CAREER PROGRESSION AND EXPERIENCES OF HEALTHCARE LEADERS AT SUB-NATIONAL LEVEL IN KENYA

Key Messages

- Gender issues were not directly identified as a significant influence on men or women's health leadership progression. However, the important influence of gender roles and relations emerged in men and women's different priorities, opportunities and concerns.
- In particular, women's role as child bearers and gendered societal expectations including child nurturing and other domestic responsibilities seemed to significantly influence career progression and uptake of health leadership positions.
- These gendered influences interact in relatively invisible ways with other factors more readily identified by respondents to influence their career progression and experience, including; professional cadre and personal and professional support systems such as family support, role models, professional mentorship and continuing education.

Introduction

Despite increased efforts at global, regional, and country level to promote gender equality, women continue to be under-represented in leadership positions across a range of sectors and geographic regions [1]. In the health sector specifically, women comprise a substantial proportion of the global health workforce [2]. However, women are over-represented in lower-paying, lower-status occupations and their representation declines with respect to higher professional categories including managerial and decision-making positions [3, 4]. This under-representation of women in leadership and managerial positions has resulted in increased research interest around gender and leadership. Nevertheless, the role of gender in healthcare leadership in low and middle-income (LMIC) settings remains under-researched; with existing research largely focusing on corporate settings or the healthcare industry in high-income contexts.

The KEMRI Wellcome Trust Research Programme undertook a study to understand and explore career progression and experiences of healthcare leaders at sub-national level in Kenya. Twenty-five healthcare managers with equal representation of male (12) and female (13) from two counties in coastal Kenya were interviewed. In addition to gender balance, respondents were selected to reflect varying length of experience in the health sector and the diversity of managerial categories within both the county and sub-county levels. This brief summarizes the key findings from the study and provides policy recommendations for addressing leadership challenges within Kenya's health system.

Key Findings

Career progression and trajectories

The study indicated that most of the respondents always intended to work in the health sector, even if not necessarily in a managerial position. After formal entry into the health sector, many of the respondents then progressed through the system usually gradually over time and sometimes more abruptly to various health leadership and managerial positions. Progression to these positions was either voluntary or involuntary and respondents had varied views about their advancement to leadership positions; with some being content to take up more managerial roles at the expense of their clinical or technical practice, whereas others were reluctant and would have preferred to focus on their practice.

"As doctors I don't think we are trained to be managers…I can give my own example. I was [abruptly] inducted into health leadership, very unfortunate…you might mess up. For me it was learning on the job. This [management] is something that actually nobody has prepared you for…To me that really doesn't work. Maybe [the person] is good with patients, perhaps maybe good with surgery, but it doesn't mean that they will actually be good with the leadership…"
(R014, male manager)

Enablers of career progression

Both female and male respondents cited a range of common factors at the personal and professional level that enabled them to advance in their careers. Personal enablers included: general family support and encouragement from parents and spouses; influential role models and personal mentors; inherent factors such as, self-determination and self-discipline; passion, commitment and ambition; and well-wishers who provided financial support for continuing education, especially as additional educational qualifications were viewed as a 'gateway' to job promotions.

"…apart from my supportive husband, I also have my parents. My father is also somebody who has really encouraged me to go further since I was a little girl…he knew that we can go higher than where we were. So, after he had educated us to that level, you feel challenged, like I should go beyond his vision. So, he has really been an inspiration to go further."
(R006, female manager)

Professional enabling factors included: professional mentorship; flexible work environments that accommodated for (paid) study leave hence enabling further study while in-service, which in turn increased opportunities for job promotions; partial study scholarships from employers; continuing professional development including on-the-job trainings; and supportive superiors.

Constraints to career progression

At a personal level time and financial limitations were highlighted as key constraints. This was particularly noted by women in the context of competing interests such as family obligations, which hindered the ability to take up certain job positions or further study, hence limiting opportunities for career progression.

"Some of the challenges especially being a family woman, it has not been very easy…you want to [further your education], money is needed for school fees for yourself and for the children, so you give the children an upper hand and sometimes you slow down…you have to balance between the family life and the career."
(R011, female manager)

The main professional constraint cited as a hindrance to career progression was limited opportunities for promotion, as there were many eligible staff and few positions available for advancement. Also noted as constraints by male and female managers were perceived biased promotions based on favoritism (including nepotism), corruption (*"mambo ya kichini chini"*) and having/not having the right connections.

Role of professional hierarchies

Professional cadre and hierarchies were widely viewed by both men and women as playing a very dominant role in both appointment to health leadership positions and general career progression. Specifically, medical doctors were stated as being preferentially selected for leadership positions and having faster and clearer career progression pathways than other health workers. This sometimes resulted in tensions between medical doctors and other categories of health workers.

"…there are some cadres, the doctor cadre, it's taken like a special cadre. You will find that their progression is faster than all these other cadres despite having similar qualifications…you could even be more learned than them, but you find [the system] favours the doctors. The other cadres have been left behind…like my son who is just doing his [medical] internship started in the same job group that I have worked in for the last 25 years. He found me with this career, I gave birth to him, I sent him to school, now he is a doctor and he has entered the same job group as me…Right from the beginning [the system] favours them.
(R011, female manager)

Gender and health leadership

Gender was not spontaneously or explicitly perceived as an issue impacting on career progression and leadership experience, and gender-specific or targeted initiatives were not raised by either male or female respondents. In fact, in the broader context of health leadership, gender was perceived by both men and women as a "non-issue".

"[Gender] is not even a side issue…it's a non-issue. Both our CECs [county executives for health] so far have been ladies…I do not think it's an issue for our department. If you look for example at the balance of our [management] team, we have about 5-6 females from a team of about seventeen."

(R005, male manager)

However, was gender really a non-issue? Indeed, even the suggestion that having approximately one-third representation of one sex within health management bodies means gender is a non-issue is problematic, as it implies that gender equity is solely about having certain numbers of each sex represented. On further discussion, some gendered distinctions related especially to women's career progression and perceptions of female leadership styles emerged. In particular, the role of women as child-bearers and nurturers was perceived by both male and female respondents as being disadvantageous to their career progression & ability to take up leadership positions.

"[When appointing a health manager] …if she is female, you have to consider if she has kids or not. That makes a difference. You will find that you select someone, train them and invest so much in them, then after working for only a few months they fall pregnant and go off on maternity leave. Also, once they have a child, the women tend to become irregular with work, there isn't that commitment…"

(R016, female manager)

Additionally, concerns around maintaining a work-life balance were primarily raised by female respondents, with many stating that they sometimes struggled to juggle between fulltime work and domestic responsibilities. This was often tied to cultural and societal expectations of the role of women, and was exacerbated by the fact that several of the female respondents were also undertaking part-time studies to increase their educational qualifications. All these potentially impacted on their ability and willingness to take up certain job positions and subsequently their career advancement.

Perceptions around male and female leadership styles were also noted as potentially influencing leadership selection and appointments. There were varying views on differences between men and women's character traits and thus leadership styles. Although in general women were perceived as being more honest and able to get more done, both male and female respondents described women as being 'emotional and reactive' in their leadership style; in comparison to male leaders who were perceived as more 'calm and level-headed'. There were also male respondents who felt that because women have previously been marginalized with respect to leadership positions, when given an opportunity to lead they are excessively forceful and authoritative as they feel that they must 'prove their ability'. However, there were male and female respondents who felt that generally women make better leaders since they are more innovative and societal roles and expectations equip them with the ability to multitask and undertake challenges in a calm and sober manner.

Conclusion

Career journeys and experiences were varied for both male and female respondents. There were, however, common overall influences both at the personal and professional level with either positive or adverse consequences. Despite the non-emergence of gender as an overt or key issue, our findings suggest that it was far from irrelevant and had a significant influence on career trajectories and health leadership experience. Most fundamentally, women's role as child bearers and gendered societal expectations including child nurturing and other domestic responsibilities, could influence their ability to take up leadership opportunities and their selection and appointment as leaders. Women's selection and appointment as leaders may also be influenced by perceptions of women and men as having different leadership styles. These gendered influences intersect in relatively invisible ways with other factors more readily identified by respondents to influence their progression and experience. These factors included: professional cadre, with doctors more likely to be selected into leadership roles; and personal and professional support systems ranging from family support and role models, through to professional mentorship and continuing education.

Policy and Practical Implications

The findings of this research suggest the importance of flexible family-friendly policies and arrangements in health systems to increase opportunities for uptake of leadership positions whilst still managing domestic responsibilities, as well as support with the challenges of balancing family and work life that were particularly pertinent for women. Such policies and arrangements have been instituted in other settings (particularly high-income countries) and could be adapted for the Kenyan context. These polices include:

1. **Flex-time;** which is a flexible working schedule that allows individuals to choose when they work as long as they put in the required hours
2. **Job-sharing;** where two or more individuals share a single position and therefore only work a fraction of the required time.
3. **Temporary or permanent switch to part-time employment;** allowing work away from the worksite.

However, for the above polices to work, country-specific settings would need to be carefully considered in adapting and implementing any of these strategies.

Beyond family-friendly policies and arrangements, positive professional-level influences can be built upon to enhance career progression and provide supportive working structures. Potential examples include: offering gender-sensitive flexible training programmes that allow trainees to undertake training over a prolonged period of time, and with modules scheduled to fit into existing work and personal life responsibilities; paid study leave for specialist leadership training, and potentially amending job descriptions and rewards to allow for and acknowledge such training; recognition of the important role played by personal support particularly for women, by for example allowing people time to do related assignments around their work and personal lives, or encouraging them to undertake assignments that take forward work-related needs thus offering double-value.

Whilst these suggested interventions are potentially relevant for all future leaders, it would be important – and even necessary – to be cognizant of the role of gender in leadership progression, and consequently design and implement them in support of having a more gender-balanced health leadership landscape.

About the Research

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