Women: An Undervalued Resource In Managerial Leadership In Healthcare

BY

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WOMEN: AN UNDervalued Resource In
Managerial Leadership In HealthCare

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of the Requirement for the Degree of Global Executive master’s in Business
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SUMMER 2015
STUDENT’S DECLARATION

I, the undersigned, declare that this is my original work and has not been submitted to any other college, institution or university other than the United States International University in Nairobi for academic credit.

Signed: __________________________ Date: __________________________

Summery Sitima (ID 644305)

This project has been presented for examination with my approval as the appointed supervisor.

Signed: __________________________ Date: __________________________

Dr. Francis Wambalaba

Signed: __________________________ Date: __________________________

Dean, School of Business

Signed: __________________________ Date: __________________________

Deputy Vice Chancellor, Academic Affairs
ABSTRACT

To better understand the dynamics involved in the gender issues in managerial leadership, this qualitative research explores the common features in the path of women aiming for top leadership or management in the healthcare industry in Kenya but currently at the level of middle management. The general objective of the study was to determine forces affecting the attainment of managerial leadership positions among women in the Kenyan health sector. Phenomenology was applied as the research design. The constructivism approach is utilized, thereby making sense of the perspectives of female leaders through a feminist lens; because the issues are only regarded from a female point of view. There were three specific objectives asked to cover three domains that contribute to managerial leadership, i.e. the role of gender in job negotiations, issues surrounding work-life balance and factors that motivate women to seek leadership positions. The stories were derived by conducting eight interviews with women in these positions. The questions asked were open ended to facilitate free flow response and elicit personal experiences from the interviewees. The journeys and experiences of the participants were explored in concert with existing literature in the area of female managerial leadership. Implications for career advancement, gender stereotyping, and role models for women in leadership capacities are highlighted in this study.

The major findings of the research were the negative effects of gender stereotyping on job negotiations. The effect tumbled to affect the women’s pay expectations and bargaining power when negotiating for a salary. Many women felt subdued and overcome by the stereotyping in organizations.

Furthermore, in the work-life balance issue, most of the participants felt that the organization and social support systems were the most essential component in establishing a positive work-life balance.

The study also revealed that most women in leadership were intrinsically motivated to attain leadership; they did not seek managerial leadership for better compensation or other external benefits.

In conclusion, gender has a major role to play in job negotiations as was shown by the findings from pay expectations and negotiating. In addition to that, gender stereotyping affects the outcome of job negotiation. In work-life balance, many women are unable to find a perfect balance and the organizational factors have a major role to play in the achievement
of the balance. In the third specific objective, it was concluded that most women leaders are more intrinsically motivate and tend to be mastery oriented in terms of goal orientation. From the above findings, it was recommended that organizations and societies a major role to play in the present gender gap. For change to be effected, structures to eliminate stereotyping, functional organizational support and mentorship programs, gender- tailored terms of service to enhance positive work-life balance and reward systems are some of the measures that can be put in place to enable women to overcome some of the barriers and rise to leadership specifically in the healthcare industry today. For future researchers, the study can be extended or modified to have a quantitative aspect with inclusion of men so that a holistic approach to gender and leadership is assessed.
ACKNOWLEDGMENT

This research could not have been completed successfully without the assistance of many people. I wish to express my gratitude to the United States International University for offering me the opportunity to study this wonderful programme. I’d also like to thank the student advisors and course facilitator Dr. Francis Wambalaba from United States International University for his patience and understanding through the entire course and research. His consideration and encouragement inspired me to complete this project and put my best effort.

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LIST OF ABBREVIATIONS

CS Cabinet Secretary
DH Department of Health
EEO Equal Employment Opportunities
EOWA Equal Opportunity for Women in the Workplace Agency
ILO International Labor Organization
KHDS Kenya Health and Demographic Survey
MOH Ministry of Health
SCMOH Sub County Medical Officer of Health
WHO World Health Organization
1.0 INTRODUCTION

1.1 Background Information of the Study

In this day and age, the idea that men and women naturally possess distinct characteristics is often treated cynically. Ideas about gender differences are derived from classical thought, Christian ideology and contemporary science and medicine. Classical thought in the African traditional set up fundamentally portrays a patriarchal society where the man plays a focal role in everything and is the chief decision maker and strategist both in the family and community as a whole. In most other societies likewise, men were perceived to be the stronger sex, more intelligent than women and possessing an in built courage. Men assumed the role of the breadwinner and women as the homemaker; the two were viewed as independent systems (Campbell & Clark, 2000).

The gender wage gap in most of the developed societies has declined in recent years. There is a remarkable difference in male and female compensation in the job market. The situation is widely the same in both corporate and government institutions. The differences cannot be accounted for by controlling for human capital factors such as gender differences in work commitment, education and experience (O’Neill 2003) or institutional considerations such as unionization (Blake and Khan 2006). The traditional division of labor between the sexes in which women managed the private realm and men the public continues to have an indirect influence on job negotiation outcomes through sex stereotypes and pay expectations (Bowles and McGinn, 2009).

The laws of economics and many studies of diversity propose that if the entire pool of human resources was exploited, the collective performance would overall improve. Legendary investor Warren Buffet has stated explicitly that one of the reasons for his great success was that he was competing with only half of the populace. The idea that the top level management, C-suite jobs and executive roles are mostly dominated by males is similar in most societies. In the United States, women are currently earning 60% of the graduate degrees and 57% of the undergraduate degrees (McKinsey, 2012). In spite of the academic achievements and accomplishments, women still lag behind at the management level. (McKinsey 2012) although a majority of the healthcare workforce in the United States is female (74%), women continue to be underrepresented in the C-suite of healthcare.
organizations (Dunn, 2014). According to the bureaus of labor statistics in 2014, United States, only a mere 7.3% of service managers was women.

According to a United Nations High Commissioner for Refugees (UNHCR, 2011) report, women in many countries are now participating in many areas of the public life. Accordingly, women are now visible as they are allowed to occupy various senior roles in both the private and public sectors. For instance, the report indicates that the participation of women in public and private sector has increased by 56% percent in the last 11 years. Unlike two decades ago, women occupy leadership positions in the media, judiciary as well as the Academia. However, the report indicates that women are underrepresented in leadership roles associated with non-traditional areas, trade unions as well as professional associations.

In the world, of the 195 independent nations, only 17 are led by women. This translates to only about 9% of the independent countries. Globally, women hold just 20% of the world’s parliamentary seats. (EOWA, 2010). Hilary Clinton, the presumptive democratic frontrunner for the United States presidential race in 2016 has criticized the underrepresentation of women by saying “We can literally count on one hand the number of women who have come here and turn their dreams into billion dollar businesses”

The McKinsey Organizational Health Index showed that companies with three or more women in top positions i.e. executive committee and higher, generally performed better than those without women in these positions. Despite the fact women make up 40% of the global work force, with double digit growth in some countries, there still exists huge gender disparities (McKinsey, 2012). Unfortunately only 3% of Fortune 500 CEOs and less than 15% of corporate executives at top companies worldwide are held by women (EOWA, 2013). In the European Union, women represent only 11% of the membership of the governing bodies of listed companies (EOWA, 2013). The employment rate for women in these countries is 21% lower than that of men (EOWA, 2013). The gender disparity is worse in southern Europe than in northern Europe. The situation is worse in the Asia-Pacific countries and the Middle East. After starting out behind the men, the women never really catch up and men move faster and higher up in the career ladder than women. However in the United States, the sudden startling recognition that 80% of new entrants in the work force over the next decade will be women, minorities and immigrants has stimulated a mushrooming incentive to “value diversity” (Schwartz, 2013). Mathew and Pachanatham
(2009) stated that the women workforce in India was mainly employed in non-managerial, subordinate or low profile positions in the past. Recent demographic research on women on corporate boards in New Zealand illustrates that while women constitute 47% of the workforce and 41% of the statutory board directorships; their proportion on the corporate boards is 7.13% (McGregor & Fountaine, 2006).

Sub-Saharan Africa’s already very high and rising female labor force participation rates unfortunately seem to be due to a negative factor: persistent and pervasive poverty, making economic activity a necessity rather than an option. (ILO, 2012)

In 2013 Global Gender Gap rankings, Kenya was placed 78th out of 136 countries, just below Uruguay and ahead of the European nations like Cyprus. South Africa was 18th while in the east African region, Uganda was placed 46th. The four criteria assessed in the survey included, economic participation and opportunity, educational attainment, health and survival and political empowerment. In order to make any strides towards national development and to attain vision 2030, the gender issues need to be addressed. In the labor force, women constitute 30% of the overall wage employment (Global Gender Gap Report, 2013).

Despite the fact that women represent 51% of Kenya’s population (KHDS, 2014), only a negligible number of women are in middle and senior management positions. None of the listed companies in the Nairobi Securities Exchange is chaired by a woman. More women have ventured into small micro enterprises, controlling 54% of the micro enterprises in the country (Global Gender Gap Report, 2013). In the judiciary, of the fifteen appeal judges, there is only one female among them. The gender gap is mainly attributed to factors such as traditional mindsets, societal beliefs and practices, poverty, domestic violence and lack of education especially beyond the secondary or high school level. In the healthcare industry, only one of the nine directors in the ministry of health is a woman. Furthermore, less than 10% of hospitals between level four and six are chaired by women. (Intrahealth Report on Gender, 2013).

The Kenya National Health Policy builds on a rights based approach which includes gender as a priority. However, the focus on gender is still in its infancy and most of the efforts and strategies put in place are geared towards access to health care by both men and women. Be that as it may, some cultures may have a negative outlook on the health systems and consequently reduced uptake of the medical services because of the gender concerns.
The determinants of health seeking behavior go far beyond the confines of geography, other factors such as religion and culture play central roles in the acquisition of medical care. A good example is in places like Garissa where the women prefer to be treated by a woman especially in sensitive disciplines like obstetrics and gynecology. The focus therefore should be holistic, from access to healthcare to management of the resources, with both men and men represented equally at all levels in the health care system. The health management systems should confer some dynamism and adaptability to deal with the needs of the communities and this can only be achieved through equal participation in management and decision making in the industry.

The career choices of middle and senior managers, men and women, are mainly influenced by their professional environment and personal aspirations (McKinsey, 2012). However, the McKinsey report further emphasizes that the successful women who had risen to the higher echelons of major corporations put career ahead of family but came up against many obstacles on their way to the top. The findings resonated for both women in top and middle management. In effect, gender cannot be merely defined by biology; it is a social construct that varies according to time, place and the prevailing circumstances.

Women face real obstacles worldwide in the professional world including flagrant and subtle sexism, discrimination and sexual harassment. In addition to that, women mostly get promoted based on performance while men get promoted based on potential. This is especially true at the middle management level. The numbers of organizations or companies that offer flexibility and access to childcare and parental leave that are necessary for pursuing a career and raising a family are wanting. Yet these women are expected to be successful in both their careers and family life. Misalignment of gender roles leads to prejudice women often face in accessing leadership roles as well as negative evaluations of their performance in leadership roles (Halman, 1983; Eagly and Karau, 2002).

Critics may argue that there is far more to life than climbing the career ladder. For some women, satisfaction is derived from raising a healthy family, seeking personal fulfilment and improving the planet and the lives of others. Be that as it may, this study is geared towards the women like me, who want more than they have. The study focuses on women who want to make decisions and aspire to make a profound effect by changing the structure and creating opportunities for women to follow. In organizational behavior and development
theories, any real change starts at the individual level. Therefore, the study will focus on individual women who want to make a change in the gender disparities that exist.

1.2 Statement of the Problem

The government of Kenya has a goal to achieve gender equality and foster women empowerment in all industries. In this regard, during the tenure of retired President Mwai Kibaki, a statement was issued (the affirmative action) which required that woman occupied a third of the jobs in the public sector. Furthermore, the constitution promotes the representation of women by allowing the parliamentary position for women representative for each of the forty seven counties. The gender quota system was however suspended ahead of the 2013 general elections and currently women make up only 19% of parliament and 15% of cabinet secretary positions in Kenya (Global Gender Gap Report, 2013). Women are still being sidelined and cannot participate fully in decision-making at any level (Wilson, 2012). Interestingly, three-quarters of the healthcare workforce comprises of women yet they are sparsely represented in the top leadership roles (WHO, 2006).

Despite the efforts put into play by many governments and organizations, women still occupy very few positions in management positions especially in the health sector. The work force at the level of management is not diverse enough. Intrahealth organization undertook a gender analysis of health work force data in Kenya which revealed occupational segregation. Most counties had less than 30% of women at the management level. In the ministry of health, only one of the nine directors is a female. In spite of this identified gender wage gap, no studies have been done so far to address the specific dynamics involved for the gap to persist besides the efforts put in place by the governing structures. Therefore, there is a need to study the dynamics that contribute to gender disparities by focusing on the women. This will further address the factors that limit opportunities for entry and growth at the management level for women in the healthcare industry. Since women's roles in leadership transpire in a multitude of settings and contexts, it is imperative that new research encompass multilevel frameworks that include both the macro and micro, and analysis across countries and institutional settings (deBruin, Brush, & Welter, 2007; Minniti


& Nardone, 2007). This study explores the dynamics involved in female leadership and managerial participation in the healthcare industry at the micro level.

1.3 General Objective

The general objective of the study is to investigate forces affecting the attainment of managerial and leadership positions among women in the Kenya health sector.

1.4 Specific Objectives

1.4.1 To investigate the role of gender in job negotiation of women in leadership and management in the health care sector in Kenya.

1.4.2 To investigate the aspect of work-life balance by women in managerial leadership in the health sector in Kenya

1.4.3 To determine the motivating factors that drive women towards attaining leadership and management positions in the healthcare sector in Kenya.

1.5 Significance of the Study

1.5.1 Institutional Authorities and Healthcare Organizations.

The research findings will be useful for institutional authorities in understanding the obstacles that female staff encounters in progressing upwards in the career ladder. These are “often invisible from above” because of the “glass ceiling,” the barrier blocking promotion for women (King, 1997). An understanding of this situation is very important in deciding on appointments and guaranteeing equal employment opportunities (EEO) for women in the health sector, because women have a vital role in promoting health at the individual, community and organizational level. Moreover, the findings will be beneficial in establishing the internal regulations in healthcare organizations towards achieving gender equality at top managerial positions. The study is a significant endeavor in promoting gender diversity in the
work environment and specifically in the healthcare industry. The study aims to contribute to global knowledge on the issues restraining or promoting career development among women in healthcare management from the perspective of developing countries. The data and discussion presented will give different managers in different industries a view of the specific metrics behind the differences when hiring managers of different genders.

1.5.2 Policy Makers and the General Public

This research will contribute to raising public awareness about gender issues. It will also have implications for policy development on women and gender equality which takes cultural influences into consideration. Policy makers can find the results useful in establishing a framework that will support women’s aspiration to leadership in different industries based on the dynamics and the influences of the barriers they face. The policies formulated will be an endeavor towards achieving gender equality at all levels of managerial leadership.

1.5.3 Researchers

This study will be beneficial to researchers in future who can build on the available data and raise questions that can be evaluated statistically to enhance knowledge and understanding of the topic. The scope of the study can also be widened to give a more comprehensive analysis. The study is expected to arouse new interest to the researcher and scholar about remapping the perceived challenges or constraints women in management face when advancing their careers. This can be achieved through establishment of new models and guidelines that propagate gender equality. Secondly, there is a growing need for research on women in managerial leadership in developing countries “so that indigenous scholars have access to research within contexts that are more relevant” (Strachan et al., 2010).

1.5.4 Women Aspiring to be Leaders

The study highlights the glass ceiling that women run into when they try to advance in their careers. The glass ceiling could be intrinsic or extrinsic. This study will be useful to women and girls in our society, especially in healthcare management. The women will have a chance
to understand the issues presented and probably use the available recommendations for career development.

1.6 Scope of the Study

The study focuses on women in healthcare management or women involved in managerial leadership in the healthcare sector in Kenya. The focus is on women because they are the primary caregivers in the Kenyan society at home and experience the phenomena surrounding management and leadership differently (Dew and Mustagh, 2005). The participant women are specifically at the middle management level, in government, non-government organizations and corporate organizations in the health industry in Kenya. Rather than spotlighting extraordinary women and elucidating the influence of their achievements, this research examines women in a lower level of leadership like business leadership and public office positions because of the importance of their involvement in economics and societies (Jones, Snelgose & Muckosy, 2006).

The participants will vary in geographical location; however, not all of the forty seven counties in Kenya might be represented. The projected number of participants will be eight to ten because qualitative research aims to explore the depth of a phenomenon rather than the content. This may be a perceived delimiting factor because the researcher may be biased to counties that have more women in management positions hence causing perceptual misrepresentations. Moreover, some geographical locations require considerable resources and logistics to access which may not be at my disposal.

The study will be conducted over a course of twenty one days. This period may be too short to give a comprehensive analysis and include more participants and therefore may influence the outcome of the study in general.
1.7 Definition of Terms

1.7.1 Glass ceiling
Glass ceiling - the phenomenon of women locked into middle management positions without much hope of moving into higher positions has come to be known as the “glass ceiling.” (Kalkowski & Fritz, 2004).

1.8 Chapter Summary
Chapter one is basically an introduction to the thesis. Various parts are outlined beginning with a background to the study with the main areas focusing on the disparities that exist in gender representation at management and leadership level in the healthcare industry in the world and specifically in Kenya. The information provided forms a backdrop to the statement of the problem and further outlines the purpose of the study. There is little evidence at present to support the gender disparities that exist and therefore there is need to explore the various dynamics that play a role on the existing gender gap. Fundamentally, the general objective and specific objectives are laid out bearing in mind that the scope of the study in terms of population is mainly centered on women.

The next chapter gives a literature review based on the research questions outlined in chapter one. Chapter 3 presents the methods and analysis section. In this chapter, a brief description of the data collection methods and the participants from which they are gathered are presented. Chapter 3 also explains the data analysis procedure chosen, including a description of the data collection instrument. Chapter 4 covers the quantitative results of the analysis and the results of the research questions, using thematic analysis. Chapter 5 includes the discussion. The discussion section, like the results, is presented in three sections, one for each research question. Conclusions and recommendations are drawn from the discussion.
2.0 LITERATURE REVIEW

2.1 Introduction
To investigate if gender plays a role in job negotiation of women in leadership and management in the health care sector in Kenya.

To investigate if a work-life balance is achieved by women in managerial leadership in the health sector in Kenya.

To understand the motivating factors that drive women towards attaining leadership and management positions in the healthcare sector in Kenya.

2.2 Role of gender in job negotiations of women in managerial leadership positions
Gender equality increases as women gain access to leadership positions (Eagley, 2013). There is a positive correlation of societal gender equality with economic productivity and national wealth (World Bank 2012). Kenya was placed 57th in terms of global gender gap study of wage equality- just ahead of countries like the United States of America and behind Switzerland holding the 56th position. Reports indicate that women earn lower salaries compared to their male counterparts (Equal Opportunities Commission in the United Kingdom, 2004).

2.2.1 “Glass Ceiling Effect”
The glass ceiling effect is defined as an unofficial barrier to opportunities within an organization or company preventing a protected class of workers, particularly women from advancing to higher positions (Glass Cliff, 2008; Olan et al, 2000). Research on women’s leadership has also found that women face barriers on their way to the top jobs, and while in those positions they may experience unequal employment opportunities and role conflict as well as patriarchal attitudes towards women (Coleman, 2009; Shah, 2009; Shakeshaft, 1987; Sperandio, 2009). Gender issues have been highlighted as the backbone that forms the discussion of the glass ceiling effect as perceived by women in leadership roles. Gender issues are the socially constructed expectations of women and their unique needs in terms of individual roles, responsibilities, opportunities and constraints in the workplace (International Labor Organization, 2009) a range of gender issues exist for women in organization including lack of access to formal and informal networks (Piterman, 2008), along with both a sense of psychological isolation and tokenism (Eagly and Karau, 2002). Other noted career barriers for women include difficulty in being promoted (Rhode and Kellerman, 2007), the
double burden of managing work and home (Piterman 2008, Stephen, 2004) and the effect on career breaks on career progression (Helwett and Luce, 2005). In addition to that, the lack of a role model is identified as a leadership barrier (Leiman et al, 2011). Research by EOWA in 2010 showed that more women reported the following as challenges to their careers, lack of supportive supervisors, exclusion from informal networks, and absence of senior role models, inhospitable culture / biased attitudes and failure of senior leadership to help in the advancement of their careers.

Women are still underrepresented in senior leadership roles across both public and private sector professions (Olsson, 2002) however, information from Powell (1999) and Helfat (2006) shows a dramatic increase in business leadership roles among women in management positions.

Table 2.1-Trend of Percentage of Women in Management Positions

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>PERCENTAGE OF WOMEN IN MANAGEMENT POSITIONS</th>
<th>FORTUNE 100</th>
<th>FORTUNE 500</th>
<th>PERCENTAGE INCREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIOR TO 1990</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MID 1990’S</td>
<td></td>
<td>8.8%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td>11.2%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td>12.5%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td>7.3%</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Helfat (2006)

In another perspective however, Vianen and Fischer (2002) maintained that because so many top managers are male, management subcultures are apt to be ruled by masculine values and standards, helping keep the glass ceiling in place. In the healthcare industry, the glass ceiling effect has not had sufficient studies to insinuate its existence. Accordingly, another issue that
attracts the attention of many researchers is empowering women with such programs as networking, mentoring, and work shadowing (Collard & Reynolds, 2005; Dean, Bracken & Allen, 2009; Dunlap & Schmuck, 1995; Eggins, 1997; Strachan, 1991; Wisker, 1996). In another opinion, the concrete wall and the glass ceiling have been replaced by the labyrinth—a navigable, yet still potentially challenging route to leadership (Eagly, 2007). Eagly offers seven reasons why the glass ceiling metaphor is misleading:

*Table 2.2-Reasons why the “Glass Ceiling” is a Misleading Metaphor According to Eagly*

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>It erroneously suggests that women have equal access to entry level Positions</td>
<td></td>
</tr>
<tr>
<td>It erroneously assumes the presence of an absolute barrier at a specific high level in organizations</td>
<td></td>
</tr>
<tr>
<td>It erroneously suggests that all barriers to women are difficult to detect and therefore unforeseen</td>
<td></td>
</tr>
<tr>
<td>It erroneously assumes the existence of a single, homogeneous barrier and thereby ignores the complexity and variety of obstacles that women leaders can face</td>
<td></td>
</tr>
<tr>
<td>It fails to recognize the diverse strategies that women devise to become leaders</td>
<td></td>
</tr>
<tr>
<td>It precludes the possibility that women can overcome barriers and become leaders</td>
<td></td>
</tr>
<tr>
<td>It fails to suggest that thoughtful problem solving can facilitate</td>
<td></td>
</tr>
</tbody>
</table>

2.2.2 Pay Expectations
Pay expectations of men and women vary from one culture to another and the outcome of negotiating for a good pay deal is different for men and women especially in management and leadership positions. Field research on job negotiations at organizational entry suggests that male managers and professionals tend to negotiate higher starting pay than their female counterparts (Bowles and McGinn, 2005; Brett and Stroh, 1997; Dreher and Cox Jr, 2000; Gerhart, 1990). Women tend to have lower pay expectations than men (Crosby, 1982; Rizzo and Zeckhauser, 1999). According to Major and Konar (1984), women tend to report lower career entry and career peak salary expectations than men. In addition to that, women tend to pay themselves less for equivalent labor and work longer with fewer errors for equivalent
Research on negotiation shows that pre-negotiation expectations are highly predictive of negotiation outcomes (Zetik and Stuhlmacher, 2002). Various studies have replicated the notion that women report lower pay aspirations than men entering negotiations and as a result negotiate less assertively (Barron, 2003; Kaman and Hartel, 1994; Major et al., 1984). However, other studies have described the pay negotiation difference as a societal expectation. Rynes, Rosen and Mahoney (1985) found in a field survey of more than 1500 managers, compensation administrators and union officials that more than 44% of those questioned rated women’s willingness to work for less money than men to be a “very” or “extremely” important cause of the gender pay gap (Gerhart and Rynes, 1991b). Reflecting and reinforcing men’s higher economic status, differential pay expectations for men and women and also influence the outcomes of job negotiations, because they color the negotiation aspirations of both candidates and employers. (Bowles and McGinn, 2008)

However research has also found those women’s lower salary outcomes is due to gender differences in negotiation performance and not necessarily the propensity to negotiate salary (Bohnet & Greig, 2007; Gerhart and Rynes, 1991a). Women may have a greater preference for negotiation than men when it comes to decision making over job components such as work and travel schedules, which impinge directly on household responsibilities (Bohnet & Greig, 2007).

### 2.2.3 Effect of Sex Stereotypes on Job Negotiations

Sex stereotypes motivate gender differences favoring men in job negotiation performance through a combination of fulfilled expectations of male superiority in negotiating ability and gendered social norms with regard to appropriate negotiating behavior. (Bowles and McGinn, 2008). According to Duehr and Bono (2006) the prevailing masculine culture in the typical organization as well as the gender stereotypes impact women’s opportunities to get
promotions. Furthermore, the masculine culture affects women’s experience at the workplace negatively. In their findings, Duehr and Bono (2006) gathered that stereotypes about the abilities and roles of women are the key barriers to advancement in leadership roles. Gender stereotypes as well as culture strongly influences the way an organization arrives at decisions regarding payment, hiring as well as promotions of women leaders (Heflick, 2009). Equally, Goldenberg (2009) posits that such stereotypes as well as assumptions can lead to biases; thus resulting to employers overlooking able and competent women candidates. Other studies however relate the lower pay expectations to the women and not just the organization or society. According to van Vianen and Fischer (2002), women may consciously or unconsciously do “self-stereotyping.”

Contrary to research findings on gender stereotypes and biases (Eagly & Carli, 2003; Eagly & Johnson, 1990; Eagly & Karau, 2002; Eagly, Karau, & Makhijani, 1995; Eagly & Mitchell, 2004; Eagly & Steffen, 1984; Jennings and McDougald 2007) explain that while past research has shown differences between men and women on several factors (human capital, social capital, financial capital, growth orientations, and industry choice), these have not necessarily accounted for the smaller size of female-headed firms or for discrimination problems toward women trying to secure funding (Fabowale, Orser, & A., 1995; Loscocco & Leicht, 1993; Rosa, Carter, & Hamilton, 1996; Watson & Robinson, 2003). Zimmer (1988) and Ciancanelli et al. (1990) suggest that it is important to target organisational and societal structures, stereotypes and ideologies of the wider society before gender related workplace discriminations can be eliminated.

Women are constrained to behave in accordance with their stereotypes as dependent, compliant (Neville, 1988), Gender stereotyping, the “consensual beliefs about character traits that describe men and women” (Weyer, 2007, p. 486), also causes barriers to women’s career progress (Coleman, 2002; Heilman, 2001; Mitroussi & Mitroussi, 2009; Truong, 2008).

2.2.4 Education Attainment
Indubitably, education is the most essential prerequisite for empowering any human being. Equally important, education attainment should be the number one priority for empowering women from all spheres of life as without education that is of equal quality to that given to men, women will ever get well-paid jobs. The education given to the girl child should be comparable both in content and quality to that given to the boy child. In addition, the
education given to women should be conscious of the real needs as well as the existing knowledge. The education given to women should allow them absorbed in the formal sector and enable them advance within careers. Women should be educated in the sense that they participate in decision-making structures within their workplaces (Lopez, 2005). Further, the education attainment will allow women to participate in government policy making and enable them to be represented in the government thus gaining political influence. Political influence is necessary in changing the existing healthcare systems by proper gender representation and in effect addressing of the needs of the population in a holistic perspective. Higher education and more working experience could instill more confidence in that individual and increased self-efficacy (Chong & Ma, 2010). Increased self-efficacy is important for leadership participation especially for women.

According to one of the United Nation’s report, the number of girls in tertiary level of education is higher than that of boys in developed countries. Though many could argue that this is commendable, it should be noted that the world’s population is dominated by the female gender. Schooling should the fundamental catalyst for change in gender stereotypes (Lopez, 2005). Women continue to face challenges such as absence of effective and efficient leadership training programs (Tharenou, 2005). Additionally, they seldom access training as well as development opportunities which can give them the required qualifications in order to compete with men effectively (Wilson, 2012). Extending education and training to women for them to become more active in the paid and productive workforce has shown to enhance economic development efforts further (Boserup, 1986). Women who have an education and work experience in social institutions with less concern for basic safety and nourishment for their families will have more opportunity to engage in leadership, than women who must be preoccupied with fundamental health and survival needs. (Bullough & Galen, 2008). Investments in girls' education have been found to benefit the home and workforce development and female participation (Lincove, 2008).
2.3 Work –life balance
Joshi et al(2002) state that work life balance is based on the belief that while work is important to all of us and to society, achievement and enjoyment in everyday life is essential to human and societal wellbeing. In a review of the literature as quoted by Simmard (2011), Kalliath and Brough (2008) identify six different definitions that are commonly used within the literature:

Table 2.3-Definitions of Work-Life Balance

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work-life balance reflects an individual’s orientation across different life roles</td>
<td>The extent to which an individual is engaged in – and equally satisfied with – his or her work role and family role</td>
</tr>
<tr>
<td>The extent to which an individual’s effectiveness and satisfaction in work and family roles are compatible with the individuals’ life role priorities at a given point in time</td>
<td>Achieving satisfying experiences in all life domains and to do so requires personal resources such as energy, time and commitment to be well distributed across domains</td>
</tr>
<tr>
<td>Low levels of inter-role conflict and high levels of inter-role facilitation contribute to higher levels of perceived work-family balance</td>
<td>The extent to which an individual’s effectiveness and satisfaction in work and family roles are compatible with the individuals’ life role priorities at a given point in time</td>
</tr>
<tr>
<td>Work-life balance is about people having a measure of control over when, where and how they work.</td>
<td>Low levels of inter-role conflict and high levels of inter-role facilitation contribute to higher levels of perceived work-family balance</td>
</tr>
</tbody>
</table>

According to Chalofsky (2003), a sense of balance is about the choices we make in terms of the time we spend at work and life domains; it includes balance of one’s work, personal and spiritual life and the amount of time allocated to oneself and others. Work- family balance is associated with quality of life when there is substantial time, involvement, or satisfaction to distribute across roles (Greenhaus et al., 2002).

The ability of professional mothers to integrate work and family is not well understood (Marckinus et al, 2007). Traditional gender ideologies continue to influence the division of domestic labor- and thereby the constraints of domestic realm on outside work-even when both men and women are competitively employed (Bowles and McGinn, 2008)
Women persistently face more household demands and family responsibility (Huang, Hammer, Neal, & Perrin, 2004; Jurik, 1998; Milkie & Peltola, 1999; Moen & Yu, 2000; Rothbard, 2001) even when working outside the home because women are still expected to be the primary caregivers. Both men and women experience work-life balance conflicts and especially at the management and leadership level. In the healthcare sector, the hours may be many, inconsistent and unpredictable. Some men and women aim to lead their own businesses is to have the control to choose the flexible hours associated with this in an effort to achieve better balance between work and family (Walker & Webster, 2007).

Recently, the emphasis has shifted towards the investigation of the positive interaction between work and family roles as well as roles outside work and family lives, and scholars have started to deliberate on the essence of work-life balance (Jones et al., 2006).

2.3.1 The ‘Double Burden’ Syndrome
According to Mckinsey (2012), the ‘double burden syndrome’ is the combination of work and domestic responsibilities. Women remain at the center of family life, with all the attendant constraints (maternity, child rearing, organizing family life and care of the elderly among others) (Mckinsey, 2007). The impact of the constraints may vary from one country to the other, depending on the support offered (infrastructure such as day care centers, tax policies that encourage women’s’ participation in the labor force etc.), but on average, European women continue to devote twice as much a time as men to domestic tasks; 4 hours and 29 minutes a day, compared with 2 hours and 18 minutes for the men in the sample (Mckinsey, 2007).

In a survey performed by Harvard Business Review in 2005, 2,443 women between the ages of 28 and 55 who obtained college degrees with honors or had a graduate degree; the main factors behind career break decisions for women were, need more time for the children(45%), sufficient household income(32%), lack of job satisfaction(29%), need more time for other family members(24%) and feeling of being ‘stuck in a rut’ professionally (23%). Innstrandt, Langballe and Falkum (2010) report that individuals working in occupations that necessitate
(1) Substantial interaction with others,
(2) Additional work roles, or
Professional responsibility for others are more apt to experience greater numbers of work life balance issues. Moreover, individuals working in a managerial or higher status occupation report higher levels of conflict between work and their personal life (Innstrandt, Langballe & Falkum, 2010). Many employees are taking work home with them, which has blurred the boundary between work and family (Baral & Bhargava, 2010).

2.3.2 Career Satisfaction and Value of Success
A research done by the World Health Organization (WHO) indicates that women often derive satisfaction from caring for others as well making others happy. They are often contended when they contribute to the society or do meaningful work. Women do not depend on the amount of compensation to get a sense of satisfaction. In fact, WHO indicates that majority of women leaders are enrolled in religious healthcare organizations that are not profit oriented. Women often prefer faith-based missions as well as community-based organizations as they believe they are more fulfilling and purposeful to work in.

The career success of women has been due to factors such flexible work practices as well as their networking within healthcare organizations. Moreover, the great support they receive from their family members has been significant in their career success as well (WHO, 2006). The success of women leaders in the healthcare sector has also been due to their leadership abilities as well as their involvement in community and professional groups. The existence of sponsors, who have often endorsed them, is also a major boost to their career success. Typically, women are known for their excellent management aspect at home as they value support and flexibility, as such, this aspect has largely contributed to their career success. As far as the traditionally male culture is concerned, the female gender in the healthcare system needs more sponsorships than the female gender within their communities. Martins, Eddleston and Veiga (2002) found that women’s career satisfaction was negatively affected by work-family conflict throughout their lives whereas men showed adverse effects only later in their career. Van Vianen and Fischer (2002) found that women cited work-home conflict as a motive for rejecting top management positions more often than men did. Rethinam and Ismai (2008) revealed that it is difficult to separate home and work life in an increasing competitive environment. Work life balance issues have been found to affect one’s identity,
well-being and quality of functioning (Cinamon & Rich, 2010). These factors in effect have an impact on the women’s career satisfaction.

### 2.3.3 Challenges to Career Advancement

Women often face various challenges when advancing in their career in the healthcare sector. More often than not, they lack supervisors who are willing to support them. Their supervisors, more so of the male gender often look down on them instead of offering support whenever needed. This often kills the women’s morale of advancing their careers. Further, women leaders in the healthcare sector are often excluded from the social networks as men often meet in social places in order to strengthen their networks. On the other hand, women cannot make up to these social venues as they have more responsibilities back at home. Purcell and Hutchinson (2007) found that supervisory leadership was among the most important factors, explaining positive psychological contracts, work satisfaction, felt excitement at work and loyalty to customers, colleagues and supervisor.

Women in leadership positions often lack role models as well as mentors. This has been considered a barrier to their career advancements as there are very few women leaders in senior positions in the healthcare boards of executives. Importantly, women face challenges within the healthcare institutions as they are characterized by an inhospitable culture. The culture within the organization plays a critical role as it can either motivate or demotivate the women’s desire to advance their career. Culture can make women in the organization feel excluded (WHO, 2006). There is little research on the impact of work-life balance practices and policies on women’s career advancement (Straub, 2007)

### 2.3.4 Support Systems

According to extensive research on work life balance, individuals with different sources of support (ex: coworkers, community and financial resources) create a buffering effect that help individuals deal with work-family conflict (Martins, Eddleston & Veiga, 2002; Cinamon & Rich, 2010). There are various forms of supportive systems in the healthcare industry such as social support systems, organizational support systems and hierarchal support systems from supervisors and mentors.

Social support is an informal social network that provides individuals with expressions of emotional concern or empathy, practical assistance, informational support or appraisal (Md-
Sidin, et al., 2008). Most societies perceive women as being unable to lead and therefore women mostly find weak social support systems when searching to attain leadership positions. The effects are worse in the healthcare industry where most administrative work and careers such as surgeons (who form part of the leadership in patient management in theatre) are traditionally male dominated.

With an increasing number of women in the workforce, Maxwell and McDougall (2004) found that organizations are more likely to offer more work-life balance programs due to individual’s home responsibilities. Work-life balance programs are used by organizations to help employees manage work life stress, with the goal being that employee’s work and personal lives can be reconciled (McCarthy, Darcy & Grady, 2010). Support from supervisors has been reported to reduce work role conflict, role ambiguity, and resultant work-family conflict (Major & Lauzun, 2010). The most common areas of employer involvement in work-family issues are: (1) the provision of child care benefits, (2) the use of options which enhance workforce flexibility such as flextime, voluntary shifts to part-time work, job sharing, work-at-home options, and flexible leaves (Johnson, 2004). It has been suggested that work life balance programs cannot yield expected results unless the organizational culture supports use of work-life balance programs (Porter & Ayman, 2010). Organizational culture is an important aspect in the success of employee’s attaining work-life balance; if the culture does not support it employees will not feel comfortable utilizing the programs (Maxwell, 2005). Research has demonstrated that supportive work-family culture and informal support have a greater effect on work-family conflict than do formal family-friendly organizational policies (Major & Lauzun, 2010). Traditionally, women are associated with the private and domestic domain of the home whereas the public sphere of work is administered by men (Coleman, 2003; Court, 1997; Qing et al., 2009).
2.4 What Motivates Women to Pursue Leadership Positions?

Motivation refers to “the reasons underlying behavior” (Guay et al., 2010). It is a prerequisite to have effective motivation of employees in the workplace (Bansal and Sharma, 2012). Gove (1994) discusses the biopsychosocial theory of motivation, describing human motivation to arise from the biological, psychological, and sociological processes that motivate behavior. This paper has relied heavily on social forces in discussing subordinate status, roles and challenges women face in attaining leadership positions, however, biological and psychological forces should not be ignored, as Gove (1994) reminded us in his work.

As discussed by Tamila (2010), many contemporary approaches to motivation study are based on Abraham Maslow’s investigations, which result from study of human’s needs as a basic behavior motive (Maslow A., 1943). Maslow disposes all needs in certain succession called hierarchy of needs where the first two groups (physiological needs and safety needs) are primary or lower level needs. The three next groups of needs (social needs, recognition needs and self-realization needs) are secondary or higher level needs. Frederick Herzberg tried to modify Maslow’s theory of needs. He created the motivation two-factor model, or Hygiene theory. According to this theory, the extrinsic motivators or hygiene factors (security, salary, work conditions, company policy and administration) and intrinsic motivators (prospective promotion, responsibility, challenges, recognition and achievement) affect feeling of satisfaction from job (Herzberg F., 1968). David McClelland recognized three types of motivation needs: need for power, need for popularity and need for success. Apart from the theory of motivation needs, a theory of motivation process exists which can be accepted as that of a great use for management (Tamila, 2010). One of the elements of motivation process theory is Victor Vroom’s theory of expectations. According to this theory, the employees are more motivated to perform better when they are sure that their efforts will lead to a high performance rating. On examination of work motivation the expectations theory envisages three interdependences: efforts and performance, performance and reward, reward and personal goal. Motivation is more effective when an employee is sure that his efforts lead to fair reward (Tamila, 2010). Motivation is reduced when an employee is given low appreciation of success or value of reward (Vroom Victor H., 1964).
2.4.1 Impact of Business Drivers on Motivation to Leadership and Management

Seemingly, recent studies indicate that there is little difference between men’s and women’s ambition. In effect, women also aspire for senior position roles both in the public and private sectors (Piterman, 2008). However, women often face stereotypical challenges in their quest for senior roles. Equally, business drivers often impact opportunities related to women leadership. Accordingly, the concentration associated with short-term financial return in the mainstream organizational culture is often prevalent. The business drivers affecting women in leadership are associated with the compulsion to respond to short-term primary performance indicators for the shareholder value maximization. Many organizations often focus on key performance indicators at the cost of market success and long-term organizational performance that is sustainable (Piterman, 2008).

Piterman (2008), points out that this impetus often influence the corporate culture as well as the daily business operations. Women in leadership find this kind of pressure challenging thus many of them often avoid taking on senior roles. They are therefore demotivated to pursue leadership positions. Business drivers determine and define good performance and as such, they influence reward of achievement as well as the measurement of that performance (Wilson, 2012). The organization’s desire to reap short-term profits often determines work practices. Accordingly, women face challenges associated with high competition and risk-taking in order to achieve the expected results (Gardner, 2011). These expectations often discourage women from competing for senior positions with their fellow male workers. Women in leadership positions are usually treated unfairly whenever a company records loss or low sales as they heavily castigated. The ability and support received in meeting performance expectations enhance the individual’s self-efficacy (Gist & Mitchell, 1992). The attainment of self-efficacy is a prerequisite in facing the challenge of managerial leadership in the healthcare industry. Women who lack self-efficacy most often refrain from leadership positons.

Contrastingly, men in similar positions are often given a second chance whenever a company’s performance falls as they believe the external factors could be the reason for the poor performance (Piterman, 2008). Apparently, the unspoken rules as well as the pressure to deliver results in corporate culture often narrow parameters thus; it makes it difficult for
women to ascend leadership positions. The underlying conditions in the corporate world, such as stereotypes undermine the “concept of equal opportunity.” The business drivers hardly accommodate the advancement of women to leadership positions. Pressurized financial focus associated with the short-term business model is the reason women find it difficult to participate in senior roles (Piterman, 2008). The concept of the pressures that business drivers stimulate is mostly experienced in profit making healthcare entities.

Women lack the confidence to implement initiatives that can alter the status quo. Following the 2008 world financial crisis, motivations as well as business drivers are now evolving quickly thus ignoring the conventional equality agenda. Businesses no longer prioritize women as far as leadership positions are concerned; instead, they are shifting their priority to meet the demands associated with the ever-changing competitive marketplace (Gardner, 2011).

2.4.2 Organizational Culture and Stereotypes on Motivation to Managerial Leadership

The expectations of people within an organization often administer the manner in which workers interact with each other, and the way they approach their work. Accordingly, all these aspects form the organizational culture (Lopez, 2005). Importantly, organizational culture impacts the way success as well as achievement is perceived and measured in an organization. Lopez (2005) also posts that culture affects the expectations of the experiences needed to realize career progression. Additionally, through culture workers get to understand the bureaucracy within the organization. Equally, Palermo (2004) is of the opinion that culture influences people’s perspective on leadership including the way potential leaders should behave.

Majority of organizational cultures globally are associated with predominant masculine ethos: stereotype patterns often dominate many workplaces in favor of men (Palermo, 2004). The masculine culture revolves around a result-focused environment, which favors an assertive ambitious and confident behavior. The masculine culture does not favor the communal characteristics of women. In the healthcare industry, this masculine culture is mostly perceived in certain professions such as orthopedics which has a predominance of men. Additionally, women are disadvantaged as the masculine culture involves navigating organizational politics as well as developing strategic relations (Palermo, 2004).
Organizational culture demands that a worker spends much of his or her time at the workplace thus lacking enough time with family. Given that women are the primary caregivers of their families in most societies, this organizational culture is a delimiting factor and may demotivate women from advancing their careers. All the above mentioned concepts often hinder women from advancing senior roles. Other cultural institutional forces inhibit women’s participation in leadership, such as sense of group belonging and responsibility (collectivism), regard for hierarchy (power distance) (Hofstede, 1980, 2001; R. J. House et al., 2004), and pessimism, prejudices, and stereotypes (cynicism) (K. Leung & Bond, 2004).

Organizational structure determines levels of responsibility, decision-making authority and formal reporting relations (Chong & Ma, 2010).

According to Duehr and Bono (2006) the prevailing masculine culture in the typical organization as well as the gender stereotypes impact women’s opportunities to get promotions. Furthermore, the masculine culture affects women’s experience at the workplace negatively, especially women at the level of top management. In their findings, Duehr and Bono (2006) gathered that stereotypes about the abilities and roles of women are the key barriers to advancement in leadership roles. Organizational culture can support or hinder the advancement of women in leadership. Some cultures within the organization can act as barriers to women’s inclusion in senior roles (Duehr and Bono, 2006). Research also indicates that masculine culture within the organization dictates how leaders should be perceived as well as the pathways an individual should take in career progression. In effect, masculine culture restricts and limits women’s progress as it favors men in management and most adversely in some industries such as healthcare and engineering. The masculine culture view men as more able and strong and as such fit for leadership roles; the males are therefore molded and encouraged to take up leadership positions. Equally, Goldenberg (2009) posits that such stereotypes as well as assumptions can lead to biases; thus resulting to employers overlooking able and competent women candidates. The effects in the healthcare industry may ripple down to patients’ perceptions and caregivers’ attitudes to the women entrusted to lead a team of professionals in the management of patients. Much research on female leadership has noted the function of patriarchal culture as a barrier to women’s advancement (Acker & Fueverger, 1996; Akao, 2008; Coleman, Qiang & Li, 1998; Dunlap & Schmuck, 1995; Eggins, 1997; Norris & Inglehart, 2000; Rutherford, 2001; Shakeshaft, 1987; White,
2003). Dana (2009) contends that “culture itself raises barriers for women’s aspirations simply because of the attitudes, learned behaviors and routine practices that are practiced and reinforced”

### 2.4.3 Intrinsic Versus Extrinsic Motivation for Women Leaders

Intrinsic motivation refers to motivation that is animated by personal enjoyment, interest, or pleasure, and is usually contrasted with extrinsic motivation, which is manipulated by reinforcement contingencies (Guay et al., 2010).

Educators typically consider intrinsic motivation to be more desirable than extrinsic motivation, and some research suggests that the learning outcomes of intrinsic motivation are better than those obtained under extrinsic motivation (Ryan, Connell, & Plant, 1990). These views can be replicated in the healthcare industry during education programs that focus on training of the professionals towards career advancement. Women work for intrinsic motivators, yet work places are filled with extrinsic motivation (Miles, 2013). Intrinsically motivated individuals satisfy their basic psychological needs for autonomy, competence and relatedness and therefore function optimally (Van den Broeck, Vansteenkiste & Has De Witte, 2010). Intrinsic work values express openness to change – the pursuit of autonomy, interest, growth and creativity in work (Ros, Schwartz & Surkiss, 1999).

The final source of motivation as integrated in Maslow’s theory is goal internalization (Kalkowski and Fritz, 2004) Closely related to Maslow’s need for self-actualization, this concept suggests that the person who is motivated has a desire to reach goals that are consistent with internalized values. (Kalkowski and Fritz, 2004)

Goals can be subdivided into mastery goals (which can be compared with intrinsic values) and performance goals (which can be compared with extrinsic motivation) (Broussard & Garrison, 2004). Mastery goals focus on learning for the sake of learning, whereas performance goals emphasize high achievement. (Miles, 2013) Mastery goals are associated with high perceived ability, task analysis and planning, and the belief that effort improves one’s ability; On the other hand, performance goals are associated with judgments about achieving, grades, or external rewards. (Miles, 2013). It is important to determine the goal
focus and motivational influences of women in healthcare leadership in order to understand why the gender gap exists and efforts that can be put in place to counter it.

2.5 Chapter Summary

This chapter has highlighted the various literature studies on women leadership following the research questions as listed in the introduction. The literature may not have been specific for the healthcare industry; however, the focus in most scholarly articles is on women in leadership and management without regard to the specific industry they are working in. The literature review forms a backdrop on the development of the methodology especially on the data collection instruments and analysis. The following chapter discusses the methodological approach for this study with sections on the research design, sampling design, research procedures, and data collection instrument and data analysis methods.
CHAPTER THREE
3.0 METHODOLOGY

3.1 Introduction
This research will be conducted from a qualitative approach. Qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Creswell, 2009) and how individuals interpret their social world (Bryman, Teevan and Bell, 2009). The sections include, research design, population and sampling design, data collection methods, research procedures, data analysis methods and a chapter summary.

3.2 Research Design
According to Yin (1994) as stated in Taole (2008), a research design is a plan that guides the investigator in the process of collecting, analyzing and interpreting observations. It is a logical model of proof that allows the researcher to draw inferences concerning casual relations among the variables under investigation (Taole, 2008).

The research will apply phenomenological research design. Phenomenology in its broadest sense refers to a person’s perception of the meaning of an event as it exists externally to (outside of) that person (Van Manen, 1990). A phenomenological research study is a study that attempts to understand people’s perceptions, perspectives and understandings of a particular situation (or phenomenon) (Van Manen, 1990). Phenomenological research is suitable for researching fields like general management, leadership, marketing, organizational and corporate strategy and accounting (Ehrich, 2005). The principle applied is from constructionist grounded theory approach (CGT) (Chamez, 2006) as it would be best to facilitate an in-depth understanding of each participant’s experience of health management and leadership and gain insight comprehensively. The areas of interest include the role of gender in job negotiations of women in health leadership and management in the Kenyan society, the phenomenon of work-life balance and lastly the factors that motivate women to progress their careers to leadership and managerial roles in the health sector in Kenya.

3.3 Population and Sampling Design

3.3.1 Population
The participant population was women in managerial leadership positions in the Kenyan health sector. Data on the number of women in these positions was lacking. However, the
table below, from a study done by USAID on Human Resources for Health showed the
distribution of health workers in Kenya. The number of women in management in the
industry however, was not explored.

Table 3.1: Provincial Distribution of Selected MOMS and MOPHS Personnel as a Share of

<table>
<thead>
<tr>
<th>Region</th>
<th>Nairobi</th>
<th>Rift Valley</th>
<th>North Eastern</th>
<th>Coast</th>
<th>Central</th>
<th>Western</th>
<th>Eastern</th>
<th>Nyanza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of national population%</td>
<td>8</td>
<td>26</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: MOMS/MOPHS HRIS, July 2010 and 2009 Kenya Population and Housing Census

3.3.2 Sampling Design

3.3.2.1 Sampling Frame
The population data was lacking and therefore convenient sampling was necessitated.
Sampling frame is hard to establish and it is assumed that cases are affiliated through links
that can be exploited to locate other respondents based on existing ones. The participant
women will be recruited based on the following criteria;

- The participant should be a woman working in the healthcare industry in Kenya
- The participant should be in managerial leadership position previously or currently.
- The participant should have interest in leadership in the healthcare industry.

3.3.2.2 Sampling Technique
Snowball technique will be used to find prospective participants. Snowball sampling is a
form of convenience sample where the researcher first makes initial contact with a small
group of people who are relevant to the research topic and then uses them to establish contact
with others (Bryman, Teevan & Bell, 2009). This initial group is then used to refer a
researcher to others who possess similar characteristics and who in turn identify others
(Cooper & Schindler, 2006). The areas the women will come from will be varied and
dependent on the participant referrals the researcher will get.
Women in healthcare management in Kenya

Theoretical population

Empirical population

Women

who Meet the criteria

Initial contact

Figure 3.1 showing snowball-exponential non discriminative snowball sampling.

3.3.2.3. Sample Size

Polit et al (2001) define a sample as a proportion of the population. Patton (2002) describes the different approaches of qualitative and quantitative research regarding the sample size as a tradeoff between breadth and depth of information gathered. The research is qualitative in nature and therefore the emphasis will be on obtaining information that has depth.

A phenomenological research method generally utilizes a small sample size (Polit and Beik, 2004). The emphasis per se is not about the number of participants in the study but about the point at which the points become repetitive i.e. saturation point. According to Boyd (2001), two to ten participants are sufficient to reach saturation. However, Creswell (1980) recommends long interviews with up to ten participants.
3.4 Data Collection Methods

According to Field and Morse (1996), a qualitative study has three phases i.e., conceptual phase, interpretative phase and narrative phase.

The conceptual phase has the following steps:

- Formulation of research questions and literature review as seen in the preceding chapters.
- Literature review information was used to formulate the concepts and understand the phenomena under investigation.

The second phase is the interpretive phase which involves data collection, analysis and interpretation.

In order to ensure ethical research and to gain the participant’s trustworthiness and confidentiality, an informed consent will be utilized. The following items were developed in the informed consent based on Bailey (1996):

<table>
<thead>
<tr>
<th>Table 3.2 showing elements used for participant selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
</tr>
<tr>
<td>Identity</td>
</tr>
<tr>
<td>Rights</td>
</tr>
<tr>
<td>Data recording and use</td>
</tr>
</tbody>
</table>

Narrative approach was the guiding framework used to understand the participant’s perceptions of women in managerial leadership in the healthcare industry. Narrative serves to connect the broad domains of art and science (Daly (2007). Daly explains narrative as “stories that create the effect of reality, showing characters embedded in the lived moments of struggle, resisting the intrusions of chaos, disconnection, fragmentation, marginalization,
and incoherence, trying to preserve or restore the continuity and coherence of life’s unity in the face of unexpected blows of fate that call one’s meanings and values into question”.

Following Singh and Vinnicombe (2006), semi-structured interviews were chosen as the primary research method in this study. In addition to the demographic details (qualifications, age, marital status, children, job position, number of years of experience in the healthcare industry in Kenya), questions discussed what the women understood to be the glass ceiling, appointment procedures, salary negotiations, reasons for women’s low representation on the corporate and government boards in the healthcare industry, gender stereotyping, aspiring women’s visibility and the issues surrounding work-life balance, the value of success and job satisfaction, role models and efforts for motivation to attain managerial and leadership positions. It was attempted to have all questions as open-ended as possible. Questions were continuously improved to enhance their clarity. In some cases where the participants are unsure about the meaning of a question, the question will be explained and examples provided from the literature to make it as understandable as possible.

3.5 Research Procedures
Prior to the commencement of field work, a research plan will be implemented with the researcher preparing materials such as the interview guides, material for note taking and tape recorders. The researcher also developed a short form for use when note taking to capture contextual and non-verbal features of the interviews. All participants were informed about the purpose of the study, what their participation meant the risks and benefits before their written consent was obtained. Participants were first asked to fill out a preliminary questionnaire about their personal characteristics; their age, gender, education level, their marital status and their parental status. The interviews themselves were conducted in the style of a structured conversation; the order of the questions varied in some cases to guarantee a natural flow of the interview. Probing open-ended questions were used to elicit more information. The interviews were tape recorded and later transcribed verbatim; the questions in the interview guides were open ended and asked as eye contact was maintained with the participant. The data was captured from audio recordings alongside transcripts. In-depth interviews took place in the office of the respondents. Contact information of principal investigators and alternative contacts were shared with study participants for any additional
information about the exercise. Furthermore, there is a question and answer section to enable participants to add any information that may be valuable to the researcher. All raw data – audio recordings, transcripts, field notes - were stored safely and in password protected files or folders adhering to IntraHealth policy on human research participant protection.

3.6 Data Analysis Methods
According to Patton (2002), qualitative data interpretation and analysis needs to focus on three aspects as follows;

1. making the obvious obvious
2. making the obvious dubious
3. making the hidden obvious

Phenomenology yields statements of meaning and groups of statements of meaning units (Sayre, 2001). Analysis of the information gathered will be performed through content analysis, specifically thematic content analysis. Content analysis, an instrument of qualitative data reduction and categorization based on core consistencies and meaning, serves to identify the most important meaning units which are referred to as patterns and themes. (Sayre, 2001) Thematic analysis examines what is said rather than how it is said (Bryman, Teevan & Bell, 2009). It is important to determine how participants make sense of what has happened (Bryman, Teevan & Bell, 2009). Transcripts coding was carried out using NVivo 10 coding software. The software was useful in converting the audio information to words in groups and further classified them according to the themes. Content analysis was used to detect patterns, similarities and differences between groups and different types of participants. Emerging typical themes and discourse were identified and matched with the topics that had been guiding tools in the development of the questionnaire. One of the emergent themes that evolved was the role of organizations in attaining work-life balance for women leaders. The question was asked under the work-life balance section but during analysis, a lot of content was drawn to the topic therefore enabling it to emerge as a theme. The analysis was carried out under the topics which had been developed from the literature review. The following table summarizes the data analysis procedure.
**Table 3.5- data analysis**

<table>
<thead>
<tr>
<th>Data analysis method</th>
<th>Computer aided using Nvivo (QSR International)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of analysis</td>
<td>At the end of data collection</td>
</tr>
<tr>
<td>Data sources</td>
<td>Primary source materials included interviews transcripts backed up with audio files</td>
</tr>
<tr>
<td>Importation</td>
<td>Documents imported in .doc(x) format. Consistent styles utilized as per interview questions; to make use of Nvivo auto coding when entering data from second or subsequent participants. Sources already structured by themes- by use of interview guide as provided in the appendix B. Audio files given in .mp3 format- data edited and stored in another file to avoid compromising software performance.</td>
</tr>
<tr>
<td>Codes and nodes use</td>
<td>Under view tab in the software, coding stripes option was selected to see which sections of the text were coded under which nodes. Quotes associated with a certain node (or theme); the ‘node’ button was clicked and associated text segments were highlighted in color</td>
</tr>
<tr>
<td>Creation of memos</td>
<td>Used to identify participants Created as a link to project item In navigation view, under sources, memos folder clicked. Then ‘create tab’ option in the sources group selected.’ Memo’ option selected. New memo dialogue box opens and description of participants given.</td>
</tr>
<tr>
<td>Creating models and charts</td>
<td>Models created based on the themes that were created as described above. Examples are given in the results section. The participants’ responses are given as per the nodes and colors are used to identify and match the responses as shown in the biodata table in chapter four.</td>
</tr>
</tbody>
</table>
3.7 Chapter Summary

This chapter has explored the research methodology used in the study. The research design, sampling method, the procedure undertaken, the instrument development, data collection and analysis have been described. The next chapter will focus on the findings from the above.
CHAPTER FOUR
4.0 RESULTS AND FINDINGS

4.1 Introduction

This chapter describes the findings of the study. The ultimate aim of the research was to investigate the dynamics involved in the gender gap in managerial leadership in the healthcare industry in Kenya. The areas covered under this chapter include; general information of the participants, results for the role of gender in job negotiations, results for work life balance and results for motivation of women to managerial leadership.

4.2 General Information of the Participants

The participants in the study were all women in middle management in the healthcare industry in Kenya, with the aim of advancing their careers to the level of top management or attaining leadership positions.

Each participant’s background and ensuing path towards a managerial leadership position however, represented individual qualities and experiences, making each story and response unique within the common bond they possessed but with the same themes emerging within the concepts of the study. The interviewees’ names are not provided to maintain confidentiality. The ages of the participants varied from twenty five years to fifty years.
Table 4.1 showing participants’ biodata

<table>
<thead>
<tr>
<th>PARTICIPANT CODE</th>
<th>AGE</th>
<th>MARITAL STATUS</th>
<th>ORGANIZATION</th>
<th>RESPONSIBILITIES/JOB POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCO1</td>
<td>38 years</td>
<td>Married</td>
<td>Government of Kenya-MOH</td>
<td>Medical superintendent at county referral hospital</td>
</tr>
<tr>
<td>PCO2</td>
<td>29 years</td>
<td>Married</td>
<td>County Government-DH</td>
<td>County pharmacist</td>
</tr>
<tr>
<td>PCO3</td>
<td>34 years</td>
<td>Married</td>
<td>Private insurance firm</td>
<td>Medical advisory role at middle management</td>
</tr>
<tr>
<td>PCO4</td>
<td>31 years</td>
<td>Married</td>
<td>University of Nairobi</td>
<td>Masters student; entrepreneur in partnership with colleagues</td>
</tr>
<tr>
<td>PCO5</td>
<td>40 years</td>
<td>Married</td>
<td>Private health sector</td>
<td>Middle management but trained nurse</td>
</tr>
<tr>
<td>PCO6</td>
<td>53 years</td>
<td>Married</td>
<td>Non-governmental organization</td>
<td>Manager aiming to attain position of country director</td>
</tr>
<tr>
<td>PCO7</td>
<td>30 years</td>
<td>Married</td>
<td>Non-governmental organization</td>
<td>Manager in various projects</td>
</tr>
<tr>
<td>PCO8</td>
<td>25 years</td>
<td>Single</td>
<td>County government-DH</td>
<td>SCMOH- aspiration of becoming CS of health in future</td>
</tr>
</tbody>
</table>

4.3 Role of Gender in Job Negotiations

4.3.1 The Glass Ceiling Effect

The glass ceiling effect was explained to the participants from the definition given in the thesis. Most of the participants could actually describe it in their own experience.

Participant PCO4 described it as an invisible barrier that women run into when women are trying to rise in their profession. She further explained it as below
“It is termed glass ceiling because you can actually see beyond the glass, where exactly you want to go; but any attempts to rise past this glass barrier are pointless, because you bounce right back to where you were.”

PC08 and PC05 believed that the glass ceiling was a sort of phenomena created by the expectations of the society that makes women illegible candidates to attain leadership positions. PC05 said,

” Young women aspiring to attain leadership positions are scorned and laughed at. They are also discouraged from going above any position which the society thinks would be inappropriate for her. In the healthcare industry the experience is very bad for young female doctors who have to perform simple tasks like leading a resuscitation team.”

PC03 noted that women in leadership had a difficult time in pursuing higher ranked positions due to the need to have children and the challenges of raising children as the primary caregiver. She stated that childbearing for women is a whole other career and women may choose or opt out of positions that will prevent them from performing this career. Participant PC02 echoed her words and said,

“For us women, the decision to progress in the career ladder is not individual. You have to consult your spouse, it has to sit well with him that you may get a better salary than he gets. For some women I know, this kind of dreaming that is, ‘to dream to lead’ is a suicide mission for the family. Most women are the rocks and the pillars of the house. Leadership is involving and that absenteeism from home can break the family apart.”
4.3.2 Pay Expectations
On the question of pay disparities, all the respondents believed there was a significant difference in the way in which men and women are compensated for their jobs.

PC02 said,

”most men negotiate for a better pay than women. The fact is their opening remarks in an interview when asked about terms of employment are usually about financial compensation.”

PC07 further emphasized by saying,

“Men seem to have more bargaining power, in my experience with my colleagues, their confidence and assertion wins them over. It’s not to say I am not confident, I am just not comfortable with negotiating for salary with ardor and vehemence. Sometimes I am so overwhelmed with thoughts of how busy I will be, how many leave days I will be entitled to, the benefits, you know.”

The third question was a follow up to the question on pay disparity. The question mainly focused on the primary negotiation terms for the position the participants had sought. The question was more appropriate for the participants working in the private health sector.
PC03 had been a manager at an insurance firm for over three years. She had taken up the position because it allowed her to have regular hours so she was able to make time for her husband and family.

“I did not think about the salary at first, all I wanted was to be in Nairobi where I could take care of my husband and sons. My previous posts were in rural areas and the travelling was hectic over the weekends especially for my sons.” These were comments made by PC01 to echo what she had gravitated towards when seeking her position.

Other factors stated by the participants as necessities when negotiating for their position were demonstrated in the comments from PC08:

”My primary terms for negotiation were largely focused on growth in my field. I had to see the potential for growth and my present position had to act like a fulcrum or a learning base.”

On the question of the challenges towards attaining leadership positions, various factors emerged at the level of the society, the organizations the participants worked in and the individuals themselves. At the society level, the challenges were almost similar among all participants. Most participants agreed that the society in Kenya, more so in the healthcare industry did not believe that women were rightfully placed even at the lower management levels.

PC01, PC02 and PC08 all served in their capacity as leaders in governmental organizations in rural areas. The challenges they noted were centered on working in a patriarchal society while at the same time being the objects of change.

Arguably, PC003 who had worked previously at a rural facility but was now placed in the urban set up was able to comparatively ascertain that though women face a lot of stigma in most of sub-Saharan Africa, there was a shift in thinking in the urban set up. She noted that more women were getting leadership positions and the society would soon embrace the culture of employing people based on merit alone; with no regards whatsoever to their gender.

PC06 noted that it was much more difficult for women to rise up the ladder in the health industry.
She said” For women in healthcare, it is much more difficult to rise to leadership levels. I would be a legendary statistic if I was given the position of chairlady. Furthermore, women lack role models. There is nobody up there who can hold your hand and tell you how it’s done. It’s like walking down an invisible path. This makes leadership an exclusive gentleman’s club because men have so many mentors to look up to. I could actually get a mentor but not someone who goes through the same challenges as I do. Men and women have it so different.”

**Figure 4.2 showing the effects of gender on job negotiation and pay expectations**

### 4.3.4 Sex Stereotypes

The next question covered sex stereotypes. The first part of the question was whether the women had encountered any sex stereotypes in the organizations they worked for. All the participants answered unanimously as yes. The explanations were varied but most of them were perturbed by the stereotypes they had encountered and to some extent had a role to play on their ability to negotiate for better terms of service. PC06 further stated that she had indeed faced many stereotypes to the extent of living up to the stereotypes.
“My competence and ability to perform even simple tasks was always in question. I felt that I was less qualified for my job eventually. The self-doubt had reached its peak and had taken over me completely. I only realized my potential when I got externally evaluated, but by that time the damage had been done. To this day my ability is still questioned.”

PCO1 attributed sex stereotyping to community or society-based beliefs or the culture and expected norms. She complained:

“I have to convince people every day that I am the doctor in charge. This is worse when I attend meetings at the county level. I have earned the position rightfully but I am often discriminated against in the boardroom. Sometimes, especially in the beginning of my career, I would be affected by such hostile attitudes but I eventually learnt to live with it. I attribute the attitudes and expectations of the community members to their culture. Men are the leaders and women fulfill domestic responsibilities, which is common in most African and even western societies.”

PC08 had more to say on the issue of sex stereotyping. She believed that women do not just have little faith in what they do hence pushing the society to treat them as if they are not able to perform their responsibilities. She believed that most women actually try to come out of the shell of stereotyping. She further stated that women in leadership positions support other women aspiring for the same. However, the women leaders are so few and far between.
4.3.6 Role of Education in the Advancement of Careers for Women in Leadership

“The education level greatly contributed to my success in attaining my position.” These were the words of PC08. She further continued, “In medical school it is a jungle for the fittest to survive. Your mind is constantly under pressure to perform yet again the stress is supposed to shape your character; I developed a thick skin and learned how to survive. I did not get my position by default or random selection. I struggled for it. People question my age and gender and second guess my qualification but I just laugh and tell them to deal with it.” All the participants’ responses highlighted the importance and the contribution of education towards promoting managerial leadership for women in the healthcare industry.

PC03 emphasized that though education was a key to attaining leadership, both formal and informal networks had to be incorporated to ensure women seeking leadership positions were all rounded and able to face the challenges that leadership entails. She said,

“Leadership is a process not an episode in one’s life. It should be nurtured right from the early years. Girls should be taught more than just domestic responsibilities. In most communities, the girl child is taught how to fetch water, how to cook and perform other domestic responsibilities. However, the boy child is educated on decision making and even left to make critical decisions at a tender age.”

Education has a role to play in leadership because the precepts taught in school shape ones thinking and most of the women in the study had attained leadership position because of both the formal and informal education they had received.

4.4 Work – life balance

4.4.1 The “Double Burden Syndrome”

The question in the interview guide for the’ double burden syndrome’ was simply asking the participants to state any challenges they were facing in combining work with domestic responsibilities or leisure activities.

PC01 stated that the challenges she had in combining her work responsibilities and domestic responsibilities were mainly due to the unpredictable nature of her work. She said,
”During the cholera outbreak in the sub county, I was part of the emergency response team and had to be recalled from my annual leave. I did not hesitate to travel back to work. There was an arrangement for someone else to take up my administrative responsibilities for the time I would be away but it was an emergency and I had to avail myself as the team leader.”

PC05 had also experienced challenges in combining her work with domestic responsibilities.

“My work schedule has irregular hours and lots of travel. I just want to settle at home sometimes so that I am able to see my children a little more than I see them. Whenever I get free time, I have to catch up with reports. Over the weekends I have to attend to my domestic responsibilities. When you put everything together at this stage in my life, it is quite difficult to make time for leisure. I have paid for annual membership at a gym in the local area but I hardly get to go.”

PC08 was not concerned about domestic responsibilities and difficulty with balancing the responsibilities with her work schedule. She was more concerned about the lack of time for leisure activities. She attributed some of the challenges in balancing work with leisure to the unpredictable nature of her work and working over the weekend and sometimes late into the night. She said,

“Regarding work-life balance, I think women face more challenges in this aspect. Most societies are okay with the men not fulfilling domestic responsibilities that entail being actively involved in raising and caring for children. As long as they provided financial support, everyone is happy. My biggest concern though, is that women do not get enough time for leisure activities. If a woman is not at work, she is involved in caring for the family and taking care of the home. If you ask some of my colleagues when the last time was when they truly had “me-time”, they were probably single.”
4.4.2 Career Satisfaction and Value of Success

The participants were asked to describe best what career satisfaction would be. The responses were varied but the theme that emerged was a positive work-life balance. Some of the participants also described career satisfaction as having a sense of purpose which eventually leads to a sense of fulfillment in the career.

PC04 said,

“Career satisfaction for me is basically doing something that gives me joy every day when I go to work. The value of success, well, I would say if I had enough time for vacation with my family and had a well-paying job that would be the pinnacle of joy. I would say I made it.”

PC07 said that for her, career satisfaction is not a one day or one moment affair. She described it as;

“A process of life where most of the days, let’s say 70% are spent satisfied at the job, it means more than just getting paid or getting time off. The place has to be convenient, the time has to work, and the people have to be mostly on
the same wavelength in terms of motivation. It’s a spectrum of events that happen in a whole lifetime.”

PC06 was of the opinion that career satisfaction and value of success go hand in hand. She explained this by saying individuals who were happy at what they were doing generally became more successful and in effect, the value of their success is placed on career goals that have been achieved. She further added that once career goals are achieved, most people will overcome the challenge of balancing work responsibilities and family responsibilities.”

PC01 however described career satisfaction as “being in a job environment where you can learn and grow and be whoever you want to be.”

**4.4.3 Role of Organizations in Work –Life Balance**

The question asked to the participants in this section was to determine the role of the organizations they work in on the effect of work-life balance in their lives was, if there was adequate support within the organization.

The responses were mixed and varied even for participants who worked for nearly the same organization.

PC08 said,

“The government is one of the best employers. One is able to fulfill domestic responsibilities, for example, you are allowed three months off for maternity leave and 30 days of annual leave. Furthermore, in my previous post as medical officer at the county hospital, we would get nights off after working at night. These could be accumulated or compounded to the leave days. The organization also allows for time off for personal development. I went to Eldoret for two weeks last month for training to that effect. However, the health docket was devolved so the terms of service are different in every county. I believe schedules are more flexible if the number of personnel is enough to cater for the coverage gaps than can arise when other members are away.”

However, PC01 who is also a government employee in the devolved sector had a different opinion. She was concerned about the high expectations from her employer. She said that
even after taking care of emergencies a whole night, she was still expected to show up at work at eight am the following day. She said she was on a lifetime continuous shift because she was often recalled even during her leave days. Therefore, attaining balance between domestic responsibilities and work responsibilities was somehow unimaginable.

4.4.4 Role of Social Support in Work–Life Balance
The respondents were simply asked if there were any existing social support systems in their lives that fostered a positive work–life interaction.

Most of the participants had their spouses to support them in fulfilling domestic responsibilities.

However, PC01 had a slightly different experience in the matter;

“"My husband is in the army and lives in Kismayu currently so I am basically by myself. The society at large knows I am a successful woman so I am expected to be able to take care of my family and work.”"

PC08 had varied opinions from her experience and journey to attaining leadership.

“Support from spouses for many women is difficult to state. Every single day of the marriage is not the same. I cannot say that every single day of my
career is the same as well. There are days I will need to work longer hours and he might also be facing the same challenge at work, so the question begs, who will compromise their time off work for the family. Naturally, the men will expect their wives to do as much. The women who ask (or leave alone ask) the women who conceive the idea that their spouse will handle the domestic responsibilities for the required time are frowned upon by society. It’s a delicate balance.”

4.4.5 Challenges in Work –Life Balance that Hinder Career Advancement
In this section of the interview guide, the respondents were asked to talk about all other challenges they have encountered as women in advancing their career, with the core problem being work-life balance. The reason for asking this question in the end was because it sort of summed up the topic of work-life balance and the participants were able to add much more that had not been adequately covered in the preceding questions on work-life balance. The responses were basically on themes such as job schedules; need to have children and expectations and culture of the society. PC07 said,

“I wanted to grow in my career two years ago and that involved taking more responsibilities. However, I had pressure from my family to start a family so I yielded and decided to start a family before embarking on my career journey. In retrospect, I wish I had followed my heart.”

4.5 Motivation of Women to Lead
This section was covered by five questions in the interview guide. The themes that were explored were in correspondence to those in the literature review as with previous sections of the research questions.

4.5.1 Factors that Motivate Women to Lead.
To explore this theme, the question the respondents were asked was to state the factors that had motivated them to attain their current positions. Since the research criteria included
women who were aspiring to rise higher in the leadership hierarchy, the questions were also asked in consideration to their aspirations.

PC06 was very motivated to attain a leadership position. She stated that she wanted to be financially independent. To achieve this, she believed that she would need to be in managerial leadership. She said,

”All my life, I have watched women who despite their career growth, they are still dependent on their spouse or another person. I think getting to the level of top management gives you good financial compensation and this is tied to independence.”

PC03 was motivated by the need to get to career satisfaction. Career satisfaction as she described earlier was getting exactly where she wanted to go. Her aspirations were to attain a position of managerial leadership.

PC07 believed she was highly motivated to succeed in her ambitions to attain top leadership. She said,

”I want to drive the wheel for change to be effected, I am doing a lot at my level but I believe if I had a better position, I would have more leverage in promoting change.”

However, another participant, PC05 maintained that leadership was a calling. She knew right from childhood that she had to lead. In addition to that, her strong religious background helped her nurture her leadership ambition.

“I grew up knowing I would always become a leader. I was brought up in a Christian family and I had to attend church and extra services on weekdays frequently. Though I received no formal training on leadership at home, the church and religion helped me grow towards attaining leadership. My motivation has always been from my heart. I am not chasing power or paper (money)”

4.5.2 Effect of Business Drivers on Motivation of Women

The question asked to cover this section was “Do you believe that when business drivers exist in an organization women in management are more motivated to lead? What is their overall effect?”
The respondents gave two sets of answers, one group was in the affirmative to both questions but four of the respondents disagreed on the question. They believed that business drivers had no effect whatsoever on women’s motivation. They stated that motivation comes from one’s heart and external influences are merely sideshows; therefore, they rarely affect women to lead. The overall effect of business drivers is therefore on the performance and not the motivation to lead. PC05, who works in the private sector said

“I know my roles and responsibilities and no matter what deadlines or expectation I am given, I still want to become CEO someday.”

The respondents whose opinions were in the affirmative included PC03. She said,

“I just want to do my thing and go home, but when they put pressure on me from me I kind of find myself going out of my way to please the board. I will work harder and to the best of my ability, obviously the results will be outstanding. What will the overall effect be? I will be so proud of myself and start believing in myself and eventually I will want to rise higher and take up more challenges.”

PC05 who works in a private organization emphasized the need for organizations to focus on long term organizational performance rather on key performance indicators which focus on immediate results. Women face more challenges in attaining leadership and may therefore not execute their roles comfortably the first few days in the position. Rather than focus on the organizational performance, the individual tasks and roles should be aligned with the personality to foster growth and prosperity by improving overall performance of all employees (including women).

4.5.3 Expectations of Colleagues and Effect on Motivation

This part of the research was explored by asking the participants if there were any expectations the colleagues in the organizations they worked for had motivated them to attain leadership.

PC02, a county pharmacist said,
“My appointment as a county pharmacist was first of all controversial. I am a woman holding a position apparently coveted for by many men with the same academic qualifications. They felt I was not good enough and I was bound to fail. Sometimes the health system has issues for example; county cash was frozen in many counties over the last financial year. Procurement of pharmaceuticals for the hospitals became a challenge because we were to get the drugs on credit and after some time, the suppliers felt we would not honor the agreement to pay. There was a resultant deficit of drugs because they did not deliver. This was translated as a failure on my part and my abilities to hold the office were questioned. I was accused of not taking responsibility yet the problem was well beyond me. This was not the first time there was a shortage of drugs, in fact, the supply had been steady during my tenure up until September last year; but the fact that I was a woman holding the office and there was a problem in it, I suddenly became the root cause of the problem. We held a crisis meeting and most members present were men. They collectively agreed that a greater part of the problem was my incompetence; however, I gave them a comprehensive report of the problem and suggested solutions together with the treasury official at the county. I had to defend myself. I constantly have to defend myself and my decisions. I think the problem is further accentuated by virtue of my youth.”

PC04 who was studying for masters in medicine program at a local university echoed the above sentiments. She said,

“I always laugh in the operating theatre. My colleagues, who in my field are mostly male, are always surprised when I perform a procedure. Sometimes I do it in less time than some of them and I think some of them mostly find it annoying. Am I driven to achieve success by their comments? Of course I am always proving a point at one time or the other so I have to keep getting better. I remember one time in my first year; my professor was very surprised that I knew the answer to a question he had asked. Afterwards, I decided to change that surprise to admiration. I do not feel good about it because I know
I put in much more effort than my colleagues just to get accepted or get approval.”

“One eventually becomes successful because of the motivation you get, but I think it’s different for everyone. For some people, such low expectations would make them do less because they would think, no matter what they do; they will still think the worst of me and expect substandard results.” These were sentiments from PC05; she felt that though motivation could be drawn from a negative situation, it may have an overall negative effect on certain individuals.

4.5.4 Intrinsic versus Extrinsic Motivation

This section of the study sought to explore the main motivation orientation of the subjects. Furthermore, the participants were asked about their goals for leadership and the focus of the goals was established, with most of the women having mastery goals. Only two participants had performance oriented goals and gave good reason. PC04 said,

“My passion to succeed and be a woman of substance is what drives me to go to work every day and face whatever challenge ahead. About the focus of my goals, well, I have set standards for self-improvement so I accomplish tasks as per these targets.”

However, PC08 had a different opinion on the goal orientation, she said,

“My goals are to prove all those who said I could not make it wrong. When all this is done, and I am an executive, I will smile at them and say, I told you so.”

Her goal orientation was performance oriented and she attributed this mentality to the stress and challenges she has overcome to attain the position she presently has. She also complained that, despite everything she had done, her efforts were unrecognized so she believed that when and if she attains top managerial leadership, her efforts will be recognized.
This chapter has presented the results from the interviews conducted for the research study. The questions asked were generally about the role of gender on job negotiation, issues to do with work-life balance for women in management and motivation for women to attain leadership positions. Most of the answers given by the respondents followed a similar pattern of experiences and opinions. Some sections had varied answers but the themes arising from the response followed similar trends. The next chapter covers the discussion, conclusions and recommendations for improvement and future studies.
CHAPTER FIVE
5.0 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS.

5.1 Introduction
The study sought to investigate the impact of gender on women leadership in the healthcare industry in Kenya. The findings indicated that both the women as individuals, the organizations they worked for and the society at large had a role to play in the present gender gap and had a substantial influence on the female participants’ exercise of leadership.
This chapter outlines the discussion of the results obtained from the research study. After the discussion, conclusions are drawn and recommendations are made. The recommendations made are for improvement and for future research on the issues surrounding women in the healthcare industry.

5.2 Summary of the study
This study explored how different forces affected the women participants’ leadership experiences and shaped their beliefs and perceptions about leadership. The general objective of this qualitative study was to explore the characteristics of women leaders, the challenges they encountered on their journey to leadership including their reasons for attaining and pursuing leadership positions. In summary, overall objective was to investigate the forces affecting the attainment of managerial leadership positions among women in the Kenyan health sector. The specific objectives were; to investigate the role of gender in job negotiation of women in leadership and management in the health care sector in Kenya; to investigate the aspect of work-life balance by women in managerial leadership in the health sector in Kenya and to determine the motivating factors that drive women towards attaining leadership and managerial positions in the healthcare sector in Kenya.
Phenomenology research design was applied, underpinning a theoretical framework to the study. The qualitative nature of the research made it possible to tell the stories of the participants’ journeys in order to understand their career progression and journey to managerial leadership and how it pertained to the concept of leadership. The eight participants recruited for the study were women in positions of influence within the healthcare industry specifically at the level of middle management. Snowball sampling was used so that the chosen participants would have experience with the central phenomenon being studied. All of the women contacted to participate in this study readily agreed to share
their experiences pertaining to managerial leadership in healthcare. There was some level of diversity regarding the age of the participants. Semi-structured personal interviews were conducted to collect data. Open-ended questions were used so the responses of the participants could guide the development of themes and the direction of the study. Once the data was collected through audio-taped interviews, codes were assigned to sections of the text to help identify themes using software called NVIVO version ten. The raw data in audio version was converted into a word document and grouped into themes using the codes derived from the interview guide.

The stories of the participants were interwoven based on the themes and also analyzed in terms of the existing research. A discussion of the findings incorporated the literature and provided evidence of connected concepts. Strategies including rich description, and clarification of biases were used to strengthen the study’s findings. Ethical issues were addressed throughout each phase of the study. The leadership experiences of these women showed that stereotyping and organizational factors such as the ‘glass ceiling effect’ strongly influenced their beliefs and perceptions about leadership. Issues around work-life balance also affected their access to leadership roles and career advancement. The major issue noted at this section was the challenge of managing work and domestic responsibilities. Lastly, the research findings also showed that women were motivated to lead intrinsically and had mastery-oriented goals. The organization and society have the biggest role to play in enhancing the motivation of women to leadership.

5.3 Discussion

5.3.1 Role of Gender in Job Negotiations

In the research questions, the participants were all aware of the glass ceiling effect and some even cited stories to describe it. As the interviews progressed, the findings seemed to agree with Eagly’s statements on the glass ceiling effect; it had been overcome or overruled by the labyrinth. In her paper she states, the concrete wall and the glass ceiling have been replaced by the labyrinth—a navigable, yet still potentially challenging route to leadership (Eagly, 2007).

The narrow aspect of the glass ceiling has been criticized but with good evidence to suggest that more than one factor exists and the factors that exist cannot be given a blanket statement.
The labyrinth phenomenon describes a journey to leadership that women take. In a journey, there different times and experiences; these form a complex understanding of an individual’s perception of the journey.

The study findings as demonstrated by comments by the participants on the glass ceiling effect, (see figure 4.1) agree with findings on other research on women’s leadership which has found that women face barriers on their way to the top jobs, and while in those positions they may experience unequal employment opportunities and role conflict as well as patriarchal attitudes towards women (Coleman, 2009; Shah, 2009; Shakeshaft, 1987; Sperandio, 2009). The results that resound with these findings from Coleman, 2009 were described best especially by the interviewees who were trained medical practitioners.

Traditionally, medical practice was a male oriented career and women were preferred in the more nurturing nursing profession in the field. Women who are in the healthcare industry, specifically doctors may not be likely candidates for programs such as surgery. Such professions in the industry are supposed to be labor intensive and the field is dominated by men who may reflect the patriarchal attitudes that bar these women from pursuing careers in such fields.

The study findings agree with Coleman, 2002, Mitroussi, 2009 and Truong, 2008 who stated the effect of gender or sex stereotyping on women’s career progress. Gender stereotyping, the “consensual beliefs about character traits that describe men and women” (Weyer, 2007), also causes barriers to women’s career progress (Coleman, 2002; Heilman, 2001; Mitroussi & Mitroussi, 2009; Truong, 2008). The findings suggested that the gender stereotypes form a barrier and may have an effect on the attitude and overall performance on women. The effect is worse for women in leadership because they face so much more criticism and are expected to perform poorly in managerial positions.

According to van Vianen and Fischer (2002), women may consciously or unconsciously do “self-stereotyping.” However, in the study, the participants felt that the society had molded the way people think. The effect of external stereotyping was worse for the women than their own stereotyping. Some of the participants were driven to attain leadership by other women who believed in them. Coleman (2002) also argues that stereotypes of women can be traced to the deep-rooted, patriarchal prejudices of society, as was suggested by the findings of the
research. One of the participants, as quoted in the results section alluded the failure of women to lead from societies expectations of women.

Accordingly, another issue that attracts the attention of many researchers is empowering women with such programs as networking, mentoring, and role shadowing (Collard & Reynolds, 2005; Dean, Bracken & Allen, 2009; Dunlap & Schmuck, 1995; Eggins, 1997; Strachan, 1991; Wisker, 1996). This was clearly brought out by the research findings because most of the participants felt that there weren’t enough programs or mentorship to attain leadership. This was also in agreement with Leiman et al., 2011 that, the lack of a role model is an identified leadership barrier.

The study also unraveled that women do not confidently ask for or negotiate for the terms of service they are entitled to. Most of the participants admitted that they felt grateful at first to attain these positions that it did not occur to them to negotiate for favorable terms of service. This interpretation is supported by Shakeshaft (1987), Coleman (2002, 2005) and Cubillo (1999), who claim that women’s lack of confidence is likely to be the result of their unfamiliarity with a working environment where leadership is expected to belong to men.

Some of the women further talked about their deficiencies in negotiating for terms of service. The most dramatic were the ones in the corporate and non-governmental sector where interview are performed and terms of employment are negotiable. The women mostly focused on getting a job with a predictable and consistent schedule coupled with a good number of off-days or leave days in a year. One of the respondents said that she had not thought about the pay or salary being negotiable. This is consistent with the findings of research done that has found that women tend to have lower pay expectations than men (Crosby, 1982; Rizzo and Zeckhauser, 1999).

The study established that the entire pool of participants had attained leadership positions because of their academic progress. The need for education to the girl child was emphasized because most of the participants believed that the degree of woman’s assertiveness is proportional to their education level. The benefit of education was not only individual but to the society at large. These findings were consistent with Linco, 2008 who stated that,
investments in girls’ education have been found to benefit the home and workforce development and female participation.

5.3.2 Work-Life Balance

The study agreed with the findings of other researchers on the barriers women face such difficulty in being promoted (Rhode and Kellerman, 2007), the double burden of managing work and home (Piterman, 2008, Stephen, 2004) and the effect on career breaks on career progression (Helwett and Luce, 2005). The career breaks noted in the study included the need to have children. One of the participants described motherhood as an entire career on its own. The general opinion was that the combination of work and domestic responsibilities was a challenge to attaining leadership. Once again leadership or managerial positions were viewed as time consuming and involving with high expectations and demands from the organizations the participants were employed in. This leads to significant challenges in rising up the ranks of leadership because some women may not be able to perform the work they are mandated to do efficiently and still have an organized family. Furthermore, for younger women trying to rise to positions of influence i.e. top management in the healthcare industry, the challenges they face are based on decision making. Their spouse or family or community may not understand their aspiration or motivation to lead. They may feel discouraged by the negative influence they get from a lack of belief from the people who matter in their lives. Some of the findings of the research highlighted the role of social support system in attaining work life balance for women in leadership. Most of the participants believed their spouses had greatly influenced their ascension to leadership by forming a support base and encouraging the women to seek leadership positions and progress upwards in their careers.

There has been varied literature on the issue of career advancement, in the Chinese context, many women sacrifice their career advancement for their husband’s success and by so doing “they realize their own value” (Qiang, et al., 2009, p. 97). The study however brings to mind a different opinion; most of the participants took career advancement as an individual task or responsibility. They only realized the influence of their partner after they had decided to seek leadership positions. In addition to that, leadership positons for the women in the study were sought on a basis of self-fulfillment and for their own personal satisfaction. I did not explore
whether the women had spouses who held leadership positions and the effect of their spouse career progression on the women therefore was not explored.

The issue of domestic roles and balancing between work and leisure time was evidently brought out in the study. Traditionally, women are associated with the private and domestic domain of the home whereas the public sphere of work is administered by men (Coleman, 2003; Court, 1997; Qing et al., 2009). These opinions were brought out in the research because most of the findings suggested that women face a lot of stigma in leadership. They are seen as going against the perceived responsibilities. Women are supposed to perform domestic responsibilities in most African communities and leave the decision making process to the men. This thinking had an effect on the organizational cultures the women worked for, with the effect tumbling down to the colleagues, the supervisors and the junior staff.

On the subject of career satisfaction, it was almost unanimous for all the participants; they all felt that a positive work life balance was the greatest denominator in attaining career satisfaction. Most of the participants described career satisfaction as a state of being glad at what they were doing but still finding time to attend to their domestic responsibilities. Other participants denoted flexible work schedules and time off from work. No single participant talked about financial compensation as a contributory factor to career satisfaction. Martins, Eddleston and Veiga (2002) found that women’s career satisfaction was negatively affected by work-family conflict throughout their lives whereas men showed adverse effects only later in their career. The findings of the research therefore agree with Martins (2002) et al.

The findings of the research also agreed with Maxwell, (2005) who explored the role of organizational culture on work-life balance. He stated that organizational culture is an important aspect in the success of employee’s attaining work-life balance; if the culture does not support it employees will not feel comfortable utilizing the programs (Maxwell, 2005). In the study, there were mixed results on organizational support for a positive work life balance. Some of the participants noted that there were mechanisms in place for work–life balance such as days off after working a night shift, three months off for maternity leave and time off for personal development for the staff. The point that emphasized Maxwell’s (2005) findings was the programs the organization had put in place such as training programs on other
aspects of life outside the industry. The staff was able to travel and accommodated in a different location; the training programs also had time off for leisure and exploration in the said locations.

Social support is an informal social network that provides individuals with expressions of emotional concern or empathy, practical assistance, informational support or appraisal (Md-Sidin, et al., 2008). Most of the participant’s responses were in tandem with Md-Sidin et al, on the subject of social support systems. The participants felt that they were an integral part of achieving a positive work-life balance. The social support systems from most of the participants were derived from their spouses and families and provided the practical assistance that is described in Md-Sidin’s interpretation of social support systems.

5.3.3 Motivation to Leadership

David McClelland recognized three types of motivation needs: need for power, need for popularity and need for success. According to the findings of this research, most of the participants were motivated by the need for success. The findings suggest that women are more motivated to lead by the need for success than the need for power or affiliation. Good motivation is critical for achieving organizational objectives. Therefore recognizing workers needs is an essential step to planning and motivational efforts to achieve gender equality in leadership.

The results of the research were consistent with most of the research perpetuating the effect or the role of culture in motivation of women to lead. Much research on female leadership has noted the function of patriarchal culture as a barrier to women’s advancement (Acker & Fueverger, 1996; Akao, 2008; Coleman, Qiang & Li, 1998; Dunlap & Schmuck, 1995; Eggins, 1997; Norris & Inglehart, 2000; Rutherford, 2001; Shakeshaft, 1987; White, 2003). Dana (2009) contends that “culture itself raises barriers for women’s aspirations simply because of the attitudes, learned behaviors and routine practices that are practiced and reinforced”. The specific culture noted in this section is organizational culture. However, one cannot separate organizational from social cultures because most organizations have cultures
arising from the beliefs and practices of the society they operate within. The organizations in the findings had a masculine culture especially at the leadership level. The results suggest that women in leadership positions are isolated at the top. They have no support from the organization and no structures or mechanisms were in place to ensure that they experience leadership without the challenges involved. Inasmuch as the organizations had elevated or appointed women to leadership positions, they had to ensure mechanisms exist to support women leadership and eliminate the negative barriers.

Shaw (2003) notes that “while the organizational culture itself is determined by what people do, it, in turn, provides the guidelines for how people will respond to any given set of circumstances that arise”. In this study, Shaw’s opinion is clearly supported by the findings that eventually the behavior of the organization becomes a pattern and is embraced by the employees vertically and horizontally. If an organization tolerated and had no policies on ensuring gender balance, then most of the leadership will follow a masculine trend and it will become acceptable as a norm. When this happens, any woman rising to managerial leadership will face opposition and might have challenges in proving her worth. The study is in agreement with Coleman’s (2009) suggestion that selectors are influenced by the female stereotype which associates women with home and family, and that this link is difficult to break. These stereotypes need organizations to form policies to counter them so that the culture of the organization shifts to embrace gender equality.

The study also agrees with findings from other research that states that, other cultural institutional forces inhibit women’s participation in leadership, such as sense of group belonging and responsibility (collectivism), regard for hierarchy (power distance) (Hofstede, 1980, 2001; R. J. House et al., 2004), and pessimism, prejudices, and stereotypes (cynicism) (K. Leung & Bond, 2004). Most of the participants felt isolated at their level of management and were faced with a lot of pessimism, prejudices and stereotypes regarding the roles they were playing. In turn, the influence on their work performance as leaders was negative.

The participants also felt that some organizations favored men and the effect was more pronounced again, in fields such as neurosurgery. The recruitment process at most medical schools involved interviews and since the discipline is dominated by men, most of the men
who aspired for the positions were favoured. This finding is in disagreement with Akao’s (2008) study but consistent with many scholars who claim that women face discriminatory attitudes from male authorities in recruitment and appointment (Coleman, 2002, 2005; Evetts, 1994, Hall, 1996; Shakeshaft, 1987).

Many organizations often focus on key performance indicators at the cost of market success and long-term organizational performance that is sustainable (Piterman, 2008). These are termed as business drivers. The results of the study are in concert with Piterman’s findings. The findings in the research suggested that organizations do not focus on the long-term organizational performance; the workers are given schedules and pressure to perform regardless of their personality or gender. In the end, the organizations lose out on human resource and some organizations are known for being unfavorable to women. In the healthcare industry, this is pronounced in certain fields especially the labor intensive ones like neurosurgery. If a woman is working for an organization as a neurosurgeon, she is put under much more pressure to perform based on very subjective key performance indicators. Organizations should therefore establish individual performance indicators and involve the employee in setting goal and targets for achieving success.

Piterman (2008), points out that this impetus often influence the corporate culture as well as the daily business operations. Women in leadership find this kind of pressure challenging thus many of them often avoid taking on senior roles and shy off from managerial leadership. Furthermore, the criticism they face is much more if the targets are not achieved and the women are regarded as failures.

The study revealed that most women attaining leadership positions are intrinsically motivated to achieve success. Intrinsically motivated individuals satisfy their basic psychological needs for autonomy, competence and relatedness and therefore function optimally (Van den Broeck, Vansteenkiste & Has De Witte, 2010). Most of the participants echoed intrinsic motivation as their drive to leadership. The participants’ description of what motivated them to pursue managerial leadership was in line with Van den Broeck et al’s 2010 definition of intrinsic motivation. Most of the women were driven to attain leadership by basic
psychological needs and the need for success. They did not seek leadership for external benefits such as financial compensation or the need for power and control. The goals most women set, as per the findings of the study are mastery goals when pursuing leadership. The description of the goals they had determined to achieve was in line with Miles (2013) description of mastery goals versus performance goals.

5.4 Conclusions

5.4.1 Role of Gender in Job Negotiations
Using a feminist lens, this study has unraveled obstacles that the women healthcare leaders face. First, this research suggests that the small numbers of women in the senior educational hierarchy are a consequence of multifactorial influences from the individual to the organization and lastly to the society. Leadership is still dominated by men in Kenya and this dominance is most prominent in the male preserve where the women in this study were working, that is, the healthcare industry. The barriers they face in attaining leadership include, the ‘glass ceiling effect’, gender stereotyping and lack of role modeling and mentorship that could be explained as lack of informal education from a tender age.

5.4.2 Work-life Balance
Today, women’s values are widely recognized and respected in most societies. Women are constantly exhorted to uphold their traditional roles and qualities in the period of change yet again they are expected to work in their careers to the best of their potential. The resultant effect has been a struggle in attaining a positive work-life balance for women. The study highlights the importance of the organization and support systems in realizing a positive work-life balance. A positive work-life balance is essential to any woman aspiring to be a leader.

5.4.3 Motivation to Leadership
The findings of this study have significant implications for the improvement of women’s representation in healthcare leadership and gender equality. Women’s motivation to leadership is intrinsically, but to maintain the momentum, the organizational culture has a significant role in helping these women achieve their desire to lead.
5.5 Recommendations

5.5.1 Recommendations for Improvement

5.5.1.1 Role of Gender in Job Negotiations

Some of the barriers in this construct include, the ‘glass ceiling effect’- which overtime will be replaced by the labyrinth, the effect of gender stereotyping, the individual women’s lack of belief in themselves therefore having lower pay expectations and the effect of training and education on the pursuit of leadership. Therefore it is recommended that training and mentoring programs should be offered to young leaders or leadership aspirants to ensure gender equality among the leaders in our society. Women should also be given these programs to nurture their self-belief therefore increasing their bargaining power- which is influenced greatly by self-worth. It is essential to re-socialize gender stereotypes in the society by putting campaigns to educate the community on the negative effects of gender stereotyping.

5.5.1.2 Work-life Balance

Apart from the development of supporting programs and networks, the internal barriers to women’s advancement must be changed. This study found that constraints caused by balancing work and family together with working in a male preserve lowered the women’s self-confidence and career aspirations. The study also found that the organization and society had a major role to play in realizing work life balance for women in leadership. It is therefore recommended that organizations set out policies that favor work-life balance for women. Organizations such as Google Inc. have facilities within the work environment where women are allowed to breastfeed their children. Others such as Safaricom in Kenya have daycare facilities. These are useful in helping women achieve career success because they will not be under pressure to abandon or choose between work and family. Furthermore, other social constructs such as the family members and the spouse can be assisted in creating an enabling environment for women to advance their careers. Domestic responsibilities can be shared among couples where the women feel that their domestic responsibilities are overwhelming. This however, will require sound minds and lots of
understanding because the present day Kenyan society does not encourage men to perform domestic responsibilities.

5.5.1.3 Motivation to Leadership

The study found that women in leadership are motivated intrinsically. Women who pursue leadership are motivated by a need for achievement rather than a need for power or affiliation; in addition to that, women who aspire to lead set mastery goals rather than performance goals. It is recommended that organizations focus on the motivation factors and build on them to create an environment that will be suitable for women to lead. The kind of incentives offered or prescribed for women aspiring to leadership positions should address their need for achievement.

5.5.2 Recommendations for Future Research

It is recommended that larger scale studies on managerial leadership be carried out to provide a clearer and more detailed picture of women leaders’ work and life in the healthcare industry and other industries as well. Comparisons can be drawn from experiences of women in different counties; because the issues they face are largely different but with the same core problems. Furthermore, men in leadership can also be incorporated in future research to understand the complexities they face when attaining leadership. A comprehensive understanding would assist authorities and policy makers in adjusting the laws on gender to mitigate the negative impact of culture on women’s exercise of leadership in the healthcare industry. Future studies can vary with quantitative or mixed methods study that would allow the researcher to conduct a comparative analysis of the research questions rather than focus on the stories that define the experiences of the participants. Future studies also need to focus on men’s participation in household chores and childcare to assess the effectiveness of the educational campaigns on gender equity. In addition to that, issues surrounding work-life balance may also be understood from the male perspective. It is recommended that researchers investigate women leaders’ demands for leadership-supporting programs and networks. These will be beneficial for designing both the content
and the mode of operation to best meet women’s needs and provide a framework for human 
resource departments to suit employment contracts and terms of service for both genders.
APPENDIX A

UNITED STATES INTERNATIONAL UNIVERSITY

GLOBAL EXECUTIVE MBA- HEALTH LEADERSHIP AND MANAGEMENT

INFORMED CONSENT TO PARTICIPATE

IN A RESEARCH INTERVIEW

Study Title: WOMEN: AN UNDERVALUED RESOURCE IN HEALTH LEADERSHIP AND MANAGEMENT

Principle Investigator: SUMMERY SITIMA

Faculty Advisor: DR WAMBALABA

Purpose of the Research

You are requested to be interviewed in a research study about the aspects of leadership and management in the health sector in Kenya from a woman’s perspective. The purpose of this research is to outline the various reasons for the gender gap in health leadership and management in Kenya. You have been asked because you are a woman in the healthcare industry and your position entails leadership and management.

Procedures

If you decide to volunteer, you will be asked to participate in an interview which will take approximately two hours. You might be requested to give contact information about other persons who you feel may be relevant participants for the study. The interview will occur in May 2015 at your office or place of convenience. You will be asked several questions about three research questions including job negotiation, work-life balance and your motivation to lead. With your permission, I will audio record the interviews in order to accurately capture what is said. The recordings will be transcribed, but your name will not be included in the transcriptions. The recording and transcription will be kept on a password-protected computer. The recordings will be destroyed after completion of the research as advised by the facilitator. Reports of study findings will not include any identifying information.
**Risks**
We do not anticipate any risks from your participation in this research. Some of the questions may cause discomfort or embarrassment. You are free to stop the interview at any point if it causes you unnecessary harm or discomfort.

**Benefits**
There are no direct benefits to participants in this research. We hope to learn more about leadership and management in the healthcare industry from a woman’s perspective and this may lead to the gender gap being addressed from a policy level based on the recommendations from the study. There will be no compensation from the investigator or interviewer from your participation.

**Confidentiality**
All information collected in this study will be kept completely confidential to the extent permitted by law. Your responses to interview questions will be kept confidential. At no time will your actual identity be revealed. You will be assigned a random numerical code. The data you give me will be used for my research towards attaining a global executive masters in business administration- health leadership and management and may be used as the basis for articles or presentations in the future. I won’t use your name or information that would identify you in audio recordings, publications, or presentations.

**Participation/Withdrawal**
Your participation is completely voluntary, and you may withdraw from the study at any time without penalty. You may also skip any question during the interview, but continue to participate in the rest of the study.

**Contact**
If you have questions or concerns about this research, please contact Summery Sitima,0736852233,summersitima@gmail.com

If you have any study-related concerns or any questions about your rights as a research study participant, you may contact the united states international university.

**Statement of Consent**
I have read the above information and have received answers to all my questions. I am at least 18 years old and voluntarily consent to take part in this research study and to have this interview audio recorded.
Participant’s Name: ________________________________

Participant’s Signature: ___________________________
APPENDIX B

UNITED STATES INTERNATIONAL UNIVERSITY

GLOBAL EXECUTIVE MBA- HEALTH LEADERSHIP AND MANAGEMENT

INTERVIEW GUIDE FOR

RESEARCH

Study Title: WOMEN: AN UNDERSERVED RESOURCE IN HEALTH LEADERSHIP AND MANAGEMENT

Principle Investigator: SUMMERY SITIMA

Faculty Advisor: DR WAMBALABA

SECTION ONE: DEMOGRAPHIC DATA

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SECTION TWO

RESEARCH QUESTION ONE- ROLE OF GENDER IN JOB NEGOTIATIONS

1. (Researcher briefly explains to participant the ‘glass ceiling effect’)
   Are you familiar with the ‘glass-ceiling effect’? Explain
2. Do you believe there is a disparity in pay expectations between the two genders when negotiating for a salary? What reasons would you attribute to your answer?
3. What were your primary negotiation terms for your position- salary or working conditions including off time and holidays? State other factors if necessary
4. What challenges have you noted in attaining a position in health leadership?
5. Are there particular sex stereotypes you face as a woman leader in the healthcare industry? If yes, do they affect ability to negotiate for better pay or better terms of service?
6. Do you believe the education level you attained greatly contributed to your advancement to managerial leadership? Explain
SECTION THREE

RESEARCH QUESTION TWO- WORK-LIFE BALANCE

1. What challenges do you find in combining your work with domestic responsibilities or leisure activities?
2. What would you best describe as career satisfaction? What would you place as the value of your success, your career goals or a positive work-life interaction; or anything else?
3. Do you believe there is adequate support in your organization to enable a work life balance? Explain how.
4. What about social support systems? Do they exist in your experience?
5. Are there specific challenges around work-life balance you have encountered especially towards advancing your career?

SECTION FOUR

RESEARCH QUESTION THREE- MOTIVATION TO MANAGERIAL LEADERSHIP

1. What factors motivated you to seek a leadership position in the healthcare industry?
2. Do you believe business drivers have a role to play in motivating women to lead in an organization? Explain
3. Did the expectations of your colleagues within the organization you work in hinder or drive you towards achieving success? Explain
4. Are there specific cultures or stereotypes in your organization that promote or have a negative effect on motivating women to lead or attain managerial positions? Briefly explain the effect and how it has impacted women leadership.
5. Are you intrinsically or extrinsically motivated? Please expound.
6. Briefly describe what you focus on, when setting goals as a leader.

SECTION FIVE

QUESTIONS AND COMMENTS SECTION – any observations the participant may have or any other additional information specific to the research question which the participant may feel is relevant or was not captured well.(INCLUDE CONTACTS OF PERSONS PARTICIPANT FEELS MAY BE RELEVANT TO THE STUDY)

Thank you for your cooperation, your time and your participation.
REFERENCES


https://docs.google.com/viewer?url=http%3A2F
