Women in Healthcare Leadership:

Advancing Women's Leadership in the Kenyan Health Sector through Organizational and Systems Change Efforts

A descriptive study on employee perceptions on how organisational elements – structure, leadership, culture, and policies – constrain or promote women's career advancement in Kenyan health sector organisations.

Kenya Healthcare Federation
The Health Sector Board of KEPSA

Strathmore UNIVERSITY
BUSINESS SCHOOL

Authors

Dr. Angela Ndunge, PhD	- Strathmore University Business School
Dr. Ben Ngoye, PhD	- Strathmore University Business School
Dr. Elizabeth Muthuma, PhD	- Strathmore University Business School
Dr. Benson Mutuku, PhD	- Strathmore University Business School
Nancy Ndirangu	- Strathmore University Business School
Kennedy Lovi	- Strathmore University Business School
Judith Amolo, MA	- Strathmore University Business School
Duncan Agenga	- Strathmore University Business School
Dr. Tim Theuri, BDS	- Kenya Healthcare Federation
Charity Kamau	- Kenya Healthcare Federation
Joan Nderu	- Kenya Healthcare Federation

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Finally, we would like to express our gratitude to all those who contributed to the Women in Health Leadership project, including researchers, educators, healthcare professionals, and advocates. Their passion, expertise, and collaboration have been essential in advancing our shared vision of gender equity and leadership excellence in healthcare.

About Strathmore University Business School

Strathmore Business School (SBS) is a leading business education institution located in Nairobi, Kenya. Established in 2005, it is part of Strathmore University, which has a rich history of providing quality education in various disciplines since its inception in 1961.

SBS offers a wide range of academic and Executive Education programmes, including MBAs and specialised programmes in areas such as Finance, Leadership, Management, Entrepreneurship, and Healthcare Management. To this end, the school aims to deliver high-quality, innovative, and practical business education that equips individuals and organisations with the skills and knowledge needed to thrive in today's dynamic business environment.

SBS has also established itself as a hub for research and thought leadership in Africa. It conducts research on various business and economic issues relevant to the region. Its faculty members are renowned experts in their fields and actively contribute to academic discourse and policy discussions.

About the Women in Health Leadership Project

The Women in Health Leadership in Kenya project is a groundbreaking initiative aimed at reshaping the narrative of gender representation in the healthcare sector. Funded by the Bill & Melinda Gates Foundation, this project delves into the challenges, triumphs, and pivotal roles of women leaders in shaping the future of healthcare in Kenya. Drawing on a commonly developed Theory of Change, Strathmore Business School, in partnership with Kenya Healthcare Federation, focuses primarily on the organisational level dimensions and at the policy space secondarily, while Women Lift Health and Women in Global Health focus on individual-level dynamics. This report presents the findings of Strathmore's assessment of the organisational factors that hinder and support women's advancement in health organisations in Kenya.

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List of Abbreviations and Acronyms

BCG
Boston Consulting Group

FGD
Focus Group Discussion

GDP
Gross Domestic Product

GGGI
Global Gender Gap Index

HSO
Health Sector Organisation

KEWOPA
Kenya Women Parliamentary Association

KII
Key Informant Interview

LMIC
Low- and Middle-Income Countries

NGEC
National Gender and Equality Commission

NGOs
Non-Governmental Organisations

OCT
Organisational Culture Theory

SDGs
Sustainable Development Goals

USAID
United States Agency for International Development

WEF
Women Economic Forum

WHA
World Health Assembly

WHO
World Health Organisation

WIGH
Women in Global Health

Glossary

Types of Organisational Culture

Clan Culture	A type of organisational culture or organisational structure for a company in which the employees have a family-like work relationship and the business makes decisions by consensus.
Adhocracy Culture	Adhocracy is an organisational culture that emphasises flexibility, innovation, and decentralised decision-making. It thrives on adaptability, allowing organisations to respond swiftly to changes and opportunities.
Market Culture	Market culture is exactly as it sounds: a culture based on the market for your company's product or service. Basically, a market culture involves a no-holds-barred focus on numbers, performance, and consistently driving higher.
Hierarchical Culture	A type of organisational culture that emphasises long-term stability, consistent structure, and a shared set of values throughout the entire organisation.

Organisational Leadership Style

Transformational leadership style	A transformational leadership style inspires employees to strive beyond required expectations to work toward a shared vision, whereas transactional leadership focuses more on extrinsic motivation for the performance of specific job tasks. Learning to balance these styles can help leaders reach their full potential.
Transactional leadership style	A transformational leadership style inspires employees to strive beyond required expectations to work toward a shared vision, whereas transactional leadership focuses more on extrinsic motivation for the performance of specific job tasks
Laissez-faire leadership	Laissez-faire leadership takes a hands-off approach to leadership and gives others the freedom to make decisions.

Executive Summary

Background

Kenya has made significant strides in promoting gender equality, but women's representation in leadership roles, especially within the healthcare sector, remains an area of concern. This report captures the findings of a study that aimed to develop a nuanced understanding of how organisational elements interact to constrain or promote women's advancement in Kenyan health sector organisations. This study thus seeks to create a strong evidence base for organisation-level interventions towards greater gender parity in the leadership of the Kenyan health sector.

Methodology and Approach

The study adopted a mixed-methods research design to first establish a baseline for organisational elements that either constrain or enable women's advancement in health sector organisations. The mixed-methods design followed a concurrent explanatory approach comprising a quantitative phase and a qualitative phase. The sequence of concurrent research activities was a cross-sectional employee survey on organisational elements country-wide and key informant interviews with organisational leaders and their respective human resource managers of selected health sector organisations. In addition, three focus group discussions with selected women leaders in the public, private and not-for-profit sectors were held to explore leadership journeys and perceptions of organisational elements and their implications on women's advancement.

The findings

Demographic Characteristics:

The sample size comprised 3,015 employees, of whom the majority worked in the private sector and health services organisations. More women than men participated in the study. Many employees were aged between 20 and 39, suggesting a relatively youthful workforce, and the majority were married. Christianity was the predominant religion among those sampled. A noticeable proportion held college diplomas, followed by undergraduate degrees, highlighting a well-educated workforce.

Organisational Policies:

At the organisation level, most respondents agreed that policies offered equitable remuneration for similar roles and skill levels, with a higher proportion indicating 'Great extent'. Additionally, the majority of employees knew what to do in case they experienced harassment within the organisation. However, a smaller but notable percentage felt that promotions were not solely based on individual performance and perceived ambiguity in promotion criteria. For the individual level knowledge of policies, significant gender differences were noted in terms of awareness of a sexual harassment policy in their organisations and perceptions of support to take up a flexible work schedule.

Organisational Culture:

The predominant culture across all sectors was the clan culture except for the supply chain and health finance sector, where the predominant cultures were market and hierarchical, respectively. At the organisational level, sampled employees generally believed that men and women were treated equally except for those in INGOs and the Supply Chain sector, and there was a moderate extent of freedom to discuss issues without fear of reprimand. However, a significant majority observed the absence of gender-specific clubs, indicating a lack of gender-based segregation. Additionally, while many felt comfortable discussing work challenges with colleagues, there was a smaller proportion expressing a sense of belonging and community within the organisation. At the individual level, employees largely felt supported by their managers. A considerable percentage found themselves not doing housekeeping duties in their organisations. Housekeeping roles would comprise activities like stocking and maintaining an inventory of housekeeping supplies, receiving visitors and showing guests around, dusting furniture or fixtures and polishing them. Many employees applauded that their opinions were generally valued in meetings, and a substantial portion did not feel intimidated by senior colleagues. According to the results from the correlation analysis, career advancement had a strong, positive, and significant correlation with organisational culture (adhocracy) and leadership style (transformational). However, career advancement had a moderate, inverse, and significant correlation with organisational culture (market) and a weak, inverse, and significant association with leadership style (transactional).

Organisational Leadership:

At the organisation level, employees perceived leaders as taking responsibility for promoting gender equality and preventing sexual harassment. Additionally, a higher percentage felt that top leadership opportunities were equally accessible to both genders. At the individual level, employees expressed a desire for leadership opportunities, and a notable portion felt that they did not miss out on such opportunities due to their gender. A chi-square test of independence was conducted to establish if there were significant sectors and types of organisations differences for types of leadership styles. The results revealed there were significant differences between the sectors and types of organisations. Transformative leadership style was most preferred in the private and NGO sectors, with laissez-faire style preferred in the public sector. The second preferred style in the public sector was transformational, while for the private sector, it was transactional style and laissez-faire leadership style in the NGO sector. Consequently, the transformational style was dominant in community-based organisations, health service providers, NGO organisations, and regulatory and policy organisations. Transactional leadership was predominant in health finance /insurers organisations, while laissez-faire leadership style was dominant in research and training institutes. According to correlation analysis, career advancement had a moderate, positive, and significant association with policies (organisational level), policies (individual level) and leadership style (laissez-faire).

The findings

Career Advancement Opportunities:

Most employees reported not receiving training focused on soft skills development, while a notable portion had not participated in formal courses or training to achieve higher qualifications. Similarly, a substantial percentage of employees had not engaged in leadership/management development programmes or training programmes related to gender equality. Additionally, many employees had not been provided with opportunities for mentoring/coaching programmes. However, a majority had been involved in tasks requiring multiple skills. Additionally, a notable portion had not been temporarily assigned or transferred to another position or project and had not participated in formal job assignments to develop professional knowledge and skills. Further, significant gender differences in career advancement opportunities were discovered for internal/external training to achieve a higher qualification and having a leadership development programme to develop knowledge, skills, and values. Moreover, significant gender differences were revealed for training programmes meant to equip employees with skills, promote change in knowledge, task with different assignments that require multiple skills and be involved in a multi-disciplinary team. Finally, significant levels of management differences for career advancement opportunities were discovered across all the characteristics.

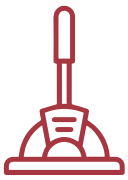
Gender in the Workplace:

There were significant gender differences in gender perceptions in the workplace, except for using the current efforts realised by organisations in addressing gender issues. In reference to the type of organisation, significant differences were discovered for missing out on a salary raise, missing out on a key assignment, missing out on a chance to advance their career, doing less to increase gender equity, doing more to increase gender equity, and using the current amount of effort to increase gender equity.

Gender Equity in the Workplace:

There was general agreement that continuous sensitisation and training on gender mainstreaming are needed. For gender equality, both men and women should be held accountable for progress towards gender equity. Gender is not a women's issue, and therefore, men need to be part of the dialogues and all interventions designed.

Critical Change Levers for Gender Equity:



Organisational policies were selected as the most critical change lever by nine out of twenty-three informants. Organisational culture was ranked second, followed by leadership. People, as a critical change lever, was mentioned together with culture. In particular, the need for continuous gender sensitisation or gender mainstreaming work to avoid it becoming a fashion fad. Thus, organisational policies seem to be perceived as an effective mechanism in providing the foundation for a more gender-equitable workplace.

The findings

Based on the key findings, we provide the following recommendations to address the multifaceted challenges faced by women in healthcare leadership and enhance gender equality, social inclusion, and equity in healthcare operations.

Establish Women's Leadership Academies:

Create specialised leadership academies tailored to the needs of women in the health sector. These academies can offer training, mentorship, and networking opportunities specifically designed to empower women to excel in leadership roles. By providing targeted support and skill development, these academies can help women overcome barriers and thrive in their careers.

Implement Gender Quotas for Leadership Positions:

Introduce gender quotas or targets for women's representation in leadership positions within health sector institutions. While controversial, quotas have been effective in increasing women's representation in leadership roles in other sectors. Implementing quotas can help break down systemic barriers and accelerate progress towards gender parity in health sector leadership.

Promote Male Allies and Advocates:

Engage male leaders as allies and advocates for gender equity in health sector leadership. Encourage male colleagues to mentor and sponsor women leaders, advocate for inclusive policies and practices, and actively challenge gender biases and stereotypes within their organisations. By fostering a culture of allyship, organisations can create more inclusive and supportive environments for women in leadership.

Incorporate Gender-Sensitive Leadership Training:

Integrate gender-sensitive leadership training into professional development programmes for health sector leaders. Equip leaders with the knowledge and skills to recognise and address gender biases, foster inclusive team dynamics, and champion diversity and inclusion initiatives within their organisations. By embedding gender sensitivity into leadership development, organisations can cultivate a more inclusive leadership culture.

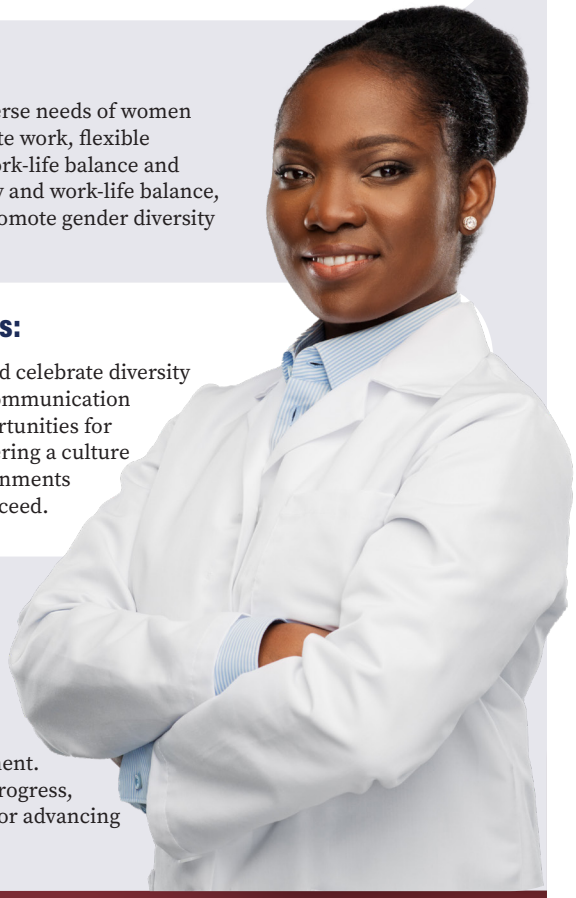
The findings

Establish Women's Leadership Networks:

Create formalised networks and support groups for women in health sector leadership roles. These networks can provide opportunities for peer support, knowledge sharing, and professional networking, empowering women to navigate the challenges of leadership and build strategic alliances. By fostering a sense of community and solidarity, women's leadership networks can amplify women's voices and drive collective action for change.

Implement Flexible Work Policies:

Implement flexible work policies that accommodate the diverse needs of women in health sector leadership roles. Offer options such as remote work, flexible hours, and job-sharing arrangements to support women's work-life balance and facilitate their career advancement. By prioritising flexibility and work-life balance, organisations can attract and retain top female talent and promote gender diversity in leadership.



Foster Gender-Inclusive Organisational Cultures:

Foster gender-inclusive organisational cultures that value and celebrate diversity at all levels of leadership. Promote inclusive language and communication practices, challenge stereotypes and biases, and create opportunities for women to participate in decision-making processes. By fostering a culture of inclusivity and belonging, organisations can create environments where women feel valued, respected, and empowered to succeed.

Invest in Research and Data Collection:

Invest in research and data collection efforts to continually monitor and evaluate gender dynamics in health sector leadership. Collect disaggregated data on leadership representation, career progression, and workplace experiences to identify trends, gaps, and areas for improvement. By leveraging data-driven insights, organisations can track progress, identify barriers, and inform evidence-based interventions for advancing gender equity in health sector leadership.

Conclusion

The call to action resonates beyond the confines of this academic report. It echoes through the hallways of health sector institutions, reverberates in policy chambers, and resonates in the aspirations of women aspiring to ascend the ranks of leadership. The future of women in health leadership in Kenya is not a passive prediction but a dynamic construct shaped by intentional interventions, systemic change, and the collective will to foster an environment where leadership knows no gender. Addressing the challenges faced by women in health leadership in Kenya requires a multi-faceted approach involving policy changes, educational initiatives, and cultural shifts. By fostering an environment that values and supports women in leadership, the healthcare sector can harness the full potential of its workforce and contribute to improved health outcomes for all citizens.

Chapter One
Background and Rationale:

Introduction

The global health sector is one of the biggest employment sectors that is recording rapid growth. However, whereas women comprise most of the global health and social care workers (70%), the proportion of women holding health leadership roles is only 27%, according to the World Health Organisation (WHO) (WHO, 2021). Closing the leadership gap between men and women will likely require concerted efforts toward addressing systemic barriers to women's advancement. These leadership barriers are well-known and include a lack of career advancement opportunities, unfavourable workplace policies, gender stereotypes, sexual harassment and bullying, lack of mentoring, work-life (im)balance, and a gendered organisational culture (Abouzahr et al., 2018; Kalaitzi et al., 2017; Newman et al., 2017). These leadership barriers reflect a combination of individual, organisational, and societal factors.

While the barriers enumerated above likely apply in a global sense, given the contextual nuances that are also widely acknowledged, we are concerned that significant research and data gaps exist in the Low- and Middle-Income Countries (LMIC) on the prevalence of gender inequity and especially, in the health sector. Yet these countries are most in need of rapid progress to achieve the Sustainable Development Goals (SDGs) and Health for All targets by 2030 (WHO, 2021). According to the Women in Global Health (WIGH) Policy Report (2023), the health leadership pipeline in most countries begins with adequate numbers of women – the bulk of whom work as junior doctors, nurses, pharmacists, and dentists. However, a 'leaky pipeline' implies that vertical career progression is not assured for women in health. Moreover, men tend to be promoted faster, while women typically encounter glass ceilings and glass walls to leadership roles that stall their career advancement (WIGH, 2023). Thus, although women are the default health workers, men are the default health leaders, resulting in the XX paradox (WIGH, 2023).

We note, however, that increasing female talent in health leadership is anticipated to help realise the Triple Gender Dividend that consists of better health outcomes, gender equality in decent work opportunities, and economic growth (WHO, 2021). Better health outcomes will be realised due to the retention of female health workers based on decent work and equal opportunities. This retention will particularly help to alleviate the global shortage of health workers, currently estimated at 18 million (WHO, 2021). Capacity investments in women to take up leadership roles and formal sector jobs will improve gender parity as women attain higher incomes and representation. Lastly, decent work opportunities for all women and men will strengthen health systems and improve health outcomes, stimulating economic growth. In this sense, therefore, greater gender equity in health leadership should result in better health for all (WHO, 2021).

Many organisations, however, do not have clear metrics for gender diversity. Indeed, in their report on measuring gender diversity, the Boston Consulting Group (BCG) identifies five key measures that could be used to track progress in workplace gender diversity: equal pay, recruitment, retention, advancement, and representation. The authors also highlight the gender pay gap between men and women in similar roles, women's retention, advancement, and representation as the biggest challenges for companies (Abouzahr et al., 2018).

Organisations are nonetheless typically perceived as neutral spaces for the organised activities of men and women. However, they are more likely to represent and reproduce the societal gender order and bias, which typically favours and values masculine attributes over feminine attributes (Casaca & Lortie, 2017; Newman et al., 2017). These authors argue that organisations are inherently gendered and operate as "inequality regimes" that are rooted in social structures and comprise people who exhibit gendered mindsets and cultures (Newman et al., 2017). Probably drawing on this understanding, the Systems Model of Organisational Change advanced by Maes and Van Hootegem (2019) describes organisations as open systems and recognises that organisational change processes will thus be influenced by factors within the organisation itself and in the external environment. A systemic approach to organisational change thus enables a comprehensive view of change because it recognises the interdependencies and interactions among the various elements - the efforts of individual women, organisational elements (such as leadership, policies, strategies, and culture), and societal change processes that ideally work in a virtuous cycle to enhance the proportion of women in leadership.

The role of leadership in driving the gender diversity agenda is also critical. The WHO Policy Action Paper, Closing the Leadership Gap, highlights government commitments to fast-track equal representation of men and women in health sector leadership and management. Further, the report calls for senior leaders to become visible and accountable champions for gender equity in their organisations. The report points out four action areas that need to be tackled to support women's leadership: national laws and policies that discriminate against women; gendered social norms and stereotypes that drive gender segregation in the health sector; workplace systems and culture that disadvantage women; and deliberate career advancement measures for women (WHO, 2021).

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Background

The under-representation of women in senior leadership roles has been explained by an interconnected web of individual, structural and societal factors (Abouzahr et al., 2018; Andrade, 2022; Benschop & Verloo, 2011; Casaca & Lortie, 2017; Kalaitzi et al., 2017). Individual factors refer to the attitudinal and capacity barriers that women face as they seek to advance in their careers and/or organisations. Structural factors describe the disparities between men and women in wielding power and control over organisational goals, resources, and outcomes. These disparities are reflected in workplace policies and decisions such as promotion, employment benefits, pay and other monetary rewards, and the organisational hierarchy. Societal factors locate individuals and organisations within the wider social, political, and economic structures.

Gender stereotypes are powerful barriers that shape individual options and aspirations, as well as managerial assumptions about the suitability of women and men as employees (Casaca & Lortie, 2017; Newman et al., 2017). These stereotypes tend to be reflected in organisational policies and practices such as the 'ideal worker' norm that favours men due to their 'round the clock, round the world' availability, unquestioned assumptions about male leadership preferences, and the relative lack of social capital (in the form of mentors, and other social support systems) for women in the workplace (Casaca & Lortie, 2017; Newman et al., 2017).

This study sought to extend research in the health sector by looking at a wide category of health sector organisations in the Kenyan health sector and examining a mix of public and private, profit and not-for-profit health organisations. This study also goes beyond describing the gender inequities in the leadership of the health sector to propose organisational interventions that can sustainably enhance gender equity. The study adopts an organisational perspective in recognition of the fact that while organisations are the primary location of gendered career barriers, they are also useful sites for investigation and change. Newman et al. (2017) have argued that more nuance and synthesis of evidence are required to better understand how organisational mechanisms and processes that perpetuate inequalities constrain women's full and effective participation in health sector organisations.

This study, therefore, seeks to develop a nuanced understanding of how organisational elements interact to constrain or promote women's advancement in Kenyan health sector organisations. It hopes to create a strong evidence base for organisation-level interventions towards greater gender parity in the leadership of the Kenyan health sector.

The study adopts an organisational perspective in recognition of the fact that while organisations are the primary location of gendered career barriers, they are also useful sites for investigation and change.

Problem Statement

Kenya has made significant strides in promoting gender equality, but women's representation in leadership roles, especially within the healthcare sector, remains an area of concern. Studies that have been done are largely enumerative – providing quantitative data on who occupies what position but have not gone into the why and have not focused on the health sector as an important sector that underpins many aspects of social and economic development. They have also failed to look at the differences between organisations, especially given the contextual differences between sectors and organisation types that may nuance gendered experiences and career progression. Finally, very few studies and practitioners have interrogated the assumptions made about the experiences of women in these organisations. Consequently, interventions seem to have a copy-paste feel, and the lack of contextualisation could have contributed to the relatively slow march toward gender equity in leadership and management in the health sector. This study attempts to correct these gaps.

Aim, Objectives, and Research Questions

The overall objective of the research was to examine how organisational elements [structure, leadership, culture, and policies] constrain or promote women's career advancement in Kenyan health sector organisations.

Research Objectives

Guided by this overall objective, the study focused on the following sub-objectives:

a. To determine whether there is equitable advancement of men and women from lower-to-mid and mid-to-senior levels of Kenyan health sector organisations.

b. To examine whether and how organisational structures and policies promote women's career advancement in Kenyan health sector organisations.

c. To examine whether and how organisational culture promotes women's career advancement in Kenyan health sector organisations.

d. To investigate the role of leadership in promoting (or not) women's career advancement in Kenyan health sector organisations.

e. To investigate the role of peer support networks and male allies in women's career advancement in Kenyan health sector organisations.

f. To establish the effectiveness of the existing interventions in promoting (or not) women's career advancement in Kenyan health sector organisations.

g. To assess the extent of domestication and operationalisation of legal frameworks into organisational policies and practices.

Research Questions

1. To what extent is there equitable advancement of men and women from lower-to-mid and mid-to-senior levels of Kenyan health sector organisations?
2. How does the organisational structure promote (or not) women's career advancement in Kenyan health sector organisations?
3. How do the organisational policies promote (or not) women's career advancement in Kenyan health sector organisations?
4. How does organisational culture promote (or not) women's career advancement in Kenyan health sector organisations?
5. How does leadership as an organisational factor influence women's advancement in Kenyan health sector organisations?
6. What is the role of peer support networks and male allies in women's career advancement in Kenyan health sector organisations?
7. What is the degree of effectiveness of the existing interventions in promoting women's career advancement in Kenyan health sector organisations?
8. To what extent are organisations cognisant of the legal frameworks around gender equity in the workplace? To what extent have they domesticated these in their workplaces in both policy and practice? What challenges/successes have they encountered in the process? What lessons have they learned from this process of domestication/operationalisation?

Research Impact and Utility of Results

Women constitute the largest number of health workers as well as most users of health services. Achieving gender equity in global health leadership is the foundation of Universal Health Coverage (UHC), robust health systems, and global health security (WHO, 2021). Addressing systemic gender inequity in global health systems will result in a Triple Gender Dividend. This Dividend consists of a health dividend in terms of better health outcomes, a gender dividend in terms of equality in career opportunities, and an economic and social dividend in terms of decent work opportunities that result in higher worker productivity and sustainable economic growth. The study findings will also help inform organisational and national interventions that will contribute to SDG 5, which aims to ensure full and effective participation of women and equal leadership opportunities at all decision-making levels in political, economic, and public life.

Chapter Two
Literature Review:

Theoretical Review

The theoretical foundation for this study was the Systems Model of Organisational Change (Maes & Van Hootegem, 2019). The authors describe four organisational elements that are well-supported by the literature as objects of change: strategy, structure, people, and culture. Strategy refers to the managerial decisions and options to improve organisational performance, chart future pathways, and generate competitive advantage. Structure refers to the organisational infrastructure for processes and systems that may include organisational redesign. People denote the organisational actors and their behaviours as they interact with one another. Behaviour is recognised in the literature as a key component in organisational change. The authors posit that effective organisational change can only be achieved through behaviour change of every employee learning the desired attitudes, knowledge, and skills. Culture refers to the values and norms exhibited in the activities, social interactions, and relationships in an organisation. It is another critical element in organisational change (Maes & Van Hootegem, 2019).

The internal context of an organisation may be characterised by resistance to change or a general willingness to change, which would either slow down or motivate the desired change in the organisation.

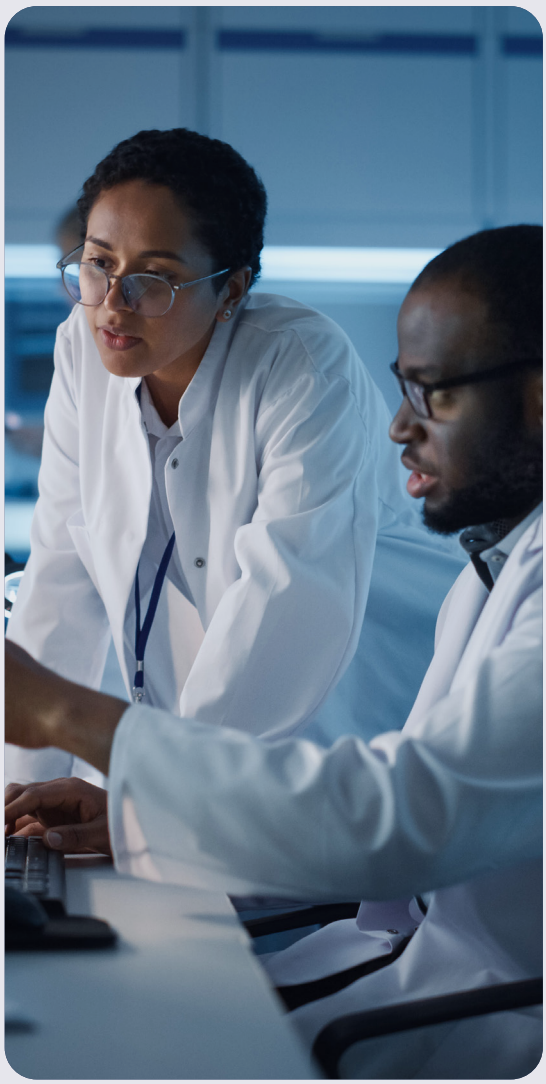
It is also important to recognise the internal and external contexts of the organisation when examining organisational change (Casaca & Lortie, 2017; Maes & Van Hootegem, 2019). The external context of an organisation includes those aspects that may directly or indirectly affect its performance and results. Indeed, changes in the environment are often the main reason for organisational change (Casaca & Lortie, 2017; Maes & Van Hootegem, 2019). The internal context, on the other hand, refers to the inner state of the organisation and its elements as outlined above - culture, people, structure and strategy. The internal context of an organisation may be characterised by resistance to change or a general willingness to change, which would either slow down or motivate the desired change in the organisation.

This systems model was adopted as the main theoretical model informing the study because of its comprehensive approach to understanding organisational change. The model unpacks the elements of organisational change as outlined above and incorporates the levels of change (individual, group, organisational, industry and society) as well as the dimension of change (from small incremental changes to large transformation changes). It also incorporates the influence of the internal and external environment of the organisation, recognising that changes to the external environment often precipitate internal changes while the status of the internal context determines the readiness for change (Maes & Van Hootegem, 2019).

Organisational Culture Theory

Integrating the Organisational Culture Theory (OCT) with the Systems Model of Organisational Change provides a comprehensive framework for understanding the dynamics of women in health leadership. By embedding the OCT within the systems model described above, we can assess how organisational culture influences women's experiences and opportunities in health leadership roles and how systemic changes can promote gender equity and inclusivity.

Organisational culture, as defined by Schein (2010), encompasses the shared values, beliefs, norms, and practices that shape behaviour within organisations. In the context of women in health leadership in Kenya, understanding organisational culture is crucial for identifying barriers and opportunities for women leaders. Research by Mulemi et al. (2021) examines the organisational culture of Kenyan healthcare institutions, emphasising the role of leadership, teamwork, and communication in fostering a supportive environment for women leaders. This aligns with the Systems Model's emphasis on leadership as a catalyst for change.



The Glass Ceiling Effect

The Glass Ceiling effect provides space for understanding the invisible barriers that hinder the advancement of women, particularly in leadership roles. This theory suggests that women encounter invisible barriers preventing their ascent to top leadership positions due to ingrained gender biases. Applying this theory to the Women in Health Leadership in Kenya project, studies such as Ongori and Agolla (2008) emphasise the existence of glass ceilings for women in Kenyan organisations, affecting their progression to senior leadership roles. This aligns with the Systems Model's focus on identifying systemic issues within organisational structures and processes.

The integration of these theories refines our theory of change and, indeed, the conceptual framework for this study, as depicted in Figure 2.1 below.

Our Theory of Change

PILLAR	DOMAINS	FOCUS AREAS	OUTPUTS	OUTCOMES
Org. Change	**Individual**	Soft skills	Acquisition of soft skills that enable achievement of outcomes	Self-esteem, efficacy, resilience Fulfilled aspirations
		Hard Skills	Leadership and management education and skills that enable achievement of outcomes	Efficacy in leadership and management Individual empowerment as measured by voice and agency Fulfilled aspirations (career growth, advancement)
	Organizational	Organizational Structure, Culture, Policies, and Processes	Organizations plans, processes, and policies reviewed	Creation of an enabling intra-organizational environment
	Leadership	Gender and leadership	Capacity development in the gender dimensions of leadership	Leadership effectively playing its role in culture formation/reformation, social normalization, ring-fencing of resources to support women develop their technical, leadership and management skills
Societal Impact Pillar	**Social-Relational**	Access to Peer networks	Formation of female leadership circles Access to networks and to networking opportunities	Supportive relationships for knowledge sharing, character building and leadership
		Access to role models	Formation of female leadership circles Access to networks and to networking opportunities	Supportive relationships for knowledge sharing, character building and leadership
	Societal/ Community	Policy and Regulatory Frameworks	Advocacy toward development, enactment and operationalization of appropriate policy	Supportive policy environment
		Industry and Sectoral Ecosystem	W+ certification standards established and accepted	Organizational role-modeling Public recognition
		Impact Stakeholders – men	Training, Capacity development and advocacy leading to the transition of men from 'resistant' to 'ready' states about supporting female leadership advancement	An empowered and supportive community

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Empirical Review

Organisational Culture

Andrade (2022) notes that greater gender diversity in the workplace can foster innovation, leading to higher revenues for companies. She found that organisational culture, rather than employment laws and regulations, presented a bigger barrier to women's career advancement. She then argues for an examination of the beliefs, norms and values an organisational culture espouses and whether such presents gender stereotypes that hinder women's full and effective participation in organisations. Although this article announced a global perspective, it only presented data and research from the United States, Europe, and Israel to the exclusion of Africa, Asia, and South America.

Still on culture, Wittenberg-Cox (2015) observes that although organisational culture is considered a top priority for organisational change and transformation, it is especially difficult to change due to established patterns, habits and mindsets that have evolved. The technology sector is an extreme version of a typical organisational culture that has long been male-oriented (Wittenberg-Cox, 2015). Achieving gender balance in the technology sector has been particularly problematic because the prevailing approach has been to get women to adapt to male-dominant corporate cultures. She argues that it is the organisational cultures that need to change rather than the women (Wittenberg-Cox, 2015).

Sabharwal (2015) also conducted a study of senior women executives in the US federal government. She found that there was a higher proportion of women executives in regulatory agencies because these agencies tended to recruit from outside (lateral entry) compared to distributive agencies, which tended to recruit from within a classic bureaucratic structure (vertical rise). Women in the distributive agencies were more likely to face glass cliffs because they were less likely to participate in policy decisions, felt less empowered and reported facing inequities at work. She concludes that gender diversity goals should not just be about the number of women who reach senior positions but also about the quality of the work environment that can lead to the inclusion and success of women in leadership roles (Sabharwal, 2015).

Organisational Structures & Policies

Structures describe the context in which care is delivered, such as the facility, equipment, and human resources (Ameh, S., Gómez-Olivé, F. X., Kahn, K., Tollman, S. M., & Klipstein-Grobusch, K., 2017).

Workplace structures and policies adopted by organisations towards gender equality may be seen as isomorphic adaptations to institutional pressures from government, peer organisations and society (Saitova & Di Mauro, 2021). The authors note that where institutionalisation of gender equality interventions is weak in organisations, women must rely on their personal abilities and ad hoc opportunities to succeed in their jobs and rise the organisational ladder. Saitova & Di Mauro (2021) conducted a qualitative study of female and male middle and senior managers in Japanese manufacturing firms. Their findings revealed that women respondents highly valued human resource interventions like leadership development and mentoring programmes and the presence of role models. However, these practices were few in the organisations examined for the study (Saitova & Di Mauro, 2021).

Saitova & Di Mauro (2021) further note that several women have been promoted to managerial positions because of Corporate Social Responsibility. However, this intervention was largely perceived as tokenism as it was ineffective in raising the legitimacy of women's participation in decision-making. Women were more likely to attribute career success to individual (personal) factors, particularly in an organisational context of ineffective gender diversity interventions. These factors included strong motivation, strength of character, being proactive, exhibiting a high level of professionalism, and having a bossy attitude (ability to stand up to male colleagues). Nevertheless, these women managers were also more likely to feel vulnerable and face isolation at work (Saitova & Di Mauro, 2021).

Coron (2020) surveyed the employees of a large French manufacturing company on their perceptions of gender equality. Gender equality was examined as a multi-dimensional construct that covered gender diversity (occupational gender segregation), equal access to responsibility (glass ceiling), equal pay (gender pay gap), and work-life balance. The findings showed that Equal Pay and Equal Access to Responsibility were the most important dimensions of gender equality among the employees, while gender diversity and work-life balance were perceived as less important. Managers had the discretion to implement only certain measures of the Gender Equality policy they deemed important. The

The findings showed that Equal Pay and Equal Access to Responsibility were the most important dimensions of gender equality among the employees, while gender diversity and work-life balance were perceived as less important.

and that where the implementation was not a key performance indicator, it was less likely to be prioritised (Coron, 2020).

Ketchiwou et al., (2022) investigated how organisational factors influenced the development of skills and career advancement among women. The study surveyed a total of 412 women working in the Gauteng service sector in South Africa. The findings revealed that personal attributes, workplace support strategies and family responsibilities play a critical role in the career progression of women. Further, workplace support strategies and individual attributes influence skills development among women. The study, therefore, recommended organisational support and skills development initiatives for women.

Kobus-Olawale et al. (2021) conducted a study to determine the challenges and issues that women encounter when attempting to advance into top management within South African banks. The study adopted a qualitative research design in the form of a case study that focused on one of the largest banks in South Africa. A total of 15 women were interviewed. The findings indicated that there were limited career progression opportunities for women, which were mainly occasioned by organisational structures, hostile workplaces, and lack of sponsorship.

Stamarski and Hing (2015) also investigated the factors that hinder women from advancing to senior leadership positions within various contexts of the South African business environment. The study adopted a qualitative approach with a sample of 9 women who had made substantive forays in their respective careers. The author utilised thematic analysis to analyse the data. The findings identified six factors that hindered the career progression of women into senior leadership roles/positions. These factors included lack of mentorship, distorted leadership identities, poor work-life balance, masculine corporate cultures and beliefs, limited training and development opportunities, and societal stereotypes and perceptions. The suggested practical implications included encouraging organisations to create more feminine-friendly workplace cultures that promote women to establish their identities as senior leaders. Networking, mentoring and professional development opportunities were identified as facilitators of women's career advancement.

Mwashita et al. (2020) examined the glass-ceiling phenomenon across the hospitality industry in South Africa with a particular focus on four Gauteng-based hotels. The study adopted a mixed-method approach that incorporated both semi-structured interviews and an online survey. The study targeted men and women in the top, mid and lower management positions within the sampled hotels. The key finding was that the glass ceiling phenomenon exists as both a fluid and dynamic concept within the various work environments. This finding challenges the existing perceptions of the glass ceiling as a fixed structural barrier and implies that the ceiling can take different shapes.

Mousa et al. (2021) undertook a systematic review to explore the under-representation of women in the healthcare leadership structure. The study entailed a systematic review of journal articles across Medline, PsycINFO and SCOPUS between January 2000 and March 2021. The inclusion criteria defined eligible studies as those that had reported on organisational interventions that advance women's leadership with a single or more measurable outcome. The

findings categorised the organisational interventions into organisational processes, mentoring and networking, awareness and engagement, support tools and leadership development. This review provided evidence for organisational initiatives for women's progression in leadership across different settings in the healthcare sector and captured measurable change across the interventions.

McKague et al. (2021) conducted a study to investigate gender-based constraints that face community health workers (CHWs) working with four health social enterprises operating in Kenya and Uganda. The analysis of data revealed that CHWs encounter seven unique gender-based limitations compared to their male counterparts, which include personal safety risks, limited career advancement and leadership opportunities, higher time burden and lack of economic empowerment, limited access to required medical equipment and products, and transport, lack of access to networking opportunities and social support, and insufficient financial and non-financial benefits and incentives. Furthermore, the data revealed that the key areas for intervention included the following units: the health social enterprise, the community health worker, the donor or partners, and the patients.

Babic and Hansez (2021) conducted a study to fill the gap pertaining to understanding the phenomenon of the glass ceiling and its implications for career progression among women. They focused on considering the antecedents and potential consequences of the glass ceiling phenomenon by extending the model developed by Elaqua et al. (2009), thus proposing a more elaborate model that included organisational gender culture as an additional factor to interpersonal and situational issues with regard to the emergence of the glass ceiling based on the perception of varied treatment. The study also investigated the consequences of the glass ceiling toward organisational attitudes and employee well-being by taking into consideration work-to-family conflict (WFC) as the mediating factor. The authors surveyed 320 women in management positions in a Belgium-based organisation. The findings were that all three factors as critical towards the emergence of the ideology of differential treatment and the perception that the glass ceiling phenomenon exists. Also, WFC was seen to fully mediate the impacts of the glass ceiling on job engagement and strain while partially mediating the effects of the phenomenon on job satisfaction and the desire to quit.

Ghasi et al. (2020) investigated the perceptions and predictors of organisational justice among healthcare professionals in two teaching health institutions in Enugu State. The study involved a survey targeting 360 healthcare professionals on organisational justice and semi-structured interviews with 18 health professionals. The survey results revealed moderate to high perceptions of various dimensions related to organisational justice. Doctors indicated the highest perception of organisational justice, while allied health professionals (AHPs) had the least perception. The qualitative findings indicated that AHPs and nurses perceive differences in pay, training, access to medical resources, work schedules and participation in decision-making between doctors and other healthcare workers as unfair because of medical dominance. Overall, supervisors were reported to have a culture of sharing information occasionally and disrespectfully treating their junior colleagues.

Gender equality was examined as a multi-dimensional construct that covered gender diversity (occupational gender segregation), equal access to responsibility (glass ceiling), equal pay (gender pay gap), and work-life balance.

Role of Leadership in Gender Transformation

researcher found that the implementation of the gender equality policy was reliant on the goodwill of managers Wittenberg-Cox (2015) highlights the critical role of senior leadership in signalling and leading organisational change towards greater gender equality. She recommends that the CEO lead the change: it should not be left to women, the Human Resource Director or the Head of Diversity and Inclusion. Secondly, senior managers/ leaders must be aligned with the need for gender change and how to implement it. This will ensure meaningful organisational reforms. Thirdly, the senior leadership must be held accountable for progress towards gender parity, just like any other business target. These recommendations are echoed by the BCG report 'Measuring what Matters in Gender Diversity' – accountability for changing a company's culture starts with the CEO and in a study conducted by Abouzahr et al., 2018.

Ingle, E., Rencken, C., Seide, J. F., & Badshah, A. (2023) in their report contend that gender transformative leadership will help improve health outcomes by addressing the legal, cultural, and social barriers that prevent women working in health globally from attaining management and leadership positions. Gender transformative leadership is based on three principles: promoting gender equity in all areas of health, validating leadership across the health spectrum, and avoiding gender stereotypes and norms that prevent women's access to leadership.

Engida et al. (2022) investigated the impact of change leadership on the readiness of employees to change within several public organisations in Amhara state, Ethiopia. The study adopted the quantitative survey method. The population comprised 2,546 employees from eight public firms that were in the process of implementing various change initiatives. The findings revealed that there was a significant relationship between organisational culture and employee readiness to change. However, change leadership was found to have no direct impact on employee's readiness to change while organisational culture does not influence the association between change leadership and employee readiness to change.

Nkomo and Kriek (2011) conducted a study to understand change leadership in South African firms. The authors adopted a two-pronged qualitative method to investigate the life stories of business leaders in South Africa and the case-study method to evaluate organisations. The study sought to describe how leaders participated in leading the change necessary to restore balance between returning firms to the global business arena and overcoming the socioeconomic challenges created by the period of inequality among most of the population. The study found that the life stories of leaders played a vital role in determining their perception and response to change situations. The four major themes that summarised the actions of leaders include their efforts to offer hope, embrace change, connect the change to African culture and values and champion diversity. The results of this study suggest that the life stories of leaders provide a critical source of perceptions, interpretations, and responses to organisational change.

The Three Principles of Gender Transformative Leadership

- promoting gender equity in all areas of health
- validating leadership across the health spectrum
- avoiding gender stereotypes and norms that prevent women's access to leadership

Socio-Cultural Factors Affecting Women's Career Progression

Mwalyagile (2020) examined the association between gender stereotypes, socio-cultural beliefs and career progression among women staff members in a Tanzanian public university. The author acknowledged that a small percentage of women have been able to advance upward into leadership and decision-making positions in institutions of higher education. Yet the issue of women's career advancement in higher education has received minimal interest from scholars and researchers. The study conducted a survey of 300 female staff members in a public university. The findings revealed that gender stereotypes had a significant influence on the career progression of women staff, thus presenting as a major barrier. On the other hand, socio-cultural beliefs were found to have an insignificant association with career progression and thus did not constitute a serious barrier.

Liani et al. (2021) also conducted a study to illuminate the familial and socio-cultural factors that contribute to gender inequities in the scientific career progression in Sub-Saharan Africa. The study aimed to better inform strategies that could promote career equity for scientific researchers in Africa. The study identified four themes illustrating women's and men's characterisation of the normal career pathway: progression requirements call for significant time commitment; gender and social power relations within the family setting and wider society shape the participation of both men and women in scientific research activities; the culmination of varied experiences between family and career and the resulting impact on career progression and personal well-being. The final theme was the different and conscious trade-offs that women made when attempting to navigate their family and career lives.

Maponya (2021), on the other hand, examined the relationship between society and religion regarding gender inequality. The paper posits that the patriarchal nature and the structural organisation of religion influence and contribute to gender inequality in the social context, especially in highly religious countries such as South Africa.

Chapter Three
Methodologuy & Approach

Research Design

The study adopted a mixed-methods research design to first establish a baseline for organisational elements that either constrain or enable women's advancement in health sector organisations and then follow that through with a concurrent explanatory approach comprising a quantitative phase and a qualitative phase (Saunders, 2016). The sequence of concurrent research activities was a cross-sectional employee survey on organisational elements country-wide and key informant interviews with organisational leaders and their respective Human Resource Managers. In addition, three focus group discussions with selected women leaders in the public, private and not-for-profit sectors were held to explore leadership journeys and perceptions of organisational elements and their implications on women's advancement.

Study Population and Sample

Study Population

The study population consisted of 10,443 health sector organisations categorised based on function, as shown in Table 3.1 below. The study population was stratified according to geographical region and institutional ownership (private or public).

10,443
Total target population of health sector organisations

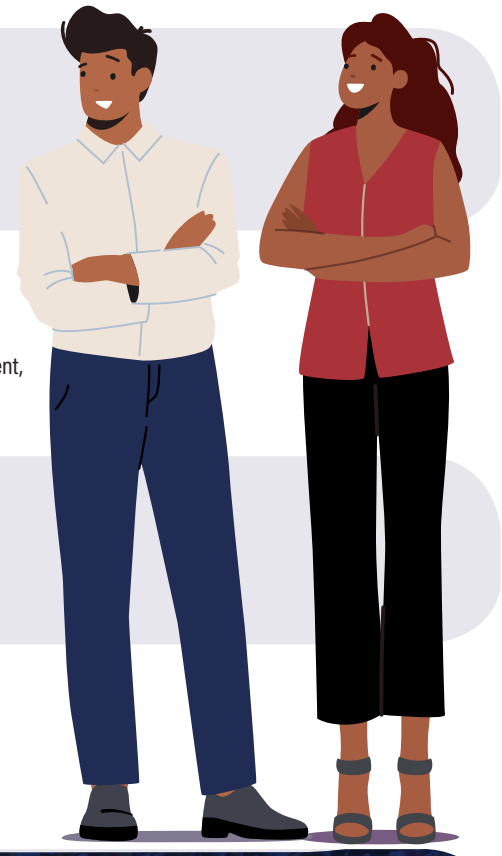
8,405
Health service providers

49
Professional & Trade associations

260
Local NGOs

239
International NGOs

19
Health finance/insurance



208
Manufacturer/distributor/ supplier (Pharmaceutical, Biopharma)

98
Manufacturer/distributor/ supplier (Medical equipment, lab, tech supplies)

69
Community-based organisations

874
Faith-based organisations

168
Research & Training institutes

54
Regulatory & Policy agencies

The eligibility criteria for inclusion in the study population was that the health sector organisation in question must:

a. Have been in operation in Kenya for more than 5 years.
b. Have organisational structures and policies in place.
c. A staff count of at least 50 full-time employees.
d. Located in one of the 8 geographic regions of Kenya.

The exclusion criteria were:

a. an organisation that is less than 5 years old.
b. an unregistered organisation.
c. an organisation with a staff count of less than 50 full-time employees.
d. Not a health sector organisation.

Sampling Size Determination

Our primary sampling unit was the health sector organisation. The sample size was determined at a 95% confidence level and calculated using a proportion sampling strategy. It was then adjusted to ensure a minimum of eight organisations covering all regions. The adjusted sample size was 403 organisations, as shown in Table 3.2 below.

Table 3.2: Sample size of health sector organisations

CATEGORY	NUMBER	PERCENTAGE	SAMPLE	ADJUSTMENT	TOTAL
Health service providers	8,405	80.48	298	0	**298**
Local NGOs	260	2.49	9	0	**9**
International NGOs	239	2.29	8	0	**8**
Health finance/insurance	19	0.18	1	7	**8**
Manufacturer/distributor/ supplier (Medical equipment, lab, tech supplies)	98	0.94	3	5	**8**
Manufacturer/distributor/ supplier (Pharmaceutical, Biopharma)	208	1.99	7	1	**8**
Professional & Trade associations	49	0.47	2	6	**8**
Faith-based organisations	874	8.37	31	0	**31**
Community-based organisations	69	0.66	2	6	**8**
Research & Training institutes	168	1.61	6	2	**8**
Regulatory & Policy agencies	54	0.52	2	6	**8**
Total	**10,443**	**100.00**	**370**	**33**	**403**

Design of Data Collection Tools

Data Collection Methods

Different tools and instruments were used to collect primary data. Quantitative data was collected through a survey questionnaire using the Kobo Toolbox online platform, which allowed for in-person data collection by the data collectors. Data collectors were trained on data collection procedures, how to use tablets for data collection and transmission, and troubleshooting in case of any errors or technical challenges during data collection. Data was captured within the online server in real time and managed by the data manager based at Strathmore University.

Qualitative data was gathered using semi-structured interviews and focus group discussions. Digital recorders were used to capture information during key informant interviews and focus group discussions. The researchers designated specific note-takers for the group interview sessions. Transcriptions were done verbatim from digital recorders. Secondary data was obtained from organisational policies, records, and reports. Table 3.3 below summarises the data collection methods and their rationale, as well as their target participants.

Data collection methods and rationale

DATA COLLECTION METHOD	RATIONALE	TARGET RESPONDENT/ PARTICIPANT	QUANTITATIVE MEASURE
Employee Survey on Organisational Elements	To determine employee perceptions of organisational structure, culture, policies on workplace gender equity, career opportunities, and the role of leadership in promoting workplace gender equity.	Employees of sample organisations. Lower, Middle, and Senior levels.	4,030 respondents targeted.
Key Informant Interviews	To identify the rationale for organisational policies, HR trends, leadership roles, and existing interventions, and explore gender equity awareness.	CEOs / Executive Directors; Human Resource Directors/ Managers.	50 for CEOs. 50 for HR Managers.
Focus Group Discussions with selected women leaders	To explore perceptions of organisational elements, enablers, and barriers to women's career advancement.	Senior women leaders in health sector organisations.	3 FGDs (Public sector, Private sector, NGO).
Documentary Review	To establish documentary evidence for organisational policies and employee trends pertaining to recruitment, retention, promotion, and representation.	Human Resource Managers & Officers.	Organisational strategies; HR Policies & Data. W+ certification (if any); Interventions on Gender Equity (if any).

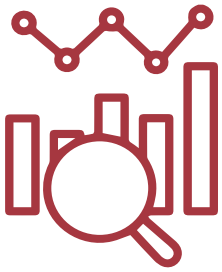
Pilot-testing of Data Collection Instruments

The researchers pre-tested all the data collection instruments (survey questionnaire, interview guide and focus group discussion guide) by sampling a few employees in health sector organisations before the data collection exercise. This exercise was used to improve the questionnaire, interview guide, and FGD guide. Furthermore, pilot testing helped to validate the research tools and provide a basis to ascertain the reliability and trustworthiness of the tools (Kombo & Tromp, 2013).

Recruitment of Research Participants

Organisation supervisors assisted the research assistants in identifying the participants from the health sector organisations and confirming eligibility to participate. This was followed by a short introduction to the activity, and those who expressed interest in participating were asked to voluntarily give consent in either English or Kiswahili, whichever the participant portrayed fluency in. Those who consented to participate were interviewed on the spot or given an interview appointment, whichever was appropriate according to their availability. To minimise loss and attrition of potential recruits, appointments given for interviews happened not more than 3 days after the initial contact. The substitution process for any unavailable potential recruit was as follows: the research assistants and senior enumerators reported any absentees and refusals, following which substitutes were drawn from the sampling frame.

Data Analysis and Management



Quantitative Data Analysis

Before data analysis, the quantitative data was subjected to data quality control processes and data cleaning. The data cleaning exercise focused on ensuring that the dataset was free of erroneous observations, duplicates, and irrelevances. The data quality checks included data completeness checks, validity checks, checking data for duplicates, and formatting variables into codes understood by the data analysis software.

Descriptive analysis for categorical variables was done by tabulation and reporting frequency counts and proportions. Descriptive analysis for continuous variables was done by generating summary statistics, which include meaning as a measure of central tendency and standard deviation for normally distributed variables or otherwise using the median and interquartile range, respectively. Comparisons for disaggregated data were done using Chi-square tests.

Relationships between the independent and dependent variables under each theme were explored further using correlation analysis.

Qualitative Data Analysis

Thematic content analysis was used to analyse the qualitative data arising from the transcripts of the key informant interviews and the focus group discussions. The thematic content analysis involved using NVIVO software and brought out patterns and themes relevant to the research questions. The qualitative data enabled the triangulation of data obtained from the survey data.

The qualitative data analysis entailed a detailed description of the research context and multiple iterations of analysis to produce the best possible and credible explanation of the phenomenon under study. The researchers also sought to promote fairness by representing all views in the research study, thereby upholding the value of authenticity.

Research Quality Assurance

Internal validity of the survey was enhanced by the choice of an appropriate and pre-tested tool, while face validity was achieved by expert reviewers who assessed how well the instrument measured the constructs. The external validity of the survey was enhanced using a representative sample and a comprehensive data set for the document review in the quantitative phase. Reliability was enhanced using a standardised questionnaire as well as the application of Cronbach's Alpha test to check for the internal consistency of the questionnaire. Objectivity was enhanced by the researchers' commitment to honest and accurate collection, analysis, and reporting of data.

The qualitative research also adhered to quality criteria such as producing a detailed description of the research context and findings and conducting a thorough analysis of the qualitative data to produce the best possible explanation of the phenomenon under study. This enhanced the study's credibility. The researchers also adopted reflexivity in the analysis, interpretation and writing of the findings. The study employed triangulation via the use of multiple data sources, different data collection techniques, and different investigators to cross-check the data and its interpretation. The researchers were also committed to participant validation by inviting feedback and participation through dissemination forums.

Ethical Considerations

Informed consent and voluntary participation

All research participants were required to read and sign consent forms prior to any data collection. The consent forms outlined the purpose and nature of the data collection activities, whether interviews, questionnaires, or focus group discussions. The data collectors explained to participants that their participation was voluntary and that if they agreed to participate, they could withdraw at any point.

Privacy and Confidentiality

All interview participants were assured of privacy and that no identifying information would be collected. Furthermore, the researchers preserved anonymity in reporting findings. Data obtained from participants was used for research purposes only.

Avoidance of harm

Any harm to the research participants was avoided. Interview guides and questionnaires did not contain questions that may cause embarrassment, stress, discomfort, pain, or conflict to the participants. Data collectors did not collect data in a way that involved mental or social pressure, causing anxiety or stress. Researchers ensured they upheld good ethical principles of confidentiality and anonymity and avoided any form of harassment or discrimination.

The research protocol was successfully submitted for review by the Strathmore University Institutional Ethics Review Committee, and a research permit was obtained from the National Commission for Science, Technology, and Innovation.

Chapter Four
Quantitative Findings

Demographic Characteristics

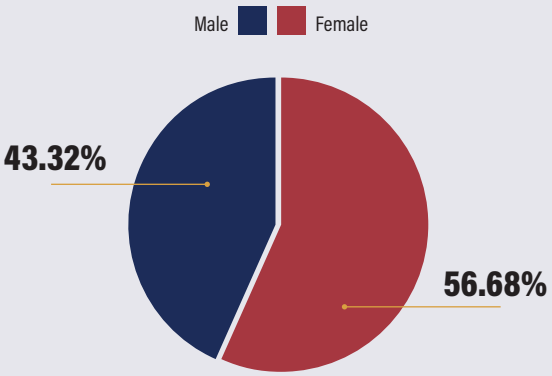
Table 4.1 presents an overview of the demographic traits of the sampled employees. The sample size comprised 3015 employees, and many worked in the private sector and health services organisations. More women than men participated in the study. Many employees were aged between 20 and 39 years suggesting a relatively youthful workforce, while the majority were married. Christianity was the predominant religion among those sampled. A noticeable proportion held college diplomas, followed by undergraduate degrees, highlighting a well-educated workforce. In terms of professional experience, the majority had between 1-10 years of experience, with a higher portion having been with their current organisation for 1-5 years, implying a relatively mobile workforce. Full-time employment is prevalent, although there is notable participation in temporary or casual arrangements. Management roles are predominantly occupied by supervisors/frontline managers, showcasing a hierarchical distribution within organisations.

Table 4.1: Summary of Demographic Characteristics

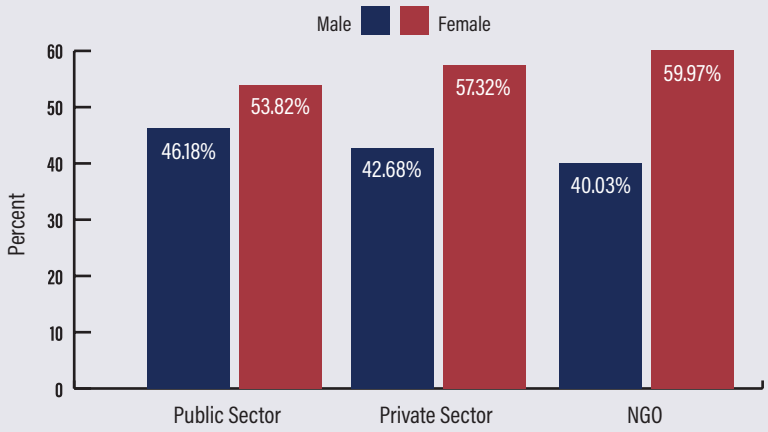
CHARACTERISTICS	FREQUENCY	PER CENT
Sector (N=3015)		
Public Sector	1085	36%
Private Sector	1223	40.6%
NGO sector	707	23.4%
Type of Organisation (N=3015)		
Community-based Organisation	54	1.8%
Faith-based Organisation	267	8.9%
Health Finance/Insurer	22	0.7%
Health Service Provider	2234	74.1%
International NGO	51	1.7%
Local NGO	143	4.7%
Manufacturer	20	0.7%
Professional & Trade Association	12	0.4%
Regulatory & Policy	9	0.3%
Research & Training Institute	136	4.5%
Supply Chain/Distributor	67	2.2%
Sex (N=3015)		
Male	1306	43.3%
Female	1709	56.7%
Age Range (N=3015)		
18-19 years	30	1%
20-29 years	932	30.9%
30-39 years	1200	39.8%
40-49 years	599	19.9%
50-59 years	224	7.4%
60+ years	30	1%
Marital status (N=3015)		
Single	896	29.7%
Married	1938	64.3%
Separated	72	2.4%
Divorced	44	1.5%
Widowed	65	2.2%
Religion (N=3015)		
African Traditional	60	2%
Christian	2480	82.3%
Hindu	4	0.1%

CHARACTERISTICS	FREQUENCY	PER CENT
Islam	465	15.4%
Other	6	0.2%
Highest level of education completed (N=3015)		
Primary	19	0.6%
Secondary	108	3.6%
Vocational training (TVET)	136	4.5%
College Diploma	1522	50.5%
Undergraduate degree	988	32.8%
Master's degree	223	7.4%
PhD degree	19	0.6%
Years worked in your profession (N=3015)		
<1 year	169	5.6%
1-5 years	1159	38.4%
6-10 years	855	28.4%
11-15 years	478	15.9%
16-20 years	174	5.8%
>20 years	180	6%
Years worked in current organisation (N=3015)		
<1 year	478	15.9%
1-5 years	1675	55.6%
6-10 years	587	19.5%
11-15 years	188	6.2%
16-20 years	47	1.6%
>20 years	40	1.3%
Employment status (N=3015)		
Employed full-time.	2301	76.3%
Employed on a temporary basis.	471	15.6%
Employed on a casual basis.	205	6.8%
Other (e.g., consultant)	38	1.3%
Level of management (N=3015)		
Board of Directors/Trustees	65	2.2%
CEO/MD, Medical Superintendent	183	6.1%
Executive Management, i.e., CFO/CMO/COO	240	8%
Heads of Departments/Administrators/Team Leaders	755	25%
Human Resource Professional (HRMS), People & Culture	348	11.5%
Supervisor/Frontline Manager/Care Managers	1424	47.2%

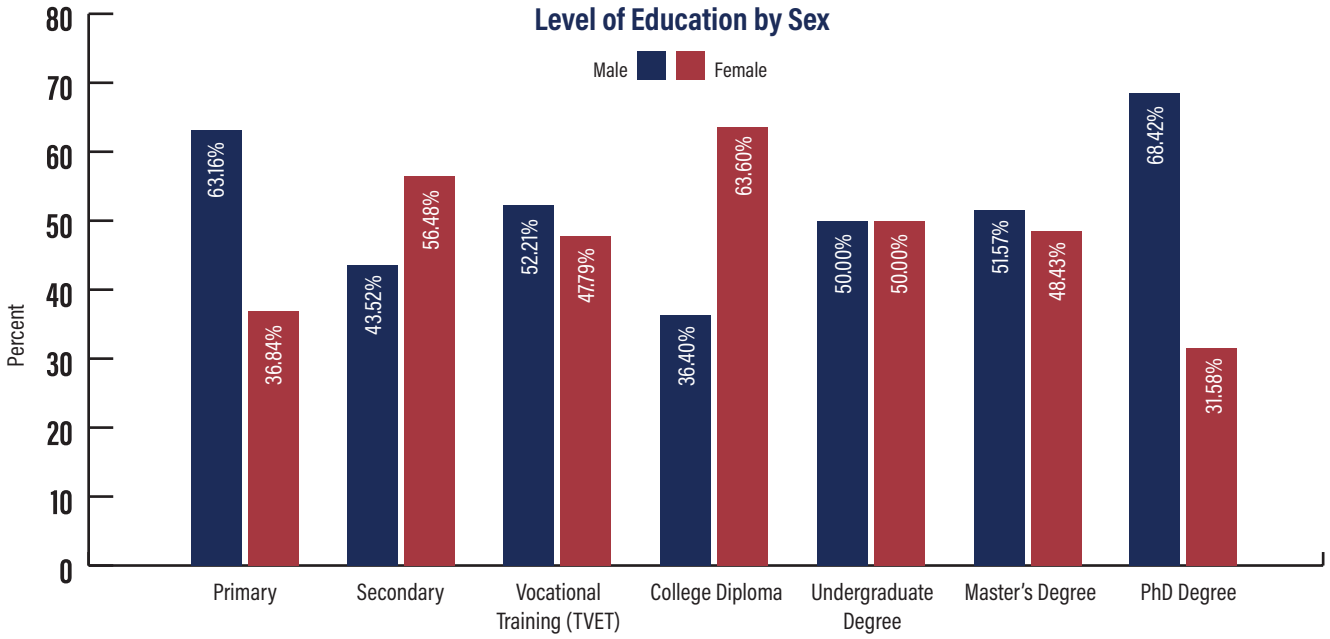
Sex of the Respondents



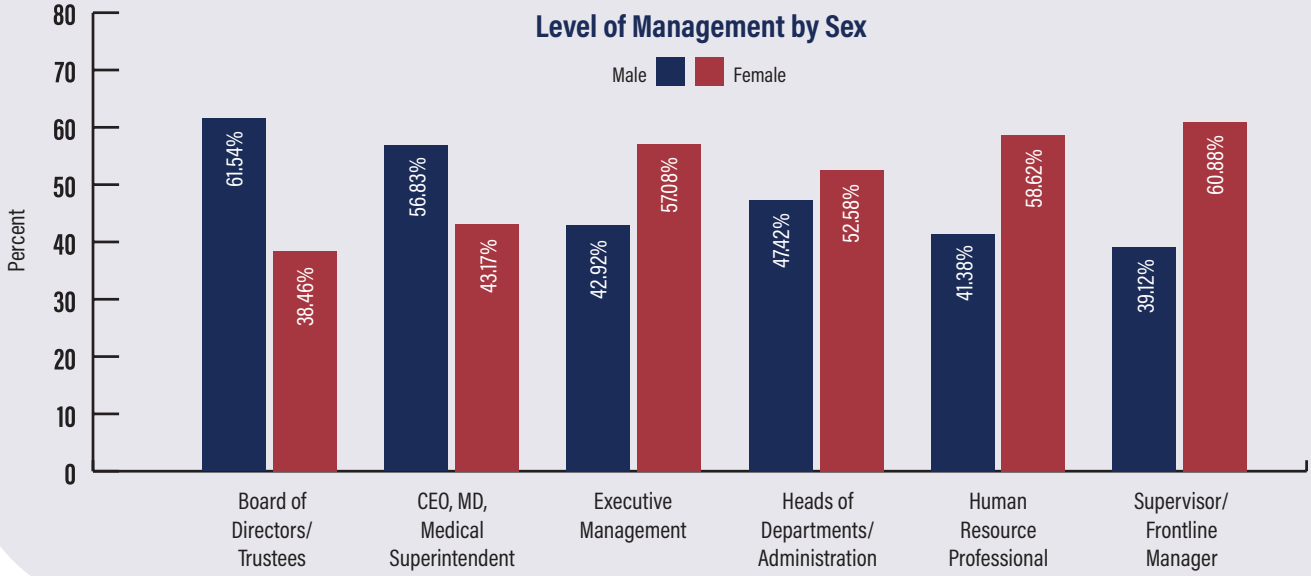
Distribution of Sectors by Sex



Level of Education by Sex



Level of Management by Sex



Objective 1:
Organisational Policies

The respondents were required to rate their perceptions of statements related to organisational and individual-level policies using a Likert scale of 1-4, where 1 is 'Not at all' and 4 is 'Great extent'. Table 4.2 summarises the responses from the sampled employees.

At the organisation level, the majority of respondents agreed that policies offered equitable remuneration for similar roles and skill levels, with a higher proportion indicating 'Great extent'. Additionally, the majority of employees knew what to do in case they experienced harassment within the organisation. However, a smaller but notable percentage felt that promotions were not solely based on individual performance and perceived ambiguity in promotion criteria.

Regarding individual-level policies, a vast majority felt well-oriented about gender-related policies and were aware of sexual harassment policies. Nevertheless, there were areas for improvement, as a notable percentage were unaware of paternity/maternity leave policies and that both genders were not equally encouraged to take such leaves. Furthermore, a substantial portion felt unsupported in accessing flexible work schedules.

Table 4.2: Summary of Responses on organisational policies

STATEMENT	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT
Organisation level					
Where I work, the policies offer similar remuneration/salary/ compensation for people in the same role with comparable skills and experience.	3015	5.3%	9.5%	29.4%	55.9%
I know what to do in case I experience harassment/bullying within the organisation.	3015	3.2%	8%	25.3%	63.4%
In my organisation, promotions in this organisation are based on individual employee performance.	3015	7%	11.6%	33.2%	48.3%
In my organisation, promotion criteria and procedures are clear and transparent.	3015	7.3%	15.6%	33.8%	43.3%
Individual level					
I am well-oriented and aware of policies related to gender, leave, paternity/maternity within my organisation.	3015	2.1%	6.9%	27.7%	63.3%
I am aware that there is a sexual harassment policy in my organisation.	3015	13.9%	11.5%	23.6%	51%
Both men and women are encouraged and supported to take paid paternity and maternity leave respectively in my organisation.	3015	5.5%	13.7%	30.7%	50.1%
In my organisation, I am supported to take up a flexible work schedule.	3015	35.3%	23.7%	23%	18%

Further analysis was undertaken to explore the differences in the perceptions of organisational and individual-level policies between sectors and sexes. The results are presented in Table 4.3 on the next page.

Regarding organisational-level policies, significant sector differences were discovered for all the organisational policies, while significant types of organisational differences were unveiled regarding what to do in case harassment is experienced within an organisation, promotions based on individual employee performance, and clear and transparent promotion criteria and procedures within organisations.

For the individual level policies, significant gender differences were noted for being aware of sexual harassment policies in their organisations and being supported to take up a flexible work schedule.

Table 4.3: Comparison of organisational policies by sector and sex

ORGANISATIONAL LEVEL POLICIES	SECTOR	SEX	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
Where I work, the policies offer similar remuneration/salary/compensation for people in the same role with comparable skills and experience.	Public Sector	Male	501	4.80%	7.40%	26.10%	61.70%	(3, n=1085) =1.414	0.702	0.036
		Female	584	3.90%	7.50%	28.90%	59.60%			
	Private Sector	Male	522	4.00%	10.00%	32.80%	53.30%	(3, n=1223) =6.426*	0.093	0.072
		Female	701	6.70%	12.40%	30.40%	50.50%			
	NGO sector	Male	283	5.70%	7.80%	27.60%	59.00%	(3, n=707) =2.480	0.479	0.059
		Female	424	6.60%	10.40%	29.20%	53.80%			
I know what to do in case I experience harassment/bullying within the organisation.	Public Sector	Male	501	3.20%	8.00%	23.20%	65.70%	(3, n=1085) =2.082	0.556	0.044
		Female	584	1.90%	8.20%	24.50%	65.40%			
	Private Sector	Male	522	3.40%	9.40%	23.90%	63.20%	(3, n=1223) =4.711	0.194	0.062
		Female	701	4.90%	7.40%	27.50%	60.20%			
	NGO sector	Male	283	2.80%	6.00%	28.30%	62.90%	(3, n=707) =2.378	0.498	0.058
		Female	424	2.10%	8.50%	25.20%	64.20%			
In my organisation, promotions in this organisation are based on individual employee performance.	Public Sector	Male	501	9.80%	12.20%	34.50%	43.50%	(3, n=1085) =2.721	0.437	0.05
		Female	584	12.00%	13.90%	34.40%	39.70%			
	Private Sector	Male	522	2.90%	10.70%	31.80%	54.60%	(3, n=1223) =10.344**	0.016	0.092
		Female	701	5.70%	13.30%	33.70%	47.40%			
	NGO sector	Male	283	4.90%	6.70%	33.60%	54.80%	(3, n=707) =1.881	0.597	0.052
		Female	424	5.40%	9.20%	30.40%	55.00%			
In my organisation, promotion criteria and procedures are clear and transparent.	Public Sector	Male	501	9.20%	15.60%	32.50%	42.70%	(3, n=1085) =6.587*	0.086	0.078
		Female	584	11.10%	18.20%	35.40%	35.30%			
	Private Sector	Male	522	3.30%	15.10%	32.20%	49.40%	(3, n=1223) =14.508***	0.002	0.109
		Female	701	7.40%	15.80%	35.40%	41.40%			
	NGO sector	Male	283	5.30%	11.70%	29.70%	53.40%	(3, n=707) =6.278*	0.099	0.094
		Female	424	6.10%	15.10%	34.90%	43.90%			

INDIVIDUAL LEVEL POLICIES	SECTOR	SEX	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
I am well-oriented and aware of policies related to gender, leave, paternity/maternity within my organisation.	Public Sector	Male	501	1.80%	6.20%	24.00%	68.10%	(3, n=1085) =1.645	0.649	0.039
		Female	584	2.40%	5.00%	25.90%	66.80%			
	Private Sector	Male	522	2.10%	7.70%	27.60%	62.60%	(3, n=1223) =3.972	0.265	0.057
		Female	701	2.70%	10.10%	29.40%	57.80%			
	NGO sector	Male	283	1.40%	5.70%	29.30%	63.60%	(3, n=707) =0.188	0.979	0.016
		Female	424	1.40%	5.20%	30.70%	62.70%			
I am aware that there is a sexual harassment policy in my organisation.	Public Sector	Male	501	13.60%	8.80%	21.60%	56.10%	(3, n=1085) =16.163***	0.001	0.122
		Female	584	8.70%	13.00%	27.90%	50.30%			
	Private Sector	Male	522	18.00%	11.90%	20.30%	49.80%	(3, n=1223) =2.883	0.41	0.049
		Female	701	19.40%	13.30%	22.40%	44.90%			
	NGO sector	Male	283	6.70%	11.70%	26.10%	55.50%	(3, n=707) =6.076*	0.108	0.093
		Female	424	12.00%	9.20%	24.50%	54.20%			
Both men and women are encouraged and supported to take paid paternity and maternity leave respectively in my organisation.	Public Sector	Male	501	4.80%	13.00%	25.30%	56.90%	(3, n=1085) =4.583	0.205	0.065
		Female	584	2.70%	12.70%	29.10%	55.50%			
	Private Sector	Male	522	6.90%	13.40%	35.10%	44.60%	(3, n=1223) =5.668	0.129	0.068
		Female	701	8.60%	17.50%	32.00%	41.90%			
	NGO sector	Male	283	3.20%	11.70%	31.40%	53.70%	(3, n=707) =1.319	0.725	0.043
		Female	424	5.00%	11.30%	31.10%	52.60%			
In my organisation, I am supported to take up a flexible work schedule.	Public Sector	Male	501	31.90%	24.60%	24.80%	18.80%	(3, n=1085) =8.709**	0.033	0.09
		Female	584	40.60%	21.70%	21.40%	16.30%			
	Private Sector	Male	522	31.20%	26.20%	23.60%	19.00%	(3, n=1223) =1.925	0.588	0.04
		Female	701	34.50%	25.80%	23.00%	16.70%			
	NGO sector	Male	283	36.00%	21.20%	22.60%	20.10%	(3, n=707) =0.305	0.959	0.021
		Female	424	38.00%	20.50%	22.40%	19.10%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

Objective 2: Organisational Culture

The respondents were required to rate their perception of statements related to organisational and individual-level culture using a Likert scale of 1-4, where 1 is 'Not at all' and 4 is 'Great extent'. Table 4.4 summarises the responses from the sampled employees.

At the organisational level, sampled employees generally believed that men and women were treated equally, and there was a moderate extent of freedom to discuss issues without fear of reprimand. However, a significant majority observed the absence of gender-specific clubs, indicating a lack of gender-based segregation. Additionally, while many felt comfortable discussing work challenges with colleagues, there was a smaller proportion expressing a sense of belonging and community within the organisation.

At the individual level, employees largely felt supported by their managers, but a considerable percentage found themselves not doing housekeeping duties in their organisations. Many employees applauded that their opinions were generally valued in meetings, and a substantial portion did not feel intimidated by senior colleagues. Furthermore, family responsibilities seem to hinder socialisation after work for some employees.

Table 4.4: Summary of Responses on organisational culture

STATEMENT	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT
Organisation level					
In my organisation, men and women are treated equally.	3015	2.6%	10.3%	28.2%	58.9%
My colleagues and I freely speak about issues without being reprimanded within the organisation.	3015	3.5%	13%	36.2%	47.3%
There is a male-dominated or men's only club within the organisation.	3015	68.7%	14.3%	12.3%	4.8%
There is a female-dominated or women 's-only club within the organisation.	3015	68.5%	16.6%	11%	3.9%
In our organisation, it is easy for me to discuss my work challenges with my colleagues.	3015	3.2%	15.2%	37.7%	43.9%
There is a sense of belonging and community within the organisation.	3015	2.3%	11.9%	38.9%	46.9%
Individual Level					
Staff feel supported by managers in this organisation.	3015	2.4%	12.8%	39.9%	44.8%
I often do the housekeeping duties in the organisation e.g., take minutes, serve tea.	3015	39.5%	25.3%	20%	15.2%
During meetings, my opinions are valued and considered by team members/colleagues within the organisation.	3015	3.7%	14.3%	35.9%	46%
I feel intimidated by seniors in my organisation and cannot approach them.	3015	62.6%	18.5%	14.1%	4.8%
There is less time to socialise in our organisation with my colleagues after work because of family responsibilities.	3015	23.6%	25.1%	29%	22.2%

Further analysis was carried out to explore the differences in the perceptions of organisational and individual-level culture between sectors and sexes. The results are presented in Table 4.5 on the next page.

Regarding organisational-level policies, significant sector differences were discovered for men and women being treated equally in their organisations, having gender-dominated clubs within their organisations, being easy for employees to discuss work challenges with colleagues, and having a sense of belonging and community within organisations. Consequently, significant sex differences were discovered across all the organisational-level cultures.

For the individual-level policies, significant sex differences were discovered between staff who felt supported by managers and who performed housekeeping duties in their organisations. Moreover, significant sex differences were unveiled between staff who felt their opinions were valued during meetings, who felt intimidated by seniors within their organisations, and those who had less time to socialise with colleagues after work due to family responsibilities.

Table 4.5: Comparison of organisational culture by sector and sex

ORGANISATIONAL LEVEL CULTURE	SECTOR	SEX	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
In my organisation, men and women are treated equally.	Public Sector	Male	501	3.60%	8.40%	29.90%	58.10%	(3, n=1085) =4.589	0.205	0.065
		Female	584	3.30%	12.30%	27.90%	56.50%			
	Private Sector	Male	522	1.90%	10.70%	28.00%	59.40%	(3, n=1223) =2.736	0.434	0.047
		Female	701	3.10%	12.40%	27.20%	57.20%			
	NGO sector	Male	283	1.40%	6.40%	28.30%	64.00%	(3, n=707) =1.632	0.652	0.048
		Female	424	0.90%	8.70%	28.10%	62.30%			
My colleagues and I freely speak about issues without being reprimanded within the organisation.	Public Sector	Male	501	3.40%	12.00%	34.30%	50.30%	(3, n=1085) =4.316	0.229	0.063
		Female	584	3.90%	13.20%	38.90%	44.00%			
	Private Sector	Male	522	2.50%	13.40%	34.90%	49.20%	(3, n=1223) =6.142*	0.105	0.071
		Female	701	4.90%	14.40%	36.20%	44.50%			
	NGO sector	Male	283	2.80%	11.30%	34.30%	51.60%	(3, n=707) =1.329	0.722	0.043
		Female	424	2.60%	12.30%	37.70%	47.40%			
There is a male-dominated or men's only club within the organisation.	Public Sector	Male	501	65.30%	14.80%	15.00%	5.00%	(3, n=1085) =0.891	0.828	0.029
		Female	584	67.60%	13.20%	14.70%	4.50%			
	Private Sector	Male	522	67.20%	15.50%	12.10%	5.20%	(3, n=1223) =1.568	0.667	0.036
		Female	701	68.80%	13.10%	12.30%	5.80%			
	NGO sector	Male	283	68.90%	17.00%	9.50%	4.60%	(3, n=707) =4.156	0.245	0.077
		Female	424	75.50%	13.90%	7.80%	2.80%			
There is a female-dominated or women 's-only club within the organisation.	Public Sector	Male	501	65.70%	19.40%	11.80%	3.20%	(3, n=1085) =0.482	0.923	0.021
		Female	584	65.20%	20.00%	11.00%	3.80%			
	Private Sector	Male	522	67.60%	16.10%	12.10%	4.20%	(3, n=1223) =1.304	0.728	0.033
		Female	701	70.50%	15.10%	10.40%	4.00%			
	NGO sector	Male	283	69.30%	14.10%	11.00%	5.70%	(3, n=707) =2.823	0.42	0.063
		Female	424	73.30%	13.20%	10.10%	3.30%			

ORGANISATIONAL LEVEL CULTURE	SECTOR	SEX	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
In our organisation, it is easy for me to discuss my work challenges with my colleagues.	Public Sector	Male	501	3.20%	13.60%	37.50%	45.70%	(3, n=1085) =1.962	0.58	0.043
		Female	584	2.70%	16.30%	38.00%	43.00%			
	Private Sector	Male	522	1.90%	16.10%	40.20%	41.80%	(3, n=1223) =7.484*	0.058	0.078
		Female	701	4.60%	17.80%	37.20%	40.40%			
	NGO sector	Male	283	2.10%	14.10%	31.40%	52.30%	(3, n=707) =6.775*	0.079	0.098
		Female	424	3.50%	11.10%	39.40%	46.00%			
There is a sense of belonging and community within the organisation.	Public Sector	Male	501	2.20%	9.60%	37.30%	50.90%	(3, n=1085) =10.594***	0.014	0.099
		Female	584	1.50%	13.70%	42.50%	42.30%			
	Private Sector	Male	522	2.90%	13.20%	39.30%	44.60%	(3, n=1223) =1.833	0.608	0.039
		Female	701	3.70%	13.60%	41.50%	41.20%			
	NGO sector	Male	283	1.40%	8.80%	34.30%	55.50%	(3, n=707) =0.545	0.909	0.028
		Female	424	0.90%	9.90%	34.00%	55.20%			
Individual Level Culture										
Staff feel supported by managers in this organisation.	Public Sector	Male	501	3.20%	13.00%	38.30%	45.50%	(3, n=1085) =1.896	0.594	0.042
		Female	584	2.90%	14.00%	41.40%	41.60%			
	Private Sector	Male	522	2.50%	11.90%	37.70%	47.90%	(3, n=1223) =6.406*	0.093	0.072
		Female	701	2.90%	14.60%	41.80%	40.80%			
	NGO sector	Male	283	1.10%	8.10%	37.10%	53.70%	(3, n=707) =6.265*	0.099	0.094
		Female	424	0.90%	12.50%	41.30%	45.30%			
I often do the housekeeping duties in the organisation e.g., take minutes, serve tea.	Public Sector	Male	501	46.70%	22.00%	19.60%	11.80%	(3, n=1085) =12.255***	0.007	0.106
		Female	584	37.30%	29.80%	20.20%	12.70%			
	Private Sector	Male	522	43.30%	24.70%	18.80%	13.20%	(3, n=1223) =11.868***	0.008	0.099
		Female	701	35.40%	25.80%	19.40%	19.40%			
	NGO sector	Male	283	41.30%	21.90%	20.80%	15.90%	(3, n=707) =2.967	0.397	0.065
		Female	424	35.10%	25.50%	21.90%	17.50%			

INDIVIDUAL LEVEL CULTURE	SECTOR	SEX	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
During meetings, my opinions are valued and considered by team. members/colleagues within the organisation.	Public Sector	Male	501	4.20%	12.20%	35.70%	47.90%	(3, n=1085) =2.592	0.459	0.049
		Female	584	4.10%	14.70%	37.50%	43.70%			
	Private Sector	Male	522	3.40%	15.70%	36.20%	44.60%	(3, n=1223) =2.479	0.479	0.045
		Female	701	4.40%	18.40%	34.70%	42.50%			
	NGO sector	Male	283	4.20%	9.20%	31.80%	54.80%	(3, n=707) =8.336**	0.04	0.109
		Female	424	1.70%	11.30%	38.40%	48.60%			
I feel intimidated by seniors in my organisation and cannot approach them.	Public Sector	Male	501	65.10%	15.00%	14.40%	5.60%	(3, n=1085) =11.612***	0.009	0.103
		Female	584	58.60%	21.90%	15.90%	3.60%			
	Private Sector	Male	522	63.00%	17.60%	14.60%	4.80%	(3, n=1223) =3.613	0.306	0.054
		Female	701	57.80%	20.80%	15.80%	5.60%			
	NGO sector	Male	283	71.70%	15.50%	8.10%	4.60%	(3, n=707) =3.321	0.345	0.069
		Female	424	66.30%	17.50%	11.80%	4.50%			
There is less time to socialise in our organisation with my colleagues after work because of family responsibilities.	Public Sector	Male	501	28.10%	23.40%	31.30%	17.20%	(3, n=1085) =7.340*	0.062	0.082
		Female	584	25.30%	22.30%	28.60%	23.80%			
	Private Sector	Male	522	24.30%	25.30%	30.80%	19.50%	(3, n=1223) =7.300*	0.063	0.077
		Female	701	20.80%	27.50%	27.00%	24.70%			
	NGO sector	Male	283	20.50%	28.60%	31.10%	19.80%	(3, n=707) =5.988*	0.112	0.092
		Female	424	21.90%	24.50%	26.70%	26.90%			

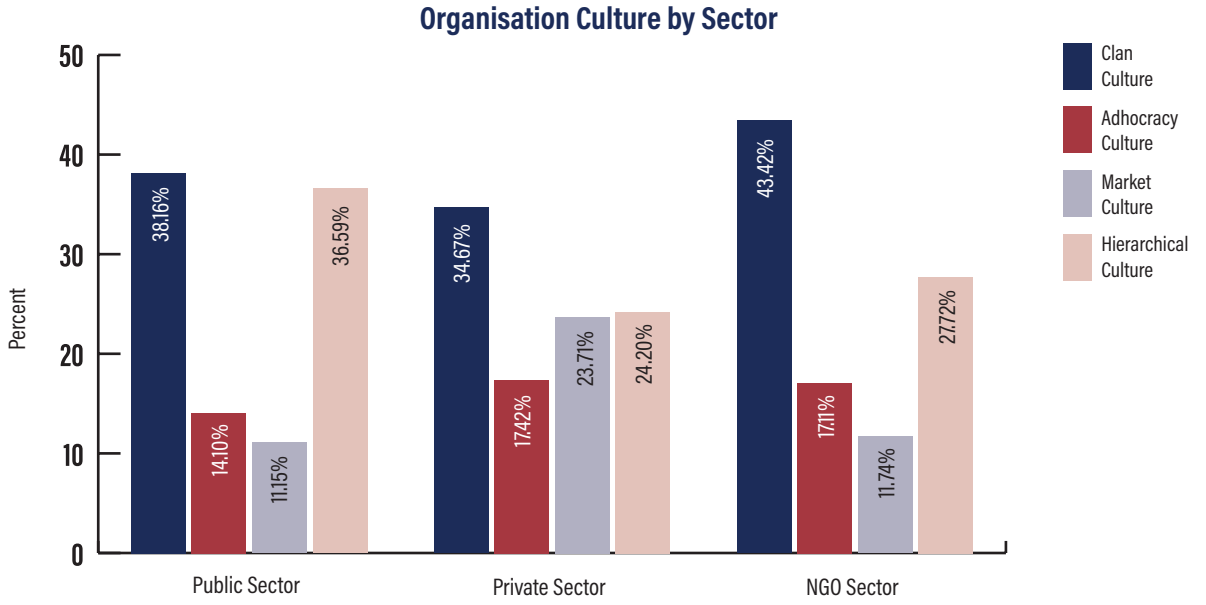
*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

Table 4.6: Comparison of types of culture by sector and sex

SECTOR	SEX	N	CLAN CULTURE	ADHOCRACY CULTURE	MARKET CULTURE	HIERARCHICAL CULTURE	CHI-SQUARE	P	PHI
Public Sector	Male	501	40.90%	12.80%	10.80%	35.50%	(3, n=1085) =3.425	0.331	0.056
	Female	584	35.80%	15.20%	11.50%	37.50%			
Private Sector	Male	522	33.50%	16.50%	26.60%	23.40%	(3, n=1223) =4.333	0.228	0.06
	Female	701	35.50%	18.10%	21.50%	24.80%			
NGO sector	Male	283	48.10%	17.30%	12.40%	22.30%	(3, n=707) =7.580	0.056	0.104
	Female	424	40.30%	17.00%	11.30%	31.40%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

A chi-square test of independence was conducted to establish if there were significant sectors and sex differences for types of cultures. The results revealed significant differences between the sectors and sex, as shown in Table 4.6 above. Clan culture is most preferred in the public, private, and NGO sectors, with hierarchical culture followed by market culture for the private sector.



Objective 3:
Organisational Leadership

The respondents were required to rate their perceptions of statements related to organisational and individual-level leadership using a Likert scale of 1-4, where 1 is 'Not at all' and 4 is 'Great extent'. Table 4.7 summarises the responses from the sampled employees.

At the organisation level, employees perceived leaders as taking responsibility for promoting gender equality and preventing sexual harassment. Additionally, a higher percentage felt that top leadership opportunities were equally accessible to both genders. At the individual level, employees expressed a desire for leadership opportunities, and a notable portion felt that they did not miss out on such opportunities due to their gender.

Table 4.7: Summary of Responses on organisational leadership

STATEMENT	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT
Organisation Level					
Our leaders (CEO and senior managers) take responsibility for promoting gender equality as a leadership priority.	3015	3.3%	11.7%	40.9%	44.1%
Our leaders (CEO and senior managers) take responsibility for preventing sexual harassment/bullying in the workplace.	3015	2%	10.7%	36%	51.3%
Top leadership opportunities (CEO and senior managers) are equally accessible to men and women in my organisation.	3015	3.6%	13.9%	37.5%	45%
Individual Level					
I often seek out leadership opportunities and promotions in my organisation.	3015	23.7%	23.3%	30.1%	22.9%
I miss out on leadership opportunities within the organisation because of my gender.	3015	70.4%	14.5%	11%	4%

Further analysis explored the differences in the perceptions of organisational-level leadership between sectors and types of organisations and individual-level leadership between genders. The results are presented in Table 4.8 on the next page.

The findings uncovered significant sector and type of organisation differences for organisational level leadership. Additionally, the individual level further analysis revealed significant gender differences across all the individual leadership characteristics.

Table 4.8: Comparison of organisational leadership between sector, type of organisation and gender

ORGANISATIONAL LEVEL LEADERSHIP	SECTOR	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
Our leaders (CEO and senior managers) take responsibility for promoting gender equality as a leadership priority.	Public Sector	1085	3.40%	13.20%	38.90%	44.50%	(6, n=3015) =23.453***	0.00	0.088
	Private Sector	1223	3.50%	12.40%	43.50%	40.60%			
	NGO sector	707	2.70%	8.10%	39.60%	49.60%			
Our leaders (CEO and senior managers) take responsibility for preventing sexual harassment/ bullying in the workplace.	Public Sector	1085	2.60%	12.30%	35.80%	49.40%	(6, n=3015) =22.999***	0.00	0.087
	Private Sector	1223	2.20%	11.30%	36.10%	50.40%			
	NGO sector	707	0.60%	7.50%	36.10%	55.90%			
Top leadership opportunities (CEO and senior managers) are equally accessible to men and women in my organisation.	Public Sector	1085	3.30%	14.20%	37.80%	44.70%	(6, n=3015) =12.064*	0.06	0.063
	Private Sector	1223	3.50%	15.50%	37.40%	43.50%			
	NGO sector	707	4.40%	10.50%	37.10%	48.10%			

ORGANISATIONAL LEVEL LEADERSHIP	TYPE OF ORGANISATION	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
Our leaders (CEO and senior managers) take responsibility for promoting gender equality as a leadership priority.	Community-based Organisation	54	0.00%	7.40%	27.80%	64.80%	(30, n=3015) =68.174***	0.00	0.15
	Faith-based Organisation	267	4.10%	9.00%	40.80%	46.10%			
	Health Finance/Insurer	22	0.00%	4.50%	77.30%	18.20%			
	Health Service Provider	2234	3.40%	12.40%	41.20%	42.90%			
	International NGO	51	0.00%	19.60%	39.20%	41.20%			
	Local NGO	143	3.50%	4.20%	40.60%	51.70%			
	Manufacturer	20	0.00%	15.00%	50.00%	35.00%			
	Professional & Trade Association	12	0.00%	8.30%	66.70%	25.00%			
	Regulatory & Policy	9	0.00%	0.00%	0.00%	100.00%			
	Research & Training Institute	136	2.20%	8.10%	36.80%	52.90%			
	Supply Chain/Distributor	67	4.50%	20.90%	40.30%	34.30%			

ORGANISATIONAL LEVEL LEADERSHIP	TYPE OF ORGANISATION	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
Our leaders (CEO and senior managers) take responsibility for preventing sexual harassment/ bullying in the workplace.	Community-based Organisation	54	0.00%	0.00%	24.10%	75.90%	(30, n=3015) =88.299***	0.00	0.171
	Faith-based Organisation	267	0.70%	6.40%	37.50%	55.40%			
	Health Finance/Insurer	22	0.00%	4.50%	50.00%	45.50%			
	Health Service Provider	2234	2.40%	11.80%	36.30%	49.50%			
	International NGO	51	0.00%	15.70%	49.00%	35.30%			
	Local NGO	143	0.70%	4.90%	37.10%	57.30%			
	Manufacturer (Medical Equipment, Pharma)	20	5.00%	20.00%	50.00%	25.00%			
	Professional & Trade Association	12	0.00%	16.70%	58.30%	25.00%			
	Regulatory & Policy	9	0.00%	0.00%	11.10%	88.90%			
	Research & Training Institute	136	0.00%	5.90%	24.30%	69.90%			
	Supply Chain/Distributor (Medical Equipment, Pharma)	67	1.50%	20.90%	31.30%	46.30%			
Top leadership opportunities (CEO and senior managers) are equally accessible to men and women in my organisation.	Community-based Organisation	54	9.30%	3.70%	31.50%	55.60%	(30, n=3015) =94.181***	0.00	0.177
	Faith-based Organisation	267	4.10%	7.90%	35.20%	52.80%			
	Health Finance/Insurer	22	4.50%	13.60%	40.90%	40.90%			
	Health Service Provider	2234	3.80%	15.40%	38.50%	42.30%			
	International NGO	51	0.00%	11.80%	54.90%	33.30%			
	Local NGO	143	2.80%	10.50%	31.50%	55.20%			
	Manufacturer	20	0.00%	20.00%	60.00%	20.00%			
	Professional & Trade Association	12	0.00%	0.00%	33.30%	66.70%			
	Regulatory & Policy	9	0.00%	0.00%	11.10%	88.90%			
	Research & Training Institute	136	0.70%	4.40%	29.40%	65.40%			
	Supply Chain/Distributor	67	3.00%	23.90%	31.30%	41.80%			

INDIVIDUAL LEVEL LEADERSHIP	GENDER	N	NOT AT ALL	SMALL EXTENT	MODERATE EXTENT	GREAT EXTENT	CHI-SQUARE	P	PHI
I often seek out leadership opportunities and promotions in my organisation.	Male	1306	21.70%	21.40%	30.40%	26.50%	(3, n=3015) =20.828***	0.00	0.083
	Female	1709	25.20%	24.80%	30.00%	20.10%			
I miss out on leadership opportunities within the organisation because of my gender.	Male	1306	72.40%	12.70%	10.90%	4.00%	(3, n=3015) =6.588*	0.09	0.047
	Female	1709	68.90%	15.90%	11.20%	4.00%			

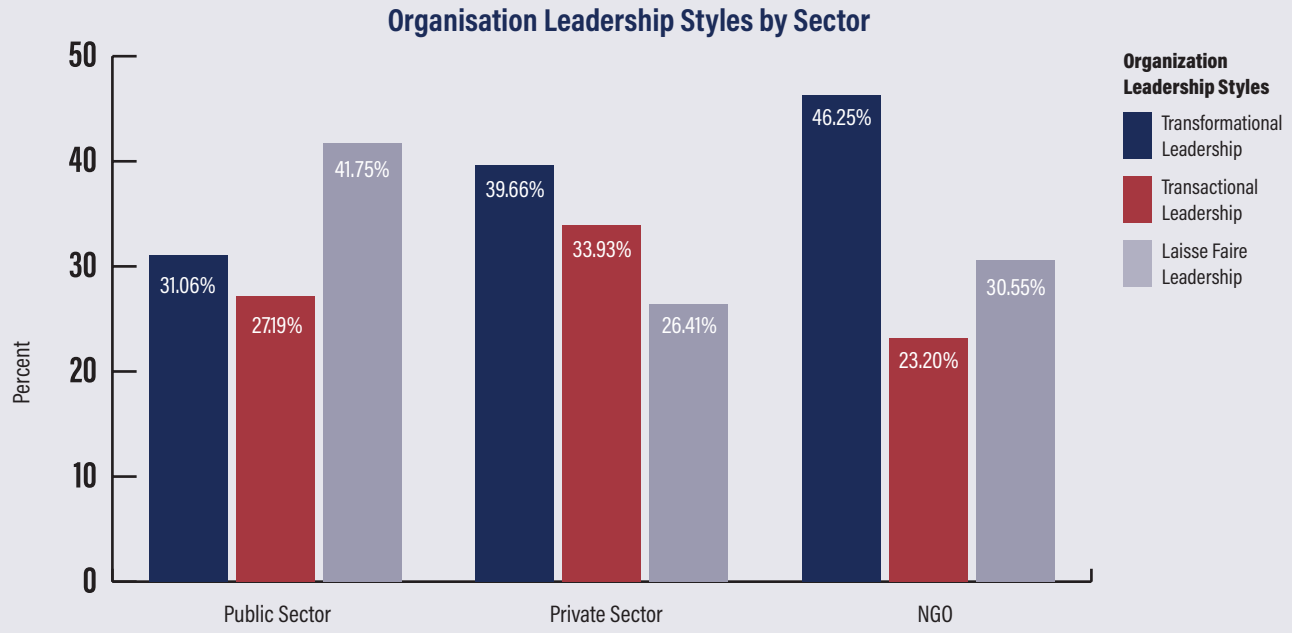
***, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.

Table 4.9: Comparison of organisational leadership style between sector and type of organisation

SECTOR	N	TRANSFORMATIONAL LEADERSHIP	TRANSACTIONAL LEADERSHIP	LAISSEZ-FAIRE LEADERSHIP	CHI-SQUARE	P	PHI
Public Sector	1085	31.10%	27.20%	41.80%	(4, n=3015) = 89.598***	0.00	0.172
Private Sector	1223	39.70%	33.90%	26.40%			
NGO sector	707	46.30%	23.20%	30.60%			
Type of Organisation							
Community-based Organisation	54	64.80%	9.30%	25.90%	(20, n=3015) =71.334***	0.00	0.154
Faith-based Organisation	267	41.20%	31.80%	27.00%			
Health Finance/Insurer	22	9.10%	50.00%	40.90%			
Health Service Provider	2234	36.40%	30.30%	33.30%			
International NGO	51	47.10%	19.60%	33.30%			
Local NGO	143	50.30%	15.40%	34.30%			
Manufacturer	20	40.00%	40.00%	20.00%			
Professional & Trade Association	12	33.30%	33.30%	33.30%			
Regulatory & Policy	9	55.60%	0.00%	44.40%			
Research & Training Institute	136	35.30%	19.90%	44.90%			

***, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.

A chi-square test of independence was conducted to establish if there were significant sectors and types of organisations differences for types of leadership styles. The results revealed there were significant differences between the sectors and types of organisations as shown in Table 4.9 above. The transformative leadership style is most preferred in the private and NGO sectors, while the laissez-faire style is preferred in the public sector. The second preferred style in the public sector is transformational, while for the private is a transactional style, and the NGO sector is a laissez-faire leadership style. Consequently, the transformational style is dominant in community-based organisations, health service providers, NGO organisations, and regulatory and policy organisations. Transactional is predominant in health finance /insurers organisations, while laissez-faire leadership style is dominant in research and training institutes.



Section 5:

Career Advancement Opportunities

The participants were asked to indicate 'Yes' or 'No' to questions about career advancement opportunities. Table 4.10 summarises the responses from the sampled employees.

The majority of employees reported not receiving training focused on soft skills development, while a notable portion had not participated in formal courses or training to achieve higher qualifications. Similarly, a substantial percentage of employees had not engaged in leadership/management development programmes or training programmes related to gender equality. Furthermore, a significant majority had not been promoted following a change in knowledge, skills, and expertise, indicating potential barriers to career progression.

Additionally, many employees had not been provided with opportunities for mentoring/coaching programmes. However, the majority had been involved in tasks requiring multiple skills. Additionally, a notable portion had not been temporarily assigned or transferred to another position or project and had not participated in formal job assignments to develop professional knowledge and skills. Moreover, more than half of the employees had been involved in learning assignments but had not been involved in multi-disciplinary teams to accomplish specific goals or objectives.

Table 4.10: Summary of Responses on career advancement opportunities

STATEMENT	N	NO	YES
Training focused on soft skills development (e.g. self-esteem, resilience, communication).	2987	55.2%	44.8%
A formal internal/external course/training to achieve a higher qualification, i.e., continuous development points, masters, undergraduate etc.	2982	61%	39%
A leadership/management development programme to develop knowledge, skills, and values on how to properly manage people/employees.	2983	59.6%	40.4%
A training programme meant to equip employees with skills, knowledge, and values to contribute to the development and implementation of gender equality at all levels.	2991	64.2%	35.8%
I have been promoted following a change in knowledge, skills, and expertise.	2932	70%	30%
I have been provided with opportunities for mentoring/coaching programmes to advance my career.	2984	60%	40%
I have been tasked with different assignments that required multiple skills.	2999	43.7%	56.3%
I have been temporarily assigned or transferred to another position or project.	2990	62.5%	37.5%
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	2992	59.6%	40.4%
I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	2994	48.5%	51.5%
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	2956	57.8%	42.2%

Further analysis explored the differences in the perceptions of career advancement opportunities between sector and type of organisation, as presented in Table 4.11 on the next page. Additionally, the differences in the perceptions of career advancement opportunities between gender and level of management were established, and the findings are presented in Table 4.12, just after Table 4.11.

There were no significant differences between sectors for all career advancement opportunities. However, career advancement opportunities had significant differences between types of organisations except for being promoted following a change in knowledge, skills, and expertise.

Further, significant gender differences in career advancement opportunities were discovered for internal/external training to achieve a higher qualification and having a leadership development programme to develop knowledge, skills, and values. Moreover, significant gender differences were revealed for a training programme meant to equip employees with skills, promote change in knowledge, and tasks with different assignments that require multiple skills and involve a multi-disciplinary team.

Finally, significant levels of management differences for career advancement opportunities were discovered across all the characteristics.

Table 4.11: Comparison of career advancement opportunities between sector and type of organisation

CAREER ADVANCEMENT OPPORTUNITIES	SECTOR	N	NO	YES	CHI-SQUARE	P	PHI
Training focused on soft skills development (e.g. self-esteem, resilience, communication).	Public Sector	1076	56.10%	43.90%	(2, n=2987) =1.270	0.53	0.021
	Private Sector	1207	53.90%	46.10%			
	NGO sector	704	55.80%	44.20%			
A formal internal/external course/training to achieve a higher qualification, i.e., continuous development points, masters, undergraduate etc.	Public Sector	1075	60.80%	39.20%	(2, n=2982) =1.457	0.48	0.022
	Private Sector	1208	60.00%	40.00%			
	NGO sector	699	62.80%	37.20%			
A leadership/management development programme to develop knowledge, skills, and values on how to properly manage people/ employees.	Public Sector	1076	59.80%	40.20%	(2, n=2983) =0.677	0.71	0.015
	Private Sector	1208	58.80%	41.20%			
	NGO sector	699	60.70%	39.30%			
A training programme meant to equip employees with skills, knowledge, and values to contribute to the development and implementation of gender equality at all levels of the organisation.	Public Sector	1081	64.50%	35.50%	(2, n=2991) =0.710	0.70	0.015
	Private Sector	1209	64.80%	35.20%			
	NGO sector	701	62.90%	37.10%			
I have been promoted following a change in knowledge, skills, and expertise.	Public Sector	1064	69.90%	30.10%	(2, n=2932) =0.026	0.99	0.003
	Private Sector	1184	70.20%	29.80%			
	NGO sector	684	69.90%	30.10%			
I have been provided with opportunities for mentoring/coaching programmes to advance my career.	Public Sector	1076	60.10%	39.90%	(2, n=2984) =0.313	0.86	0.01
	Private Sector	1207	59.50%	40.50%			
	NGO sector	701	60.80%	39.20%			
I have been tasked with different assignments that required multiple skills.	Public Sector	1081	43.40%	56.60%	(2, n=2999) =1.733	0.42	0.024
	Private Sector	1214	45.10%	54.90%			
	NGO sector	704	42.00%	58.00%			
I have been temporarily assigned or transferred to another position or project.	Public Sector	1076	64.40%	35.60%	(2, n=2990) =2.729	0.26	0.03
	Private Sector	1211	61.80%	38.20%			
	NGO sector	703	60.90%	39.10%			
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	Public Sector	1080	59.70%	40.30%	(2, n=2992) =0.577	0.75	0.014
	Private Sector	1211	58.90%	41.10%			
	NGO sector	701	60.60%	39.40%			
I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	Public Sector	1074	48.10%	51.90%	(2, n=2994) =0.151	0.93	0.007
	Private Sector	1215	48.50%	51.50%			
	NGO sector	705	49.10%	50.90%			
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	Public Sector	1065	58.50%	41.50%	(2, n=2956) =1.464	0.48	0.022
	Private Sector	1199	56.50%	43.50%			
	NGO sector	692	59.10%	40.90%			

CAREER ADVANCEMENT OPPORTUNITIES	TYPE OF ORGANISATION	N	NO	YES	CHI-SQUARE	P	PHI
Training focused on soft skills development (e.g. self-esteem, resilience, communication).	Community-based Organisation	54	35.20%	64.80%	(10, n=2987) =61.793***	0.00	0.144
	Faith-based Organisation	266	51.90%	48.10%			
	Health Finance/ Insurer	22	81.80%	18.20%			
	Health Service Provider	2209	54.90%	45.10%			
	International NGO	51	88.20%	11.80%			
	Local NGO	142	50.00%	50.00%			
	Manufacturer	20	60.00%	40.00%			
	Professional & Trade Association	12	100.00%	0.00%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	135	60.00%	40.00%			
	Supply Chain/ Distributor	67	44.80%	55.20%			
A formal internal/external course/training to achieve a higher qualification, i.e., continuous development points, masters, undergraduate etc.	Community-based Organisation	54	50.00%	50.00%	(10, n=2982) =15.667*	0.11	0.072
	Faith-based Organisation	260	63.80%	36.20%			
	Health Finance/ Insurer	21	90.50%	9.50%			
	Health Service Provider	2211	60.90%	39.10%			
	International NGO	51	68.60%	31.40%			
	Local NGO	142	59.90%	40.10%			
	Manufacturer	20	70.00%	30.00%			
	Professional & Trade Association	12	58.30%	41.70%			
	Regulatory & Policy	9	66.70%	33.30%			
	Research & Training Institute	135	56.30%	43.70%			
	Supply Chain/ Distributor	67	55.20%	44.80%			

CAREER ADVANCEMENT OPPORTUNITIES	TYPE OF ORGANISATION	N	NO	YES	CHI-SQUARE	P	PHI
A leadership/management development programme to develop knowledge, skills, and values on how to properly manage people/ employees.	Community-based Organisation	54	55.60%	44.40%	(10, n=2983) =17.623*	0.06	0.077
	Faith-based Organisation	262	58.40%	41.60%			
	Health Finance/ Insurer	21	76.20%	23.80%			
	Health Service Provider	2212	59.70%	40.30%			
	International NGO	51	78.40%	21.60%			
	Local NGO	140	53.60%	46.40%			
	Manufacturer	20	70.00%	30.00%			
	Professional & Trade Association	12	33.30%	66.70%			
	Regulatory & Policy	9	66.70%	33.30%			
	Research & Training Institute	135	60.00%	40.00%			
	Supply Chain/ Distributor	67	55.20%	44.80%			
A training programme meant to equip employees with skills, knowledge, and values to contribute to the development and implementation of gender equality at all levels of the organisation.	Community-based Organisation	54	42.60%	57.40%	(10, n=2991) =18.740**	0.04	0.079
	Faith-based Organisation	261	60.90%	39.10%			
	Health Finance/ Insurer	22	72.70%	27.30%			
	Health Service Provider	2218	65.20%	34.80%			
	International NGO	51	64.70%	35.30%			
	Local NGO	142	62.00%	38.00%			
	Manufacturer	20	50.00%	50.00%			
	Professional & Trade Association	12	66.70%	33.30%			
	Regulatory & Policy	9	44.40%	55.60%			
	Research & Training Institute	135	68.10%	31.90%			
	Supply Chain/ Distributor	67	61.20%	38.80%			

CAREER ADVANCEMENT OPPORTUNITIES	TYPE OF ORGANISATION	N	NO	YES	CHI-SQUARE	P	PHI
I have been promoted following a change in knowledge, skills, and expertise.	Community-based Organisation	54	61.10%	38.90%	(10, n=2932) =12.521	0.25	0.065
	Faith-based Organisation	244	66.00%	34.00%			
	Health Finance/ Insurer	22	81.80%	18.20%			
	Health Service Provider	2191	70.40%	29.60%			
	International NGO	46	76.10%	23.90%			
	Local NGO	139	71.90%	28.10%			
	Manufacturer	20	55.00%	45.00%			
	Professional & Trade Association	12	66.70%	33.30%			
	Regulatory & Policy	5	100.00%	0.00%			
	Research & Training Institute	132	72.70%	27.30%			
	Supply Chain/ Distributor	67	64.20%	35.80%			
I have been provided with opportunities for mentoring/coaching programmes to advance my career.	Community-based Organisation	54	35.20%	64.80%	(10, n=2984) =20.748**	0.02	0.083
	Faith-based Organisation	263	60.80%	39.20%			
	Health Finance/ Insurer	22	68.20%	31.80%			
	Health Service Provider	2212	60.20%	39.80%			
	International NGO	49	69.40%	30.60%			
	Local NGO	143	62.90%	37.10%			
	Manufacturer	20	70.00%	30.00%			
	Professional & Trade Association	12	58.30%	41.70%			
	Regulatory & Policy	9	77.80%	22.20%			
	Research & Training Institute	134	54.50%	45.50%			
	Supply Chain/ Distributor	66	62.10%	37.90%			

CAREER ADVANCEMENT OPPORTUNITIES	TYPE OF ORGANISATION	N	NO	YES	CHI-SQUARE	P	PHI
I have been tasked with different assignments that required multiple skills.	Community-based Organisation	54	27.80%	72.20%	(10, n=2999) =34.036***	0.00	0.107
	Faith-based Organisation	265	43.40%	56.60%			
	Health Finance/ Insurer	22	40.90%	59.10%			
	Health Service Provider	2224	45.00%	55.00%			
	International NGO	49	61.20%	38.80%			
	Local NGO	143	31.50%	68.50%			
	Manufacturer	20	45.00%	55.00%			
	Professional & Trade Association	12	25.00%	75.00%			
	Regulatory & Policy	9	88.90%	11.10%			
	Research & Training Institute	135	40.00%	60.00%			
	Supply Chain/ Distributor	66	34.80%	65.20%			
I have been temporarily assigned or transferred to another position or project.	Community-based Organisation	54	64.80%	35.20%	(10, n=2990) =21.423**	0.02	0.085
	Faith-based Organisation	266	56.00%	44.00%			
	Health Finance/ Insurer	22	54.50%	45.50%			
	Health Service Provider	2215	63.60%	36.40%			
	International NGO	49	73.50%	26.50%			
	Local NGO	142	55.60%	44.40%			
	Manufacturer	20	65.00%	35.00%			
	Professional & Trade Association	12	66.70%	33.30%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	136	64.00%	36.00%			
	Supply Chain/ Distributor	65	50.80%	49.20%			
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	Community-based Organisation	54	35.20%	64.80%	(10, n=2992) =32.081***	0.00	0.104
	Faith-based Organisation	261	60.90%	39.10%			
	Health Finance/ Insurer	22	54.50%	45.50%			
	Health Service Provider	2220	59.80%	40.20%			
	International NGO	50	84.00%	16.00%			

	Local NGO	143	60.80%	39.20%			
	Manufacturer	20	55.00%	45.00%			
	Professional & Trade Association	12	50.00%	50.00%			
	Regulatory & Policy	9	77.80%	22.20%			
	Research & Training Institute	134	60.40%	39.60%			
	Supply Chain/ Distributor	67	47.80%	52.20%			
I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	Community-based Organisation	54	37.00%	63.00%	(10, n=2994) =51.048***	0.00	0.131
	Faith-based Organisation	265	48.70%	51.30%			
	Health Finance/ Insurer	22	45.50%	54.50%			
	Health Service Provider	2218	48.20%	51.80%			
	International NGO	51	86.30%	13.70%			
	Local NGO	142	50.70%	49.30%			
	Manufacturer	19	42.10%	57.90%			
	Professional & Trade Association	12	66.70%	33.30%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	135	45.20%	54.80%			
	Supply Chain/ Distributor	67	32.80%	67.20%			
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	Community-based Organisation	50	48.00%	52.00%	(10, n=2956) =16.884*	0.08	0.076
	Faith-based Organisation	256	62.90%	37.10%			
	Health Finance/ Insurer	19	57.90%	42.10%			
	Health Service Provider	2199	57.60%	42.40%			
	International NGO	51	66.70%	33.30%			
	Local NGO	140	55.70%	44.30%			
	Manufacturer	19	68.40%	31.60%			
	Professional & Trade Association	12	41.70%	58.30%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	136	55.90%	44.10%			
	Supply Chain/ Distributor	65	50.80%	49.20%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

Table 4.12: Comparison of career advancement opportunities between gender and level of management

CAREER ADVANCEMENT OPPORTUNITIES	GENDER	N	NO	YES	CHI-SQUARE	P	PHI
Training focused on soft skills development (e.g. self-esteem, resilience, communication).	Male	1293	55.10%	44.90%	(1, n=2987) =0.001	0.98	-0.001
	Female	1694	55.20%	44.80%			
A formal internal/external course/training to achieve a higher qualification, i.e., continuous development points, masters, undergraduate etc.	Male	1292	57.80%	42.20%	(1, n=2982) =9.496***	0.00	-0.056
	Female	1690	63.40%	36.60%			
A leadership/management development programme to develop knowledge, skills, and values on how to properly manage people/ employees.	Male	1292	57.40%	42.60%	(1, n=2983) =4.655**	0.03	-0.04
	Female	1691	61.30%	38.70%			
A training programme meant to equip employees with skills, knowledge, and values to contribute to the development and implementation of gender equality at all levels of the organisation.	Male	1294	62.50%	37.50%	(1, n=2991) =2.891*	0.09	-0.031
	Female	1697	65.50%	34.50%			
I have been promoted following a change in knowledge, skills, and expertise.	Male	1270	68.10%	31.90%	(1, n=2932) =3.895**	0.05	-0.036
	Female	1662	71.50%	28.50%			
I have been provided with opportunities for mentoring/coaching programmes to advance my career.	Male	1293	58.90%	41.10%	(1, n=2984) =1.290	0.26	-0.021
	Female	1691	60.90%	39.10%			
I have been tasked with different assignments that required multiple skills.	Male	1298	42.20%	57.80%	(1, n=2999) =2.174*	0.14	-0.027
	Female	1701	44.90%	55.10%			
I have been temporarily assigned or transferred to another position or project.	Male	1296	61.90%	38.10%	(1, n=2990) =0.382	0.54	-0.011
	Female	1694	63.00%	37.00%			
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	Male	1295	58.30%	41.70%	(1, n=2992) =1.581	0.21	-0.023
	Female	1697	60.60%	39.40%			
I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	Male	1295	47.60%	52.40%	(1, n=2994) =0.789	0.38	-0.016
	Female	1699	49.20%	50.80%			
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	Male	1285	55.20%	44.80%	(1, n=2956) =6.662***	0.01	-0.047
	Female	1671	59.90%	40.10%			

CAREER ADVANCEMENT OPPORTUNITIES	LEVELS OF MANAGEMENT	N	NO	YES	CHI-SQUARE	P	PHI
Training focused on soft skills development (e.g. self-esteem, resilience, communication).	Board of Directors/ Trustees	65	44.60%	55.40%	(5, n=2987) =57.207***	0.00	0.138
	CEO/MD, Medical Superintendent	180	46.10%	53.90%			
	Executive Management, i.e., CFO/CMO/COO	238	45.40%	54.60%			
	Heads of Departments/ Administrators/ Team Leaders	752	49.30%	50.70%			
	Human Resource Professional (HRMS), People & Culture	343	52.80%	47.20%			
	Supervisor/ Frontline Manager/ Care Managers	1409	62.20%	37.80%			
A formal internal/external course/training to achieve a higher qualification, i.e., continuous development points, masters, undergraduate etc.	Board of Directors/ Trustees	65	50.80%	49.20%	(5, n=2982) =178.764***	0.00	0.245
	CEO/MD, Medical Superintendent	182	37.90%	62.10%			
	Executive Management i.e., CFO/CMO/COO	240	45.40%	54.60%			
	Heads of Departments/ Administrators/ Team Leaders	751	51.80%	48.20%			
	Human Resource Professional (HRMS), People & Culture	348	57.80%	42.20%			
	Supervisor/ Frontline Manager/ Care Managers	1396	72.90%	27.10%			
A leadership/management development programme to develop knowledge, skills, and values on how to properly manage people/ employees.	Board of Directors/ Trustees	65	32.30%	67.70%	(5, n=2983) =281.228***	0.00	0.307
	CEO/MD, Medical Superintendent	180	31.70%	68.30%			
	Executive Management, i.e., CFO/CMO/COO	240	41.70%	58.30%			
	Heads of Departments/ Administrators/ Team Leaders	753	49.10%	50.90%			
	Human Resource Professional (HRMS), People & Culture	346	53.50%	46.50%			
	Supervisor/ Frontline Manager/ Care Managers	1399	74.60%	25.40%			

A training programme meant to equip employees with skills, knowledge, and values to contribute to the development and implementation of gender equality at all levels of the organisation.	Board of Directors/ Trustees	65	35.40%	64.60%	(5, n=2991) =160.442***	0.00	0.232
	CEO/MD, Medical Superintendent	181	45.90%	54.10%			
	Executive Management, i.e., CFO/CMO/COO	240	50.40%	49.60%			
	Heads of Departments/ Administrators/ Team Leaders	750	58.50%	41.50%			
	Human Resource Professional (HRMS), People & Culture	347	57.10%	42.90%			
	Supervisor/ Frontline Manager/ Care Managers	1408	75.10%	24.90%			
I have been promoted following a change in knowledge, skills, and expertise.	Board of Directors/ Trustees	60	40.00%	60.00%	(5, n=2932) =269.892***	0.00	0.303
	CEO/MD, Medical Superintendent	168	44.00%	56.00%			
	Executive Management, i.e., CFO/CMO/COO	233	54.50%	45.50%			
	Heads of Departments/ Administrators/ Team Leaders	746	60.20%	39.80%			
	Human Resource Professional (HRMS), People & Culture	341	64.50%	35.50%			
	Supervisor/ Frontline Manager/ Care Managers	1384	83.70%	16.30%			
I have been provided with opportunities for mentoring/coaching programmes to advance my career.	Board of Directors/ Trustees	64	25.00%	75.00%	(5, n=2984) =246.505***	0.00	0.287
	CEO/MD, Medical Superintendent	181	33.70%	66.30%			
	Executive Management, i.e., CFO/CMO/COO	239	45.60%	54.40%			
	Heads of Departments/ Administrators/ Team Leaders	751	50.90%	49.10%			
	Human Resource Professional (HRMS), People & Culture	347	54.50%	45.50%			
	Supervisor/ Frontline Manager/ Care Managers	1402	73.80%	26.20%			

I have been tasked with different assignments that required multiple skills.	Board of Directors/ Trustees	62	29.00%	71.00%	(5, n=2999) =146.742***	0.00	0.221
	CEO/MD, Medical Superintendent	181	25.40%	74.60%			
	Executive Management i.e., CFO/CMO/COO	240	31.70%	68.30%			
	Heads of Departments/ Administrators/ Team Leaders	751	34.60%	65.40%			
	Human Resource Professional (HRMS), People & Culture	348	38.20%	61.80%			
	Supervisor/ Frontline Manager/ Care Managers	1417	55.00%	45.00%			
I have been temporarily assigned or transferred to another position or project.	Board of Directors/ Trustees	63	49.20%	50.80%	(5, n=2990) =87.214***	0.00	0.171
	CEO/MD, Medical Superintendent	182	54.40%	45.60%			
	Executive Management, i.e., CFO/CMO/COO	238	56.30%	43.70%			
	Heads of Departments/ Administrators/ Team Leaders	748	56.60%	43.40%			
	Human Resource Professional (HRMS), People & Culture	346	51.40%	48.60%			
	Supervisor/ Frontline Manager/ Care Managers	1413	71.10%	28.90%			
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	Board of Directors/ Trustees	63	34.90%	65.10%	(5, n=2992) =184.552***	0.00	0.248
	CEO/MD, Medical Superintendent	182	34.10%	65.90%			
	Executive Management, i.e., CFO/CMO/COO	238	49.60%	50.40%			
	Heads of Departments/ Administrators/ Team Leaders	751	50.90%	49.10%			
	Human Resource Professional (HRMS), People & Culture	346	54.90%	45.10%			
	Supervisor/ Frontline Manager/ Care Managers	1412	71.50%	28.50%			

I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	Board of Directors/ Trustees	64	45.30%	54.70%	(5, n=2994) =30.678***	0.00	0.101
	CEO/MD, Medical Superintendent	180	40.60%	59.40%			
	Executive Management, i.e., CFO/CMO/COO	240	42.90%	57.10%			
	Heads of Departments/ Administrators/ Team Leaders	752	43.50%	56.50%			
	Human Resource Professional (HRMS), People & Culture	343	46.90%	53.10%			
	Supervisor/ Frontline Manager/ Care Managers	1415	53.60%	46.40%			
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	Board of Directors/ Trustees	65	35.40%	64.60%	(5, n=2956) =226.784***	0.00	0.277
	CEO/MD, Medical Superintendent	183	32.20%	67.80%			
	Executive Management, i.e., CFO/CMO/COO	239	42.70%	57.30%			
	Heads of Departments/ Administrators/ Team Leaders	745	48.30%	51.70%			
	Human Resource Professional (HRMS), People & Culture	344	51.50%	48.50%			
	Supervisor/ Frontline Manager/ Care Managers	1380	71.70%	28.30%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

I have been tasked with different assignments that required multiple skills.	Board of Directors/ Trustees	62	29.00%	71.00%	(5, n=2999) =146.742***	0.00	0.221
	CEO/MD, Medical Superintendent	181	25.40%	74.60%			
	Executive Management i.e., CFO/CMO/COO	240	31.70%	68.30%			
	Heads of Departments/ Administrators/ Team Leaders	751	34.60%	65.40%			
	Human Resource Professional (HRMS), People & Culture	348	38.20%	61.80%			
	Supervisor/ Frontline Manager/ Care Managers	1417	55.00%	45.00%			
I have been temporarily assigned or transferred to another position or project.	Board of Directors/ Trustees	63	49.20%	50.80%	(5, n=2990) =87.214***	0.00	0.171
	CEO/MD, Medical Superintendent	182	54.40%	45.60%			
	Executive Management, i.e., CFO/CMO/COO	238	56.30%	43.70%			
	Heads of Departments/ Administrators/ Team Leaders	748	56.60%	43.40%			
	Human Resource Professional (HRMS), People & Culture	346	51.40%	48.60%			
	Supervisor/ Frontline Manager/ Care Managers	1413	71.10%	28.90%			
I recently participated in a formal job assignment that sought to develop my professional knowledge and skills.	Board of Directors/ Trustees	63	34.90%	65.10%	(5, n=2992) =184.552***	0.00	0.248
	CEO/MD, Medical Superintendent	182	34.10%	65.90%			
	Executive Management, i.e., CFO/CMO/COO	238	49.60%	50.40%			
	Heads of Departments/ Administrators/ Team Leaders	751	50.90%	49.10%			
	Human Resource Professional (HRMS), People & Culture	346	54.90%	45.10%			
	Supervisor/ Frontline Manager/ Care Managers	1412	71.50%	28.50%			

I have been involved in a learning assignment to learn how to execute a particular task by observing a more experienced team member.	Board of Directors/ Trustees	64	45.30%	54.70%	(5, n=2994) =30.678***	0.00	0.101
	CEO/MD, Medical Superintendent	180	40.60%	59.40%			
	Executive Management, i.e., CFO/CMO/COO	240	42.90%	57.10%			
	Heads of Departments/ Administrators/ Team Leaders	752	43.50%	56.50%			
	Human Resource Professional (HRMS), People & Culture	343	46.90%	53.10%			
	Supervisor/ Frontline Manager/ Care Managers	1415	53.60%	46.40%			
I have been involved in a multi-disciplinary team to accomplish a specific goal or objective.	Board of Directors/ Trustees	65	35.40%	64.60%	(5, n=2956) =226.784***	0.00	0.277
	CEO/MD, Medical Superintendent	183	32.20%	67.80%			
	Executive Management, i.e., CFO/CMO/COO	239	42.70%	57.30%			
	Heads of Departments/ Administrators/ Team Leaders	745	48.30%	51.70%			
	Human Resource Professional (HRMS), People & Culture	344	51.50%	48.50%			
	Supervisor/ Frontline Manager/ Care Managers	1380	71.70%	28.30%			

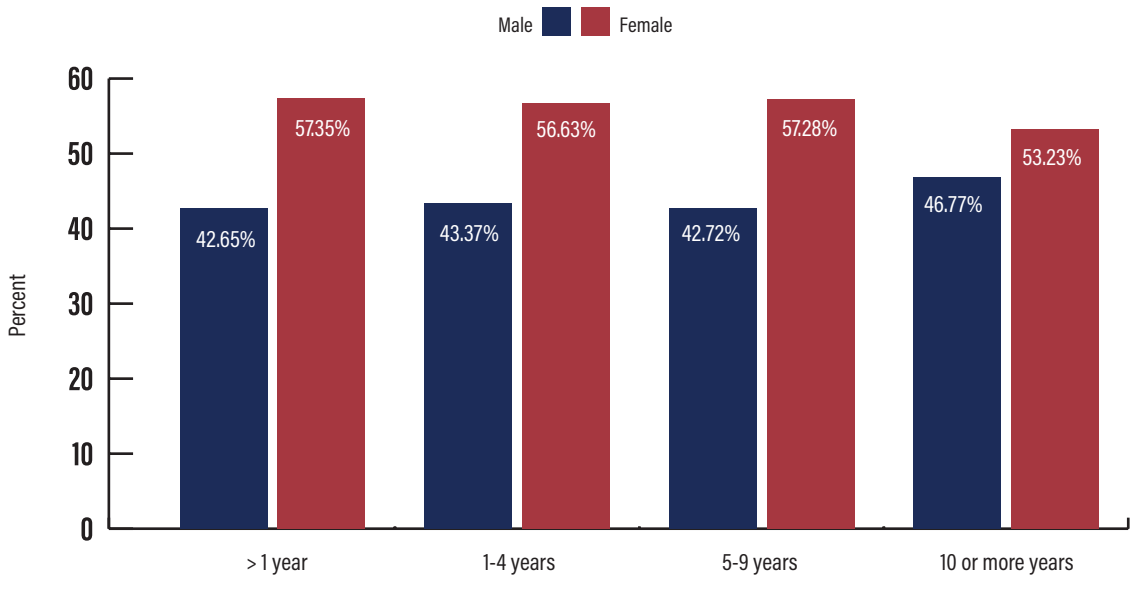
*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

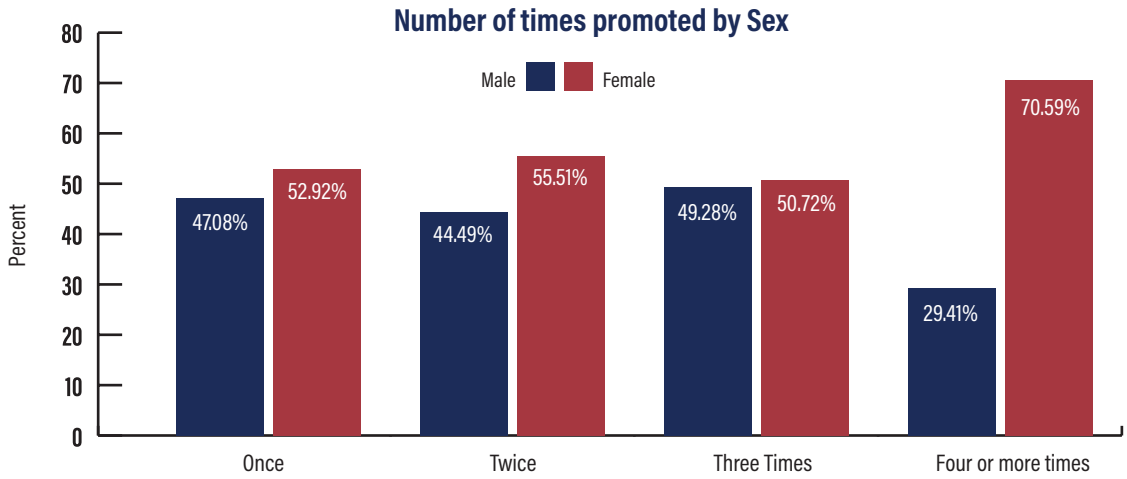
Table 4.13: Comparison of career advancement between gender

CAREER ADVANCEMENT	CHARACTERISTIC	N	MALE	FEMALE	CHI-SQUARE	P	PHI
Duration served in the current position	<1 year	544	42.60%	57.40%	(3, n=3015) = 1.097	0.78	0.019
	1-4 years	1667	43.40%	56.60%			
	5-9 years	618	42.70%	57.30%			
	10 or more years	186	46.80%	53.20%			
Recently promoted to a higher position in the current organisation	No	2222	42.40%	57.60%	(1, n=3015) = 2.649*	0.10	-0.03
	Yes	793	45.80%	54.20%			
Number of times promoted	Once	463	47.10%	52.90%	(3, n=3015) = 4.478	0.21	0.075
	Twice	227	44.50%	55.50%			
	Three Times	69	49.30%	50.70%			
	Four or more times	34	29.40%	70.60%			
Duration in the immediate last position before promotion	<1 year	103	44.70%	55.30%	(3, n=3015) = 4.631	0.20	0.076
	1-4 years	525	46.30%	53.70%			
	5-9 years	142	41.50%	58.50%			
	10 or more years	23	65.20%	34.80%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

A chi-square test of independence was conducted to establish if there were significant gender differences in career advancement. The results revealed significant gender differences in promotion to a higher position in their current organisations. More women reported having been recently promoted to a higher position than their male counterparts. None of the other gender differences were significant, as shown in Table 4.13 above.





Section 6:
Gender in the Workplace

The participants were asked to indicate 'Yes' or 'No' to questions related to gender in the workplace. Table 4.14 summarises the responses from the sampled employees.

The vast majority of employees reported experiencing disparities, with a significant percentage indicating they have missed out on salary raises, promotions, key assignments, and chances to advance in their careers due to gender-related factors. Additionally, a substantial portion felt they were paid less because of their inability to negotiate. Moreover, the majority of employees felt that their organisations should not do less to increase gender equity, while more than half of the sampled employees felt they should put in more effort towards this goal. Consequently, a notable number felt that their organisations should not use the current amount of effort to address gender equity issues.

Table 4.14: Summary of Responses on gender in the workplace

STATEMENT	N	NO	YES
Missing out on a salary raise	2987	93.6%	6.4%
Missing out on a promotion	2982	87.5%	12.5%
Missing out on a key assignment	2994	87.9%	12.1%
Missing out on a chance to advance in your career	2988	87.9%	12.1%
Being paid less due to their inability to negotiate	2971	88%	12%
Doing less to increase gender equity	2943	93.3%	6.7%
Doing more to increase gender equity	2979	28.9%	71.1%
Using the current amount of effort	2872	61.9%	38.1%

Further analysis explored the differences in gender, sector, and type of organisation's perceptions of gender in the workplace. The results are presented in Table 4.15 on the next page.

There were significant gender differences in gender perceptions in the workplace, except for the current amount of effort by organisations to address gender issues.

Regarding the sector, significant gender differences were discovered for missing out on a salary raise, missing out on a chance to advance their career, being paid less due to inability to negotiate, and doing less to increase gender equity.

Paying attention to the type of organisation, significant differences were discovered between those who missed out on a salary raise, a key assignment, a chance to advance their career, doing less to increase gender equity, doing more to increase gender equity, and using the current amount of effort to increase gender equity.

Table 4.15: Comparison of gender in the workplace between gender, sector, and type of organisation

GENDER IN THE WORKPLACE	GENDER	N	NO	YES	CHI-SQUARE	P	PHI
Missing out on a salary raise	Male	1299	96.80%	3.20%	(1, n=2987) =40.905***	0.00	0.117
	Female	1688	91.10%	8.90%			
Missing out on a promotion	Male	1295	92.00%	8.00%	(1, n=2982) =42.855***	0.00	0.120
	Female	1687	84.10%	15.90%			
Missing out on a key assignment	Male	1298	93.10%	6.90%	(1, n=2994) =58.449***	0.00	0.140
	Female	1696	84.00%	16.00%			
Missing out on a chance to advance in your career	Male	1297	93.00%	7.00%	(1, n=2988) =55.362***	0.00	0.136
	Female	1691	84.00%	16.00%			
Being paid less due to their inability to negotiate (negotiation skills and bargaining)	Male	1296	91.60%	8.40%	(1, n=2971) =28.268***	0.00	0.098
	Female	1675	85.20%	14.80%			
Doing less to increase gender equity	Male	1278	94.10%	5.90%	(1, n=2943) =2.658*	0.10	0.030
	Female	1665	92.60%	7.40%			
Doing more to increase gender equity	Male	1287	31.50%	68.50%	(1, n=2979) =7.068***	0.01	0.049
	Female	1692	27.00%	73.00%			
Using the current amount of effort	Male	1243	60.50%	39.50%	(1, n=2872) =1.755	0.185	-.025
	Female	1629	62.90%	37.10%			

GENDER IN THE WORKPLACE	SECTOR	N	NO	YES	CHI-SQUARE	P	PHI
Missing out on a salary raise	Public Sector	1073	95.40%	4.60%	(2, n=2987) =9.869***	0.01	0.057
	Private Sector	1212	92.30%	7.70%			
	NGO sector	702	92.90%	7.10%			
Missing out on a promotion	Public Sector	1073	88.60%	11.40%	(2, n=2982) =4.115	0.13	0.037
	Private Sector	1211	86.00%	14.00%			
	NGO sector	698	88.40%	11.60%			
Missing out on a key assignment	Public Sector	1075	89.30%	10.70%	(2, n=2994) =3.284	0.19	0.033
	Private Sector	1216	86.80%	13.20%			
	NGO sector	703	87.80%	12.20%			
Missing out on a chance to advance in your career	Public Sector	1073	88.40%	11.60%	(2, n=2988) =5.935**	0.05	0.045
	Private Sector	1211	86.30%	13.70%			
	NGO sector	704	89.90%	10.10%			

Being paid less due to their inability to negotiate (negotiation skills and bargaining)	Public Sector	1062	89.50%	10.50%	(2, n=2971) =5.393*	0.07	0.043
	Private Sector	1214	86.40%	13.60%			
	NGO sector	695	88.30%	11.70%			
Doing less to increase gender equity	Public Sector	1063	93.00%	7.00%	(2, n=2943) =6.384**	0.04	0.047
	Private Sector	1197	92.30%	7.70%			
	NGO sector	683	95.30%	4.70%			
Doing more to increase gender equity	Public Sector	1074	29.50%	70.50%	(2, n=2979) =2.430	0.30	0.029
	Private Sector	1213	29.80%	70.20%			
	NGO sector	692	26.60%	73.40%			
Using the current amount of effort	Public Sector	1046	63.40%	36.60%	(2, n=2979) =3.144	0.21	0.033
	Private Sector	1171	59.90%	40.10%			
	NGO sector	655	62.90%	37.10%			

GENDER IN THE WORKPLACE	TYPE OF ORGANISATION	N	NO	YES	CHI-SQUARE	P	PHI
Missing out on a salary raise	Community-based Organisation	53	98.10%	1.90%	(10, n=2987) =37.543***	0.00	0.112
	Faith-based Organisation	266	88.30%	11.70%			
	Health Finance/ Insurer	22	86.40%	13.60%			
	Health Service Provider	2209	94.30%	5.70%			
	International NGO	51	84.30%	15.70%			
	Local NGO	143	96.50%	3.50%			
	Manufacturer	20	80.00%	20.00%			
	Professional & Trade Association	12	100.00%	0.00%			
	Regulatory & Policy	9	88.90%	11.10%			
	Research & Training Institute	135	96.30%	3.70%			
	Supply Chain/ Distributor	67	89.60%	10.40%			
Missing out on a promotion	Community-based Organisation	53	88.70%	11.30%	(10, n=2982) =14.837	0.14	0.071
	Faith-based Organisation	264	86.70%	13.30%			
	Health Finance/ Insurer	22	77.30%	22.70%			
	Health Service Provider	2210	87.30%	12.70%			
	International NGO	51	80.40%	19.60%			

	Local NGO	139	92.80%	7.20%			
	Manufacturer	20	80.00%	20.00%			
	Professional & Trade Association	12	100.00%	0.00%			
	Regulatory & Policy	9	88.90%	11.10%			
	Research & Training Institute	136	92.60%	7.40%			
	Supply Chain/ Distributor	66	84.80%	15.20%			
Missing out on a key assignment	Community-based Organisation	54	90.70%	9.30%	(10, n=2994) =17.893*	0.06	0.077
	Faith-based Organisation	266	83.80%	16.20%			
	Health Finance/ Insurer	22	86.40%	13.60%			
	Health Service Provider	2215	88.10%	11.90%			
	International NGO	51	80.40%	19.60%			
	Local NGO	143	89.50%	10.50%			
	Manufacturer	19	73.70%	26.30%			
	Professional & Trade Association	12	91.70%	8.30%			
	Regulatory & Policy	9	88.90%	11.10%			
	Research & Training Institute	136	94.90%	5.10%			
	Supply Chain/ Distributor	67	89.60%	10.40%			
Missing out on a chance to advance in your career	Community-based Organisation	54	85.20%	14.80%	(10, n=2988) =18.012*	0.06	0.078
	Faith-based Organisation	264	86.40%	13.60%			
	Health Finance/ Insurer	22	72.70%	27.30%			
	Health Service Provider	2211	87.70%	12.30%			
	International NGO	51	82.40%	17.60%			
	Local NGO	143	95.10%	4.90%			
	Manufacturer	20	85.00%	15.00%			
	Professional & Trade Association	12	91.70%	8.30%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	136	91.90%	8.10%			
	Supply Chain/ Distributor	66	86.40%	13.60%			

Being paid less due to their inability to negotiate (negotiation skills and bargaining)	Community-based Organisation	52	88.50%	11.50%	(10, n=2971) =6.099	0.81	0.045
	Faith-based Organisation	260	89.60%	10.40%			
	Health Finance/ Insurer	22	86.40%	13.60%			
	Health Service Provider	2203	87.80%	12.20%			
	International NGO	51	86.30%	13.70%			
	Local NGO	142	85.20%	14.80%			
	Manufacturer	19	94.70%	5.30%			
	Professional & Trade Association	12	100.00%	0.00%			
	Regulatory & Policy	9	100.00%	0.00%			
	Research & Training Institute	134	89.60%	10.40%			
	Supply Chain/ Distributor	67	86.60%	13.40%			
Doing less to increase gender equity	Community-based Organisation	54	96.30%	3.70%	(10, n=2943) =19.804**	0.03	0.082
	Faith-based Organisation	250	94.80%	5.20%			
	Health Finance/ Insurer	22	95.50%	4.50%			
	Health Service Provider	2193	92.30%	7.70%			
	International NGO	50	100.00%	0.00%			
	Local NGO	142	92.30%	7.70%			
	Manufacturer	19	100.00%	0.00%			
	Professional & Trade Association	12	100.00%	0.00%			
	Regulatory & Policy	6	100.00%	0.00%			
	Research & Training Institute	130	98.50%	1.50%			
	Supply Chain/ Distributor	65	98.50%	1.50%			
Doing more to increase gender equity	Community-based Organisation	54	18.50%	81.50%	(10, n=2979) =24.173***	0.01	0.09
	Faith-based Organisation	259	25.10%	74.90%			
	Health Finance/ Insurer	22	9.10%	90.90%			
	Health Service Provider	2213	30.50%	69.50%			
	International NGO	50	18.00%	82.00%			
	Local NGO	142	31.00%	69.00%			
	Manufacturer	20	45.00%	55.00%			

	Professional & Trade Association	12	33.30%	66.70%			
	Regulatory & Policy	9	22.20%	77.80%			
	Research & Training Institute	131	19.10%	80.90%			
	Supply Chain/ Distributor	67	25.40%	74.60%			
Using the current amount of effort	Community-based Organisation	53	41.50%	58.50%	(10, n=2872) =28.054***	0.00	0.099
	Faith-based Organisation	231	60.60%	39.40%			
	Health Finance/ Insurer	22	72.70%	27.30%			
	Health Service Provider	2160	63.50%	36.50%			
	International NGO	41	65.90%	34.10%			
	Local NGO	138	56.50%	43.50%			
	Manufacturer	20	50.00%	50.00%			
	Professional & Trade Association	12	58.30%	41.70%			
	Regulatory & Policy	5	80.00%	20.00%			
	Research & Training Institute	126	47.60%	52.40%			
	Supply Chain/ Distributor	64	65.60%	34.40%			

*****, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.**

Correlation Analysis

Table 4.16 below presents the Pearson correlation analysis for career advancement as the dependent variable and 9 explanatory variables. Career advancement had a moderate, positive, and significant association with policies (organisational level), policies (individual level) and leadership style (Laissez-faire). Moreover, career advancement had a strong, positive, and significant correlation with organisational culture (Adhocracy) and leadership style (transformational). However, career advancement had a moderate, inverse, and significant correlation with organisational culture (market) and a weak, inverse, and significant association with leadership style (transactional).

Table 4.16: Correlation Analysis

	1	2	3	4	5	6	7	8	9	10
1. Career Advancement	1									
2. Policies (Organization level)	.234***	1								
3. Policies (Individual level)	.330***	.561***	1							
4. Organizational Culture (Clan)	0.007	.132***	.049***	1						
5. Organizational Culture (Adhocracy)	.052***	-0.006	0.025	-.343***	1					
6. Organizational Culture (Market)	-.049***	-.080***	-.071***	-.346***	-.194***	1				
7. Organizational Culture (Hierarchical)	-0.009	-.071***	-0.014	-.506***	-.284***	-.286***	1			
8. Leadership Style (Transformational)	.092***	.079***	.072***	.211***	0.025	-.124***	-.143***	1		
9. Leadership Style (Transactional)	-.146***	-.169***	-.128***	-.209***	-0.022	.169***	.103***	-.501***	1	
10. Leadership Style (Laissez-Faire)	.046***	.082***	.049***	-0.016	-0.004	-0.035**	.049***	-.549***	-.447***	1

Dependent variable is career advancement. ***, ** and * denotes level of significance at 1%, 5% and 10% correspondingly.

Chapter Five
Qualitative Analysis

Introduction

This chapter describes the qualitative phase of the study.
The research setting comprised 26 health sector organisations (HSOs). Table 5.1 below shows the HSO breakdown per category. Service providers constituted most health organisations sampled in accordance with their higher proportion in the overall sample. We consequently conducted key informant interviews with the CEO/Executive Directors and the Human Resource Managers of the sampled organisations and focus group discussions with selected women leaders. Participants in the focus groups were also purposefully selected to ensure representation across diverse organisational contexts, geographic regions, and levels of leadership within the health sector. Selected organisations in the Manufacturer and Regulatory categories declined to participate in the study.

26
Number of Participating organisations

3
Service provider (public)

7
Service provider (private)

5
Service provider (non-profit)

3
International NGOs (National level)

3
Local NGOs and CBOs

2
Health finance/insurance

1
Professional trade organisation

2
Research & Training institutes

-
Manufacturer

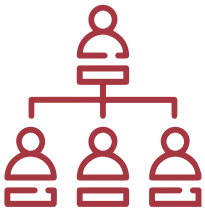
-
Regulatory agencies

We consequently conducted 38 key informants and 3 focus group discussions (FGDs). Eighteen CEOs and sixteen Human Resource Managers consented to be interviewed. Two County officers and two officials of a professional association were also interviewed. We additionally conducted three focus group discussions (FGDs) involving a total of 43 participants. Both Key informant interviews and Focus Group Discussions were conducted using a semi-structured interview guide. This guide enabled the exploration of emergent themes. The average duration of the interviews was 35-45 minutes, while the focus group discussions were 2.5 hours long. All the interviews and FGDs were audio-recorded and transcribed verbatim to accurately capture participant responses. Thematic content analysis techniques were then employed to systematically describe, analyse, and interpret the qualitative data. The aim was to identify patterns, themes, and insights relevant to understanding the role of organisational elements in women's career advancement in the health sector.

This qualitative data analysis strategy involved a series of steps. First, a file naming system was created to manage and organise the data. Then, a preliminary reading of all the transcripts was done to get a sense of the data. Reflective memos were written to capture emergent ideas. A deeper reading of the transcripts was subsequently done to identify conceptual categories guided by the overall organisational elements – structures, policies, leadership, and culture. A table of sub-categories was created to capture the emergent themes. Several iterations of reading and examination of the qualitative data were done to develop interpretations that captured a detailed and representative picture of the data. The themes were then related to the study's research questions and existing literature. Data displays in the form of figures and tables were generated to represent and visualise the data. A descriptive account of the findings was then produced.

Findings

Table 5.2 below represents a summary of the overarching themes and sub-themes that were related to the research objectives.



Organisational Structures

- Gender proportions.
- Performance and Promotion Management.
- Career advancement pathways.
- Support mechanisms.

Organisational Policies and Practices

- Job Design and Flexibility.
- Gender Pay Equity.
- Retention and Promotion Practices.
- Provision of physical facilities.
- Workplace harassment (sexual harassment, bullying, verbal harassment).

Organisational Culture

- Organisational values and norms.
- Gender stereotypes.
- General workforce perceptions.

Organisational Leadership

- Leadership support for gender equity.
- Board commitment to gender equity.
- Gender as a strategic priority. *Includes operationalising legal frameworks.*

Gender in the workplace

- Experiences with gender mainstreaming.
- Critical change levers.
- Strategies and interventions. *What does success look like?*

Organisational Structures

Organisational structures ranged from large bureaucratic hierarchies to flat and lean structures for smaller organisations (< 30 staff). Moving up the organisational structure was typically performance-driven, and this was reiterated in the interviews. Thus, it was expected that outstanding performance would result in promotion and progression up the ladder. The key informant interviews brought out the issue of gender-neutral performance. In most organisations, gender was a secondary concern to the ability to perform well on the job. Smaller organisations, in particular, faced the stark reality of balancing between business survival and gender considerations. It appeared that these organisations were less bothered by gender considerations, preferring to focus on who could get the job done.

"Support we give them depends on their performance at work and their education. So, not really based on the gender." KI01.

"We don't look at it in terms of this is a female working here, and this is a male working here, we look at it in terms of how your work is and how do you relate with the clients." KI02

Small women-led organisations also tended to have more female staff. Some large organisations used gender disaggregated data to inform decision-making about recruitment generally. It was not immediately clear if the same gender-disaggregated data informs decision-making about promotion. Perhaps, a deeper gender analysis is required to identify if there is any bias in who is rising within the organisations. Even so, there was an overriding sense (even among women) that performance should be on merit and not gender considerations. At least two participants noted that moving up the organisational ladder was more competitive and that some women easily gave up.

In summary, the findings indicate that the higher up the organisational hierarchy, the fewer women. There did not seem to be systematic gender discrimination or bias at the recruitment level, and as mentioned above, multiple factors influence promotion processes.

Gender Proportions

Most organisations did not provide their personnel data due to data privacy concerns.

"We don't look at it in terms of this is a female working here, and this is a male working here, we look at it in terms of how your work is and how do you relate with the clients." KI02

Nevertheless, the HR Managers were able to provide aggregate gender-disaggregated figures. Nine HSOs disaggregated their Human Resource data, while six HSOs indicated they did not. Tracking gender parity was thus done by the more gender-conscious HSOs, and it did seem to inform decision-making. Public sector organisations were said to be required to report on gender data, maternity, sexual harassment GBV, and provision of lactation rooms with a fridge and creche. Gender mainstreaming is also part of their performance contracting.

> **"How you mentor other younger people, especially younger women that's what is really going to help." FGD01**

In terms of personnel numbers, women constituted a higher proportion of nurses and support personnel compared to their male counterparts. Fifteen out of the twenty-six sampled organisations were health service providers, and the majority of their staff were female nurses. This result confirms the global health picture of a majority of women in the health sector workforce, who are mainly nurses.

The findings also indicate a relatively easier advancement of women from lower to middle-level management and a slower conversion from middle to senior-level management in Kenyan organisations. Again, this appears to confirm the global health picture, where the bulk of women are found in the lower ranks of organisational hierarchies. Moving up from the middle to senior level requires women to be equipped with leadership skills in addition to technical competence.

The findings also revealed a strong picture of occupational segregation. For example, nurses are typically women while doctors are predominantly men; laundry or medical stores have male employees because of the physical demands of the jobs; maintenance personnel are men while cleaners are women; and receptionists are women. This is also a societal expectation.

"If you look at the casuals we have, most of them are females. Men don't apply for that job because they feel like it is a ladies' job. When you come to the medical side in terms of the doctors' part, you will realise men are more in this field than ladies. So, you find that in an institution, you will always find who is where. If you count all the nurses, it is rare to find many men being nurses. You'll find most of the nurses are female." KI027

Performance and Promotion Management

Performance was often cited as an enabler for women to rise within organisations. A combination of confidence and competence, as well as relevant experience, enables women to perform well.

"Ensuring that you perform if you [do] not, there would be a very good reason to have you replaced." FGD02

"There is a lady that you put her anywhere, and she'll perform. So, we've been promoting her from one level to the other. You take her to procurement; she does well. You take her to housekeeping; she does well. You take her to NHIF; she does well. You take her to the reception. So, we call her a multi...somebody who can multitask." KI030

"Since I came here, the various senior promotions ... [have been] to females. And they're really working very hard because you see, you look at people's performance not based on their gender". KI024

"And again, the support from those at the very top leadership, both men and women at that level, they would look who is good at that level, and they will actually promote you by merit." FGD02

Career Advancement Pathways

Further education and training were among the participants' important enablers of career advancement, as exemplified by these quotes below.

"It really depends on individuals' initiative. And what enables them to climb is the... extra training that they get. If somebody is able to go back to school, and then they, they achieve a certain level of education, it will enable them to climb up, like in the laboratory department [we had] two employees who... joined us at diploma level. But the one who is now in charge went back to school and got a degree and so that is naturally why she is the one in charge." KI001

"One enabler... is the training opportunities that we have created. So, sometimes you realise that they want to do extra hours, for example, and they want to go back to school, they want to take care of their families. You realise that when you have a good system, these women can still be able to actualise their dreams within that kind of set-up. So good policy framework, good training programme, good internet, ICT, infrastructure, and technological support that enable them to access. These are the enablers that we have been able to create." KI015

"How you mentor other younger people, especially younger women that's what is really going to help." FGD01

An individual's initiative captured by the salient quote "know your worth" was also cited as an enabler of career advancement.

"One thing I think first is that women themselves should enable themselves. I feel women suffer a lot from Imposter syndrome; they always feel it's not enough, whatever they are doing, they don't deserve it. So, I think the first enabler is yourself as a woman. What are you willing to put forward to be able to match up to the expectations? We should not play the victim card: I am a mother, I'm a wife, I'm a doctor; you have to be able to prove your worth with the actual work that you produce, the outcome." KI014

"Because the bias is really at an individual level, it is not at a policy level…it's this internal, which is knowing your worth. That is internal; nobody can give you that." KI023

"So, women have to themselves, I mean, invite themselves to the chambers, so to say." KI025

Moreover, rising to senior leadership was deemed to require an ability to network and have strategically placed allies.

"From mid-level to senior, I think that's where sometimes the rubber meets the road. Here, your experience, you're networking and your allies are what help to break the glass ceiling." KI038

"When they are leaders, what can be done to actually move them to the next level, I would say it's things around networking, using leveraging networks." KI034

However, the presence of self-limiting beliefs among women is an individual factor that was cited as a barrier to career advancement.

"I usually find that women are the ones who have this imposter syndrome more than the other gender. Imposter syndrome is where they have self-doubt and everything else, so just some equipping around confidence, putting themselves out there trying even if you don't have everything in the job description because that is what we find when we are interviewing; the male colleagues will be very happy to put themselves out there for a role even an internal role even if they don't meet the 50%." KI034

"I also think that maybe there's a certain level where female candidates may become unsure. Am I ready for this position? I don't want to go to this other level. I don't have the capacity to handle the stress at the highest office." KI024

"First, there's that lack of self-belief. Second, we want to be handed down [opportunities]. We don't want to grab opportunities. And even if an opportunity comes up, you feel like you're not qualified for that opportunity. Or you do not have the experience. So, you'll find we tend to take back seats." KI032

"Obstacles, most of the time, are the women themselves. Somebody will fear, 'Will I really make it?' There is that doubt that I am not so sure that I am going to make it." KI015

Another barrier cited was competing priorities usually derived from family responsibilities. In particular, child-rearing may delay women's opportunity to further their education, thus locking them out of advancement opportunities.

"Women have their seasons, e.g. marriage and motherhood. These days, we [are] also talking about menopause…because that has an impact. I know in my career I wanted to step back a bit because I had young children. And the demands of work versus the demands of family play a critical role. And you have to strike a balance." KI038

"For women, I think they are also competing with demands and priorities for family, so sometimes you put yourself later on and say, maybe when my child graduates, I am going to do it. So, we have so many competing priorities." KI014

Another barrier was patriarchal mindsets.

"My reflection is that there are still places in Kenya where male leadership is more appreciated than women leadership because we are a very patriarchal society, so there can be places where respect for men is greater than respect for women in leadership." KI034

"Middle to top, you will get there are obstacles, and at times, it's also the attitude of the male leaders like someone can say, "Mimi [siwezi] kufanya kazi na wanawake". [The previous management team] was a male-dominated kind of management, and …it could explain where these attitudes were coming from." KI037

"The society is still patriarchal; I worked with a male of a certain tribe in this cadre, where male chauvinism was very prominent. He was working under me since I was the Meds Sup, and anytime I gave him instructions, he made sure that he did the complete opposite." FGD03

Insufficient qualifications were also cited as a barrier, sometimes due to no self-drive or financial resources.

"So, I think sometimes what happens is that it's the limit in terms of your skills and qualifications. Because many organisations … have cadres, we have M1, M2, all the way to M6. And they [require] certain levels of skills, qualifications, and experience. So, if you don't meet those criteria, and those credentials, that can actually limit the growth of that individual in the organisation". KI014

"Sometimes, women enter a comfort zone. I

always encourage them to learn a new skill (upskill) every year." KI020

Support Mechanisms

The respondents also considered mentoring and coaching to be important enablers for women's career advancement.

"If the recruitment process is transparent, it's more about how…you pass the selection criteria; a lot of that, at the lower level for entry, is your technical skills. Also, for the lower level, there's a bit of mentoring and handholding required to prime you into the mid-level. Yes, I have seen the results of mentoring and coaching. So, I think… sometimes you pass it forward…. You pass it on, and you hope they also do." KI038

"When they are leaders, what can be done to actually move them to the next level? I would say it's things around networking, using leveraging networks… And then give them access to mentors and people who have gone ahead of them and can act as sounding boards." KI034

"How you mentor other younger people, especially younger women that's what is really going to help." FGD01

"X was my first boss, and she modelled what a proper female boss should be like, and I do so many things the way X did…" FGD01.

However, deliberate provisions for formal mentoring and coaching for staff were made only in a few HSOs. One HSO representative said the mentoring programme was only eight months old and would require time to yield results. Another informant reported they had established a coaching and mentoring system for interns: when these interns performed well, they were almost always absorbed in the organisation. Yet another HSO representative noted they had begun to see marked improvements from the initiative.

"Yes, especially the nursing cadre… it is more of mentorship where seasoned or senior nurses are able to train the upcoming nurses. We [also] have a robust onboarding programme that also creates that opportunity for peer training." KI015

"The results have been excellent. So, one of the success factors that we look at is the internal promotion rate. So, when it comes to any new positions that have opened, what percentage of the existing workforce has been promoted to that position? And we are seeing a growth in our internal promotions rate." KI033

Coincidentally, the FGDs highlighted the strong need for women to support other women in rising. There was an acknowledged need for women's networks or affinity groups where women could gain support and mentorship.

Men can also play a role by giving women a fair chance at leadership. For example, they can recommend women whom they know can deliver the job requirements. Two women recounted how their propulsion to leadership roles was through male allies.

Therefore, male allyship is important. However, men may be blind to their male privilege: "The eye doesn't see what the mind doesn't know." Gender awareness is therefore required so that men can be sensitised and speak out for women.

In the interviews, male allies were discussed from a personal or anecdotal perspective. Although some men were clearly responsible for several women's rise, the mention of male allies was limited. It appeared to be an ad-hoc arrangement rather than a formal support strategy.

"I have found mentorship within the workplace to be quite useful so that you can grow other women leaders. I have been supported in those opportunities occasionally, even by males. So, it also depends on the male ally. So, that is professional mentorship and support." KI038

"Small pockets, I would not talk of a system that is in place. What I see is particular male colleagues who are always talking about 'where are the women in the room today?' They are very conscious of the fact that if there are few women, then there is low representation of them." KI034

Gender awareness efforts at the Board level could also include the added value of women's representation. One lady shared with appreciation how, early in her career, she had once worked with an almost entirely male board (elderly, father-like men) who listened to her and supported her decisions.

"Was it not for that board, I don't think I would have achieved the work that I did. It was mainly men… almost all white-haired. But they listened to me. They consulted me. They elevated me, and I was so tiny at that time." FGD01

Coincidentally, the FGDs highlighted the strong need for women to support other women in rising.

Organisational Policies and Practices

There was no evidence of organisational policies being a hindrance to the advancement of women. Instead, it was more likely that the non-compliance of existing policies may have been a constraint to women's advancement. Several participants mentioned that an organisation had to be very intentional about gender equity interventions – from the policies, recruitment, promotion, training opportunities and staff sensitisation.

"When we say women are encouraged to apply it means we are really committed to having them occupy some of those positions." KI04.

"I think we are over 90% when it comes to gender equity. We usually recognise gender in every aspect or every project." KI06.

IIn this regard, the loss of autonomy in Human Resource policy administration in public hospitals appears to have created a loophole for political interference in HR recruitment and promotion within the facilities.

At the bare minimum, all the sampled organisations appeared to have legal provisions for maternity and paternity leave in their HR policies, as well as a sexual harassment policy. A few organisations had exceeded the mandatory provisions, clearly creating a very conducive environment for women. In one of the FGDs, a participant shared that their organisation had implemented a period of leave - 12 days per year.

There was no evidence of struggling to comply with legal provisions. People were, in fact, concerned about compliance with the law.

"We usually follow the 1/3 gender rule that is an act of parliament..." KI06.

"When we want to employ people, we have to form a committee, with 1/3 gender rule." KI08.

This made the question about operationalising legal frameworks largely redundant. Participants who answered this question also talked about efforts towards operationalising the 2/3 gender rule. It was also perceived as a responsibility for public organisations rather than all organisations. Most organisations have not taken a deliberate step towards implementing gender equity practices beyond the legal requirements. Even so, most participants struggled to answer the question about having gender-equitable workplace policies.

Job Design and Flexibility

Flexible work schedules were credited as a factor that contributed to favourable working conditions for women.

"So, I had an uncomfortable conversation with my male boss: from the word go, I can't work certain hours, you know, I must leave at 4:30 and 4:30 on the dot to be able to pick my child up at this time, and I can't work on weekends. But if you want me to be up at 2 am writing a report, I can do that." FGD01

Gender Pay Equity

Regarding gender pay equity, the general response was that pay was determined by one's qualifications and job group, irrespective of gender. Variance in pay was attributed to tenure in the organisation and performance. However, two participants were honest to admit that a gender pay gap did exist in their organisations and that it was a historical issue. This disparity was being corrected.

"Our safeguarding policy expands beyond sexual exploitation and abuse; it also includes workplace intimidation or bullying. So, what we see are incidences of workplace bullying." KI034

In one progressive HSO, the participant noted a periodic gender parity analysis that enables them to note any disparities.

"Yes, they are paid the same... equal pay for equal work. So, we would periodically do a gender parity analysis across the organisation, and this could help us to confirm if there are any unexplainable differences, and if there [are] any differences that are not clear to understand the reason for that disparity, then we course-correct." KI034.

One participant noted that poor negotiation skills for women sometimes contribute to this disparity.

"I think [the] gender pay gap has [been] a challenge. Sometimes, it is the negotiation skills. I think at the junior and middle level, women are not very good at negotiating and also, knowing their value. This could affect them because even if they change organisations or sectors, Employers tend to ask for your last payslip...if they go by your last pay, you could come in at the lower level, but men have a way of negotiating. I think that [it] affects Junior-middle, and then now the spillover comes into the middle to senior, so I think that remains a thorny area." KI038.

Workplace Harassment

In reference to sexual harassment, two cases came out strongly where deterrence enabled women to rise. The offenders were expelled. Organisations that had zero tolerance for sexual harassment among staff appeared to have a conducive working environment with minimal or 'light' cases reported.

"We have had reported incidences of sexual harassment, and this might occur in a social setting after work, where somebody feels that they have either been touched inappropriately or things like that". KI034

Sexual harassment doesn't just occur between staff but also between staff from patients or clients. Receptionists, nurses, and even female doctors are particularly vulnerable to this.

"We don't have any men at the reception. And most of the harassment coming from the clients is at the reception. So, it's these females who receive the blow." KI011

"I can only recall it was between a patient and the staff. Ah, where a patient was not behaving well. But the staff reported. And then because in the department, there is a male and there's a female, [we said] whenever this patient comes, let the male staff attend to him. So, [stay] away." KI030

However, there appears to be a stigma associated with sexual harassment and some employees, despite having the organisational mechanisms to deal with the issue, prefer to look for informal ways to deal with the problem.

"We still find people are very sceptical... they will tell you this, and this has happened, but I will not report it. I am reporting it now, but I don't want to sit on a committee to discuss this. People are still afraid and don't want to come out very strongly because they feel they don't want people to know what is happening. They will tell you, 'I am having [an] issue here', ... to see where you can be able to change the environment. But they don't want to take it all the way, to go and sit across a table to discuss it with strangers." KI021

A few observations were made that women can also be the instigators of sexual harassment. And that men also have a hard time coping with "visual" harassment.

"Men are so harassed, but they have nothing to show this is the evidence. We also have a dress policy because we do not want our men to lose focus in the company, but they're really harassed. Men are seriously harassed in the workplace. Some of them come here to say, 'I can't focus, I can't work'." KI024

Workplace bullying appeared more prevalent than sexual harassment.

"We have faced other types of harassment – our staff are harassed by WAKUBWA, policemen guarding inmates, and relatives of deceased patients who attack the staff in anger." KI018

"At times, we have work harassment you know... they say that the way their supervisor is treating them is not right, they're not happy about the way the supervisor is handling them. Yeah, those we handle, and we are able to amicably resolve so that work can continue." KI032

"Our safeguarding policy expands beyond sexual exploitation and abuse; it also includes workplace intimidation or bullying. So, what we see are incidences of workplace bullying." KI034

One FGD participant identified other types of workplace bullying, e.g. age bullying, appearance bullying, accent bullying (targeting minority groups), marital status (motherhood, singlehood), and disability (especially women with disabilities) bullying.

"I think we are over 90% when it comes to gender equity. We usually recognise gender in every aspect or every project." KI06.

An organisational policy of internal promotions was cited as favourable for women's advancement. Another participant credited their high rate of staff retention to a favourable working environment and said that senior management is instrumental in setting the right tone for the environment.

Sometimes, bullying or harassment happens when women seek career advancement and follow due process. Two examples were given of denial of leave applications. Additionally, bullying (in the form of coercion) can happen during salary negotiations, especially when one has been given a heavier workload, as happened during COVID-19. Desperation for employment also makes women vulnerable to bullying and sexual harassment. One participant remarked that self-confidence is critical to avoiding or deterring bullying and harassment. Another woman commented, "You must know your worth."

Retention and Promotion Practices

An organisational policy of internal promotions was cited as favourable for women's advancement. Another participant credited their high rate of staff retention to a favourable working environment and said that senior management is instrumental in setting the right tone for the environment.

"Internal promotions - women have risen due to internal promotions, and training is then provided to enable them [to] do their jobs." KI020

"One enabler, amongst many others, is... the policies we have put in place that have enabled women to rise. The rest of the employees look up to us and realise there is a lot of stability, support, and care." KI015

A synthesis of the FGD responses provided some pointers for creating a favourable working environment for women's retention and growth.

- Ensure objective processes to allow for equality of opportunity.
- Gender rotation for secondment opportunities.
- Recognise the growth of employees.
- Ensure promotion is based on merit.
- There needs to be a transparent and structured policy on work compensation/pay.

Provision of Physical Facilities

Organisational policies can create an equitable working environment for women when they provide facilities suitable for working mothers, e.g., creches and lactation rooms, and generally for women, e.g., separate washrooms with provisions for sanitary pad disposal. The following quotes from participants capture these sentiments.

"We are currently in the process of creating a nursery just for...the children of our staff ..." KI033.

One participant did not see the need for a lactation room, suggesting that not all senior managers understood the role of physical facilities in creating a favourable working environment for women.

"Okay, the other thing that we are not very sensitive about, and I know we are not alone in that, there is this thing that they were discussing in Parliament just the other day that in an institution like this, we should have a room where the mother should be going to breastfeed. That one we have not provided that, yes, because we don't have staff who are coming to work with their babies. We give you maternity leave, you breastfeed for three months, and come back when you are ready to work. So, we don't have that room for that, and we do not anticipate it." KI013

This was a good example of gender-equitable organisational interventions. It was also remarked that as much as we need women-friendly facilities, we should not forget the people with disabilities and, therefore, a focus on inclusivity in organisational policies. Several key informants also mentioned the need for inclusivity and not just gender equity.

"We are targeting to... they call it inclusivity. So that we are all, we are walking the talk. We are creating awareness, we have sign language interpreters, braille [visual aids], for those who can't see small prints, there's screen enlarger management. I mean, everything is accommodated to meet that inclusivity." KI020

Organisational Culture

Although leaders readily shared the values and purpose of their organisations, it was not discernible if these values had shaped the organisational culture. Thus, although the leaders spoke of the desired organisational culture, it was difficult to tell if this was the real or experienced culture. Nevertheless, organisational policies (e.g. Diversity Equity & Inclusion policies) and strategies that were deliberate about gender equity were credited with shaping the culture of the organisations.

The emergent issues around organisational culture were well brought out in the FGD discussions. For example, how organisational culture manifests itself in the prevalent (and largely unquestioned) practice of derogatory comments about women and the use of double standards when evaluating the behaviour of male vs. female leaders.

"Unfortunately, the scrutiny for women is so much more. Therefore, whatever, we have policies in place, we have to really ensure that [they] are followed and go the extra mile." FGD01

An organisational culture that sustains gender inequity is reflected in behaviour and practices that don't support a gender-equitable workplace. An example of such a practice was the presence of Boy's Clubs and Smoke Breaks, where key organisational decisions were made, often to the exclusion of women. Another practice was the automatic allocation of stretch/growth assignments to men which sets them up for promotion. Trip opportunities were often skewed towards men under the excuse that women had family roles and, therefore, were unavailable.

"The other thing I would say is in terms of organisational culture and where decisions are made. So, the majority of the time, people will meet, as I said, up to midnight in the club. And then tomorrow, everyone is set on what is where... you can go to the club to meet with [them] and if you wanted to, suppose maybe you have a family, you have other things to do." FGD01

"I think there's an automatic priority given to men in complex assignments, regional assignments, stretch assignments, there's an assumption that women can't travel, or you can't really arrange your [side] of things to leave your children... they'll quickly say that X has a child, you know. But the child doesn't stop your ambitions." FGD01

Another practice is inordinate attention paid to women's appearance. Unlike men, women are subjected to unfair scrutiny based on appearance. One FGD participant commented that she stopped plaiting corn rows because they contributed to her not being taken seriously at work.

A widespread practice is the cultural expectation that women will serve tea during meetings. It was humorously observed that no matter how high women climb the corporate ladder, they are still asked to pray before meetings and serve tea. One lady said that it is important to set the tone from the word go. As a seasoned board member, she has resolved never to serve tea in the board room.

Another practice is the non-compliance of gender equitable policies, e.g. pregnancy discrimination at recruitment and non-response to sexual harassment cases. Women leaders are particularly susceptible to false rumours, especially of a moral nature, e.g. one got her position by sleeping around. Some participants knew of actual incidences of slander and defamation affecting women co-workers.

Organisational culture discussions in the key informant interviews revolved around the need for teamwork, including covering for each other (when one was sick or unavailable). This appeared to be equitable, with both men and women recognising the need to work collaboratively.

The key informants almost always understood peer support networks as staff welfare groups. These exist in most organisations and provide informal support for non-work-related activities like weddings, burials, and the birth of children.

An organisational culture that sustains gender inequity is reflected in behaviour and practices that don't support a gender-equitable workplace.

Organisational Leadership

Leadership emerged as a strong organisational change lever for women's career advancement. Organisations with strong evidence of gender equity interventions tended to have a senior management/leadership that was very deliberate about it. Leadership sets the tone and pace of gender equity in the organisation and any interventions geared towards gender equity. Leadership support was experienced at the Senior Management level and from the Board level.

Leadership support for organisational interventions is exemplified in the following quotes.

"I have received absolute support for everything we wanted to do from a gender equity perspective, so even for that question that you asked, when we find that there are unexplainable differences around compensation between men and women doing the same job, it's been possible to find the budget and make the adjustment in the minute, not to say that let us wait for next year. So that kind of support is available." KI034

"I think for us [Senior Management Team], we have got a lot of support from our board…I think we have a very good board. Especially the board chairman is so PRO woman. My leadership journey has been thanks to his mentorship, his trust and confidence in us leaders. I think it has been one of the most empowering successes." KI014

The Board gender composition was 36% women and 64% men for a total figure of 108 board members. This was slightly over a third for women, which was encouraging. However, in disaggregated figures, the board composition was skewed towards men. Only two HSOs had women as majority members in their Boards. Although women were clearly occupying Board positions, the push for equitable representation should continue. One FGD participant was emphatic that gender transformation will not happen organically in these board. - *"Being resilient and also consistent even during that bad day, you are still afloat and they will say that there is something that keeps this girl going, and this one is also tied to self-integrity." FGD02* A related issue was the need for continuous Board Training on Diversity, Equity, and Inclusion (DEI). This was brought out during interviews when it was discovered that as much as board members had some form of 'equity', the composition of the boards still lacked women with the top leadership positions. For example, *"Board members are given equal opportunity… [out of 9 board members] - Out of these there are only two females." KI08; "Our board is governed by 100% men." KI14*

The interviews revealed that Boards were generally more concerned about business performance than gender equity. Two informants noted that since they preach gender equity as part of their programming work, they must "walk the talk." Where the Board was female-led, there appeared to be more commitment towards gender equity. Some Boards were addressing gender equity as part of their Diversity, Equity, and Inclusion strategy.

In the concluding conversations on this issue, the respondents felt that organisational leadership is responsible for making gender equity a strategic priority. The participants gave several suggestions on how to do this, which are provided below.

i. Align organisational budgets to Gender Equity goals, e.g. equitable training opportunities.

ii. More awareness creation on gender equity but packaged positively: not a feminist agenda.

iii. Having a gender lens in all our work.

iv. Being intentional about gender equity.

v. Going beyond the legal requirements.

vi. Being conscious about the 2/3 gender rule at the Board and Senior Management level.

vii. Integrating gender equity into the organisation. Not treating it as a separate issue.

The interviews revealed that Boards were generally more concerned about business performance than gender equity.

Gender Equity in the Workplace

The need for gender balance in the HSOs was highlighted as a valid intervention and a challenge, as depicted in the quotes below.

"Gender balance is important because it matches client preference: some prefer female doctors, others male clinicians." KI002

"When we are shortlisting for the interview, we always balance, but at the end of the day, we find out that more ladies will turn up compared to men. So, in such a scenario, we have to get the best. So, once we take the best, then we take in whoever will pass. Whether it's a male or female. But we have been really... trying as a facility to ensure we balance." KI028

"Remember, if in a ward, you have 10 women in a department, and you only have two men. You'll not survive. Because there is a stage that a woman cannot do night duty." KI030

Cultural expectations also influence the staffing of service providers. In one region, it is culturally expected that obstetrics and gynaecology are female occupations. One of the FGD participants recounted how she had to let go of a talented male midwife because it was culturally unacceptable.

One of the challenges of addressing gender equity in the workplace was the need for maternity replacements. This sounded like the 'Motherhood Penalty' where women of reproductive age face discrimination at work due to their potential for pregnancy.

"Challenges of hiring young ladies – they may need to go on maternity leave. Also, [the] youth these days [are] unsure of their career goals; we now recruit those who are eager to learn and upgradable in terms of skills." KI020

Another challenge was male resistance to the interventions – where men feel excluded.

"In implementation, I think the men feel lonely at times because there is so much women empowerment happening [here]. So, sometimes they speak out also... they say that [X] is always talking about women. So, sometimes, this works against us when we try to balance it out." KI014

"Challenges of hiring young ladies – they may need to go on maternity leave. Also, [the] youth these days [are] unsure of their career goals; we now recruit those who are eager to learn and upgradable in terms of skills." KI020

One participant alluded that having too much of one gender in the workplace may be counterproductive.

"In my experience, there's a danger of having too many women [in the] same place. Usually, it's not always smooth most of the time. So, the internal tensions have to come in." KI020

When asked to gauge the general workforce perceptions on gender equity, the informants' perceptions suggested a mixed bag that requires further exploration. It would appear that there is a need for more advocates for gender equity across all levels in these organisations.

"When you mention gender equity, you find that men wanatetea upande ya wanaume (sic) (defend the male view or position) and ladies wanatetea upande ya ladies (sic) (defend the female view or position). But sometimes there is a consensus." KI004

"I think the men are still against it; I still feel like they won't understand the women, like, for example, the lower cadre. For example, the people in housekeeping don't understand the women's problems, you know, we need to be on maternity leave, and sometimes our children can fall sick. You realise whenever we go for our children's Parents' Day and school visits, it's always the women who are there more than the men. So, we have to get permission from work to go and attend. And I feel sometimes they don't understand that there are some unique problems that women face, and they should be more understanding of them." KI014

"Some women would say that they probably appreciate the effort that we have made towards gender equity from a policy perspective and practice. But maybe the ones who are more middle-level would be more aware of the barriers or the enablers." KI034

Success in terms of gender equity was often described as equal opportunity for both genders and as having a balance of both genders in the organisation.

"It will give equal opportunity to all genders to pay based on productivity. It wouldn't look at what gender you are. Even when it comes to recruitment it would have a recruitment policy which encourages equal representation when we are bringing people on board. They will be sensitive to the unique needs of the genders when they are onboarded." KI021

"I would endeavour to have it 50/50 because I have seen the strength of our female employees. I have also seen the strength and resilience of our men. The thinking and the approach to issues are so diverse... Generally, I have seen ladies taking more time to make a decision, but the decision after it has been made, ... is slightly better than what the men do faster. So, for me, that balance, if I were CEO or wanted to run an organisation, I would endeavour to achieve 50/50." KI024

"A successful organisation is purposeful about ensuring that women and all genders [have] representation, inclusion, participation, and growth. Not just stating the policies but making them come to life; ... that women or men feel that they have a place to contribute, they have the opportunity to exploit, and they have support to actually achieve their full potential." KI034

There was general agreement among FGD participants that men have a critical role to play in enhancing gender equity in the workplace. Suggestions included the following:

- Men can accept to be mentors and coaches.
- They can speak up for women when they are absent (sponsor).
- Being decent.
- Accepting to be champions of gender equity.
- Amplifying women's contributions in meetings.

In addition, there was general agreement that there needs to be continuous sensitisation and training on gender mainstreaming. One lady noted that men need to be made accountable for progress towards gender equity. Gender is not a women's issue, and therefore, men need to be part of the conversation. Another observation was that it is more impactful when senior men promote women than when asking lower-ranked men to support women: *"Was it not for that board, I don't think I would have achieved the work that I did. It was mainly men and always white-haired. But they listened to me. They consulted me. They elevated me, and I was so tiny at that time." FGD01*

It would appear that there is a need for more advocates for gender equity across all levels in these organisations.

"Create work environments where vulnerabilities related to womanhood are not treated as weaknesses and strengths are not regarded as threats."

Critical Change Levers for Gender Equity

Organisational policies were selected as the most critical change lever by nine out of twenty-three informants. Organisational culture was ranked second, followed by leadership. People, as a critical change lever, was mentioned together with culture. In particular, the need for continuous gender sensitisation or gender mainstreaming work to avoid it becoming a fashion fad. Thus, organisational policies seem to be perceived as an effective mechanism in providing the foundation for a more gender-equitable workplace.

All the participants were asked about organisational interventions that had been most effective for addressing gender equity and were required going forward. Below is a synthesis of the responses.

i. Senior leadership needs to be deliberate about making gender equity a reality. They can endorse the intentional promotion of capable women. This requires intentional human resource planning and gender-disaggregated data to inform decision-making.

ii. Consistent implementation of gender equitable policies.

iii. Opportunities for further training and skills development.

iv. Fostering male allyship. Male champions of gender equity can be spotlighted and celebrated.

v. Consistent sensitisation about gender mainstreaming in organisations.

vi. Training on unconscious bias.

vii. Creating women's affinity groups.

viii. Individual women's proactivity in seeking leadership opportunities.

ix. Involving men in gender equity interventions.

x. A long-term commitment is required to avoid gender equity becoming a fashion fad.

One of the FGD participants talked of creating a winning environment: *"Create work environments where vulnerabilities related to womanhood are not treated as weaknesses and strengths are not regarded as threats."*

Chapter Six

Discussions, Conclusions and Recommendations

Introduction

The preceding chapters have underscored the multifaceted nature of workplace gender equity, highlighting the interplay of cultural norms, institutional policies and practices, and individual factors that either facilitate or impede women's career advancement. This final chapter aims to synthesise key findings and present actionable recommendations to propel the discourse on workplace gender equity and advance women's leadership in Kenya's health sector.

Kenya Healthcare Federation
The Health Sector Board of KEPSA

Strathmore UNIVERSITY
BUSINESS SCHOOL

Discussion of Research Findings

Discussion on Organisational Structures

Hierarchical Dynamics:

The exploration of organisational hierarchical dynamics for women in health leadership within the context of the Kenyan health sector unveils a complex interplay of structural influences that shape women's experiences and opportunities. Through the integration of qualitative narratives and quantitative analyses, our investigation reveals both the subtle nuances and systemic challenges within hierarchical structures. Qualitative insights illustrate the impact of entrenched gender biases, revealing how organisational hierarchies can inadvertently perpetuate disparities in decision-making, resource allocation, and access to leadership roles. Concurrently, quantitative data elucidates patterns of underrepresentation at higher echelons, exposing the existence of glass ceilings that hinder women's ascent. The intersectionality lens further magnifies the unique challenges faced by women from diverse backgrounds within this hierarchical framework. To advance gender equity in health leadership, organisational structures must, therefore, transform, challenging traditional power dynamics, embracing diversity, and fostering environments where women can ascend with merit and contribute meaningfully to health sector decision-making.

> **Quantitative data revealed disparities in promotion rates and leadership representation, underscoring structural inequities embedded within organisational systems.**

Mentorship and Sponsorship Networks:

Women leaders consistently emphasised the significance of mentorship and sponsorship networks in navigating organisational structures. In delving into the role of organisational mentorship and sponsorship networks for women within Kenya's health sector landscape, a nuanced understanding emerged of the intricate support systems crucial for nurturing women's professional growth and advancement. The qualitative key informant interviews and Focus Group Discussions illuminated the transformative power of mentorship and sponsorship in shaping women's career trajectories. These narratives underscored the invaluable role of mentors and sponsors in providing guidance, support, and career opportunities for skills development, professional networking, and visibility. Conversely, the quantitative analysis from the cross-sectional survey brought out disparities in access to mentorship and sponsorship, highlighting systemic barriers that hinder women's participation and advancement in leadership roles. Recognising the intersectionality of gender with other factors, such as socioeconomic status and geographical location, underscores the importance of tailored mentorship and sponsorship initiatives that address diverse needs and amplify the voices of women from marginalised communities. By cultivating inclusive mentorship and sponsorship networks, health sector organisations can foster work environments conducive to women's leadership, driving organisational innovation and enhancing better health outcomes for all.

Promotion and Advancement Patterns:

Combining qualitative narratives and the quantitative analysis from the cross-

sectional survey, our exploration uncovers systemic barriers and enablers influencing women's progression. Qualitative insights showed the pivotal role of supportive environments in facilitating women's career advancement. Concurrently, quantitative data revealed disparities in promotion rates and leadership representation, underscoring structural inequities embedded within organisational systems. By embracing inclusive promotion policies and fostering environments conducive to women's leadership, health sector organisations in Kenya can harness the full potential of gender-diverse leadership teams, thereby enhancing health service delivery and organisational effectiveness.

Workplace Accessibility, Design & Childcare Facilities:

Through a comprehensive analysis integrating qualitative narratives and quantitative analysis from the cross-sectional survey, our inquiry uncovered the profound impact of physical environments on fostering workplace gender equity. Qualitative insights underscored the pivotal role of workplace accessibility and design in shaping women's engagement, productivity, and sense of belonging within health sector organisations. Discussions surrounding childcare facilities revealed how the availability and accessibility of such amenities directly influence women's ability to balance professional responsibilities with caregiving duties, thus enhancing their participation and advancement in the workplace. Moreover, quantitative analyses offered empirical evidence of disparities in access to these facilities, highlighting systemic barriers that hinder women's full participation in the workforce. By prioritising workplace accessibility, inclusive design, and comprehensive childcare support, health sector organisations in Kenya can foster environments that empower women to thrive, innovate, and lead with excellence, thereby catalysing transformative change in the health sector in Kenya.

Discussion on organisational culture

Organisational and Individual Values and Norms:

The exploration of organisational and individual values and norms within the context of Kenya's health sector offered profound insights into the dynamics shaping gender equity and leadership opportunities. Drawing from qualitative narratives and the quantitative analysis from the cross-sectional survey, our research delved into the intricate interplay between organisational cultures, societal expectations, and individual aspirations. Qualitative insights unveil the influence of organisational values and norms on women's experiences, highlighting the presence of entrenched gender biases, implicit stereotypes, and structural barriers within health sector institutions. Concurrently, quantitative data provided empirical evidence of disparities in leadership representation and advancement trajectories, reflecting systemic inequities perpetuated by organisational and societal norms.

Moreover, the intersectionality lens illuminates how factors such as religion, geographical positioning, and socioeconomic status intersect with gender to shape women's leadership journeys, underscoring the importance of addressing multifaceted barriers to achieving true workplace gender equity By fostering inclusive organisational cultures, challenging traditional norms, and empowering women to challenge systemic barriers, health sector organisations in Kenya can pave the way for transformative change, ensuring that women in health leadership roles are valued, supported, and empowered to realise their full potential for the betterment of health systems and communities.

Gender and Stereotype Biases:

The scrutiny of organisational gender and stereotype biases within the realm of women in health leadership in Kenya's health sector offered a nuanced understanding of the barriers that impede gender equity. Through an analysis combining qualitative narratives and quantitative survey data from the Women in Health Leadership in Kenya project, the research exposed the pervasive influence of gender and stereotype biases on women's professional experiences and opportunities. Qualitative insights uncovered the subtle biases embedded in organisational cultures, affecting decision-making processes, leadership expectations, and promotional opportunities for women.

Simultaneously, quantitative data provide empirical evidence of gender disparities in leadership representation and the prevalence of stereotypical assumptions that hinder women's advancement. The intersectionality revealed how these biases intersect with other dimensions of identity, exacerbating challenges for women from diverse backgrounds. Challenging and dismantling these biases is imperative for fostering an inclusive environment where women in health leadership roles can thrive, challenge stereotypes, and contribute meaningfully to the transformation and innovation of health sector systems in Kenya.

The research exposed the pervasive influence of gender and stereotype biases on women's professional experiences and opportunities.

Discussion on organisational leadership

Leadership Support and Commitment:

The assessment of organisational leadership support and commitment within the context of women in health leadership in Kenya's health sector serves as a critical lens through which to understand the pathways to gender equity and inclusion. Drawing insights from qualitative narratives and quantitative analyses derived from the research phase of the project, our exploration shed light on the pivotal role of leadership in shaping organisational cultures and practices. Qualitative findings exposed the profound impact of supportive leadership in fostering environments where women feel valued, empowered, and supported in their professional endeavours.

Leadership commitment to gender equity initiatives and inclusive policies emerged as a key driver in dismantling systemic barriers and fostering opportunities for women's advancement. Quantitative data provided evidence of the correlation between strong leadership support and the representation of women in leadership positions, underscoring the transformative potential of committed leadership in driving organisational change. By championing gender equity as a strategic priority and embodying inclusive leadership practices, health sector organisations in Kenya can cultivate environments where women in health leadership roles thrive, innovate, and lead with excellence, thereby enriching the fabric of health service delivery and contributing to the advancement of gender equity in society.

> **Qualitative findings exposed the profound impact of supportive leadership in fostering environments where women feel valued, empowered, and supported in their professional endeavours.**

Board Representation:

The analysis of organisational board representation unveiled crucial insights into the structural dynamics shaping gender equity and leadership opportunities. By synthesising qualitative narratives and quantitative data from the research obtained from the Women in Health Leadership in Kenya project, our investigation elucidated the profound impact of board composition on women's pathways to leadership. Qualitative narratives underscored the pivotal role of diverse board representation in fostering inclusive decision-making processes, shaping strategic priorities, and advocating for gender equity initiatives within health sector organisations. Conversely, quantitative analyses revealed disparities in gender representation on boards, highlighting systemic barriers that hinder women's access to influential leadership positions. Addressing these disparities and promoting diverse board representation is essential for cultivating inclusive organisational cultures, driving transformative change, and advancing gender equity in health leadership in Kenya.

Gender Equity as a Strategic Priority:

The sub-theme of gender equity as a strategic priority for leadership within the context of women in health leadership in Kenya's health sector highlighted the potential of intentional organisational and leadership commitments to equity and inclusion. By evaluating qualitative narratives and quantitative data from the Women in Health Leadership in Kenya project, our analysis showed the multifaceted dimensions of gender equity initiatives and their impact on women's leadership trajectories. Qualitative insights underscored the significance of organisational leadership in championing gender equity as a core value, driving cultural transformation, and fostering environments where women are empowered to thrive and lead with authenticity. Concurrently, quantitative data provided empirical evidence of the correlation between gender-equitable policies, representation of women in leadership roles, and organisational effectiveness. The intersectionality lens further exposed how gender equity intersects with other dimensions of identity, emphasising the importance of holistic approaches that address diverse barriers and amplify the voices of women from marginalised communities.

Discussions on organisational policies and practices

Job Design & Flexibility:

The exploration of organisational job design and flexibility for leadership roles within Kenya's health sector sheds light on the pivotal role of structural factors in fostering gender equity and professional advancement for women in health leadership. Drawing from qualitative narratives and quantitative data derived from the Women in Health Leadership in Kenya project, our analysis revealed the transformative potential of innovative job design and flexible work arrangements in promoting inclusive environments. Qualitative insights highlighted examples such as job sharing, telecommuting options, and flexible scheduling, which empower women to balance professional responsibilities with personal commitments. Concurrently, quantitative analyses provided empirical evidence of the positive correlation between organisational flexibility, women's participation in leadership roles, and organisational performance indicators. Embracing tailored job design strategies and promoting flexibility as a core organisational value, health sector institutions in Kenya can dismantle systemic barriers and foster inclusive cultures in the health sector and beyond.

Pay Equity Practices:

Pay equity practices and the gender pay gap within the purview of women in health leadership in Kenya's health sector brought out critical insights into the inequalities that persist in compensation and professional advancement. Drawing from qualitative analysis and quantitative data obtained from the Women in Health Leadership in Kenya project, our analysis exposed disparities in pay and compensation structures that disproportionately affect women in leadership roles. Examples include instances where women brought up issues of being systematically underpaid compared to their male counterparts for similar positions or roles. Additionally, qualitative insights highlighted the nuanced factors contributing to the gender pay gap, such as implicit bias in performance evaluations, lack of transparency in salary negotiations, and systemic barriers to career progression for women. Addressing pay inequities through transparent salary structures, performance-based compensation, and gender-sensitive pay policies, health sector organisations in Kenya can mitigate the gender pay gap, promote fairness and equity in remuneration practices, and foster environments where women in health leadership roles are valued, recognised, and fairly compensated for their contributions.

Workplace Harassment:

Workplace harassment, including sexual harassment, bullying, verbal harassment, and shaming, within the context of women in health leadership in Kenya's health sector exposed challenges that hinder gender equity and professional advancement. Drawing from qualitative narratives and quantitative data gathered through the Women in Health Leadership in Kenya project; our analysis uncovers instances where women leaders face various forms of harassment and discrimination in the workplace. Examples may include situations where female leaders experience unwanted advances, derogatory comments, or exclusionary behaviour based on their gender. Verbal harassment and shaming tactics may also manifest through disparaging remarks, intimidation, or undermining of women's authority and contributions in leadership roles. By addressing workplace harassment through comprehensive policies, training programmes, and zero-tolerance approaches, health sector organisations in Kenya can create safe, inclusive, and respectful work environments where women in health leadership roles can thrive, lead with confidence, and contribute to the advancement of equitable and supportive organisational cultures.

Our analysis revealed the transformative potential of innovative job design and flexible work arrangements in promoting inclusive environments.

Organisational Implications

Discussion on Organisational Structures

The study's findings have manifold implications for organisations. First and foremost, the research underscores the imperative of promoting gender equity and inclusivity in health sector leadership. It calls for the implementation of gender-sensitive policies, mentorship programmes, and organisational initiatives aimed at dismantling systemic barriers and fostering a culture of inclusivity and empowerment. Furthermore, the study highlights the need for institutional accountability and transparency in recruitment, promotion, and decision-making processes to ensure equitable opportunities for women in leadership roles.

Organisational structures, cultures, policies, and leadership play a pivotal role in shaping workplace dynamics, opportunities for advancement, and the overall culture of inclusivity within health sector institutions. The following are key implications for organisations based on the findings of the study:

Gender-Inclusive Leadership Development Programmes:

Organisational structures should prioritise the establishment of gender-inclusive leadership development programmes aimed at nurturing talent, fostering mentorship relationships, and providing opportunities for skill-building and career advancement. These programmes should be designed to address the unique needs and challenges faced by women in health sector leadership roles and offer tailored support to facilitate their professional growth and progression.

Transparency and Accountability in Recruitment and Promotion Processes:

Organisational structures should promote transparency and accountability in recruitment and promotion processes to mitigate biases and ensure equitable opportunities for women in leadership positions. Clear and objective criteria should be established for evaluating candidates, and mechanisms for monitoring and addressing gender disparities in hiring and promotion decisions should be put in place.

Flexible Work Arrangements and Family-Friendly Policies:

Organisational policies should accommodate the diverse needs of women in health sector leadership roles by offering flexible work arrangements, parental leave policies, and other family-friendly benefits. By recognising and supporting women's work-life balance needs, organisations can create a more inclusive and supportive environment that enables women to thrive professionally while balancing their personal and familial responsibilities.

Promotion of Gender Diversity in Leadership Teams:

Organisational leadership and boards should prioritise promoting gender diversity in leadership teams to harness the full spectrum of talent and perspectives. Efforts should be made to ensure that women are represented at all levels of leadership, including executive and board positions, and that decision-making bodies reflect the diversity of the workforce and the communities they serve.

Cultural Sensitisation and Awareness Training:

Organisational structures should invest in cultural sensitisation and awareness training to challenge gender stereotypes, promote inclusive attitudes, and foster a culture of respect and equality within health sector institutions. Training programmes should be mandatory for all employees and leaders and should emphasise the importance of diversity, equity, and inclusion in organisational success.

Strengths and Limitations of the Research

The following sub-sections detail the strengths and limitations of the research.

Strengths:

1. Mixed Methods Approach:

The research utilised both qualitative and quantitative methods, providing a comprehensive understanding of women's experiences in health sector leadership roles. This approach enabled triangulation of data, enhancing the validity and reliability of the findings.

2. In-Depth Qualitative Analysis:

The qualitative analysis allowed for a rich exploration of the nuances and complexities of women's experiences, perceptions, and challenges in health sector leadership in Kenya. Through interviews, focus groups, and open-ended surveys, the study captured diverse perspectives and uncovered hidden insights.

3. Quantitative Rigor:

The quantitative analysis employed robust statistical techniques to analyse large datasets and identify trends, patterns, and disparities in women's representation and advancement in health sector leadership positions. This quantitative rigour added depth and credibility to the research findings.

4. Participant Engagement and Collaboration:

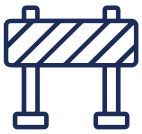
The research actively engaged stakeholders, including women leaders, health sector practitioners, policymakers, and advocacy groups, throughout the research process. This collaborative approach ensured the relevance, applicability, and sustainability of the research findings and recommendations.

5. Contribution to Knowledge Generation:

The research contributes to knowledge generation by advancing scholarly understanding of gender equity and inclusivity within the health sector in Kenya. By synthesising empirical evidence, theoretical insights, and practical implications, the research informs policy, practice, and advocacy efforts aimed at promoting gender diversity and leadership development in health sector organisations.

6. Analytical Depth:

The research employs robust analytical frameworks to examine the complex interplay of gender, power, and organisational dynamics. By critically interrogating structural barriers and enablers of women's leadership, the research offers deep insights into the underlying mechanisms shaping gender disparities in health sector leadership roles.



Limitations:

1. Sampling Bias:

The study may have been subject to sampling bias, particularly in the recruitment of participants for qualitative interviews and surveys. Women who agreed to participate may have had unique experiences or perspectives, leading to potential selection bias and limiting the generalizability of the findings.

2. Cross-Sectional Design:

The research adopted a cross-sectional design, capturing a snapshot of women's experiences in health sector leadership at a specific point in time. This design limitation precludes longitudinal analysis and does not account for temporal changes or variations in leadership dynamics over time.

3. Social Desirability Bias:

Participants may have been influenced by social desirability bias, particularly in self-reporting attitudes, behaviours, and experiences related to gender and leadership. This bias may have resulted in the underreporting of sensitive issues or the overrepresentation of socially acceptable responses.

4. Contextual Specificity:

The research focused specifically on women in health sector leadership in Kenya, limiting the generalisability of findings to other contexts or settings. Cultural, institutional, and socioeconomic factors unique to Kenya may influence women's experiences differently in other countries or regions.

5. Data Validity and Reliability:

While efforts were made to ensure data validity and reliability through rigorous data collection and analysis procedures, inherent limitations such as recall bias, measurement error, and data quality issues may have impacted the accuracy and integrity of the findings.

6. Resource Constraints:

Limited resources, including time, funding, and access to data, may have constrained the research. These resource constraints may have influenced the scope, scale, and depth of the research, potentially compromising the comprehensiveness and robustness of the findings.

While the research on women in health sector leadership in Kenya demonstrates several strengths, including its mixed methods approach, qualitative depth, and intersectional perspective, it is not without limitations. Addressing these limitations through methodological refinements, broader sampling strategies, and contextual sensitivity can enhance the validity, reliability, and applicability of future research on this important topic. Despite its limitations, the research contributes valuable insights into the complex dynamics of gender and leadership in the health sector and underscores the importance of advancing gender equity and inclusivity within the health sector in Kenya and beyond.

Recommendations

The recommendations outlined in this chapter are not exhaustive; rather, they are catalysts for discussion, inspiration for innovation, and foundations for future endeavours. They include the following:

1 **Establish Women's Leadership Academies:** Create specialised leadership academies tailored to the needs of women in the health sector. These academies can offer training, mentorship, and networking opportunities specifically designed to empower women to excel in leadership roles. By providing targeted support and skill development, these academies can help women overcome barriers and thrive in their careers.

2 

Implement Gender Quotas for Leadership Positions: Introduce gender quotas or targets for women's representation in leadership positions within health sector institutions. While controversial, quotas have been effective in increasing women's representation in leadership roles in other sectors. Implementing quotas can help break down systemic barriers and accelerate progress towards gender parity in health sector leadership.

3 **Promote Male Allies and Advocates:** Engage male leaders as allies and advocates for gender equity in health sector leadership. Encourage male colleagues to mentor and sponsor women leaders, advocate for inclusive policies and practices, and actively challenge gender biases and stereotypes within their organisations. By fostering a culture of allyship, organisations can create more inclusive and supportive environments for women in leadership.

4 

Incorporate Gender-Sensitive Leadership Training: Integrate gender-sensitive leadership training into professional development programmes for health sector leaders. Equip leaders with the knowledge and skills to recognise and address gender biases, foster inclusive team dynamics, and champion diversity and inclusion initiatives within their organisations. By embedding gender sensitivity into leadership development, organisations can cultivate a more inclusive leadership culture.

5 **Establish Women's Leadership Networks:** Create formalised networks and support groups for women in health sector leadership roles. These networks can provide opportunities for peer support, knowledge sharing, and professional networking, empowering women to navigate the challenges of leadership and build strategic alliances. By fostering a sense of community and solidarity, women's leadership networks can amplify women's voices and drive collective action for change.

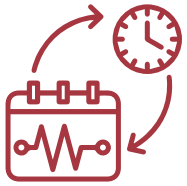
6 **Implement Flexible Work Policies:** Implement flexible work policies that accommodate the diverse needs of women in health sector leadership roles. Offer options such as remote work, flexible hours, and job-sharing arrangements to support women's work-life balance and facilitate their career advancement. By prioritising flexibility and work-life balance, organisations can attract and retain top female talent and promote gender diversity in leadership.

7 **Foster Gender-Inclusive Organisational Cultures:** Foster gender-inclusive organisational cultures that value and celebrate diversity at all levels of leadership. Promote inclusive language and communication practices, challenge stereotypes and biases, and create opportunities for women to participate in decision-making processes. By fostering a culture of inclusivity and belonging, organisations can create environments where women feel valued, respected, and empowered to succeed.

8 **Invest in Research and Data Collection:** Invest in research and data collection efforts to continually monitor and evaluate gender dynamics in health sector leadership. Collect disaggregated data on leadership representation, career progression, and workplace experiences to identify trends, gaps, and areas for improvement. By leveraging data-driven insights, organisations can track progress, identify barriers, and inform evidence-based interventions for advancing gender equity in health sector leadership.

Possible Research Directions

It is imperative to chart a course for future research endeavours that will continue to advance our understanding of gender dynamics, leadership practices, and organisational structures within the health sector. The insights gleaned from this study lay the groundwork for further exploration and inquiry, guiding future research directions aimed at addressing existing gaps, uncovering emerging trends, and informing evidence-based interventions for promoting gender equity in health sector leadership.

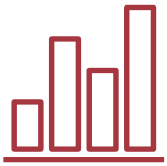


Longitudinal Studies:

Future research should prioritise longitudinal studies to track the progression of women's careers in health sector leadership over time. By examining career trajectories, promotion patterns, and leadership transitions, longitudinal studies can provide insights into the factors that contribute to women's advancement or hinder their progress within the health sector.

Intersectional Analyses:

Research that adopts an intersectional lens is needed to explore how multiple dimensions of identity, including gender, race, ethnicity, and socio-economic status, intersect to shape women's experiences in health sector leadership roles. Intersectional analyses can illuminate the unique challenges faced by women from marginalised and underrepresented groups and inform targeted interventions to address their needs



Comparative Studies:

Comparative studies that examine gender dynamics in health sector leadership across different countries, regions, and cultural contexts can offer valuable insights into the contextual factors that influence women's leadership experiences. By comparing leadership practices, organisational policies, and societal norms, comparative studies can identify best practices and lessons learned from diverse contexts.

Organisational Interventions:

Future research should focus on evaluating the effectiveness of organisational interventions aimed at promoting gender equity and inclusivity in health sector leadership. This includes interventions such as mentorship programmes, leadership development initiatives, diversity training, and policy reforms. Rigorous evaluation studies can assess the impact of these interventions on leadership representation, organisational culture, and employee outcomes.

The research directions outlined in this section represent a roadmap for future inquiry into women's health leadership in Kenya and beyond. By embracing innovative methodologies and adopting intersectional perspectives, researchers can continue to push the boundaries of knowledge, challenge entrenched norms, and advocate for a future where women's leadership in the health sector is celebrated, supported, and empowered.

Conclusion

The findings presented in this report underscore the urgency of addressing systemic barriers and fostering a culture of inclusivity, equity, and empowerment within health sector leadership. Qualitative narratives and quantitative analyses reveal that women continue to face formidable obstacles in their pursuit of leadership roles.

As we navigate the path forward, it is evident that transformational change requires collective action and shared responsibility. Organisational leaders, policymakers, health sector practitioners, and civil society actors need to unite for a common purpose to dismantle structural barriers, amplify women's voices, and create environments where leadership is truly inclusive and representative of diverse perspectives.

The recommendations outlined in this report offer a blueprint for action toward advancing gender equity in health leadership. From establishing women's leadership academies to implementing gender quotas, fostering male allies, and promoting flexible work policies, these recommendations provide a pathway to realising the full potential of women leaders and harnessing their talents to drive innovation, improve patient outcomes, and transform health sector delivery.

The journey continues, and with each step, we advance towards a health sector that embodies the principles of equity, inclusivity, and excellence for the benefit of all.

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Women in Healthcare Leadership:

Advancing Women's Leadership in the Kenyan Health Sector through Organisational and Systems Change Efforts

A descriptive study on employee perceptions on how organisational elements – structure, leadership, culture, and policies – constrain or promote women's career advancement in Kenyan health sector organisations.

Kenya Healthcare Federation
The Health Sector Board of KEPSA

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