57.1%)	2(25%)	4(50%)	2(40%)
	Female	5(62.5%)	3(42.9%)	6(75%)	4(50%)	3(60%)
Education	Bachelors	1(12.5%)	5(71.4%)	1(12.5%)	5(62.5%)	0
	Masters	7(87.5%)	2(28.6%)	5(62.5%)	3(37.5%)	3(60%)
	Doctorate	0	0	2(25%)	0	2(40%)
Religion	Protestant	5(62.5%)	3(42.9%)	6(75%)	5(62.5%)	5(100%)
	Catholic	2(25%)	3(42.9%)	1(12.5%)	3(37.5%)	0
	Muslim	0	1(14.2%)	0	0	0
	None	1(12.5%)	0	1(12.5%)	0	0
Marital Status	Married	6(75%)	6(87.5%)	8(100%)	8(100%)	5(100%)
	Single	2(25%)	1(14.2%)	0	0	0
Age	30-34	0	1(14.2%)	1(12.5%)	1(12.5%)	0
	35-39	3(37.5%)	3(42.9%)	2(25%)	2(25%)	3(60%)
	40 and above	5(62.5%)	3(42.9%)	5(62.5%)	5(62.5%)	2(40%)

Socio-demographic profiles of the participants for the specific hospitals were as follows:

Hospital A: The total number of respondents was 8. The Males respondents recruited from the hospital management committee were 3, which accounts for 37.5% of the total respondents in the hospital, and females, 5, accounting for 62.5% of the total respondents from the hospital. 7 of the respondents had obtained a master's degree, and one a bachelor's degree. Most of the respondents (5) were protestant while two were Catholics. The other respondent (1) was not affiliated with any religion. The marital status of the respondents indicated that 6 are married while two are single. Majority (5) of the respondents in this hospital were 40 years and above while three were in the age group 35-39 years.

Hospital B: The total number of respondents was 7. The number of male respondents in the management committee were 4, accounting for 57.1% of the total respondents, and females, 3, accounting for 42.9% of the total respondents from the hospital. 2 of the respondents had obtained a master's degree, and 5 a bachelor's degree. Three (3) respondents were protestant, 3 were Catholics and 1 was Muslim. The marital status of the respondents indicates that 6 are married while 1 is single. There was one respondent in the age group 30-34, 3 respondents in the age group 35-39 years and the other 3 were 40 years and above.

Hospital C: The total number of respondents was 8. Males who participated from this hospital were 2, accounting for 25% of the total respondents, and females, 6, accounting for 75% of the total respondents. Two respondents had obtained a doctorate, 5 a master's degree, and 1 a bachelor's degree. Most of the respondents (6) were protestants while one was Catholic. The other respondent (1) was not affiliated with any religion. The marital status of the respondents indicated that all 8 respondents were married. Forty years and above had the highest respondents at 5, 35-39 years were the second highest with 2 respondents, and 30-34 years had only one respondent.

Hospital D: The total number of respondents was 8. Males who participated from this hospital were 4, which accounts for 50% of the total respondents, and females, 4, accounting for the other 50%. Five respondents had obtained a master's degree, and 3 a bachelor's degree. Most of the respondents (5) were protestants while 3 were Catholic.

The marital status of the respondents indicated that all 8 respondents were married. Forty years and above had the highest respondents at 5, 35-39 years were the second highest with 2 respondents, and 30-34 years had only one respondent.

Hospital E: The total number of respondents was 5. Males who participated from this hospital were 2, which accounts for 40% of the total respondents, and females, 3, accounting for 60% of the total respondents. Two respondents had obtained a doctorate and 3 a master's degree. All 5 respondents were protestants. The marital status of the respondents indicated that all 5 respondents were married. Two respondents were 40 years and above while the other three were aged between 35 and 39.

4.3. Objective 1: Representation status of women in executive medical leadership in selected higher level public hospitals in Nairobi, Kenya

Table 4.3: Representation Status of women in specific hospitals

Hospital	Total executive leadership positions	Number of women in executive leadership	% women Representation
A	25	14	56
B	28	16	57.14
C	33	19	57.58
D	32	18	56.25
E	21	7	33.33

Hospital A had a total of 25 executive leadership positions, of which 14 were women making up 56% of the total executive leadership. The number of executive leadership positions in hospital B was 28, with 16 occupied by women making 57.14 % of the total executive leadership. Hospital C had a total number of 33 in the executive leadership, of which 19 were women, translating to 57.58%, the highest percentage of women representation amongst the five hospitals. Hospital D had a total of 32 executive leadership positions out of which 18 were women making a percentage of 56.25%. The last hospital, E, had a total of 21 executive leadership positions where 7 of them were women making 33.33%, the least percentage of women representation among the five hospitals.

Table 4.4: Representation status of women in medical leadership

	Representation status of women in medical leadership			
	Totals	Percentage Representation (%)	Maximum % of women representation	Minimum % of women representation
How many of those in hospital leadership positions are women?	74	53.24	57.58	33.33
In your institution, how many people form the executive leadership team?	139	100.00		

To assess the representation status of women, the total number of medical executive leadership positions were summed up and the total positions occupied by women was calculated as a proportion of this total. The total number of executive leadership positions in the institutions represented in the study was 139, and the total number of women in leadership positions was 74, representing about 53%. Amongst the institutions used in the study, the highest representation of women in leadership positions had a percentage of roughly 58 %. In comparison, the institution with the fewest proportion of women in leadership had 33.33% of women in its leadership.

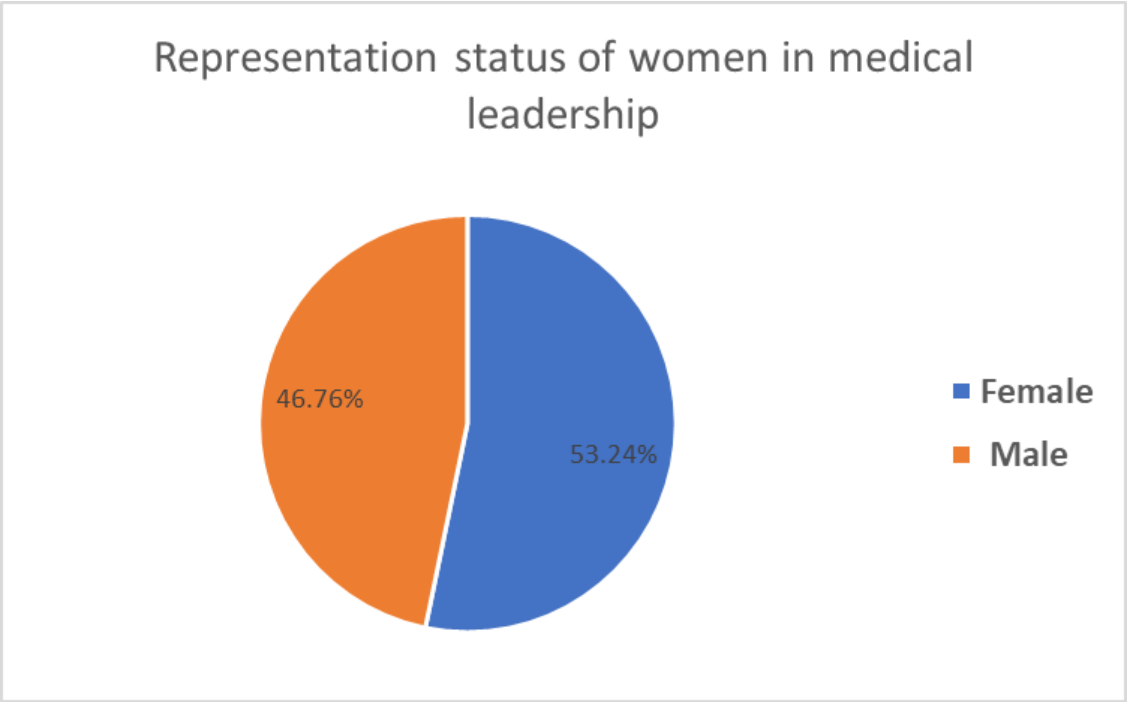

Figure 4.1: Gender Representation

This pie chart illustrates the percentages of female and male representation in the executive leadership committees of the hospitals.

4.2. Objective 2: Factors associated with representation of women in executive medical leadership in Nairobi County

4.2.1. Barriers and Enablers to Women Representation

The study sought to determine the level of agreement on factors that influence representation status of women in executive medical leadership positions. The factors were divided into three key categories; attitudes and perceptions of women, organizational culture and practices and barriers and challenges that women may face in their career progression journey. The responses were rated on a five point Likert scale where 1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; and 5= Strongly Agree. The frequencies and percentages were generated from SPSS and results were as shown in Table 4.5, Table 4.6 and Table 4.7.

4.2.1.1. Attitudes and Perception

Table 4.5: Attitudes and Perceptions

Factors	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Women are more likely to choose active family roles over career development.	5	13.9	12	33.3	1	2.8	18	**50**	0	0
Women are more impulsive in their decision-making than their male counterparts.	8	22.2	9	25	4	11.1	12	**33.3**	3	8.3
The family status of women in leadership is a barrier to career advancement	6	16.7	14	**38.9**	3	8.3	12	33.3	1	2.8
Women face more barriers to career progression than men	1	2.8	3	8.3	9	25.0	15	**41.7**	8	22.2
Women should be paid less for doing the same job as men because they have to take career breaks	24	**66.7**	9	25.0	1	2.8	0	0	2	5.6
Women do not have the confidence required of a good executive leader.	16	**44.4**	13	36.1	1	2.8	3	8.3	3	8.3
Women, compared to men, want fewer responsibilities to perform a job	15	**41.7**	10	27.8	5	13.9	4	11.1	2	5.6
Women prefer working with men compared to working with their fellow women	2	5.6	4	11.1	19	**52.8**	6	16.7	5	13.9
Women in executive leadership positions are reluctant to support other women in executive leadership positions	5	13.9	15	**41.7**	3	8.3	5	13.9	8	22.2

For the attitudes and perception, the level of agreement on most participants' statements in the Likert scale is outlined below.

Almost half of the respondents (50%) of both genders agreed that women are more likely to choose active family roles over career development. About one third of the respondents agreed to the question; Women are more impulsive in their decision-making than their male counterparts, at 33% .38.9% disagreed that the family status of women in leadership is a barrier to career advancement. However,41.7% agreed that women face more barriers to career progression than men. There was strong disagreement for the statement: Women should be paid less for doing the same job as men because they have to take career breaks, with the majority of the respondents (66.7%) strongly disagreeing with this statement. Similarly, 44.4% strongly disagreed with the statement that women do not have the confidence required of a good executive leader and the statement that women, compared to men, want fewer responsibilities to perform a job with about 42% of the respondents strongly disagreed. Majority of the respondents (52.8%) took a neutral stance on the question: women prefer working with men compared to working with their fellow women. For the statement that women in executive leadership positions are reluctant to support other women in executive leadership positions,41.7% of the respondents disagreed.

4.2.1.2. Organizational Culture and Practices

Table 4.6: Organizational Culture and practices

Factors	Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Organizational culture highly impacts the advancement of women into executive leadership positions.	6	16.7	6	16.7	7	19.4	12	**33.3**	5	13.9
In my institution, men and women are accorded equal opportunities in executive leadership positions	1	2.8	3	8.3	6	16.7	16	**44.4**	10	27.8
Patriarchal structures play a role in women's representation status in medical leadership positions.	6	16.7	7	19.4	4	11.1	11	**30.6**	8	22.2
Limited succession planning in most organizations affects the advancement of women into executive medical leadership positions	0	0	2	5.6	10	27.8	15	**41.7**	9	25.0
Gender Discriminatory practices affect the advancement of women into executive leadership positions.	3	8.3	9	25.0	6	16.7	10	**27.8**	8	22.2

The level of agreement by the majority of the respondents on the statements was as follows; 33.3 % agreed with the statement that organizational culture highly impacts the advancement of women into executive leadership positions. For the statement: In my institution, men and women are accorded equal opportunities in executive leadership positions, 44.4% strongly agreed. Most respondents strongly agreed that patriarchal structures play a role in women's representation status in medical leadership positions. Similarly, 41.7% strongly agreed that limited succession planning in most organizations affects the advancement of women into executive medical leadership positions. 27.8%,

who agreed with the statement that gender Discriminatory practices affect the advancement of women into executive leadership positions formed a majority of the respondents

4.2.1.3. Barriers and Challenges

Table 4.7: Barriers and challenges

Factors	**Strongly Disagree**		**Disagree**		**Neutral**		**Agree**		**Strongly Agree**	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Lack of leadership skills	9	25.0	9	25.0	3	8.3	12	**33.3**	3	8.3
Lack of confidence	7	19.4	10	27.8	8	22.2	11	**30.6**	0	0
Lack of flexible working hours	4	11.1	5	13.9	8	22.2	11	**30.6**	8	22.
Lack of social support	2	5.6	9	25.0	6	16.7	10	**27.8**	9	25.0
Lack of networking	5	13.9	12	**33.3**	4	11.1	11	30.6	4	11.1
Lack of role model	9	25.0	5	13.9	6	16.7	13	**36.1**	3	8.3
Lack of mentoring	2	5.6	6	16.7	9	25.0	16	**44.4**	3	8.3
Lack of executive sponsor	1	2.8	11	**30.6**	11	**30.6**	11	**30.6**	2	5.6
Lack of equal career development opportunities	4	11.1	5	13.9	7	19.4	16	**44.4**	4	11.1
Gender discrimination in the workplace	2	5.6	13	**36.1**	2	5.6	12	33.3	7	19.4

In determining the level of agreement on the barriers and challenges that may influence women representation, the majority of the respondents took the following stance for the various factors: lack of leadership skills,33.3 % agreed, for both lack of confidence and lack of flexible working hours, 30.6% agreed. For lack of social support, a majority was formed by 27.8% who agreed. Majority of the respondents,33.3%, disagreed that lack of networking was a factor that influenced women's representation. For lack of a role model

and lack of mentoring,36.1% and 44.4 % respectively agree. Similarly,44.4% agreed that lack of career development opportunities influenced women's representation status. For gender discrimination in the workplace,36.1% formed the majority who disagreed. A neutral stance by a majority formed 30.6% on lack of executive sponsor being a factor that influenced women's representation.

4.2.2. Association of Variables

4.2.2.1. Relationship between Sociodemographic characteristics and women representation

A multiple linear regression analysis was conducted to establish the relationship between respondents' sociodemographic characteristics and women's representation. The results are as shown in Table 4.8 below.

Table 4.8: Relationship between Sociodemographic characteristics and women representation

					95.0% CI(β)	
Demographic factors	**B**	**Std. Error**	**T**	**P-value**	**Lower Bound**	**Upper Bound**
(Constant)	67.859	11.644	5.828	0.000	44.079	91.638
Age	0.647	2.163	0.299	0.767	-3.771	5.065
Level of education	-4.602	2.228	-2.065	**0.048**	-9.152	-0.051
Protestant	-0.453	7.747	-0.058	0.954	-16.275	15.368
Catholic	2.526	5.601	0.451	0.655	-8.912	13.964
Single	0.085	5.442	0.016	0.988	-11.029	11.199

The findings from multiple linear regression analysis established a statistically significant relationship between education level and women's representation status in public medical institutions with a T-value of -4.602 and a p-value of 0.408 suggesting that higher levels of education are associated with a decrease in women representation. The negative β coefficient of -4.602 indicates that a unit increase in respondents' education level was associated with a roughly 5 times decrease in women representation status (β = -4.60, 95%CI: -9.15 - -0.051, p =0.048) as shown in Table 4.8.

4.2.2.2. Reliability Statistics

Reliability statistics for the three scales which include attitude and perceptions, respondent's perception on organizational culture and barriers and challenges was done to assess the reliability and consistency of a scale. The results are as shown in Table 4.9 below.

Table 4.9: Cronbach's Alpha Test

Variable	Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of items
Attitudes and Perception	0.755	0.759	6
Organizational culture and practices	0.762	0.764	2
Barriers and challenges	0.736	0.739	10

With values of Cronbach's alpha above 0.7 the scales are generally considered acceptable, suggesting good internal consistency and reliability.

4.2.2.3. Relationship between Attitude and perception and women representation in public medical institutions

A spearman's rho correlation analysis was conducted to determine the relationship between respondent's attitude and perception and women representation in public medical institutions. The findings are as shown in Table 4.10 below.

Table 4.10: Relationship between Attitude and perception and women representation in public medical institutions

Correlations				
			Proportion of women representation	Attitudes and perceptions
Spearman's rho	Proportion of women representation	Correlation Coefficient	1.000	-0.020
		Sig. (2-tailed)		0.909
		N	36	36
	Attitudes and perceptions	Correlation Coefficient	-0.020	1.000
		Sig. (2-tailed)	0.909	
		N	36	36

The findings from spearman's rho correlation analysis revealed that there was no statistically significant relationship between respondent's Attitude and perception and women representation in public medical institutions.

4.2.2.4. Relationship between respondent's perception on organizational culture, practices and women representation in public medical institutions

A spearman's rho correlation analysis to determine the relationship between respondent's perception on organizational culture, practices and women representation in public medical institutions. The results are as shown in Table 4.11 below.

Table 4.11: Relationship between respondent's perception on organizational culture, practices and women representation in public medical institutions

Correlations				
			Proportion of women representation	Organizational culture and practices
Spearman's rho	Proportion of women representation	Correlation Coefficient	1.000	-0.072
		Sig. (2-tailed)		0.675
		N	36	36
	Organizational culture and practices	Correlation Coefficient	-0.072	1.000
		Sig. (2-tailed)	0.675	
		N	36	36

The findings from spearman's rho correlation analysis revealed that there was no significant relationship between respondent's perception on organizational culture, practices and women representation in public medical institutions.

4.2.2.5. Relationship between respondent's perception on barriers and women representation in public medical institutions

A spearman's rho correlation analysis to determine the relationship between respondent's perception of barriers and women representation in public medical institutions. The results obtained are as shown in Table 4.12.

Table 4.12: Relationship between respondent's perception on barriers and women representation in public medical institutions

Correlations				
			Proportion of women representation	Barriers and challenges
Spearman's rho	Proportion of women representation	Correlation Coefficient	1.000	-0.010
		Sig. (2-tailed)		0.956
		N	36	36
	Barriers and challenges	Correlation Coefficient	-0.010	1.000
		Sig. (2-tailed)	0.956	
		N	36	36

The findings from spearman's rho correlation analysis revealed that there was no significant relationship between respondent's perception of barriers and women representation in public medical institutions.

4.2.2.6. Differences in means for the main outcome and three subscales

An independent t-test was conducted to compare the means between the female group (N = 20) and the male group (N = 15) on the proportion of women representation and the three sub-scales. The mean difference (diff mean) represents the mean of the female group minus the mean of the male group. The t-value and p-value indicate the statistical significance of the difference. The results obtained are as shown in Table 4.13 below.

Table 4.13: Differences in means for the main outcome and three subscales

	Female (N = 20)		Male (N=15)		diff mean = mean (F) – mean (M)	t value	p value
Constructs	**mean**	**Std error**	**mean**	**Std error**			
Proportion of women representation	0.5443	0.0162	0.5356	0.0213	0.0087	0.3310	0.7427
Attitudes and perceptions	2.4000	0.1522	2.5333	0.2557	-0.1333	-0.4724	0.6398
Organizational culture and practices	3.8000	0.2575	3.0000	0.3651	0.8000	1.8447	0.0741
Barriers and challenges	3.2000	0.1864	3.0000	0.2182	0.2000	0.6983	0.4899

There are no significant differences between male and females at 5% level of significance on the proportion of women representation and all the three subscales.

4.4.2.7. Differences in means for the main outcome and individual items in the three subscales

An independent t-test was conducted to compare the means between the female group (N = 20) and the male group (N = 15) on the proportion of women representation and individual items in the three sub-scales. The mean difference (diff mean) represents the mean of the female group minus the mean of the male group. The t-value and p-value indicate the statistical significance of the difference. The results for the variables that showed statistical significance are as shown in Table 4.14 below.

Table 4.14: Independent samples test

		Levene's Test for Equality of Variances		**t-test for Equality of Means**						
		F	**Sig.**	**T**	**df**	**Sig. (2-tailed)**	**Mean Difference**	**Std. Error Difference**	**95% Confidence Interval of the Difference**	
									Lower	**Upper**
Women face more barriers to career progression than men	Equal variances assumed	0.425	0.519	3.880	33	**0.000**	1.133	0.292	0.539	1.728
	Equal variances not assumed			3.756	26.187	0.001	1.133	0.302	0.513	1.753
Lack of executive sponsor	Equal variances assumed	0.367	0.549	2.102	33	**0.043**	0.683	0.325	0.022	1.345
	Equal variances not assumed			2.131	31.682	0.041	0.683	0.321	0.030	1.337

For the variable; women face more barriers to career progression than men the Levene's test for equality of variances yielded an F-value of 0.425 and a p-value of 0.519. Therefore, we fail to reject the null hypothesis of equal variances assumed since the p-value is greater than the Level of significance at 95% confidence interval, $\alpha = 0.05$. With equal variances

assumed, the t-value is 3.880 with 33 degrees of freedom, and the associated p-value is 0.000. This means that the difference in mean scores between women and men is statistically significant. The mean difference is 1.133, suggesting that, on average, women report higher barriers to career progression than men. 95% confidence interval = (0.539,1.728).

For the variable; Lack of executive sponsor the Levene's test results in an F-value of 0.367 and a p-value of 0. 549. Therefore, we fail to reject the null hypothesis of equal variances assumed since the p-value is greater than the Level of significance at 95% confidence interval, $\alpha = 0.05$. With equal variances assumed, the t-value is 2.102 with 33 degrees of freedom, and the associated p-value is 0.043 This means that the difference in mean scores between women and men is statistically significant. The mean difference is 0.683, indicating that, on average, women perceive a greater lack of executive sponsors compared to men, 95% confidence interval = (0.022,1.345).

4.4.3. Work place policies

4.4.3.1. Workplace gender policy

Presence of gender policies in the specific institutions was established and the results are as shown in Table 4.15 below.

Table 4.15: Presence of Gender policy at the workplace

	Frequency	Percent	Valid Percent	Cumulative Percent	
Valid	Yes	23	63.9	63.9	63.9
	No	8	22.2	22.2	86.1
	Maybe	1	2.8	2.8	88.9
	Don't know	4	11.1	11.1	100.0
	Total	36	100.0	100.0	

Twenty-three out of thirty-six of the respondents, or 63.9 percent indicated they had a gender policy in place while eight indicated they do not have a policy in place. 1 respondent was unsure if there is a gender policy in place while 4 indicated they were unaware if their organization had a gender policy.

4.4.3.1.1. Effectiveness of existing gender policy

The level of effectiveness of the gender policies in promoting equity at workplace for the respondents who stated they had a gender policy in their institution was established. The results are as shown in Table 4.16 and figure 4.2.

Table 4.16: Effectiveness of the gender policy in promoting equality at the workplace?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Applicable	13	36.1	36.1	36.1
	Very ineffective	5	13.9	13.9	50.0
	Neutral	2	5.6	5.6	55.6
	Effective	12	33.3	33.3	88.9
	Very Effective	4	11.1	11.1	100.0
	Total	36	100.0	100.0	

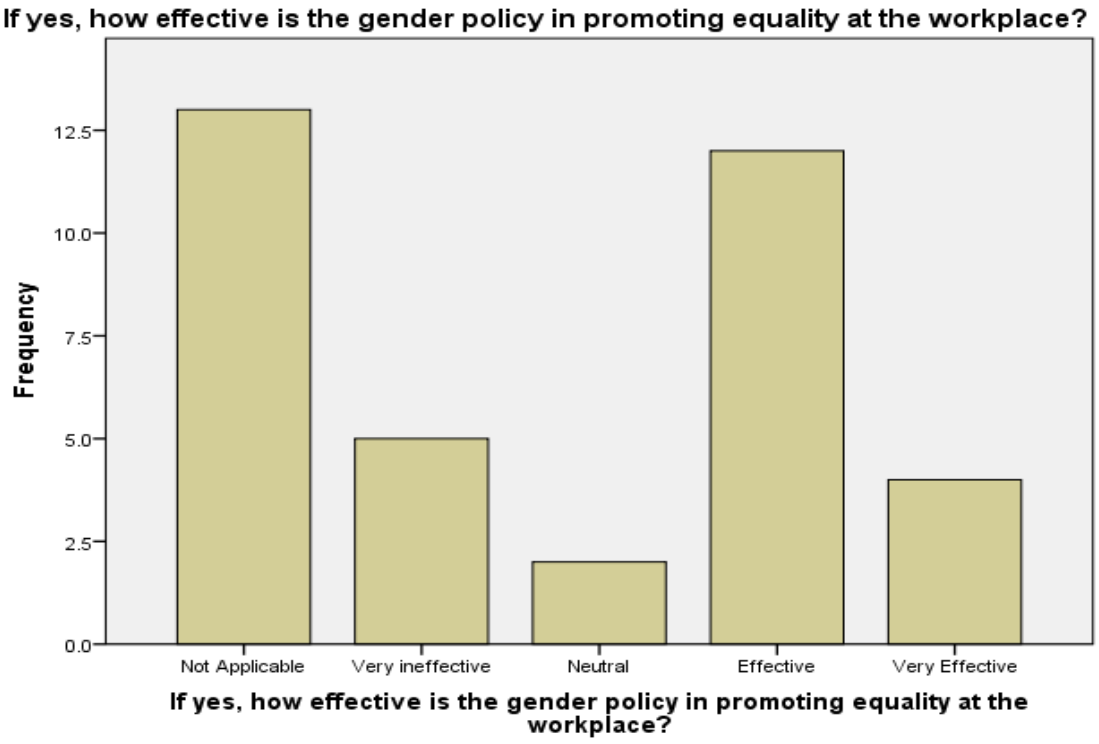

Figure 4.2: Effectiveness of Gender Policy

Thirteen respondents had indicated they either do not have a policy, are uncertain if it is in place or even the policy exists. From the 23 who indicated that there is a policy, 5 indicate that the policy is very ineffective, 2 could not vouch for or against the policy, 12 of the respondents indicated that the policy is effective and 4 were certain that their policy was very effective.

4.4.3.2. Equal opportunity policy

Presence of an equal opportunity policy was established. The results are as shown in Table 4.17.

Table 4.17: Presence of equal opportunity at the workplace

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	27	75.0	75.0	75.0
	No	4	11.1	11.1	86.1
	Maybe	2	5.6	5.6	91.7
	Don't Know	3	8.3	8.3	100.0
	Total	36	100.0	100.0	

Thirty-six respondents responded to this question where 27 indicated that there is an equal opportunity policy, 4 indicated the policy is not in place, 2 are unsure if such a policy exists. At the same time, 3 didn't know the policy's existence.

4.4.3.3. Training policy

Presence of training policy was established. The results are as shown in Table 4.18 below.

Table 4.18: Presence of training policy at workplace

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	27	75.0	75.0	75.0
	No	4	11.1	11.1	86.1
	Maybe	2	5.6	5.6	91.7
	Don't Know	3	8.3	8.3	100.0
	Total	36	100.0	100.0	

36 respondents responded to this question where 27 indicated an equal opportunity policy, 4 indicated the policy is not in place, 2 were unsure if such a policy existed in their workplaces. At the same time, 3 didn't know the policy's existence.

4.4.3.4. Relationship between respondent's perception on policies and frameworks and women representation in public medical institutions

A regression analysis was conducted to determine the relationship between respondent's perception on policies and frameworks and women's representation in public medical institutions. The results are shown in Table 4.19.

Table 4.19: Relationship between respondent's perception on policies and frameworks and women representation in public medical institutions

Policies and frameworks	B	Std. Error	t	P-value	95.0% CI(β) Lower Bound	95.0% CI(β) Upper Bound
(Constant)	51.502	3.320	15.512	0.000	44.739	58.265
Do you have a gender policy at your workplace?	-1.322	1.640	-0.806	0.426	-4.662	2.019
Does your institution have an Equal Opportunity Policy or equivalent, to ensure non-discrimination against any type of demographic group including women?	1.103	1.695	0.651	0.520	-2.350	4.555
Does your institution have a training policy covering all employees, including men and women?	1.666	1.611	1.034	0.309	-1.615	4.947

The findings from linear regression revealed that there was no statistically significant relationship between respondent's perception on policies and frameworks and women representation in public medical institutions as shown in Table 4.19 above

4.5. Objective 3: Experiences and perception of male and female medical leaders regarding ascending into medical leadership

4.5.1. Current Position and Selection Criteria

In investigating the experience of male and female medical leaders regarding the issue of ascending to top medical leadership positions, the study interviewed respondents serving in the hospital leadership positions- specifically the executive management committee. The members of the executive management committee form the hospital's top leadership. They are responsible for decision making at the hospital level on the daily running of the hospitals. Leaders that responded held positions including the hospital chief executive

officer, medical superintendent, directors and heads of various departments and other heads of clinical services within the various hospitals. Deputies of these leaders were also interviewed, particularly where their seniors were unavailable to respond since they also met the criteria set to qualify as participants. The leaders provided responses that were used to investigate their experiences regarding ascending through leadership ranks within their hospital facilities.

In determining the participant's tenure at the workplace, the interviewed leaders observed that they had stayed in their current roles between three years and eleven years. The majority had stayed in their positions between five and six years. When asked about their specific motivation for their current roles, the majority noted that they were driven by the desire to be in a position to influence decisions and impact on service delivery within the hospitals. Some mentioned that they needed change in their respective organizations, hence a leadership position was a good way to influence change within the organization. One interviewee said she needed career growth and her current role as a hospital leader gave her that opportunity to be in a position to influence decisions hence the reason she accepted the position.

> "*We all yearn for growth. For me, this role gave me an opportunity to grow career wise since I can now be on the decision making table and influence change."*
>
> (HL007- Female medical leader, hospital A).

Others said there was no specific motivation behind taking up the current role while some noted that they had been either passionate about the job or passionate about the leadership position.

> *"I cannot point out any specific thing that motivated me. I just took up this position because it had been assigned to me and there was no reason to decline."*
>
> (HL002-Male medical leader, hospital A).
>
> *"For me leadership is inborn. I have been in several leadership positions and I must say I am driven by passion to lead so I was happy to take up my current role."*
>
> (HL026-Female medical leader, Hospital D).

The study also explored the means by which people are selected for senior roles within the organizations. More than two-thirds of interviewees said leaders are selected for their current position through promotions.

> *"The organization mostly promotes employees from junior positions progressively until the top, provided they have shown good performance over time."*
>
> *(*HL015-Female medical leader, hospital B).

Several interviewees mentioned the aspect of internal promotions within the medical leadership, and most of those at the top had served in lower positions at one point in their career. However, some noted that some leaders had been selected based on other considerations, like the number of years they had worked at the facility, their level of seniority, and their level of passion for the job. Furthermore, some persons have been selected based on merit, even without substantive experience or seniority.

4.5.2. Challenges and barriers to career progression.

Participants provided insights on their challenges to get to their current senior positions. The challenges were categorized into personal, organizational, and societal challenges. Demanding schedules topped the list of personal challenges. Leadership roles came with high expectations, and meeting them was a huge challenge for some of the participants. Establishing a work-life balance was also a major challenge faced by the majority of the participants.

> *"When you are in a leadership position like this one, it may get very demanding, sometimes at the expense of your relationship with your family. As you try to balance this, you find yourself choosing to forego some opportunities."*
>
> (HL004-Female medical leader, hospital A).

The issue of a work-life balance was also related to family roles and expectations, which were challenging for some of the interviewees. The tradeoff between family, school, and work affected their level of efficiency as observed by a few of the respondents.

Additionally, many cited lack of family support, particularly from their partners as a personal barrier to career progression.

> *"Partner support is central to progress at the workplace, and when there is no support or sabotage at home, it becomes hard to meet your core work obligations, affecting your performance score and consequently slowing you down career-wise."*
>
> (HL017-Female medical leader, hospital C).

Family concerns, like potential divorce, were also cited as a challenge many experienced in pursuing some leadership ambitions. Some noted they had taken a long time to get to their current position because of lack of proper academic qualifications and resources to advance it. There were also other obstacles, like poor communication skills, negotiation skills, and leadership skills that were mentioned as factors that may impede career growth.

Outside personal issues, participants also cited organizational challenges that they had faced. The politicization of roles and fears topped the list of organizational challenges. Majority of the interviewees noted that the leadership positions are in many occasions influenced by political alignment. Some individuals within the organizations felt threatened by ambitious individuals and either failed to support them or moved to sabotage their rise within the ranks.

> *"As a leader, it is normal that people may feel threatened as you try to push yourself to achieve your goals. This may make them block you as you advance the career ladder."*
>
> (HL015-Female medical leader, hospital B).

The issue of gender bias emerged, where men were preferred due to perceptions that they are more level-headed than women. Some leaders cited that the perceptions that men would make better leaders affected men's rise, while disadvantaged women leaders. Women also noted the existence of dismissive attitudes towards women leaders, especially by seniors. These dismissive attitudes acted as stumbling blocks to their ambitions.

"Women have to work harder to be in leadership positions and when they do, they are sometimes deemed to be very aggressive. Some of the bosses do not like when their juniors are very aggressive and may end up sidelining them. This may eventually make you miss out on many opportunities."

(HL019-Female medical leader, hospital C).

Individuals whose rise had been hampered by lack of proper academic qualifications experienced an additional problem and lacked opportunities for further studies. The lack of opportunities was either a result of financial difficulties or failure to secure a study leave due to labor shortages in their respective positions. There are also instances where ageism was an issue, with older individuals seen as incapable while younger people were excluded due to insufficient experience. All these existed within organizations where they worked, challenging their ambitions of rising to the top.

Participants also reported societal problems, including cultural issues and societal expectations as some of the challenges women faced in career progression. These issues were seen to act as barriers to career progression. One interviewee mentioned:

"Due to the family responsibilities, socializing outside workplaces becomes hard for women unlike their male counterparts who have time to socialize hence broaden their network and get more opportunities to grow"

(HL022-Female medical leader, hospital C).

Specifically, as noted, even within personal space, gender bias was a serious problem women have to particularly deal with. Some interviewees cited the issue of stereotyping women as a barrier to career progression since they are given a blanket judgment and denied opportunities to progress in their careers.

"Family roles slow a woman down. Women are often considered unable to deliver because of the numerous career breaks they have to take, especially during their reproductive ages, hence are not given opportunities to lead and participate in decision making."

(HL029-Female medical leader, hospital D).

However, some female interviewees did not see natural factors like pregnancy or childbearing as barriers to career progression. They saw these factors as motivators that make women plan and work harder towards achieving their career goals. One interviewee even stated that these factors should not be used to discriminate against women and deny them opportunities to progress career-wise.

> *"Being a natural thing, I do not think motherhood and pregnancy should be something to discriminate against a woman and use it as a factor to deny her an opportunity to grow or progress in her career."*
>
> (HL026-Female medical leader, hospital D).

Some respondents also cited lack of support from fellow women as a challenge women faced in their career progression journey.

> *"Sometimes it's fellow women who hold you back. They feel you belong home, discouraging you from pursuing your career goals 'at the expense' of your family."*
>
> (HL014-Female medical leader, hospital B).

While no role was considered specifically reserved for any gender, perceptions that one gender would do better at some role than another impacted the prospects of some candidates. Political interference, particularly regular changes of top leadership, was seen as having a bearing on the prospect of people serving under getting promotions.

> *"For a society anchored on nepotism and cronyism, political appointments can easily exclude competent leaders as they fill the existing positions with loyalists. This societal problem in Kenya's political space leaves many frustrated."*
>
> (HL033-Female medical leader, hospital E).

4.5.3. Enablers of women's representation in Medical Leadership

The enablers for women's representation in medical leadership were classified as personal, organizational, or societal. On a personal level, majority of the participants reported that passion for leadership was the driving force for the positions they held. This includes doing what leadership positions require as a strategy for achieving the status. Self-motivation was perceived to equally play an important role. The urge to push oneself into achieving leadership positions, despite the challenges one faced was cited by many participants. Some also cited hard work, proactiveness, and commitment to the job as enablers to career progression.

> "*I am passionate about leadership but equally very proactive. It may look like chance had part to play but I feel being very proactive and ready to face challenges has led me here"*
>
> *(*HL013-Male medical leader, hospital B).

Some interviewees noted that an individual's personal attributes had a major role to play in their career progression journey.

> "*A leader can either be broken or made by the people they work with. You might be very good at coming up with interventions and strategies to make the organization work but without the buying in of the people below you, it tends to be an uphill task even trying to convince them that this is the right direction, so interpersonal relations tend to be a very important skill"*
>
> (HL006-Male medical leader, hospital A).

> "*The most competent person at this leadership level tends to get the job. All the same, if you look and you see someone has emotional maturity, that is they don't necessarily antagonize their colleagues, treat them with respect, they confine themselves within the ethical boundaries set by the employer and also have good interpersonal relationships, then they are likely to get the leadership position if an opportunity opens up."*
>
> (HL034-Male medical leader, hospital E).

Some respondents were keen on the fact that one needs to invest in themselves to keep adding value to themselves by improving their professional skills and knowledge to remain competitive. One interviewee pointed out that having a career coach could also improve prospects of taking over senior leadership roles.

> *"Career coaches enable one to grow leadership skills through guiding one to the path of defending an individual career goal, developing relevant skills and building their network. Each effort through a career coach can be rewarding and enables one to have an upper edge and compete positively in their career path."*
>
> (L018-Female medical leader, hospital C).

There are also organizational factors that enable leaders within the hospital facilities in Nairobi County to get into leadership positions that the interviewees pointed out. Leadership development programs and training opportunities were cited as the most important enablers within the organization.

> *"Organizations that design and implement leadership development programs that provide training, coaching, and mentoring enable leaders to progress in their career trajectories."*
>
> (HL 032-Female medical leader, hospital E).
>
> *"Hospitals that facilitate these programs provide a good basis for developing leaders who take over after senior ones leave due to retirement or other reasons."*
>
> (HL015-Female medical leader, hospital B).

> *"Training programs provide employees with the necessary skills in communication, negotiation, leadership, and another aspect that are key to their progression to top leadership."*
>
> (HL011-Male medical leader, hospital B).

Some noted that having executive sponsors was critical in their career progression. These are persons who lobby for their interests and defend their promotion. Some lobbyists provide referrals and the reputation necessary to secure leadership positions.

"Even when you have the necessary qualifications, it is important to have a godfather to help you get where you want to be. This is someone who can give a recommendation and even put in a good word for you in case you have a career opportunity."

(HL020-Female medical leader, hospital C).

Societal enablers to career progression included support from family. Majority observed that the existence of family support would play an important role in their leadership pursuits. Specifically, spousal support was a critical enabler in rising to the top leadership in the facilities where the participants came from. Specifically, the spouse's financial, emotional, and spiritual support was important.

"I am lucky to have a very supportive partner. It is important to have that peace of mind to focus on things like education and career."

(HL012-Female medical leader, hospital B).

"My spouse was all about furthering my education to be well positioned when an opportunity comes up. He even paid for my postgraduate course"

(HL030-Female medical leader, hospital E).

Some interviewees also noted that other social support groups are important and serve as enablers to career progression, especially in the digital world. These groups provide both emotional support and networking opportunities and are platforms for learning new opportunities, as pointed out by some interviewees.

4.6. Objective 4: Role of gender in enabling women's representation in executive medical leadership in Nairobi County, Kenya.

Gender equality in leadership roles is an issue that has been gaining attention in recent years. This is because women continue to be underrepresented in leadership positions in various fields. Research has been conducted to explore the factors contributing to this

gender imbalance in leadership positions. This section highlights the findings from this study on the role of gender in enabling or deterring women's representation in leadership.

4.6.1. Gendered Roles in Medical Leadership

The research study found that the majority of the interviewees reported a lack of gendered roles in medical leadership within their hospitals. Instead, they mentioned that competence was considered to be the most important factor in determining who was given the leadership roles. This means that both men and women were assumed to be given equal opportunities to lead, and their qualifications and abilities were the primary considerations. Human factors that exist in women, largely perceived to be disadvantageous, such as childbearing or motherhood, were seen by majority of the interviewees as push factors that helped them plan ahead and work harder improving their competence levels hence working in their favor as opposed to seeing them as barriers to career progression.

4.6.2. Working Late Hours

This study found that men had an easier time working late hours for various reasons, such as the fact that they have less demanding roles at home, security considerations, and preference from other leaders who could request them to work late hours and not do the same to female staff. Women, especially weaning mothers and pregnant women, perceived to be at a disadvantage when it came to working late hours.

> *"Women are disadvantaged when it comes to working late hours especially due to the high expectations at home given that there is a way the society expects a woman to run her home."*
>
> (HL018-Female medical leader, hospital C).

> *"Being a mother and a wife, it becomes hard to balance more so when one is a nursing mother. It often becomes pretty uncomfortable especially with long working hours and worse when you are supposed to work late hours."*
>
> (HL029-Female medical leader, hospital D).

4.6.3. Stereotyping of Gender Roles

Another theme that emerged from the study was the stereotyping of some roles to better-fit men than women.

> *"When men lead, there are usually no interruptions on the period they will be in the role, but women leaders are often interrupted as they may take breaks to engage in family roles or other factors naturally prevalent in women."*
>
> (HL028-Male medical leader, hospital D).

Those who addressed these concerns noted that some appointing authorities might consider their biases, which would affect women's career progression. Furthermore, socializing outside the workplace and building networks becomes hard for women, which may be important when lobbying for senior roles and positions in the workplace. The majority of the interviewees agreed that men had more time to socialize and build networks outside of work, which puts women at a disadvantage. These networks play an important role later when men seek leadership positions, putting them at an advantaged position compared to women.

4.6.4. Personal Bias and Policies

The study found that preference of appointing a certain gender may be based on the personal bias of appointing officers as opposed to organizational or societal-wide culture. This specifically results from appointing or hiring authorities that have negative perceptions about the ability of women to take over some leadership positions. The perceptions are not universal in the entire organization or society. However, there were policies in favor of promoting an enabling environment, such as the 2/3rd gender rule as envisioned in the Kenyan 2010 Constitution and other affirmative action initiatives. While most interviewees were aware of these policies and their implementation, others said the policies had not been implemented and their impact had not been felt within their organization.

4.6.5. Gender Inequality and Affirmative Action

The majority of interviewees noted that gender inequality exists. However, they also acknowledged that gender equality is improving due to affirmative action, relevant policies, and the 2/3rd gender rule. To achieve gender equality, some interviewees suggested that a leader should be deputized by the other gender whenever such an arrangement existed within the organization. For instance, if the nurse in charge was a woman, participants noted that policies should be put in place to ensure that she is deputized by a man and vice versa. They also noted some other initiatives to support leadership development, like policies to support breastfeeding women, mentorship programs to improve education, support programs to enhance leadership skills, and encouragement for both genders to pursue opportunities equally should be put in place. Other policies that enhance the security and safety of women in the workplace, including Gender Based Violence (GBV) awareness programs, were also suggested as initiatives that would be helpful in women's leadership and development journey.

4.6.6. Obstacles to Gender Equality

The study identified several obstacles that hinder the achievement of a better balance between men and women in leadership positions. The main obstacles highlighted by the interviewees were education, policies, the skew of competence towards one gender, and organizational culture. In the case of education, most noted that lack of proper qualification with regard to education affected many people from assuming some higher leadership roles within their organizations. This is where people required to assume some roles were also required to have a specific level of education or certifications. Women were largely affected by a lack of proper academic qualification or certifications. Some interviewees also highlighted the lack of appropriate policies and enforcement as a factor hindering women's progress towards getting to medical leadership positions.

Perceptions that some appointing authorities favor one gender over the other were also reported, and that skew affected the gender balance at the top. Organizational culture, particularly workplace politics, affected women more than men, and most women noted they would rather exclude themselves than subject themselves to organizational politics. For instance, some women preferred to avoid leadership due to the existing political

culture in the organization. This is where seeking leadership positions generates too much politics; sometimes people even bring issues beyond the specific leadership position.

> *"Some of our colleagues prefer to stay away from leadership positions because there is too much politics involved. Our organizational culture has allowed workplace politics to infiltrate and even interfere with work ethics."*
>
> (HL035-Female medical leader, hospital E).

Additionally, women noted a lack of support from fellow women who have accepted cultural roles that suggest women belong at home and not pursuing career goals that jeopardize their family roles and positions.

Overall, gender stereotyping in leadership continues to be a prevalent issue in various fields, including healthcare. This section has provided important insights into the factors that are perceived to contribute to gender imbalance within medical leadership positions. To achieve gender equality in leadership positions, it is crucial to address the obstacles and biases that hinder women's progress. Policies and affirmative actions can be implemented to promote an enabling environment, and education and mentorship programs can be put in place to enhance the leadership skills of women.

Chapter 5. Discussion, Recommendations, and Conclusion

5.1. Introduction

This chapter provides the summary of the findings of the study, and the discussions, particularly focusing on congruence with other research studies or areas of diversion. The section also highlights the limitations of this study and areas that would generate interest for future research.

5.2. Summary of Findings

This study focuses on the representation of women in medical leadership positions in Nairobi County, Kenya. The findings indicate that women were not underrepresented in medical leadership positions within the selected hospitals in Nairobi County, Kenya. There were statistically significant findings that were established from the quantitative analysis. The multiple linear regression analysis to establish the relationship between respondents' sociodemographic characteristics and women's representation had a negative β coefficient of -4.602 suggesting that higher levels of education are associated with roughly 5 times decrease in women representation status. A spearman's rho correlation analysis to determine the relationship between respondent's perception of barriers and women representation in public medical institutions had a correlation coefficient of -0.010. The p-value associated with this correlation coefficient was 0.956 suggesting there is no substantial linear association between these two variables. However, an independent t-test comparing the means between the female group and the male group perspectives on variables associated with the proportion of women representation suggested that on average, women report higher barriers to career progression than men. The mean difference was 1.133 with a p-value of 0.000 at 95% confidence interval (0.539,1.728). There was also a finding that on average, women perceive a greater lack of executive sponsors compared to men, t-value was 2.102 and associated p-value of 0.043 at 95% confidence interval (0.022,1.345).

The qualitative study also identified factors that limit women's opportunities for career development and advancement, such as gender bias, limited opportunities for career development, a lack of mentorship and sponsorship, and unconscious bias in the promotion process. The study categorized the challenges faced by both male and female

leaders in ascending to top medical leadership positions, into personal, organizational, and societal challenges. In the personal category, factors that demand flexible schedules, work-life balance, and lack of family support, among others, were identified as limiting factors. Organizational challenges like work politics, gender bias, ageism, and lack of opportunities for higher education were identified as limiting factors. There were also some societal factors such as stereotyping, lack of support from fellow women and patriarchal structures within the society. These issues can be addressed not only to increase representation but to make the progression easy for women.

5.3. Discussion of Results

5.3.1. Representation status of women in medical leadership in Nairobi County, Kenya

Evidence emerging from the study is that women are not underrepresented in samples of the medical executive leaders interviewed in the selected hospitals in Nairobi County, Kenya. Upon analysis, I found all five management committees of the public hospitals sampled had met the one third representation threshold of female gender. The general representation across the five hospitals was on average 53% women and 47% men in executive medical leadership positions, a contrast to the hypothetical assumption that women were underrepresented given the findings from previous studies which suggest underrepresentation of women in medical leadership. For the specific hospitals: In hospital A, women formed 56% of the total executive leadership. Hospital B, women formed 57.14 % of the total executive leadership while hospital C had 57.58% women representation in the executive leadership which was the highest percentage of women representation amongst the five hospitals. For hospital D, the percentage of women in executive leadership positions was 56.25% and hospital, E, had 33.33% representation of women in executive management which is the least percentage of women representation among the five hospitals.

5.3.2. Factors associated with representation of women in executive medical leadership in Nairobi County

The representation of women in medical leadership positions is a persistent issue that has been widely studied (Bismark et al., 2015). The findings from this study give multiple perceptions about women's representation in medical leadership as discussed below.

Regarding attitudes and perceptions, studies have shown that gender bias and stereotypes can negatively impact women's career advancement (Catalyst, 2018). Women may be seen as less competent or less committed to their careers because of societal expectations that they prioritize family responsibilities over work (Shung-King, et al., 2018). This can lead to women being overlooked by the appointing authority due to personal bias, for leadership positions or not being given the same opportunities for career development as their male colleagues. The findings from the analysis showing that 42% of respondents in the study agreed that women face more barriers to career progression than men are consistent with this literature. The independent t-test conducted to compare the means between the female and the male perceptions on the proportion of women representation reporting a mean difference of 1.133 with a p-value of 0.000 at 95% confidence interval (0.539-1.728), suggested that, on average, women report higher barriers to career progression than men. These findings can imply that women perceive limited access to leadership positions or systemic barriers that hinder their career progression. These align with the glass ceiling theory that talks about the invisible barriers and obstacles preventing women's progress, usually underpinned by multiple discriminatory myths against women (Duquesne University School of Nursing, 2020). The study by Babic & Hansez (2021) highlighting conscious and unconscious actions, attitudes, gender myths, and misconceptions as factors that create a glass ceiling give plausible reasons why these findings are seen. The importance of promoting diversity and inclusion, and implementing supportive policies and practices to enable equitable career advancement for women is emphasized by these findings.

The preference for working with men over women is a complex issue that has also been studied extensively. Research has shown that women may perceive that working with men is associated with greater opportunities for career development, mentoring, and

networking (Daniels, et al., 2019). This may be because men are more likely to hold senior leadership positions and thus have more organizational power and influence. However, this preference can also perpetuate gender bias and limit women's opportunities for advancement if they are not included in informal networks or excluded from important decision-making processes (Ibarra, Carter, & Silva, 2010). However, the study's findings indicated that most respondents (52.8%) took a neutral stance. This would suggest that the perceptions in leadership are changing. A majority (66.7%) of respondents strongly disagreed that women should be paid less for doing the same job as men because they have to take career breaks. This finding is consistent with research that highlights the gender pay gap as a significant barrier for women in the workforce (World Economic Forum, 2020). Women may be penalized for taking time off for caregiving responsibilities or for working part-time, which can impact their earning potential and limit their opportunities for career advancement.

The logistic regression analysis established that respondents who had higher levels of education were associated with an almost 5% decrease in women representation. This could imply that women with higher levels of education are less likely to ascend to leadership and face additional barriers. These might include implicit biases, societal expectations, work-life balance issues, or systemic barriers within the healthcare industry (Kalaitzi et al. (2019). Barriers to women representation have been documented as a key aspect that undermines their rise into leadership positions (Howe-Walsh, & Turnbull, 2016). Leadership development initiatives and inclusive policies could help mitigate these barriers and create equitable opportunities for women representation in executive medical leadership positions.

Regarding organizational culture and practices, respondents agree that men and women are accorded equal opportunities in executive leadership positions in their institutions. However, research has shown that women still face barriers to advancement due to limited opportunities for career development, lack of mentorship and sponsorship, and unconscious bias in the promotion process (Shung-King, et al., 2018). This literature supports the finding by the independent t-test indicating that, on average, women perceive a greater lack of executive sponsors compared to men, with the mean difference being 0.683 and associated p-value of 0.043 at 95% confidence interval (0.022,1.345). This

implies that there might be a gender disparity in the availability or effectiveness of executive sponsors mostly affecting women. This could be influenced by organizational cultures that favor men in leadership positions and lack of access to networking opportunities as identified by women in the qualitative interviews. The organizational culture theory as discussed by Olejniczak & Yasuyuki (2019) emphasizes that there are specific norms, beliefs, and practices that undermine balanced gender representation and identifies organizational practices like good mentorship and development programs as some of the organizational practices that promote balanced representation.

The finding that limited succession planning in most organizations affects the advancement of women into executive medical leadership positions is also consistent with the findings in the study by Kalaitzi et al. (2019). It is important to address issues of limited succession planning within organizations in order to promote equality and increase women representation in leadership positions. This can help reduce stereotypes and bias especially in organizations where certain roles are perceived to be more suitable for a certain gender.

The findings discussed highlight some of the key factors that contribute to women's underrepresentation in leadership positions. Addressing these issues will require a concerted effort from organizations and individuals to challenge gender stereotypes, promote diversity and inclusion, and create more equitable opportunities for career development and advancement.

5.3.3. Experiences of male and female medical leaders with regard to ascending into leadership within Nairobi County

The study investigated the perceptions and experiences of male and female leaders in ascending to top medical leadership positions. The study found that more than two-thirds of interviewees said leaders are selected for their current position through promotions. This is consistent with other research findings within the healthcare industry, which state that internal referrals and promotions are common in obtaining senior persons in various ranks in hospitals (Yoder-Wise, et al., 2022). Evidence of internal promotions was strong within the medical leadership, and the majority of those at the top had served in lower positions. However, some noted there are leaders who had been selected on the basis of

other considerations, like the number of years they had worked at the facility, their level of seniority, and their level of passion for the job and their proactive nature on the job. Furthermore, there are persons who had been selected on the basis of merit, even when they had no substantive years of experience or seniority.

The study also categorized the challenges faced by participants in their attempts to get to their current senior roles. The challenges were categorized into three groups; personal, organizational, and societal challenges. The personal challenges included demanding schedules, establishing a work-life balance, lack of family support, limited education, and lack of resources to advance education. Chisholm-Burns et al. (2017) found that personal challenges, like demanding schedules at home and associated family challenges were a major stumbling block to women's progression into senior roles within the healthcare sector. Organizational challenges like the politicization of roles, gender bias, ageism, and lack of opportunities for further studies also affected women's leadership roles (Chisholm et al., 2017). The overall impression is that factors that act as hindering blocks exist within the industry.

Enablers of leadership are other factors that were reviewed in this study. The investigation on what serves as enablers considered personal, organizational, or societal. On a personal level, participants reported that passion for leadership, self-motivation, hard work, proactiveness, and commitment to the job were critical factors. Heise et al. (2019) provide that progressing into a leadership position requires much personal effort. Individuals who exhibit personal effort with the ambition to achieve leadership positions are better placed to achieve them than those who do not. Family support, specifically spousal support, is another key to career progression into leadership (Heise et al., 2017). On an organizational level, studies have found that organizational support, mentorship, and training and development programs as critical enablers of leadership (Howe-Walsh, & Turnbull, 2016). Societally, social capital, political connections, and resource access were identified as leadership enablers.

Many of the study's findings are consistent with research suggesting that promotions are a common way of selecting leaders in organizations (Wei et al., 2019). However, the study also suggests that other factors, such as passion and merit, can also play a role in the

selection process. The challenges participants face, such as gender bias and ageism, are also consistent with research that suggests that women and older individuals face significant barriers in ascending to leadership positions (Ng & Feldman, 2015). The enablers of leadership identified in the study, such as organizational support, mentorship, and training and development programs, are also consistent with research that suggests that these factors are critical in developing leaders (Avolio, Zhu, Koh, & Bhatia, 2004; Choi & Ruona, 2011).

The study agrees that there are challenges faced by male and female leaders in ascending to top medical leadership positions. The study also identifies factors that enable leadership, such as passion, self-motivation, family support, organizational support, mentorship, and training and development programs. The findings of the study are consistent with research that suggests that promotions are a common way of selecting leaders in organizations, but also suggest that other factors such as passion and merit can also play a role in the selection process. The study has important implications for organizations that wish to develop and promote leaders, particularly in the healthcare sector.

5.3.4. Role of gender in enabling women's representation in executive medical leadership in Nairobi County, Kenya.

Gender equality in leadership positions is an issue that has gained considerable attention in recent years. Despite this attention, women continue to be underrepresented in leadership positions in various fields. The study found no gendered roles in medical leadership; competence was the most important factor in medical leadership appointments. However, the study also identified several obstacles to gender equality, including inadequate education, policies, the skew of competence towards one gender, organizational culture, and personal bias. Women were disadvantaged when working late hours due to their roles at home and natural factors like pregnancy and nursing. At the same time, building networks was difficult, making it challenging to lobby for senior positions.

Despite all that, the study sought to understand the impact of gender policy at the workplace. About one third of respondents said they had an effective gender policy, while

11.1 percent said it was very effective. These results were not statistically significant, but there is research that indicates a gender policy can help in increasing women's representation. Rhinehart et al. (2021) argues that gender policy, especially on a political level, has been instrumental in increasing gender representation at all levels of leadership. This is consistent with Kenya's 2010 constitutional provisional that no elective or appointive bodies shall have more than two thirds of one gender. Many organizations in Kenya have adopted that provision, increasing women's representation in leadership positions. Some policy adoptions include equal opportunity, where employees noted that they exist in hospitals. Equal opportunities including providing each staff with an opportunity equivalent to that of the other gender in terms of earnings, promotions, off days among others. The overall perception is that policies at the workplace have been creating an enabling environment to provide women with opportunities.

The finding that there is lack of equal career development opportunities as perceived by 44% of the respondents despite the majority of them, nearly three quarters indicating that their organizations accorded similar opportunities to both men and women may be attributable to several factors that perpetuate a form of gender inequity. The invisible barriers alluded to by the glass ceiling theory that may favour a certain gender, such as inflexible working hours, stereotypes, policies that are not supportive of family responsibilities, may impede work life balance and disadvantage a certain gender. Lack of mentorship and networking opportunities may also be a contributing factor to lack of equal career development opportunities despite there being similar opportunities to both genders in the organization. The other factor that may lead to such findings is the personal bias which can result in the perception that a certain gender has certain capabilities which are absent in the other gender. These biases may affect decision making processes related to promotions hence perpetuate inequality in career development opportunities. These findings can also be influenced by individual experiences and perspectives which may suggest lack of implementation of existing policies within the organization.

The study is consistent with previous research on gender and leadership, showing that personal bias and organizational culture are significant barriers to gender equality in leadership positions (Shung-King, et al., 2018). Moreover, other studies have found that women are disadvantaged regarding access to opportunities, including promotions,

training, and development (McGowan, & Stokes, 2019). The current study's findings are consistent with these findings, demonstrating that gender inequality exists in leadership positions.

The study suggests that policies and affirmative action's when implemented can promote gender equality in leadership positions. The 2/3rd gender rule in Kenya is one such policy that has been put in place to promote gender balance in leadership positions. Other initiatives suggested by the study include mentorship programs to improve education, support programs to enhance leadership skills, and policies to support breastfeeding women, programs other research findings support as effective (Powell & Butterfield, 2013). These policies can help to address some of the obstacles identified in the study, including inadequate education and development policies, and organizational culture.

The study provides important insights into the factors contributing to gender inequality in leadership positions. To achieve gender equality, addressing the obstacles and biases hindering women's progress is crucial. Policies and affirmative actions can be implemented to promote gender equality in leadership positions. However, it is also important to recognize that gender inequality is a complex issue requiring a multifaceted approach.

5.4. Study Limitations

The number of respondents who participated in this study was 36, which is a relatively small sample. The sample may not represent those in leadership roles in and outside Nairobi since there are many other sub-County and Private hospitals with varying representation in medical leadership. In addition to this, respondents were drawn from a small subsection of the medical leadership within Nairobi county hence medical leaders from professional colleges such as Kenya Medical Training College(KMTC) and associations such as Kenya Medical Association(KMA) and the Kenya Medical Practitioners and Dentist Union(KMPDU) were not represented. The findings in this study highlights the representation status and the perspectives of medical leaders in Public hospitals. The views and perspectives of medical leaders in other institutions like faith based and private institutions have not been taken into account and yet they also have a

number of hospitals within Nairobi that provide high quality healthcare services that might be associated with good leadership at the facilities

5.5. Conclusion

The study found that women are sufficiently represented to meet one third of the total number of participants in the management committee of selected national and county referral hospitals in Nairobi County, Kenya However, some factors were perceived to hinder women's progression into leadership roles such as limited opportunities for career development, personal challenges such as difficulties in establishing work-life balance and lack of resources for further education. Other challenges identified included, women choosing active family roles over career development, lack of support from the spouses, poor communication and negotiation skills. Additionally, the findings indicate that women face more career development barriers than men.

The finding that organizational culture highly impacts the advancement of women into executive leadership positions is a reflection of the organizational culture theory, which posits that the behavior and interactions within an organization influence its outcomes including gender representation status in leadership positions, limited succession planning, patriarchal structures within the society and gender discriminatory practices, politicization of roles within the organizations, dismissive attitude towards women leaders, lack of mentorship, stereotyping, lack of support from fellow women, personal bias from appointing authority against women, and gender bias.

The barriers to women representation in executive medical leadership emerging in this study, are worsened by the unique needs and experiences women face in urban settings such as Nairobi county. These barriers are often invisible as suggested by the glass ceiling theory. It may prove challenging for women to balance their work and personal responsibilities due to the fast paced and demanding schedules in urban environments. This is further worsened by the difficulties women may face in establishing networking and mentorship opportunities with mentors who can lobby for them and support their career growth. The diverse nature of people within the urban areas and cities also brings a mix of cultures within the organizations that may promote personal bias and

discriminatory practices that may be a hindrance to women's career progression as identified by implicit bias theory.

To promote gender equity and diversity in medical leadership, concerted efforts are needed to challenge gender stereotypes, promote diversity and inclusion, and create more equitable opportunities for career development and advancement.

5.6. Recommendations

Based on the findings discussed above, the following recommendations would be useful in addressing issues within the leadership in Nairobi County.

1. Develop supportive policies and programs that address the personal, organizational, and societal challenges that impede women's progression into senior leadership positions within the medical industry. These challenges include demanding schedules, lack of work-life balance, limited education and career development opportunities, and gender bias. Some of these policies exist but they are poorly enforced. Sensitization on the management and specific employees within the healthcare industry should be embraced to invoke the policies. For instance, the healthcare industry should have an elaborate policy that allows its staff to go for further training while still working, as part of capacity building to assume a senior role. In places where maternity and breastfeeding policies exist, evaluation, revision to suit the employees' specific needs within the organization and implementation would enable women to balance between work and their personal life, creating a conducive environment for their personal development and career progression.
2. Encourage and support mentorship and sponsorship programs for women within hospitals and succession planning initiatives that prioritize women's advancement into executive medical leadership positions. One way of capitalizing on this policy is informing potential leaders about the existence of such opportunities. Many miss them because they do not know the opportunities exist.
3. Challenge gender stereotypes and promote diversity and inclusion by adopting policies and practices that ensure equal opportunities for both men and women. This could include creating more flexible work arrangements, eliminating

the gender pay gap, and establishing merit-based promotion systems. The law already prohibits issues like pay gap, and enforcement should be taken more seriously.

4. Foster a culture of continuous learning and development by offering training and educational opportunities to medical leaders, especially in areas such as leadership, management, and communication skills. This can enhance their abilities to effectively lead and manage teams.

5. Conduct regular assessments and evaluations of hospital leadership practices and policies to identify barriers to women's advancement into leadership positions. The findings of these assessments should be used to inform the development of evidence-based strategies to address these barriers.

The list is not exhaustive but provides critical aspects that can advantage women in the county based on the research findings.

5.7. Suggestions for Future Studies

Given the assumption that women are underrepresented in medical leadership, and the same has been proved otherwise with regards to Nairobi County medical leadership, studies to determine representation status of women in medical leadership in other counties and the barriers and enablers to their representation should be carried out to provide evidence on the general situation of women representation status in public hospitals in the country. Other smaller sub-County hospitals, Private and faith-based organizations should also be included in future studies to give a more holistic picture. Women face unique challenges, and this research has identified them. Additional research to determine if these challenges exist exclusively in women would be helpful. Equally, research to determine if compensation was standard among all medical leaders and the gender pay gap would also shed more light on the research interest.

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APPENDICES

Appendix I: Ethical Clearance Letter

Strathmore UNIVERSITY

25th March 2022

Dr Obino Lilian,
obino.lilian@strathmore.edu

Dear Dr Obino,

RE: Factors Influencing The Under-Representation Of Women In Medical Leadership In Nairobi County Kenya: A Mixed Method Study

This is to inform you that SU-IERC has reviewed and **approved** your above **SU masters'** research proposal. Your application reference number is **SU-IERC1259/21.** The approval period is **25th March 2022 to 24th March 2023.**

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-IERC.
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-IERC within 48 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-IERC within 48 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to SU-IERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) https://research-portal.nacosti.go.ke/ and obtain other clearances needed.

Yours sincerely,

for: **Dr Ben Ngoye,**
Secretary; SU-IERC

Cc: Prof Fred Were,
Chairperson; SU-IERC

STRATHMORE UNIVERSITY INSTITUTIONAL ETHICS REVIEW COMMITTEE
(SU-IERC)
25 Mar 2022
Email:ethicsreview@strathmore.edu
P.O BOX 59857-00200
NAIROBI-KENYA

Ole Sangale Rd, Madaraka Estate. PO Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034000
Email admissions@strathmore.edu www.strathmore.edu

Appendix II: Research Permit from NACOSTI

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **493465**

Date of Issue: **22/April/2022**

RESEARCH LICENSE

This is to Certify that Dr.. Lilian Nyabonyi Obino of Strathmore University, has been licensed to conduct research in Nairobi on the topic: FACTORS INFLUENCING THE UNDER-REPRESENTATION OF WOMEN IN MEDICAL LEADERSHIP IN NAIROBI COUNTY KENYA: A MIXED METHOD STUDY for the period ending : 22/April/2023.

License No: **NACOSTI/P/22/17044**

493465

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearence from relevant Government Agencies
5. The License does not give authority to tranfer research materials
6. NACOSTI may monitor and evaluate the licensed research project
7. The Licensee shall submit one hard copy and upload a soft copy of their final report (thesis) within one year of completion of the research
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National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix III: Participant Information Sheet

Study Title: FACTORS INFLUENCING THE UNDER-REPRESENTATION OF WOMEN IN MEDICAL LEADERSHIP IN NAIROBI COUNTY KENYA: A MIXED METHOD STUDY

Principal Investigator and Institutional affiliation: Lilian Nyabonyi Obino, MBA-Healthcare Management student at Strathmore University, School of Business Studies.

Introduction:

Dear Participant,

My name is Lilian Obino, I am a student at Strathmore University, School of Business Studies

pursuing master of business administration in healthcare management. I would like to invite you to participate in this research project. Before you decide to do so, it is important to understand why the research is being done and what it will involve. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer and anything else about the study or this form that is not clear. After answering all your questions, you are free to decide whether or not you would want to take part in the study. You should also understand the general principles which apply to all participants in a research study:

1. **Your decision to participate is entirely voluntary.**
2. **You may withdraw from the study at any time without necessarily giving a reason for your withdrawal.**

Once you understand what this study entails and agree to take part in the study, I will request you to sign a copy of the informed consent form.

A copy of this form will be given to you for your records. Please take your time to read the following information carefully.

What is this study about?

The aim of this study is to examine the factors that lead to the underrepresentation of women in medical leadership in Nairobi County, Kenya and to gain insights on the experience of both male and female medical leaders with regards to ascending into leadership positions within medical institutions in Nairobi County. The researcher named above will be interviewing both male and female medical leaders in the hospital management committees in public hospitals of level four and above in Nairobi county.

Understanding these factors will help inform policies around women leadership and gender balance as well as help in finding sustainable remedies for ensuring women are well represented in leadership positions. It will also promote diversity and effective leadership which will stimulate growth in the health sector.

What will happen if you decide to be in this research study?

If you agree to take part in this study, you will be asked to fill in a questionnaire which should take approximately fifteen minutes after which you will be taken through an interview which should take an additional fifteen minutes. The discussions will be recorded using an audio device and all the recordings will be destroyed once transcribed. Strict confidentiality of the data collected will be ensured.

Are there any risks, harm, discomfort associated with this study?

Risk of the information that you will give leaking out will be averted by maintaining confidentiality and keeping the records under lock and key and issuing personal identifiers as opposed to your name being used in the study. If there are any questions that make you uncomfortable and you do not want to answer, you can skip them. There will be no harmful physical effects because the study is non-invasive.

Are there any benefits being in this study?

No monetary benefits will be given for participation in this study.

Will being in the study cost you anything?

This study will not cost you any money and there will be no monetary gain to me as the researcher as it is purely for academic purpose. However, you will be required to sacrifice 30-35 minutes of your time for the interview.

What if you have questions in the future?

If you are not sure about anything mentioned above, please do not hesitate to ask me either by email (obino.lilian@strathmore.edu) or by phone (0727854178).

If you want to ask someone independent anything about this research, please contact: The Secretariat, KNH-UoN Ethics and Research Committee, P. O. BOX 19676, 00202, Nairobi.

Email: uonknh_erc@uonbi.ac.ke. Tel number: (254-020) 2726300-9 Ext 44102

What are your other choices?

Your participation in this study is completely voluntary and you have a right to withdraw if at any time you wish to no longer take part in the research.
All the information you give will be anonymous and confidential and will only be used for the purpose of this study. No third parties will have access to any information you provide.

If you agree to take part in this study, you will be asked to sign a consent form which will be filed separately and will not be used to identify you.
Thank you very much for your time and help.

Appendix IV: Informed Consent Form

Participant's statement

I confirm that I have read and understood the participant information sheet. I have had the opportunity to ask questions and have them answered. I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that the study includes an interview where it will be recorded using an audio device. I agree to the audio-recording of the interview.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I voluntarily agree to take part in this study: Yes □ No □

Participant's Signature:

Date:

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: Lilian Nyabonyi Obino

Signature:

Date:

Appendix V: Questionnaire

The purpose of this study is to establish the factors that lead to underrepresentation of women in medical leadership in Nairobi County, Kenya. The questionnaire consists of five Sections. Section A will cover the demographic information of the respondents and section B-E will collect data on the study Variables.

Confidentiality of the information gathered from the responses given will be ensured.

Questionnaire No. ----------

Date----------

Start time----------End time----------

Name of your Institution----------

Current role----------

SECTION A: Demographic Information

1. Kindly indicate your gender
   i. Male □
   ii. Female □
   iii. Other □

2. What is your age?
   i. 25-29 □
   ii. 30-34 □
   iii. 35-39 □
   iv. 40 AND ABOVE □

3. What is your highest level of Education?
   i. Less than a high school diploma □
   ii. High school degree or equivalent □
   iii. Bachelor's degree □
   iv. Master's degree □
   v. Doctorate □

4. What is your religion?
   i. Protestant □
   ii. Catholic □

iii. Muslim □

iv. None □

5. Kindly Indicate your marital status

i. Married □

ii. Single □

iii. Divorced □

iv. Widowed □

SECTION B: Gender Representation

6. In your institution, how many people form the executive leadership team?

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7. How many of those in hospital leadership positions are women?

SECTION C: Cultural Influences

1.Attitudes and perceptions

Using a Likert scale where 1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; and 5= Strongly Agree, indicate with a tick the extent to which you agree or disagree with each of the following statements:

	1	2	3	4	5
Women are more likely to choose active family roles over career development.					
Women are more impulsive in their decision making as compared to their male counterparts.					
Family status of women in leadership is a barrier to career advancement					
Women face more barriers to career progression than men.					
Women should be paid less for doing the same job as men because they have to take career breaks					
Women do not have the confidence that is required of a good executive leader.					
Women compared to men want less responsibilities to perform a job					
Women prefer working with men compared to working with their fellow women					
Women in executive leadership positions are reluctant to support other women into executive leadership positions					

2. Organizational culture and practices

Using a Likert scale where 1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; and 5= Strongly Agree, indicate with a tick the extent to which you agree or disagree with each of the following statements:

	1	2	3	4	5
Organizational culture highly impacts advancement of women into executive leadership positions.					
In my institution, men and women are accorded equal opportunities in executive leadership positions					
Patriarchal structures play a role in women's representation status in medical leadership positions.					
Limited succession planning in most organizations affect advancement of women into executive medical leadership positions					
Gender Discriminatory practices affect advancement of women into executive leadership positions.					

SECTION D: Barriers and challenges

Using a Likert scale where 1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; and 5= Strongly Agree, indicate with a tick the extent to which you agree or disagree with each of the following factors being causes of Women medical leadership underrepresentation

	1	2	3	4	5
Lack of leadership skills					
Lack of confidence					
Lack of flexible working hours					
Lack of social support					
Lack of networking					
Lack of role model					
Lack of mentoring					
Lack of executive sponsor					
Lack of equal career development opportunities					
Gender discrimination at workplace					

SECTION E: Policies and regulatory frameworks

1) Do you have a gender policy at your workplace?
   i. Yes □
   ii. No □
   iii. Maybe □
   iv. Don't know □

   b) If yes, how effective is the gender policy in promoting equality at the workplace?

i. Very ineffective □
ii. Ineffective □
iii. Neutral □
iv. Effective □
v. Very effective □

2) Does your institution have an Equal Opportunity Policy or equivalent, to ensure non-discrimination against any type of demographic group including women?
   i. Yes □
   ii. No □
   iii. Maybe □
   iv. Don't Know □
3) Does your institution have a training policy that covers all employees including both men and women?
   i. Yes □
   ii. No □
   iii. Maybe □
   iv. Don't know □

Appendix VI: Key Informant Interview Guide

Key Informant Interview Guide for Executive leaders in Medical Institutions within Nairobi County, Kenya.

Section A: Introduction and Consent

My name is Dr. Lilian Nyabonyi Obino. I am a student at Strathmore University conducting research on Factors influencing the Under-Representation of Women in Medical leadership in Nairobi County, Kenya. With your consent, I am going to ask you a few questions in relation to this study. I also request your permission to record this interview using an audio device and short notes. Our discussion will last no more than thirty minutes.

Section B: Background Information

Date	
Interview Code	
Organization / Institution	
Current role of Interviewee	

Section 3: Key Informant Interview Guide Questions

Questions	**Probe**	**Interviewer notes**
Please tell me more about yourself and your career progression journey.		
How did you get this job?	Probe to find out the enablers to career progression	Aim to get at least 3 enablers to career progression
What is your current role in your organization?	Probe to find out more about what the interviewer does in their current role and their understanding of their role in the organization	
How long have you held your current position?		
What prompted you to consider taking up your current position?		
What are some of the challenges you experienced as you tried to get your current position?	Probe to get both personal, societal and organizational factors.	
How do you think people are selected into leadership positions in your organization?	Probe to find out how the interviewee perceives the selection process for executive leadership positions in their organization.	

Are there any leadership positions that you perceive as designed for a specific gender within your organization?	Probe to see whether there are any gendered roles within the organization.	
Do you know if there are policies in favor of promoting an enabling environment for women within your organization?	If yes, probe for specific examples of such policies	Aim to have get at least 2 if present
What in your opinion are the main obstacles in achieving a better balance between women and men members in your organization?	Probe for both personal and organizational factors so as to get the views of the interviewee.	Aim to get 3-5 obstacles
Has your family/spouse been supportive towards your journey in career advancement to executive medical leadership position?	Ask if they can describe - in what ways? Probe them for work-life balance/child care/working late?	
What do you think is the role of gender in decision making behind how leaders are chosen within your organization?	Probe for both positive and negative factors.	
What are your thoughts on gender inequality in your workplace? Do you think they exist?	If yes, how do you think they could be improved? If not, how do you think they can be avoided?	
Apart from the factors we raised earlier, are there any other factors that you think may contribute to the current representation status of women in executive medical leadership positions within your organization?	Highlight some of the factors including barriers and enablers that have been raised by the interviewee during the interview.	