GENDER DISPARITY IN HEALTHCARE LEADERSHIP IN SOUTHERN

ETHIOPIA

by

GETACHEW LENKO YIMMAM

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SUPERVISOR: Prof T. MAKUA

CO-SUPERVISOR: Prof GB THUPAYAGALE-TSHWENEAGAE

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DECLARATION

I declare that **GENDER DISPARITY IN HEALTHCARE LEADERSHIP IN SOUTHERN ETHIOPIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

15 September 2017

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SIGNATURE   Date

GETACHEW LENKO YIMMAM

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STUDENT NUMBER: 61983497

STUDENT: GETACHEW LENKO YIMMAM

DEGREE: DOCTOR OF LITERATURE AND PHILOSOPHY

DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. T. MAKUA

CO-SUPERVISOR: PROF GB THUPAYALE-TSHWENEAGAE

ABSTRACT

Gender disparity in healthcare sector leadership positions is a major problem among female healthcare professionals in Southern Ethiopia. This study explored gender disparities among healthcare professionals in healthcare sector leadership positions. The findings would be used to develop guidelines to reduce gender disparities in healthcare leadership in healthcare sectors to a minimum in Ethiopia. This study used exploratory and descriptive cross-sectional research design incorporating a mixed methods research approach to collect both quantitative and qualitative data simultaneously which were analyzed during the same phase of the research process.

The quantitative survey data was collected using piloted structured questionnaire while qualitative data was collected using semi-structured interview guide containing open questions. Quantitative data was collected from a random sample of 414 healthcare professionals and qualitative data from a purposive sample of 21 healthcare professionals from seven districts having the experiences of gender disparity in healthcare leadership positions. Quantitative data had a compliance rate of 98% and it was entered into EpiData version 3.1 and exported to SPSS (version 24) for further analysis, and the qualitative data was coded and analyzed manually into thematic content.

Quantitative findings of the study revealed that only 26% (n=108) of the participants reported that representation of women in healthcare sector leadership positions in the

past few years has been increased. The majority of leadership positions assumed by study participants were at department head level while only 1.3 % were on chief excutive officers and 2.3% medical director positions respectively. Of these none was a female and 67%, n=264 of the participants do not have leadership role in a health service facility. Study participants having bachelor degree level of education were 2.3 times more likely to be represented in healthcare sector leadership positions than those participants having master's degree and diploma [AOR=2.3, (95% CI: 1.289, 4.252)].

Challenges experienced by women health professionals regarding gender disparity in leadership positions in health service facility included family responsibilities, lack of support, lack of self-esteem or self-confidence, lack of career advancement, and cultural bias. The conclusions derived from the study was that women need all the opportunities, encouragement and support to allow them access to and success in healthcare sector leadership positions through informal and formal leadership training.

Keywords: Gender, Disparity, Healthcare, Leadership

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It seems like only yesterday that I began the doctoral journey and I cannot believe that I have come this far. First and foremost, my gratitude and praise goes to the Lord and my Good Sheppard for the protection. He gave me the strength to be able to move a step further in my career path, despite all the difficulties, He has been my strength, without whose power and love neither I nor this study would have been conceived.

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Dedication

This study is dedicated to the memory of my late beloved father, Lenko Yimmam whose wish was to see me educated and independent, and to my late younger brother, Demsis Lenko.

My daughters, Saron and Fitsum, for their unconditional love and unrelenting support whilst I was pre-occupied with my study and writing this dissertation.

Last but not least, I dedicate this study to all the female health professionals who are tirelessly working in lower-end jobs in the health facilities crack the ceiling and placing women in key healthcare leadership positions in resource limited settings. May their potential of leading healthcare sector be truly acknowledged!

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LIST OF ABBREVATIONS

ACHE – American College Health Executive

AOR - Adjusted Odds Ratio

BMC – British Medical Council

BMJ – British Medical Journal

CEO – Chief Executive Officer

CCG – Clinical Commissioning Group

CI – Confidence Interval

COR – Crude Odds Ratio

DC – District of Colombia

CSA – Central Statistical Agency

EBC – Ethiopian Broadcasting Corporation

EDHS – Ethiopian Demographic and Health Survey

ETB – Ethiopian Birr

FDRE – Federal Democratic Republic of Ethiopia

FMOH – Federal Ministry of Health

HRH - Human Resource for Health

HRIS – Human Resource Information System

NHS - National Health System

OECD - Organization for Economic Cooperation and Development

PBE – Performance Based Evaluation

PHD – Doctor of Philosophy

PHCU – Primary Health Care Unit

SDG – Sustainable Development Goal

SNNPRS – Southern Nations, Nationalities and People's Regional State

SPSS – Statistical Package for Social Science

SRS – Simple Random Sampling

UK – United Kingdom

UNISA – University of South Africa

UN – United Nation

USA – United States of America

USD – United States Dollar

WHO – World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

A critical leadership gap exists in today's healthcare system and women are missing in top leadership positions in healthcare, even though they are well suited for leadership position (Kathryn, McDonagh, Paula, Bobrowski, Mary Ann Keogh, Hoss, Nancy, Paris, & Margaret, Schulte 2014:20-29). Women make up more than 65% of the healthcare workforce which is relatively high compared to other industries such as financial services (46%) or technology (26%) and they are the largest consumers of health services but they remain significantly under-represented in healthcare leadership positions (Wyman 2019:2).

A great number of influences have shaped the leadership opportunities available to women in the healthcare sector overtime. Gender roles, relations, norms and expectations negatively impacted women's advancement to healthcare leadership positions at multiple levels including the individual, household, community and within health systems (WHO 2018:13). This perpetuates the division of roles traditionally, with domestic tasks largely deemed to be women's role while men are assigned to decision-making roles, and women are still significantly under-represented in healthcare leadership positions (Hyde & Hawikns 2017:3).

As explained by Dhatt, Theobald, Buzuzi, Ros, Vong, Muraya, Molyneux, Hawkins, Beiras, Ronsin, Lichtenstein, Wilkins, Thompson, Davis & Jackson (2017: 2) women are under-represented within top healthcare leadership positions, in policy and governance forums, and across decision-making structures in the public and private sectors globally. Women lack representation and voice in decision-making positions in the community. Organized political community causes the discrimination to continue indefinitely, in terms of access to public services, such as schooling and healthcare, or discriminatory laws (Mulatu 2016:24-37).

Traditional views and practices of men being leaders in the households have pervaded the healthcare system (Henwood 2014:140). This has in a subtle way led to the management positions being assigned to males rather than to females. Such imbalances need to be acknowledged and challenged in the healthcare system (Henwood 2014:140) Diversity drives productivity, loyalty and motivation, but many organizations fail to create corporate cultures that embrace diversity and inclusion as a priority (VanderBoegh et al 2017:3). Recent developments indicate the growing recognition of healthcare service organizations that value and promote gender diversity (VanderBoegh et al 2017:3).

Gender inequity in the health workforce can restrict women's entry into the health sector, career progression, access to professional development opportunities, and motivation (Hyde & Hawkins 2017:1). The researcher believes that it is this bias that has provided men with the opportunity for success and relegated women to junior positions where they cannot influence decisions. Human Resource for Health (HRH) has noted that health workforce gender imbalances are a major challenge for health policy-makers. They have also observed that improving gender equity in healthcare leadership positions is essential to strengthen health workforce number, distribution, organizational performance and skill mix (Newman 2014a: 12-25).

Although women from the critical mass for the global health workforce, but they are under-represented in leadership positions in health service facilities (Hyde & Hawkins 2017:1). Health service facilities unlike other industries, does not have a "women in healthcare" problem, but has "women in healthcare leadership" problem (Wyman 2019:2). Therefore, gender disparity in healthcare leadership is persistent in South Ethiopia and this study addresses a well-documented evidence of existing gender disparity in healthcare leadership in the study setting.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Women make up approximately 75% of the specialized global health workforce and yet their representation at higher level of healthcare sector leadership positions is limited (Javadi, Vega, Etienne, Wandira, Doyle & Nishtar 2016: 229-240). Javadi et al (2016: 229-240) further posited that under-representation of women in healthcare sector leadership positions and the obstacles to their advancement has significant implications for motivation and job satisfaction of women who make up a large portion of the health workforce. Furthermore, untapped potential of women in healthcare leadership undermines the contribution they could make in improving the effectiveness of those occupying leadership positions for health system strengthening.

Workforce comprises three quarters of women in the healthcare system but they are sparsely represented in a senior executive positions in health service facilities (McDonagh et al 2014:20-29). The author further argues that there is a demand for diverse leadership teams with transformational leadership skills to successfully lead healthcare organizations (McDonagh et al 2014:20-29). Part of this dilemma is related to gender stereotypes about women as leaders, women's experience in advancing their own careers, and organizational cultures that prevent the advancement of women to the top leadership position in healthcare. For example, women comprising 80% of the workforce in the healthcare sector in the USA, they are under-represented in leadership positions in the healthcare system (Rotenstein 2018:1).

Newman alleges that good HRH leadership, governance, and management involve recognizing the diversity of health workforces. These could be done through acknowledging gender constraints and opportunities, eliminating gender discrimination and equalizing opportunity. Making health systems responsive to life course events, and protecting health professionals labour rights at all levels further ensure gender diversity (Newman 2014a:12:25).

Over a decade ago, less than 50% of the top leaders likely believed in egalitarianism at work and home (Wyman 2019:4). Leaders are aware of the challenge and intellectually recognize the need to change, and well-intended executive teams have hired inclusive & diversified leaders to set goals in order to attract and promote women health professionals and diverse populations, but under-representation of women is still persistent (Wyman 2019:4).

In Ethiopia gender disparity exists despite article 35(3) of the constitutions which outlines the historical legacy of inequality and discrimination suffered by women in Ethiopia (Constitutions of FDRE 1995:35). By taking this scenario into consideration, in order to remedy this legacy women are entitled to affirmative measures. The purpose of such measures shall be to pay special attention to women so as to enable them to compete and participate on the basis of equality with men in political, social and economic life as well as in public and private institutions (Constitutions of FDRE 1995:35).

Women health professionals are disproportinately under-represented in leadership position in the healthcare sectors but leadership positions are skewed towards men and global health sector organizations neglect the issue of gender equity in healthcare sector leadership positions (Downs et al 2014:1103-1107).

1.3 STATEMENT OF THE RESEARCH PROBLEM

Gender disparity is one of the most significant issues negatively affecting health outcomes worldwide. Women are concentrated in certain occupations and are poorly represented in management positions and at senior levels. Gender stereotypes, norms, and practices keep women health care workers in lower-end jobs (Giorgis 2017: 5). Despite their strong contribution to the overall world economic growth, gender gaps are wide in many countries in Sub-Saharan Africa and low representation of women in the private health sector is wider than in other sectors. While youth and women utilize the majority of health services both in private and public sectors, but women are under-represented in leadership positions (World Bank 2015:4).

The researcher in his area of employment observed that there are a total of 26,700 healthcare professionals of all categories in public health centre, public hospitals, and health sectors, which constitute nearly 956 top decision-making positions. Among this only 0.63% of women hold healthcare leadership positions (Regional Health Bureau, health worker profile 2017). This is despite the fact that the majority of women health professionals have similar or higher educational preparation than their male counterparts.

As explained by Kuhlmann et al (2017:2-7), under-utilization of women's expertise in healthcare leadership and management position and gender inequality continue to persist globally, attention is not paid to leadership and management positions. Little is known about the experiences of women in the healthcare sector leadership position in South Ethiopia. In an attempt to address this knowledge gap, the current study explores and describes gender disparity and determines the extent of women representation in healthcare leadership as well as barriers that contribute to the lack of advancement of women to the top decision-making position in healthcare sector.

There is no documented study known to the researcher conducted among women and men investigating gender disparity in healthcare leadership in Ethiopia. The above reasons led the researcher to explore and describe gender disparity in healthcare leadership in Southern Ethiopia in order to develop guidelines on effective ways for reducing this huge discrepancy.

1.4 SIGNIFICANCE OF THE STUDY

The findings would demonstrate that gender disparity exists in health care systems. Such knowledge would assist in the planning of the health care systems and this would lead to a notable change in gender representation. The insights gained from the study would inform policy makers on how to spread and use the skill mix in health care. The skill mix would inadvertently improve health care service delivery.

1.5 RATIONALE FOR THE THE STUDY

According to the Southern Ethiopia Regional Health Bureau health worker profile (2017), majority of women health professionals working in Southern Nations Nationalities and people's Regional State of Ethiopia have similar or higher educational preparation than their male counterparts but women face challenges at varying stages of their career that keep them from attaining top healthcare leadership positions. Gender stereotypes, norms, and practices keep women health care professionals in lower-end jobs (Giorgis 2017: 5).

To dtae, there is no study conducted about gender disparity in healthcare leadership in South Ethiopia. Therefore, research in this area as well as the development of guideline for reducing gender disparities is meant to bridge that gap.

1.6 PURPOSE OF THE STUDY

The intent of this study was to investigate gender disparity in healthcare leadership, with the ultimate aim of developing guidelines for reducing gender disparities in healthcare leadership in the study setting.

1.7 Research objectives

To explore and describe gender disparity in healthcare leadership at health sectors in South Ethiopia.

To determine factors affecting women's role in healthcare leadership at health sectors in South Ethiopia.

To develop guidelines for reducing gender disparities in healthcare leadership in South Ethiopia.

1.8 RESEARCH QUESTIONS

Why does gender disparity in healthcare leadership exists in Ethiopia?

What factors have contributed to the lack of advancement of women to healthcare leadership position in Ethiopia?

What are the appropriate guidelines that can reduce gender disparities in healthcare leadership in Ethiopia?

1.9 THEORETICAL FRAMEWORK

Theoretical Framework**:** is a blueprint or a guide based on an existing theory which is 'borrowed' by the researcher to build his or her own research inquiry related to the hypothesis of a study (Adom et al 2018:438-441).

In this study, a modified three steps theoretical model for gender sameness/difference or equity/inequity was used to understand gender bias in health care settings in Ethiopia as depicted in Figure 1 (Risberg, Johannsson & Hamberg 2009:1475-9276).
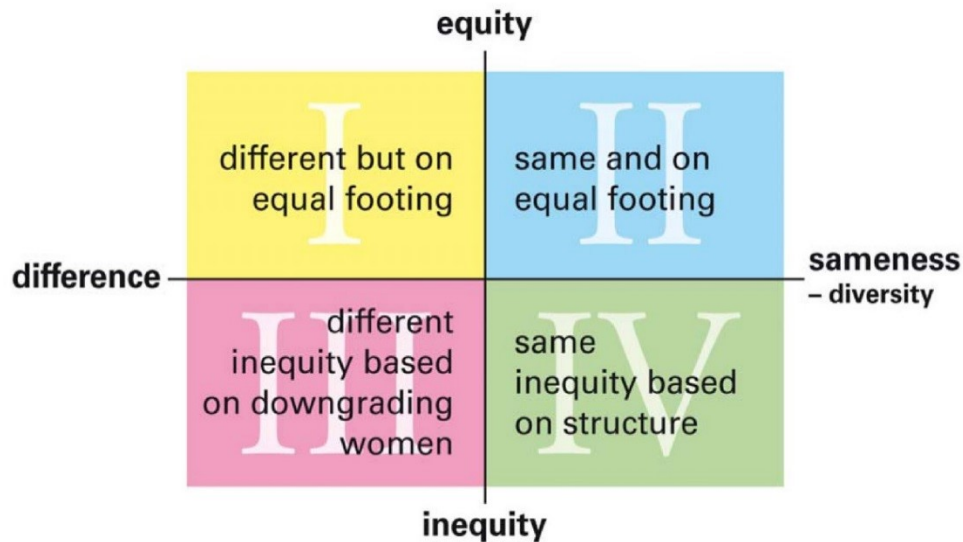
Figure 1:1 Visual model of theoretical framework (Gender theory)

The three steps are made about assumptions of male and females in healthcare leadership position.

Step 1: Assumptions about women and men (Divergent assumption about men and women).

I. Women and men are on equal footing but different. "Female and male health professionals can function equally well in health care leadership".

II. Women and men are on equal footing but the same.

III. Women and men are different and there is inequality emanating from downgrading of women's duties and their characteristics.

IV. Women and men are the same but there is inequality between them, emanating from differences in position, leading to gendered experience and life conditions.

Step 2: Approaches to the subject of gender

I and II: Emphasizing equity and denying that gender is a basis for inequities.

II and IV: Emphasizing diversity among women and men and questioning gendered dichotomies.

III and IV: Emphasizing inequity and working for change.

I and III: Emphasizing differences and accepting stereotype dichotomies about women and men as social realities.

Step 3: Gender bias

In fields I and II, equity between men and women is presumed. There is blindness to gender difference in position, life condition and experiences, which are important factors for health and illness and for the opportunity to make a career.

In fields II and IV, sameness between and diversity within each gender is emphasized. Differences are understood as originating in power asymmetry and/or norms.

In fields III and IV, differences in position and power between men and women are acknowledged. In order to obtain equity, there is a risk of assigning women in an inappropriate way.

In fields I and III, there is unawareness of the influence of gender norms and doing gender processes. There is a risk that differences are assumed where there are none, due to un-reflected dichotomous thinking about women and men.

1.10 DEFINITIONS OF TERMS

Gender: Gender is a social construct. It defines and differentiates the roles, rights, responsibilities, and what is appropriate behaviour and obligation for women and men (Mulatu 2016: 24-37).

Gender Bias: Refers to unjustified differences in treatment of male and female in workplaces and most of the evidence suggests that women experience more difficulties for this reason (Tyszczarz 2017:2).

Gender Disparity: is the difference between men and women at the top level of political decision-making (World Economic Forum 2018:4).

Gender Diversity: Is the full range of human similarities and differences in group affiliation including gender, race/ethnicity, social classes, role within an organization, age, religion, sexual orientation, physical ability, and other group identities (Gordon 2015:15).

Gender Stereotype: Is a generalized view or preconception about attributes, or characteristics that ought to be possessed by women and men or the roles that should be performed by men and women (UN Human Right 2014:1).

Dichotomous Thinking: refers to the tendency to think in terms of polar opposites, that is, in terms of the best and the worst or good or bad, and black or white without accepting the possibilities that lie between these two extremes (Pedneault 2019:1).

Dichotomous thinking can be a problem when extreme conclusions about oneself or other people interfere with emotional stability, personal relationships and decisions(Pedneault 2019:1).

Gender Equity*:* Is fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men (WHO 2016:2).

Gender Equality: Is the outcome reached through gender equity. It is the equal valuing by the society of the similarities and differences between women and men, and the varying roles that they play (Gender Equity Strategy 2014:4).

Leadership: is the process by which one enables self and others to face challenges and achieve an organizationally-defined goal (FMOH 2017:33).

A leader is a strong individual with the vision to see what needs to be done and the courage to implement it (Kenney 2015:18).

Healthcare Leadership: Is knowing how to get things done today and in the future while adapting to a new dynamic healthcare organization business model, so healthcare leaders are evolving and developing new skill sets so they can successfully lead their organizational members (Flanagan 2016:1).

Level of Women Representation: The degree to which participation of women in leadership and decision-making position increases (Mulatu 2016: 24-37).

1.11 OPERATIONAL DEFINITIONS

Gender: Is socially constructed expectations and roles for women and men,. Specifically, women are expected to demonstrate feminine behaviour, and men are expected to act masculine.

Gender Bias: Is behaviour that shows favouritism toward one gender over another. Most often, gender bias is the act of favouring men over women.

Gender Disparity: Refers to unequal treatment or perceptions of individuals wholly or partly due to their gender. It arises from differences in socially constructed gender roles.

Gender Diversity: Involves the consideration, recognition and promotion of different skills, resources and potential of women and men in workplace. It is achieved when all employees, regardless of sex, gender, race, ethnicity, ability, sexual orientation, and age, receive equal respect and benefit from the same rewards, resources and opportunities.

Gender Equity: Is the process of being fair to women and men.

Gender Equality: Is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including economic participation and decision-making, and when the different behaviours, aspirations and needs of women and men are equally valued and favoured.

Gender Stereotype: Is a standardized and contempt idea or image held about an individual based on their gender. As a 'typical picture' about a social group, a stereotype

may be negative or positive, accurate or inaccurate, justified or unjustified. Some easily recognized gender stereotypes is that women are emotional and unpredictable, are not good at leadership and good at housekeeping, or that men are rational and instrumental, not good at the management of household affairs and good at leadership.

Dichotomous Thinking: Is the extension of a difference between two entities into an opposition and the subordinate entity can only gain value or move upwards by transcending himself or becoming the dominant part of the dichotomy.

Leadership: Is about creating a sense of urgency, a shared vision, and aligned expectations.

Healthcare Leadership*:* Refers to senior positions in the healthcare sectors.

Level of Women Representation: The extent to which women's representation are constructed and communicated to the population at large and this representation reinforced dominant ideologies of gender difference and the qualities of ideal-type femininity.

1.12 RESEARCH VARIABLES

1.12.1 INDEPENDENT VARIABLES

Is a variable that is manipulated or controlled by the researcher and can be thought as the cause being investigated in a study. A research study may include more than one independent variable (Terrell 2016:261; Prathapan 2014:92). In this study, gender disparity is the independent variable.

1.12.2 DEPENDENT VARIABLE

Is the "effect" that is being measured in a study and influenced by independent variables (Terrell 2016:259). Level of women representation in healthcare leadership position is the dependent variable. Overall level of women representation in healthcare sector leadership position determines differences in position and decision-making power between men and women.

1.13 THE SCIENTIFIC RIGOR OF THE STUDY

1.13.1 TRUSTWORTHINESS

1.13.1.1 Credibility

Stating that study results are believable or credible from the perspective of participant or a qualitative researcher's confidence in the truthfulness of the study findings. In this study, the researcher would ensure credibility by prolonged engagement with respondents, and triangulation, and further enhanced through frequent debriefing sessions, researcher's reflection of field notes and member checking (Terrell 2016:173-174; Maree 2016:123).

1.13.1.1.1 Prolonged Engagement

The researcher's position in the health service facilities in which the study was carried out allows him to stay in one health institution for a couple of days. This would allow the researcher to observe the existing situation in detail and realize the structure of each health service facilities.

1.13.1.1.2 Triangulation

The use of mixed method research approach called methodological triangulation would give credibility of the study findings and the study findings that was found quantitatively was complemented qualitatively for cross-validation of the results.

1.13.1.2 Dependability

Refers to the consistency and replicability of the study findings. In this study, dependability was demonstrated by an external supervisor examining and evaluating the research process and the accuracy of the results (Terrell 2016:173-174). The researcher demonstrate or ensure dependability through the implementation of qualitative study design, the operational detail of data collection and the interpretation of the study findings (Maree 2016:124).

1.13.1.3 Confirmability

The extent to which the findings of the study reflect the participants' views instead of the researcher's interests. Confirmability audit, audit trial, and reflexivity are key approaches to enhancing confirmability (Polit & Beck 2014:457; Terrell 2016:175). The researcher ensured that the results of this study could be reviewed or verified by other researcher and agreed that the researcher's conclusions are logical (Grove et al 2015:392).

1.13.1.4 Transferability

Transferability is often compared to the idea of external validity in quantitative research and attempting to demonstrate the research findings are replicable to other settings. To

ensure transferability of the results, the researcher provided a **"thick description"** of the result and purposeful sampling of the study participants in terms of the context being studied (Maree 2016:124; Terrell 2016:174).

1.13.2 Reliability and Validity

1.13.2.1 Reliability

The characteristics of a data collection instrument that shows consistency in measuring a content area. Depending up on the type of test being developed and the reliability approach being used, **reliability coefficient** can be computed by using **Cronbach's alpha.** Values of theses coefficients ranges from zero (low reliability) to 1.0 (high reliability). The larger the reliability coefficient, the more comfortable the researcher would feel about having consistent results regardless of when the test will be taken or who will administer it (Terrell 2016:82-83).

1.13.2.2 Validity

The idea that a data collection instrument measures what it is designed to measure (Terrell 2016:86).

1.13.2.2.1 Construct Validity:

The degree to which an instrument measures an intended content area. It is usually established by a review of the instrument by the statistician (Terrell 2016:256).

1.13.2.2.2 Content Validity:

A measure of how well a test or evaluation actually measures what it is designed to measure (Terrell 2016: 256). To ensure content validity the researcher was looking at each item (i.e. item validity).

1.13.2.2.3 External Validity:

The ability of study results to be generalized to the population from which data are collected other than the sample (Terrell 2016:259).

1.13.2.2.4 Internal Validity:

The degree to which the dependent variable is affected by the manipulation of independent variable, rather than by actions or events outside of the scope of the study (Terrell 2016:260).

1.14 ETHICAL CONSIDERATIONS

Research ethics is professional standards to conduct research in health science studies. These diverse set of values, norms and institutional relationship help to plan, imply and regulate scientific activity (Prathapan 2014:233). Rea & Parker (2014:34) explained that when the researcher conduct the study, he is highly expected to adhere to a variety of ethical standards.

According to Belmont principle, the following cardinal ethical principles in all research conducted with human participants were considered (Prathapan 2014:249).

Informed consent: The autonomy of the study participant to ensure the opportunity to decide whether to participate or not. The voluntary consent of the study participants is essential because individuals are capable of making their own decisions. The subjects who are participating in the research should be given sufficient information regarding the

purpose of the study, the research procedure and anticipated benefits (Prathapan 2014:252).

Confidentiality and Anonymity: assumes that the information provided by the participants will not be publicly disclosed and that it cannot be accessed by anyone other than the researcher and the supervisors. This can be ensured by securing all field notes and audio-recorded information in a privately locked cabinet. Anonymity is when the participant's identity cannot be linked to the responses given and can be ensured by assigning participants a code number instead of capturing participants' names (Tadesse 2014:34).

Beneficence: The principle of beneficence is based on Hippocrates's ethical tradition of medicine that declares a transitional movement from no ethics to ethics implies complementing a focus on do not harm and maximize possible benefits and minimize potential harms (Prathapan 2014:250; Pruzan 2016: 296).

In order to protect the study participants, the researcher, as well as the institutions in which the study was conducted, the researcher was required to secure permission from the concerned individuals prior to collecting data from the study participants (Fowler 2014:140). For the purpose of ethical considerations, research proposal was submitted to the University of South Africa (UNISA) Ethical and Higher Degree Committee for the issuance of the ethical clearance certificate.

The research proposal was also submitted to Dilla University Research and Dissemination Directorate and Regional Health Bureau of Southern Nations, Nationalities and Peoples Regional State of Ethiopia to secure approval letter for the conduct of the study and to access the study participants after explaining the purpose and the significance of the study involving human subjects.

On the specific data collection days, the researcher met all the study participants in their office and copies of the ethical clearance certificate from UNISA and approval letter from Dilla University and Regional Health Bureau was given to the study participants. Signed informed consent was also obtained from each study participants who were willing to

participate. The study participants did not experience any risk and emotional discomfort attributable to their participation in the study.

1.15 ASSUMPTIONS, LIMITATIONS AND DELIMITATIONS

Assumptions: Characteristics of data set the researcher assumed to be true prior to using a given statistical procedure but cannot verify (Terrell 2016:255).

In this survey, if male participants were asked about their perception on gender disparity in healthcare leadership, the researcher would assume that they would not tell the truth. It is a false assumptions that could lead to spurious results. The researcher informs the reader that he know the possibility exists that some male respondents would not tell the truth to the researcher.

Limitations: Constraints outside of the control of the researcher and inherent to the actual study that could affect the generalizability of the results (Terrell 2016:260).
The scope of the study was limited to Southern region based on small samples and hence may not produce representative results to similar setting throughout Ethiopia is also a potential weakness of the study.

Findings of the qualitative study in which the study participants' selected purposively may not be generalized to other region of Ethiopia but it might be transferable to similar settings.

Delimitations: are further limitations actively put in place by the researcher in order to control factors that might affect the results of the study, or to focus more specifically on a problem (Terrell 2016:257). Public Universities found in Southern Ethiopia were under the management of Federal government, and they were excluded from the study. Again, by delimiting the study, the door is left open to replicate the study in different regions with similar study population research approach.

1.16 THE STUDY LAYOUT

Chapter 1 Orientation to the Study

An overview of the study covered in chapter 1 includes introduction, background to the research problem and statement of the research problem. Theoretical framework (gender theory), definition of key terms used and operationalized in the study. The purpose statement, study objectives and research questions were also discussed.

Chapter 2 Literature Review

The aim of chapter 2 was to search relevant literature on the topic in order to be acquainted with the relevant body of knowledge in the area of the study.

Sources included were journal articles, report relevant to the study, literature on the topic, policies and guidelines related to gender disparity in healthcare leadership, books and dissertations on the related topics were reviewed to enable the researcher to situate the study. The chapter elaborated the connection between socio-cultural and environmental concerns as a barrier, as well as the effect of such factors on women's intrinsic motivation to advance up to the healthcare sector leadership positions.

Chapter 3 Research Design and Method

In chapter 3 the researcher discussed the research methodology with respect to the research design, data sources, data collection techniques, as well as issues of sampling methods and procedures. The chapter also detailed ethical considerations as well as piloting of data generating instruments.

Chapter 4 Data Analysis and Findings

Collected data, statistical analysis and its interpretation are presented in Chapter 4.

Chapter 5 Discussion of the Findings

Findings of the study are discussed in chapter 5 and validated with similar related studies. The gap between the realities of gender disparity experienced by women who aspire for

healthcare sector leadership positions and how it can be addressed through gender theory are mapped out.

Chapter 6 Conclusion, Limitations and Recommendations

General conclusions, limitations of the study and recommendations are discussed in this chapter. A summary of the findings in terms of the stated research objectives and discussion on the factors affecting women's role in healthcare sector leadership are presented and recommendations are made.

1.17 CONCLUSION

This chapter discussed the issues related to gender disparity in healthcare leadership position and its effect on the women's role in healthcare leadership at healthcare sectors in Southern Ethiopia. In particular, the chapter focused on the plight of women health care professionals advancing to the top leadership position in healthcare sector and their appointment in lower-end jobs arising from gender stereotypes, norms, and practices. The following chapter presents the review of related literature on gender disparity in healthcare leadership related to socio-cultural and environmental concerns as a barrier, as well as the effect of such factors on women's intrinsic motivation to advance to healthcare leadership position.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The literature review is an intensive reading of the available or previous work publication to determine whether the topic is worth studying and it provides insight into ways in which the researcher can limit the scope of the study to the required area of inquiry (Creswell 2014:57). The literature review points out areas in which prior studies agree, disagree and major questions remained to be answered by other researchers (Newman 2014b:126). Literature review collects what is known up to a point in time and indicates the direction for future research. It shares with the reader the work of accredited scholars that are closely related to the research topic being investigated (Creswell 2014: 60).

Terrell (2016:46) posits that literature review enables the researcher to contextualize their own studies with reference to what is already known in literature. It gives the researcher a broader understanding of the topic under study.

For this study, the purpose of the literature review was to understand the views of other scholars regarding gender disparity in healthcare sector leadership to avoid duplication of other scholars work. It assisted the researcher to understand the experiences of health care professionals on gender disparity and gave guidance to the development of guidelines aimed at reducing gender disparity to a minimum.

In order to understand gender disparity in healthcare leadership the researcher reviewed literature on gender, gender disparity, and gender disparity in health care.

2.2 GENDER DISPARITY

Gender is a social construct. It defines and differentiates the roles, rights, responsibilities, and what is appropriate and obligation for women and men (Mulatu 2016:24-37). Gender is socially constructed expectations and roles for women and men, specifically women are expected to demonstrate feminine, and men are expected to act masculine (Mulatu 2016:24-37). Gender gaps are wide in Sub-Saharan Africa and under-representation of women in healthcare sector leadership is wider than the other sectors (Monnet et al 2015: 5), this also applies to health sector.

Gender disparity refers to unequal treatment or perceptions of individuals wholly or partly due to their gender. It arises from differences in socially constructed gender roles. Gender gaps favouring males in personal autonomy which are systematically larger in developing countries than in developed countries (Javachandran 2015: 63-88).

Gender disparities in healthcare sector leadership positions are also prevalent in post-conflict settings in Cambodia, where incentives to motivate health workers, particularly women to continue working during and after a crisis have been overlooked (Hyde & Hawkins 2017:1).

A study concerning gender disparity in healthcare sector leadership provides a framework to gain a better understanding of the knowledge gap, and thus help to answer ''Why does gender disparity in healthcare sector leadership exists?'' These questions answer the persistence of the leadership gap in healthcare sector and contributing factors to the lack of advancement of women to the healthcare sector leadership positions (McDonagh et al 2014:20-29).

Mulatu (2016:24-37) explained that the goal of development cannot be attained and realized without significant participation of gender. Globally, it is proved that exclusion of women in development has rendered their development efforts futile. If a country is successful in minimizing or closing the gender gap, it will have a better chance to develop through alleviating poverty (Mulatu 2016:24-37).

Gender stereotype is a generalized view or preconception about attributes, or characteristics that ought to be possessed by women and men. It also includes the roles that should be performed by men and women (UN Human Right 2014:1). It is a standardized and contempt idea or image held about an individual based on their gender. As a 'typical picture' about a social group, a stereotype may be negative or positive, accurate or inaccurate, justified or unjustified. Some easily recognized gender stereotype is that women are emotional and unpredictable, they are not good at leadership and good at housekeeping, or that men are rational and instrumental, not good at the management of household affairs and good at leadership (UN Human Right 2014:1).

The researcher finds significant gender differences between managers with regard to gender stereotyping attitudes (Eriksson, Smith & Smith 2017:3). Male leaders on average tend to have stronger gender stereotype views with respect to the role as a successful leader than their female counterparts. However, female Chief Executive Officer (CEO) gender stereotypes do not differ from their male peers' and have significantly more pronounced masculine stereotypes than female leaders at lower levels (Eriksson et al 2017: 3). The authors also argue that female leaders have stronger beliefs in their own leadership abilities regarding feminine skills and weaker beliefs in their masculine skills, whereas the opposite is observed for male leaders.

Across different occupations in healthcare sector, higher proportion of women were represented at lower leadership positions which require less educational preparation and women have less earning potential (Morgan et al 2016: 3). As explained by Morgan (2016: 3), within the same occupation and in female dominated health workforce, women are often promoted less frequently to healthcare sector leadership positions and earn less than their male counterparts (Morgan et al 2016: 3). According to the authors, a study that does not disaggregate data by sex could therefore generate evidence that fails to adequately portray the true nature of the health workforce leading to policy-making which fails to consider gendered drivers of inequality. For example, during the development of lay health worker policy in South Africa, while poor working conditions were recognized, structural and labour market discrimination leads to gender bias and left women with few

employment options, failure to prioritize women's career pathways failed to gain policy attention (Morgan et al 2016: 3).

Besides family roles and responsibilities, power of influence and type of employment contribute to gender disparity, which results in feminization of occupations contributed to inequality and is associated with devaluation of women's leadership role(Carbajal 2018:3).

Human Resources Information Systems (HRIS) gender reports from Uganda revealed that concentrations of male and female health professionals by pay scale level shows vertical segregation and less female representation at the higher leadership positions (Newman 2014a:12-25).

A 2012 survey of healthcare executives conducted by the American College of Healthcare Executives noted a substantial gender disparity in the proportions of women and men who advanced to CEO positions (Burns-Chisholm et al 2017**:** 312-324). Between 2006 and 2012, women achieved CEO positions at the rate of 50% than their male counterparts and a decline from 63% rate reported in 2006 ACHE survey (Burns-Chisholm et al 2017**:** 312-324).

Studies show that women in medicine get less pay for equal work, are promoted less frequently, have fewer opportunities to publish, and receive less recognition than their male counterparts (Silver 2018:2). An environment that does not treat women fairly compromises excellence in patient care and the advancement to leadership positions (Silver 2018:2), and gender disparities are discouraging women from reaching their full professional potentials.

Organizational efforts to address gender disparities in healthcare sector leadership are often altogether absent. In some cases, leaders of organizations have used "diversity structures" such as task forces to address gender disparities (Silver 2018:5). But without prioritization, proper funding, utilization of metrics, and accountability, these approaches may give false impression to the leaders that gender disparities are being addressed,

even when metrics reveal little or no improvement. This is unacceptable, according to Silver (2018:5).

Gender equity, diversity, and inclusion are core leadership competencies and all leaders should be committed to create a culture of professionalism and ethical conduct through education and research on health workforce disparities, and the use of scientific methodologies to drive desired outcomes (Silver 2018:3).

The following suggestions reveals commitment to address gender disparity:

"All healthcare leaders should receive formal leadership training in order to understand gender disparities that impact women and other under-represented individuals in health service facilities. We must commit to evidence-based management practices that are transparent and ethical in order to accomplish sustainable organizational change." (Silver 2018:3).

According to the study conducted by Newman (2015:12-25), women make up only 36% of chief executive officers, 24% of medical directors. In 211 clinical commissioning groups (CCGs), 70% of the workforce is female while women make up only 37% of governing board members (Newman (2015:12-25).

2.3 GENDER DISPARITY IN HEALTHCARE LEADERSHIP

Women were not perceived as lacking effective leadership skills. Rather, prescriptive gender stereotypes may lessen women's advancement to leadership positions because they entail different norms for how women and men should lead (Carbajal 2018:10), which is based on gender rather than leadership skills. A crucial point about women in leadership is aspiration to leadership positions (Carbajal 2018:10). This issue is at the heart of socialization and how the patriarchal system has reinforced its values.

The survey conducted jointly by Diversified and the Women's Leadership Centre through the Coles College of Business at Kennesaw State University on 157 female study subjects and 125 males working at healthcare systems, hospitals, health centres and other facilities in a broad range of sizes throughout the USA found striking differences between women and men in their career paths, earning potentials, responsibilities, perceptions and views on barriers to career advancement or family support (Healthcare Leadership & Gender 2014:4).

Significantly more women reported that lack of supportive supervision, exclusion from informal networks, and lack of senior role models, inhospitable culture or biased attitudes and failure of senior leadership to help in advancement as barriers to their careers (Healthcare Leadership & Gender 2014:7).The culture of the organization is clearly important to women and they feel that if the environment is exclusionary, it will hold them back in their careers. Women also mentioned the need to prioritize their family over work as a challenge (Healthcare Leadership & Gender 2014:7).

A male health professional view in a qualitative study conducted in Australia revealed gender disparities in the number of women in leadership roles in health service facilities as ''natural'' and somewhat inevitable (Bismark et al 2015:4). The respondent offered three justifications for this view. First, there was a view that leadership roles are best suited to people who are ''a born leader'' with ''a strong personality'' and women were inherently less likely to meet those criteria. Second, there was a perception that biological roles are something that you just cannot change and women often prefer to forgo leadership roles to spend more time with their families (Bismark et al 2015:4).

Gender has been influenced by various factors like social-cultural and environmental factors as well as factors related to female health professional motivation and job satisfaction that may contribute to the problem under investigation

2.3.1 Socio Cultural Factors

Most developing countries have cultural factors that exacerbate favouritism towards men than women (Javachandran 2015:63-88). As evidenced by Wyman (2019:9), men and women often behave and perceive actions differently based on socialization and cultural norms about the roles of men and women and the difference abound regarding how health service facility team to be led. Women view collaboratively driven discussions as a way to empower the team but men perceive a woman as being not good at leadership or unclear about her role in producing results(Wyman 2019:9). These unconscious bias and perceptions result in misinterpretations or skewed evaluations of women by men.

Women typically have fewer opportunities to build relationship with men in informal, outside work environment after duty hours or during weekends (Wyman 2019:8). It is more culturally loaded for a men and women to be connecting in an informal way outside work environment but social activities tend to be more aligned with male interests that may not appeal to women who often shoulder more responsibilities at home to care for their families than their male counterparts (Wyman 2019:8).

In Cambodia, there is a social tendency which restrict girls not to study much as they would still become someone's wife in the future (Hyde & Hawkins 2017:2). In general, women were encouraged to stay at home rather than attending school. This was due to safety concerns as well as gender roles (Hyde & Hawkins 2017:2). In most cases, women who pursued further studies were single, did not have children, or they were supported by husbands and family members (Hyde & Hawkins 2017:2).

Women were constrained by gender norms in carrying out their jobs, facing disapproval from family members and the community as well as undervalued by male counterparts when they were assigned to night shift in health centre or hospital (Hyde & Hawkins 2017:2).

The extent to which healthcare sector promoting gender equality at operational level as measured by perceptions of political will, accountability, and organizational culture was perceived by healthcare sector leadership to be only moderate (Newman 2014a:12-25).Finally, the extent to which healthcare sector is able to promote gender equality as measured by perceptions of technical capacity was perceived to be limited by healthcare sector leader (Newman 2014a:12-25).

Health system is a reflection of the overall cultural context in which women are often excluded from decision-making positions in their lives starting from the household level up to the higher levels of policy-making (Giorgis 2017:1). Gender relations are socially constructed; males and females from the same country may be raised differently due to localized cultural values, which may result in gender inequity (Monnet et al 2015:17).

Nationwide cultures and policies shape women's participation in national workforces, organizational cultures and practices also play a significant role (World Economic Forum 2016:2). Across all industries, including healthcare sectors women currently make up on average 33% of junior level staff, 24% of mid-level staff, 15% of senior level staff and only 9% of CEO positions (World Economic Forum 2016:2).Under-representation of women in senior leadership positions is seen across all sectors in the UK and points to systemic cultural and social barriers preventing the attainment of gender equality (Newman 2015: 13).

There are still more male CEOs in health service facilities, and the leadership standard primarily has been based on masculine characteristics (Carbajal 2018:12). This male-dominated situation is a direct effect of the patriarchal system. Thus, women are forced to follow the same traditional leadership style, even though their preferred style may be egalitarian (Carbajal 2018:12), rather than autocratic. This expectation undermines women, as the expected norm of leadership is masculinized, which creates gender disparity in healthcare sector and hostile work environment.

Genesis 2:18 states, *"The Lord God said, 'It is not good for the man to be alone; I will make him a **helper** suitable for him.* ''The interpretation of the word "helper" is assumed

to convey inferiority (Carbajal 2018:2). From a patriarchal societal perspective, which is highly influenced by the Bible, women are considered inferior to men, a perception based on biblical interpretations (Carbajal 2018:1).

The construct of women being perceived as inferior to men is the problem of women's leadership aspiration and biblically the notion of women being inferior to men is not supported (Carbajal 2018:15). This perception is a fallacious assumption and an adulterated understanding of women. Gender bias free work climate could lead to structural and societal changes of the gender construct (Carbajal 2018:15).

Power status and hierarchical structure often diminish women looking for leadership positions in health service facility (Carbajal 2018:7) as expectations are geared towards men being in top leadership positions.

Silver (2018:7), identified perpetuating myths most commonly mentioned by the community is that *"there are not enough qualified women, or females are not as skilled or dedicated in leadership positions as their male counterparts."* and the above myths was disproved by (Silver 2018:12)……..*"There is no lack of qualified and interested women health professionals suitable for leadership positions in health service facilities rather the selection process is flawed."*

Oftentime , women are characterized as weak, and the role faith plays can help change this perception. Male and female characteristics are balanced when both are held together in harmony (Carbajal 2018:12), and one is not better than the other, rather they are complementary. However, a three-step-theoretical model in this study (gender theory) illustrates an ongoing social construction of what is considered 'feminine' and 'masculine' ('doing gender'); a construction based on power and socio-cultural norms about women and men (Risberg, Johannsson & Hamberg, 2009:1475-9276). The power asymmetry between women and men has been conceptualized as 'the gender order, a structuring principle in a society characterized by separation and hierarchy. Socio-cultural norms build on a dichotomous thinking about women and men, suggesting innate differences (Risberg et al 2009:1475-9276).

According to the Rock Health Report estimates, women hold 21% of chief executive roles and 21% of board members at fortune 500 companies. This is despite the fact that, 78% of job in these companies are held by women. These findings allude to gender stereotypes and cultural factors (Rock Health Report 2017:2).

Nurses predominantly make up the largest proportion of the health workforce in hospitals and health centres, however; most healthcare decisions are made by nurses but they are not equally represented in CEO positions as their male counterparts (VanderBoegh et al 2017:5). The author notes that lack of senior female leaders is not unique to healthcare system and only 8 out of the top 100 hospitals in the USA have woman CEO, this disparities are attributed to race, ethnicity and culture (VanderBoegh et al 2017:5).

As described by Carbajal (2018:5), professional women felt pressure from male managers to live up to the expectations stemming from what the wives were expected to do and women were not judged for their leadership potential and capabilities but instead viewed as mothers of children or house wives.

The problem of women's leadership aspiration attributes developing and testing different aspects that were correlated to their aspiration, these are connectedness needs, self-confidence, fear of negative evaluation, and gender roles (Carbajal 2018:10). The researcher discovered, "…the more women considered themselves as fitting in with the traditional feminine gender stereotype, the less likely they were to report leadership aspirations" (Carbajal 2018:12). Thus, women view fitting into feminine gender stereotypes is impeding factors of their leadership aspirations.

2.3.2 Environmental Factors

Women health professionals who want to aspire into top healthcare leadership positions lack self-confidence, they experience self-doubt, and underestimating their own personal capabilities, which is common to women in general (Wyman 2019:22).

Wyman (2019:22) points out that, women do not want to apply for top leadership positions unless they feel they meet 100% of the qualifications and position requirements. However; men can apply if they believe they meet 60% because women tend to value competency more highly than men and women think job candidates should "check all the boxes." But men tend to disagree.

The following quotes from a 58-year-old married woman illustrate the perspective of some women that they were considered themselves suited to leadership positions…………..*"I always perceive that whatever men can do, women can also do it. I always want to show my output and results to others."* (Hyde & Hawikns 2017:3).

A 35 years-old woman physician mentioned that*…..*"*My aunt was also a doctor and this also inspired me more to love this position. Wearing white uniform was what I dreamed about when I was a child."* (Hyde & Hawkins 2017:2) The importance of role models was highlighted by a successful senior health professional who inspired women health professionals to study medicine and enter the health sector leadership position (Hyde & Hawkins 2017:2).

In Zimbabwe, human resource managers prefer to deploy men to rural areas as they believe they will stay longer and not request for transfer. In the absence of senior health professionals, rural posting was discussed positively as a way to gain a wide range of experiences and in turn valued by men in terms of future access to professional development opportunities, invitations to international workshops, and promotion (Dhatt et al 2017:5).

Female talent remains one of the most under-utilized business resources, either squandered through lack of progression or untapped from the onset (World Economic Forum 2016:1). Although women are more educated than men on average globally and now participate more fully in professional and technical occupations than a decade ago, as of today, their chances to climb to the top leadership positions are only 28% when compared to their male counterparts (World Economic Forum 2016:1).

Across all industries, there are expectations of 7 to 9% increase in the share of women in mid-level leadership positions by 2020 and 8 to 13% increase in senior roles (World Economic Forum 2016:3). This suggests an expectation that the workforce strategies employed to promote gender equity will be successful in retaining and promoting the majority of incoming female talent against past experience (World Economic Forum 2016:3).

According to Gramling (2015:2), respondents to the Rock Health survey universally felt that discrimination plays a role in the gender gap with 96% responding "gender discrimination still exists." Forty percent of respondents in the survey reported that "their firms do not support women in their career development." Other barriers to career growth cited included lack of confidence, the challenges of work-life balance and shortage of role models and effective mentoring. Half of the women in the survey reported less access to mentors than their male counterparts (Gramling 2015:2).

A study conducted in Tanzanian medical school revealed that, only 36% of medical students were women and 29% of them pursuing specialization from 2010 through 2012, but one of the Tanzania's four regional referral hospitals and one of its five major medical schools have 10% of female medical directors (Downs et al 2014:89). The two institutions in the United States share this perspective of the women in global health and this represents a larger trend for Tanzania with the hope that this demonstrates that many young women were committed to filling the gender gap in global health leadership if the obstacles of career development can be overcome (Downs et al 2014:89).

In Australia, women make up more than half of medical graduates but only 28% of medical school deans, 29% of governing board or committee members of medical colleges, and 12.5% of Chief Executive Officer of hospitals having more than 1000 bed capacity (Kuhlmann et al 2017:1). In the United Kingdom, only two out of ten Chief Executive Officers of the largest teaching hospitals are women (Kuhlmann et al 2017:1).

According to the United States Bureau of Labor Statistics 2017, women in the United States healthcare workforce comprises 90% of registered nurses, 69% of clinical

laboratory technologist and technicians, 68% of physical therapist, 40% of physicians and surgeons (Silver 2018:3)

Major tools include equal opportunity to men and women during recruitment, periodic monitoring of gender equality, career development workshops and seminars, gender-sensitive appointment and promotion criteria, support during career development, flexible working hour arrangements, mentoring programs and networking for women, and diversity training for all health professionals, and inclusion of gender issues in teaching curriculum is important to ensure gender equity (Kuhlmann et al 2017:1).

Only one in five top leadership positions in the Cambodian Ministry of Health are held by women. Just 16% of senior health workers (such as doctors) are female, compared to 100% of midwives (Hyde & Hawikns 2017:2). This is because women's concerns are not reflected in health policies, including HRH strategies, human resource policies, such as those related to career advancement do not take into account women's life course events, such as childbearing and childcare (Hyde & Hawikns 2017:2).

Across all industries, unconscious bias among leaders and lack of work life balance are cited as the two top barriers affecting women's role in healthcare sector leadership over the period of 2015 to 2020. According to the World Economic Forum (2016: 4), the proportion of employers reporting these two factors as the main concern is 44% for each. Thirty six percent of the respondents also reported a concern about the lack of qualified professionals. This reflects low current share of female junior staff (World Economic Forum 2016:4).

A study conducted in United Kingdom's Athena Swan Charter suggests that financial remuneration, catalyzed structural and cultural changes, and career support for women health professionals creates an increased awareness of gender equity and gender diversity issues (Rotenstein 2018:1).

In Cambodia, female health professionals were expected to look after their children and home, as well as work. Some women were supported by their husbands and family members (Hyde & Hawkins 2017:2). In the Cambodian health system, gender working

group was created to support female health professionals and gender training helped build women's leadership skills and confidence (Hyde & Hawkins 2017:2). On the contrary, traditional gender responsibilities in Cambodia include women's role is childbearing and caring for her children and husband, and men's role as the breadwinner as well as lack of support from health system managers are barriers to women's career advancement (Hyde & Hawkins 2017:2).

Women do not invest their time expanding their networks and implicitly building more personal relationship outside work environment because it establishes trust and promotion decisions, and women have essentially defaulted to over-relying on their own leadership potential and ability to lead health service facilities to produce expected and possible health outcome (Wyman 2019:15).

Female senior director mentioned that……*"If you are not willing to promote yourself, it's impossible to get someone else to promote for you. Women are not as self-promotional as men. There is a huge awareness factor and invisible barrier for women's aspiration to leadership positions in health service facilities"* (Wyman 2019:15).

Female, Senior Vice President reported that……..*"Without mentors, I would have fallen into the trap of, 'I do not know anything about strategic plan about health service facilities,' and do not have taken leadership training. Men thought you just need to surround yourself with the right people and do not need to be an expert."* (Wyman 2019:23).

To climb the ladder of healthcare leadership, a mentor who guides female health professionals is critical. Furthermore, mentors at the top level of healthcare leadership can mediate for female health professionals and guide her upward mobility better than anyone else (Carbajal 2018:5). As described by Carbajal (2018:5), mentors often provided the occasion for female health professionals at lower-end jobs to bypass the hierarchy, to get inside information, to short-circuit cumbersome procedures, and to cut red tape, if women health professionals want to climb to the top leadership positions in health service facilities without mentor, she might hit a glass ceiling.

Factors contributing to the lack of empathy and advocacy to help women ascend to leadership positions are inequality that women experience in the workplace, perceptions about women, and the subtle discrimination that women experience (Carbajal 2018:1). Women in leadership positions often face opposition from other women co-workers, as well as men (Carbajal 2018:7). This opposition may be related to the cyborg leadership approach (Carbajal 2018:7), which is important to counter the patriarchal perception of gender discrimination, which asserts that for women to obtain careers in top leadership, they must adopt male characteristics (Carbajal 2018:6), those who seek leadership positions are expected to act like men, i.e., women often are viewed as emotional and subjective, whereas men are viewed as rational and objective, thus cyborg approach creates a "super-leader" persona that top female leaders take on "to fight gender stereotyping and break through the glass ceiling."

Silver (2018: 12) point out that lack of intentional effort to recruit and hire women health professionals in leadership positions, but the provision of appropriate support will ensure women to be successful at leadership positions in a realm that has many proven barriers."

Female health managers in Cambodia identified constraints effecting their leadership role in a such way that, as leaders, they were treated by the community and other co-workers with less respect than men but even when women were sufficiently qualified, they were still not considered suitable for leadership positions and not stereotypically consistent with being a leader (Hyde & Hawikns 2017:3; Bismark et al 2015:4).

Greater involvement of women in leadership and management positions is not only an issue of gender equality and human rights but also an important strategy towards effective utilization of women's qualifications, greater creativity and innovation, and improved organizational performance (Kuhlmann et al 2017:2-7).

2.3.3 Factors Related to Women Health Professionals Motivation and Job Satisfaction

Low motivation and job satisfaction of women who make up a large proportion of the health workforce are considered as the obstacles to advancement of women health

professionals to leadership positions (Javadi et al 2016: 229-240). In the United States academic medicine, only 25% of top executive positions are held by women and 24% of directors at global health centres across 50 United States medical schools were women.

In Cambodia, few proportion of women discussed the challenges they faced in family responsibilities, including breastfeeding, child raising and domestic chores, and their decisions tended to prioritize families rather than their career (Dhatt et al 2017:5). A 44 years old health manager reported that…….. *The hardest thing for women was when I had meeting at province. I had to bring both my husband and children to go with me. After the meeting, I had to rush to breast-feed my children. If men have mission at province, they will go alone."*

Another 30 years-old married health professionals mentioned the challenge associated with family versus office responsibilities as follows…………*"I carried my child with me as no one look after my child. Here health facility staff that I am working can help take after my child…"* (Dhatt et al 2017:5).

In Cambodia, women who had children valued their partners' support in being able to continue their further education, in spite of challenges. Some husband shared responsibility for housework and childcare. Women were motivated by role models, such as women who combined further studies with motherhood (Hyde & Hawkins 2017:2).

Cambodian women who progressed to leadership positions emphasized the strong family or parental and spousal support in their career, or were single or married late. Some Cambodian male managers emphasized that women's role and priorities should be in the home. Similarly, analysis of research on gender and leadership positions in Kenya suggested that women were often perceived as child bearers and nurturers and that was seen as a disadvantage to their career progression and ability to take up health care leadership positions. As the following comment from a female senior manager explained this view:

"When appointing a health manager…if she is female you have to consider if she has children or not. That makes a difference. You will find that you select someone, train them and invest so much in them, then after working for only a few months they fall pregnant and go off on maternity leave. Also once they have a child, the women health professionals tend to become irregular with work, there is no more commitment to leadership positions…" (Dhatt et al 2017:5).

Research in Cambodia showed positive trends in national and provincial government structures in terms of greater sensitivity with the implementation of gender focal points and gender working groups to provide training on gender and leadership skills to health professionals and ensure women representation at all levels (Dhatt et al 2017:5).

A 58 years-old female health manager mentioned her perspective as follows:

"I already have a plan to promote women in leadership. First, I will organize training on gender to my staff and monitor their performance… Second, we will build capacity of men and women in leadership skills… I want to see more women to become the head of health centres" (Dhatt et al 2017:5).

Under-representation of women in National Health System leadership pipeline is horizontal differentiation of them into lower-end jobs and female-friendly roles, and has significant implications on the quality of healthcare services they provide (Newman 2015:12).

More than 150 years ago, many of the first hospitals were founded by Catholic nuns. They perform activities ranging from healthcare leadership to the operations of clinical as well as outreach public healthcare services. These women were the first leaders in healthcare sectors and laid the foundation for the American health care system. Their accomplishments forged a natural path and place for women in the workplace (Walker 2017:2).

Women make up approximately 75% of the health workforce and yet their representation on top healthcare sector leadership positions is limited (Javadi et al 2016:229-240). Untapped potential of women health professionals undermine their contribution to be effective leadership for health systems strengthening (Javadi et al 2016:229-240). According to Javadi et al (2016:229-240), lived experiences of women leaders can help understand and make use of their potential by identifying the challenges, highlighting enablers, and sharing appropriate guidelines used to become effective healthcare sector leaders.

Women are severely under-represented in leadership positions across not only in business sphere but in academic health professions program, pharmacy and healthcare sector in general. These disparities cannot be attributed to lack of education, as women having similar or higher educational preparation than their male counterparts (Burns-Chisholm et al 2017: 312-324).

This has been attributed to a number of reasons, but many researchers believe that gender stereotypes, norms, and practices keep women health care professionals in lower-end jobs (Giorgis 2017:5).

In spite of the fact that, a large number of studies in the literature support diverse executive teams results enhanced organizational performance, yet career development and succession planning that focus on a concrete plan for development of women health professionals for decision-making roles is not considered as a priority for healthcare sector leadership and they are major deterrent factor for women advancing to top leadership positions (McDonagh et al 2014:20-29).

Authors from science faculty members at American Universities viewed that men are more competent in healthcare sector leadership positions and deserving a higher starting salary than their equivalently qualified women counterparts (Downs, Reif, Hokororo & Fitzegerald 2014:1103-1107).

VanderBoegh et al (2017:3) suggest that gender diversity is proven to attract more competitive candidates, as well as more committed, dedicated, and engaged healthcare

sector leadership, and all of which lead to improvements in quality of healthcare services rendered to the community and improve client satisfaction.

Quasi randomized trials conducted in India and Afghanistan using randomization of men and women leaders at village council levels support the link between female leadership and improved women's socio-economic situations (Downs et al 2014:89).

Like many societal challenges, the root cause of this problem is multifaceted and nearly impossible to pin on one factor. But gender stereotypes still play a role, along with balancing family responsibilities and work schedules, parental leave policies, and access to professional networks, contacts and sponsoring structures that are vital channels for promotions. And sometimes women themselves temper their own aspirations, believing their upward mobility to leadership positions may be limited (Walker 2017:2).

Outcome: The current study discussed why healthcare sector leadership positions have become more male-dominated and the researcher breach the following gaps identified. Finally, the researcher develops guidelines that ensure gender disparities in healthcare sector leadership are reduced to a minimum. Women health professionals hopefully aspire to higher leadership positions in healthcare sector and exert themselves as equal competitors with their male counterparts.

Gaps Identified:

- There are limited studies on gender disparities in healthcare sector leadership positions in developing countries including Southern Ethiopia.
- Gender stereotype, norms and practices keep women health professionals in lower-end jobs.
- Absence of continuous professional development plan impede the advancement of female health workers into the higher decision-making positions.
- Lack of gender diversity in healthcare sector leadership positions, and inability to protect the interest of dominant groups.

- Failure to attract competitive women health professionals to be engaged in to top healthcare leadership positions.

2.4 CONCLUSION

The researcher reviewed literature pertinent to gender disparity in healthcare sector leadership positions. It is evident that motivation and job satisfaction of women who make up of a large proportion of the health workforce was negatively affected by gender disparity. This then affects career outcomes and perceptions of workplace gender equity and opportunity for women health care professionals who aspire to healthcare sector leadership positions.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter presents detailed account of the approach taken in the present study, its background and theoretical position in relation to the mixed methods used to elucidate the perspectives of gender disparity in health care systems. The chapter describes the research methods, recruitment strategy, sampling strategy and selection criteria. Data collection, data analysis, ethical considerations, the processes used to achieve rigor, trustworthiness, and explanation of the methodological issues and conclusion of the research methods are also discussed in this chapter.

3.2 PURPOSE OF THE STUDY

As explained by Terrell (2016:264), purpose of the study is a statement made to inform the reader why a study is being undertaken. The author further contends that a good purpose statement for a mixed methods study comprises the intent of the study, research design, the question the researcher needs to answer and the rationale behind what the researcher propose to do.

3.3 RESEARCH DESIGN

According to Gray, Grove & Sutherland (2017:52), research design is a general strategy for the implementation of a study to answer a specific research question. Maree (2016: 72) defined research design as a strategy that moves from the underlying philosophical assumptions to specifying the selection of study subjects, data collection methods to be used and the statistical methods considered for data analysis. As defined by Kothari & Garge (2014:29), a research design is the conceptual structure and blueprint for collection, measurement and analysis of data in a manner that aims to combine relevance to the purpose of the study. As explained by Creswell (2014:44), convergent parallel mixed methods designs was used to collect both quantitative and qualitative data sets during the same phase of the research process, analyze them separately and merging the two sets of results into an overall interpretation in order to provide a comprehensive analysis of the research problem. The rationale for the choice of convergent parallel mixed methods over the sequential-explanatory and sequential-exploratrory designis that the researcher gives equal emphasis for both quantitative and qualitative data concurrently then the two sets of reults was mixed during interpretation.

3.3.1 Quantitative Research Design

Quantitative research design originated from post-positivist world view with a deterministic philosophy that objective reality can be discovered using the deductive approach in which ideas or concepts are reduced into discreet set of variables that comprise hypothesis and research questions (Creswell 2014:36; Terrell 2016:69). Quantitative descriptive and exploratory research was used in this study. In this study the descriptive or exploratory quantitative research design's major emphasis was to determine the frequency of occurrence of a concept and its characteristics (Gray et al 2017:200). The main function of a descriptive research design is to measure variables by using statistical methods to organize and summarize data in a meaningful way. This

enhances the understanding of the properties of data (Maree 2016:204). In a descriptive study, variables are not manipulated, the researcher examines and describes the situation as it exists in a natural setting (Grove, Gray & Burns 2015:224). According to Polit & Beck (2014:160), the researcher in descriptive study observes, describes, and documents various aspects of gender disparity in healthcare sector leadership positions. This design was selected because it seemed mostly pertinent for obtaining empirical information that address the research questions for this study.

3.3.2 Qualitative Research Design

The 'qualitative research approach' refers to a broad range of research designs and methods used to investigate an in-depth description and understanding of realities subjectively (Brink, Walt & Rensburg 2018:104). As the name implies, qualitative methods focus on the qualitative aspects of meanings and understanding used to investigate individual experience from the viewpoint of research participants (Brink et al 2018:104). Exploratory-descriptive qualitative research design in contrast to quantitative research design ascribed a perceived view of reality subjectively from constructivist position, which allows for multiple meanings of individual experiences (Gray et al 2017:70; Maree 2016:309). In this study qualitative descriptive design was used in order to provide an in-depth information and thick description of the phenomenon being studied from the participants' viewpoint. According to Grove et al (2015:67), qualitative research design aims to provide holistic pictures of phenomenon guided by multiple and constructed realities from the perspective of the study participants.

The process of exploratory-descriptive qualitative research involves emerging questions and procedures; the researcher collects data in the participant's natural setting in health sectors where the health care providers work, data analysis inductively building from specific to general themes, and the researcher made interpretations of the meaning of the data (Creswell 2014:32).

3.3.3 Mixed Methods Design

Mixed methods design is defined as a procedure for collecting, analysing and mixing both qualitative and qualitative data at some stage of the research process within a single study or a series of studies to understand a research problem (Maree 2016:313). To ensure representativeness and generalizability of quantitative research and the in-depth, contextual nature of the qualitative research, mixed methods designs are combined in a single study (Grove et al 2015:244).

As explained by Gray et al (2017:310), researchers who support pragmatic view and seek to answer research questions using mixed methods design have considered the dichotomy of positivism and constructivism for the ''epistemological middle ground'' of pragmatism. As a philosophical underpinning for mixed methods studies, Creswell (2014:39) convey the importance of pragmatic philosophy for focusing attention on the research problem in social science and then using pluralistic approaches to derive knowledge about the problem.

According to Creswell (2014:39), pragmatism provides the following philosophical basis for the research:

- Pragmatism is not carry out to a single system of philosophy and reality. Pragmatism applies to mixed methods research in that the researcher draws liberally from both quantitative and qualitative assumptions that best meet the purpose of the study when he/she engaged in a research.

- In mixed methods research design, the researcher used both quantitative and qualitative data because he/she works to provide the best understanding of the research problem.

- Mixed methods researcher needs to establish the rationale for mixing quantitative and qualitative data in a single study or series of studies.

- In mixed methods design, pragmatism opens the door for multiple methods, different worldviews, and different assumptions, as well as different methods of data collection and analysis.

Mixed method design was selected based on the purpose of the study, timing of quantitative and quantitative data collection, and prioritization of one data set over the other (Gray et al 2017:311).

Mixed method design is a systematic convergence of quantitative and qualitative data set which involves the combination of qualitative and quantitative research in a single study (Creswell 2014:43). Convergent parallel mixed methods are a form of mixed methods design in which the researcher converges or merges quantitative and qualitative data sets in order to provide a comprehensive analysis of the research problem (Creswell 2014:44). In this design, the researcher collects both qualitative and quantitative forms of data at the same time and then integrates the information during the interpretation of the overall results.

Mixing the features of both qualitative and quantitative methods build on their complementary strength within a single study (Neuman 2014b:165) to establish the topic of the research under investigation, gender disparity in healthcare sector leadership in the study setting.

In this study mixed methods approach was used to integrate qualitative and quantitative data collection methods which can help the researcher in overcoming the intrinsic bias that arises from using single method alone (Grove et al 2015:244). Using qualitative and quantitative methods as a methodological triangulation help researcher to obtain more complete and substantive picture of reality under investigation, thus increase validity and credibility of the study, which constitutes an important strategy in the synthesis of the research findings (Brink et al 2018:84; Maree 2016:122).

Mixed methodsresearch involves a combination of the paradigms of quantitative and qualitative methods and techniques into a single study to complement the strength of both approaches to answer different stage or parts of a complex research question (Gray et al 2017:310). In this study the researcher used quantitative and qualitative approach to better understand gender disparity faced by female health professionals who aspire to

healthcare sector leadership positions and to determine factors affecting women's role in decision-making in healthcare sector and to make an accurate representation of the reality under study, and to confirm the findings.

3.4 STUDY SETTING

Study setting is described as the location where the study is conducted, according to Gray et al (2017:353), is a natural or field setting in which the researcher is interested to conduct a study in an uncontrolled, real-life situation or natural environment. However; the researcher did not manipulated or changed a natural setting or the environment for the study (Grove et al 2015:38). This study was envisaged to be conducted in all the public health facilities and healthcare sectors found in 16 zones in Southern Nations, Nationalities and Peoples Regional State of Ethiopia. Figure 1 shows administrative maps depicting the districts and zones of South Ethiopia. Each zone has at least one health department, several district health offices, hospitals and health centers which are disproportionately distributed.

Southern region is one of the third largest and populous regions in Ethiopia. It is situated in the South and Southwest part of Ethiopia. The region shares international boundaries with Republic of Sudan in Southwest and Kenya in the South.

The region has a growing population of 17, 359, 008 on a total land mass of 118, 000 square kilometers (CSA 2010). It has 15 zones, 136 woreda/districts (the basic decentralized administrative units), 4 special districts, 25 town administrations, 3,926 kebeles (small administrative units).

A multi-ethnic state, Southern Nations, Nationalities and Peoples Regional State of Ethiopia includes 56 ethnic groups and 93% of the population lives in rural areas. In Southern Nations, Nationalities and Peoples Regional State of Ethiopia, there are 54

public hospitals, 716 health centers, 3, 866 community health posts, 5 health science colleges, and 10 public Universities (RHB 2017).

According to the *Southern Ethiopia Regional Health Bureau, Health worker profiles (2017)* there are 26,700 health professional mixes of all categories in public health facilities and health sectors and nearly 945 top decision-making positions are available in the study setting (RHB 2017).
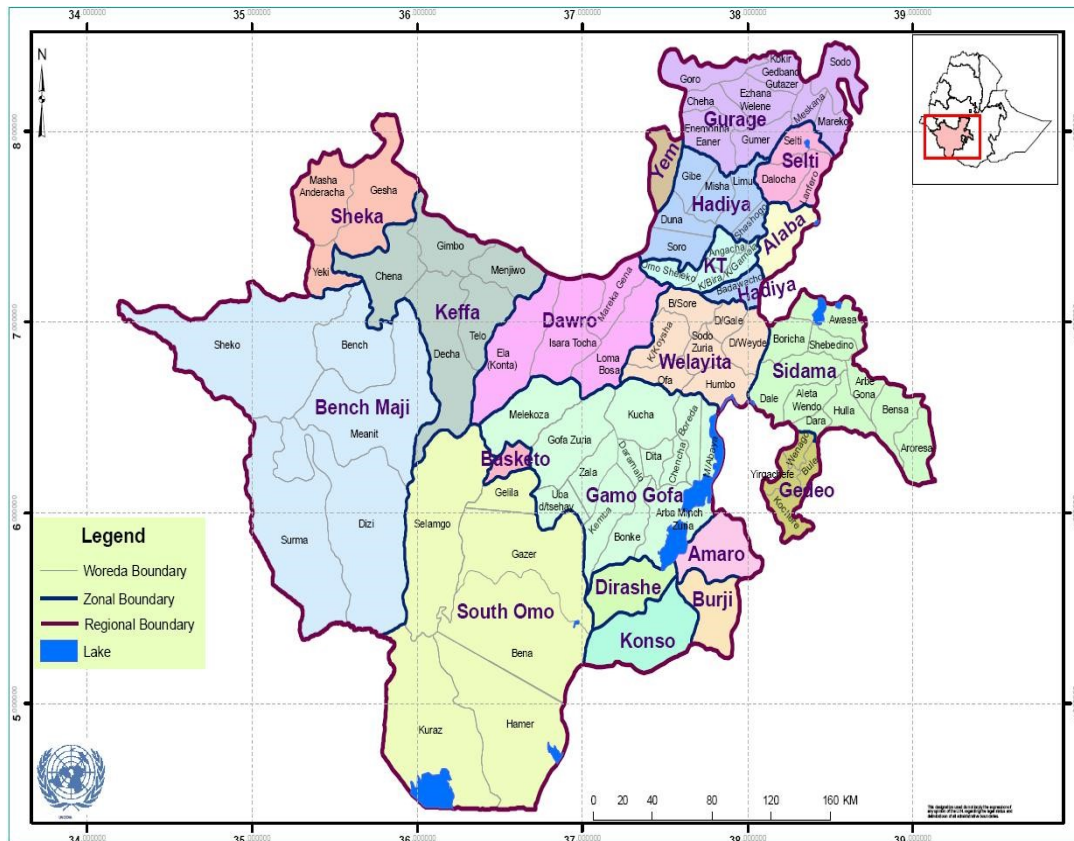
Figure 3:1 Administrative maps in Southern Nations, Nationalities and Peoples Regional States of Ethiopia.
(Source: https://reliefweb.int/sites/reliefweb.int/files/resources/21_adm_snp_010515)

According to the current organization of health service delivery in Ethiopia as depicted in the figure below, primary hospitals and health centers are under primary level healthcare category and general hospital is classified as secondary level health care (FMOH 2014:26).
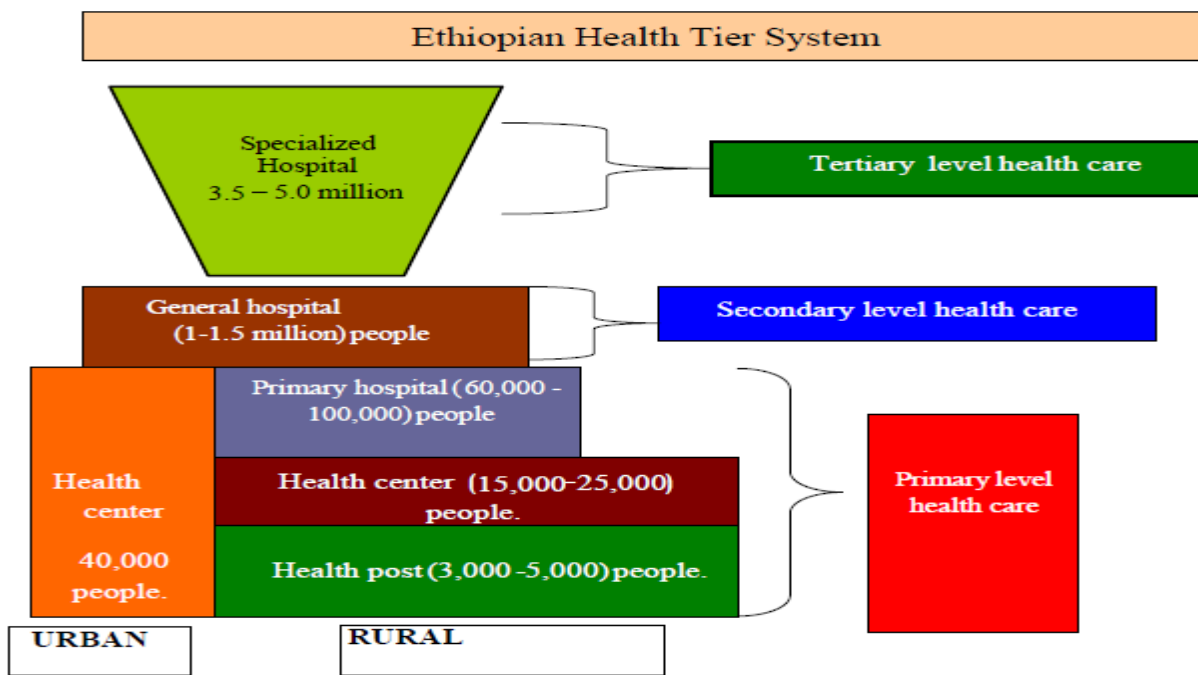
Figure 3:2 The Organization of Ethiopian Healcare Delivery System
(FMOH 2014:26)

3.5 RESEARCH METHODS

According to Kothari & Garge (2014:6), a research method is a general methods or techniques used by the researcher during the course of conducting his research problem. Research methods are tools that the researcher used to collect and analyze data about social reality from individual study participants (Maree 2016:74). According to the author, research methods used by the researcher are influenced by the research questions, ontological position or conceptual framework and the purpose of the study. In this study qualitative and quantitative methods were used.

Gray et al (2017:315) explained that convergent concurrent design was selected by the researcher to use qualitative and quantitative methods in an attempt to confirm cross-validate, or corroborate study findings within a single study or a series of studies. Convergent concurrent designs use separate quantitative and qualitative methods as a mechanism to allow the strengths of the two methods to complement each other.

Therefore, quantitative and qualitative data collection processes are conducted concurrently (Gray et al 2017:315). The researcher used quantitative and qualitative data collection strategy concurrently to integrate the results of the two methods during interpretation phase, and convergence strengthens the knowledge whereas lack of convergence indentifies areas for future research or theory development (Gray et al 2017:315).

Mixed methods research is described by various authors in terms of philosophy or methods used. Polit & Beck (2014:390-340) define mixed methods research as a planned collection and integration of both qualitative and quantitative data within single studies or coordinated cluster of studies. According to Polit & Beck (2014:340) the rationale for mixed methods research include:

- **Complementarities:** Quantitative and qualitative approaches are complementary and the use of mixed methods avoids the limitations and bias arises from a single approach.
- **Practicality:** It is practical to use mixed methodological tools to answer research questions than single approach.
- **Incrmentality:** Qualitative study can generate hypothesis to be tested quantitatively, and quantitative findings demands clarification through an in-depth probing.
- **Enhanced validity:** Methodological triangulation can provide opportunities for testing alternative interpretations of the data and examining the extent to which the context helped to shape the findings of the research.

The convergence of technology with the complexity of healthcare system given rise to several research problems that cannot be answered completely with single method alone, as a result the researcher combined quantitative and qualitative methods and techniques into a single study or series of studies to complement the strength of both approaches to answer different stage or parts of a complex research question (Gray et al 2017:310).

Convergent concurrent design was used to gain a better understanding of the research problem and the researcher collect both quantitative and qualitative data simultaneously, analyzing each separately, merging the two sets of results, and then interpreting them together allow the strengths of the two methods to complement each other (Gray et al 2017:315; Terrell 2016:210).

In convergent concurrent design, the quantitative and qualitative strands interact independently and when both strands contribute to the same degree, equal priority was given (Terrell 2016:211) and data collection requires timing, that is, the researcher decided to collect both strands simultaneously. The same authors assert that the data may have equal priority and the integration of the two data sets occur during data analysis and interpretation.

The authors provides a visual model of the convergent or parallel mixed methods in which the researcher used quantitative and qualitative strands in an attempt to confirm, cross-validate or corroborate findings within a single study (Gray et al 2017:315-316; Terrell 2016: 211).
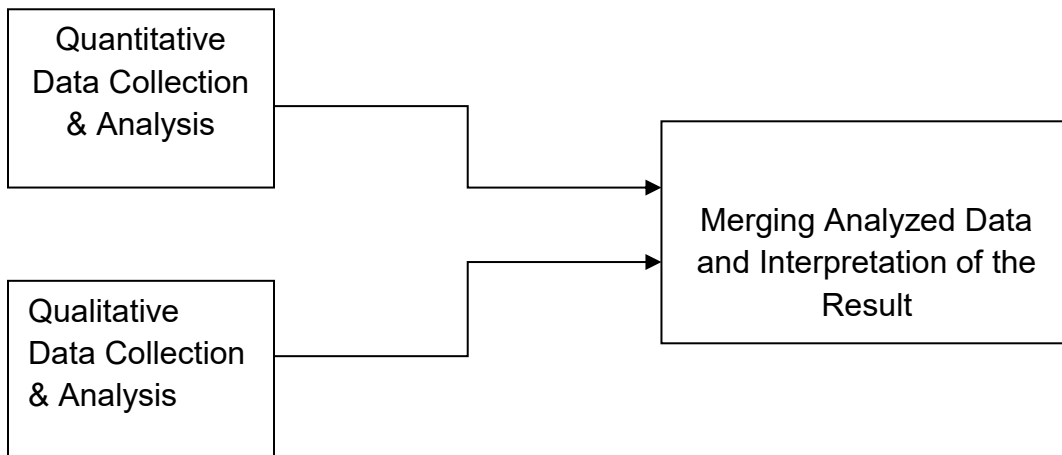
Figure 3:3 Visual model of convergent parallel method (Terrell 2016:211)

3.6 TARGET POPULATION

The study population is described as the target population which is, according to Gray et al (2017:330), is the entire set of individuals that meet the sampling criteria under investigation. However; researchers do not have access to the whole population and therefore make use of the accessible population which is described by Gray et al (2017:330) as the portion of the target population to which the researcher has reasonable access. Target population is the entire set of elements about which the researcher is interested to make generalization (Brink et al 2018:116).

The researcher also sets eligibility or inclusion criteria which, according to Grove et al (2015:251), are list of the characteristics essential for eligibility or membership in the target population.

The study population included all healthcare professionals working in healthcare sectors found in the study setting. The target population includes all female healthcare professionals who sought healthcare sector leadership positions and female healthcare sector leaders in different hierarchy in a study setting.

The accessible population included female healthcare sector leaders in different hierarchy in a study setting who were available at the time of the study. Inclusion criteria were female health professionals who assigned to healthcare sector leadership and lower decision-making positions and can speak either Amharic and were able to give consent and available at the time of the study were included in this study.

3.7 SAMPLING

Prathapan (2014:95) explains that sampling is the selection of some part of the aggregate on the basis of which a judgment or inference about the aggregate is made whilst Kothari & Garge (2014:147) describes sampling as the process of obtaining information about the entire population by examining a smaller set of cases. According to Grove et al (2015:37), sampling is the process of selecting study participants who are representative of the population being studied. Simple Random Sampling (SRS) method provides a sample that is representative of a population because each member of the population is selected independently and has an equal chance or probability of being included in the study (Grove et al 2015:37).

Table 3.1 Composition of Target Population

Districts	Position Occupied				Sample from each district	Total
	Senior Position		Junior Position			
	Male	Female	Male	Female		
Aleta Chuko	115	60	125	128	45	473
Dara	86	66	20	101	42	315
Aleta Wondo	95	75	36	120	48	374
Dale	275	90	55	300	108	828
Hawassa	119	107	87	160	71	544
Boricha	150	121	26	75	56	428
Shabedino	123	80	40	104	52	399
Total	963	599	389	988	422	3,361

The study participants were selected using the following procedures.

3.7.1 Sampling Strategy

In a mixed method study design, a randomly selected quantitative sample that are large enough for generalize for the target population and the researcher tends to have much smaller samples of purposively selected qualitative data (Terrell 2016:212).

Gray et al (2017:342) explained that non-probability sampling methods used in qualitative research increase the likelihood of obtaining samples that are not representative of the target population. Maree (2016:197) also pointed that, non-probability sampling has the limitations in terms of representing the population and generalizing the study findings to the target population. For the qualitative study, non-probability sampling procedure was employed and 21 study participants was purposively selected from the following administrative hierarchy of healthcare sectors in the study setting.

i.   Zonal health department.
ii.   District health office.
iii.   Town administration health office was envisaged for an in-depth individual interview and actual sample size for qualitative study was determined by data saturation (Creswell 2014:269).

Probability or random sampling technique was used to increase the sample's representativeness of the target population (Grove et al 2015:257). The main sampling method employed for the quantitative study was stratified random sampling techniques (Tadesse 2014:32; Kothari & Garge 2014:59). Simple Random Sampling (SRS) techniques was used to select study participants independently from each stratum, and this refers to the methods of sample selection which gives each possible sample combination having an equal probability of being selected and each participants in the entire population is having an equal chance of being included in the sample (Kothari & Garge 2014: 56).

3.7.2 Recruitment Strategy

After the researcher made a decision about the actual size of the study participants, the next steps according to Gray et al (2017:354) is developing a plan for recruiting study participants, which involves identifying, accessing and communicating with potential study participants who are representatives of the target population. According to Gray et al (2017:355), the researchers' initial communication with potential study participants affects the subject's decision about participating in the study. Therefore, the approach must be pleasant, positive, informative, culturally sensitive and non-aggressive. This process involves having the researcher explain the importance of the study and providing information to the potential participants about the duration of the study and how much of the subject's time was involved (Gray et al 2017:355).

After securing ethical clearance certificate from the Ethics and Higher Degrees Committee of the Department of Health Studies, University of South Africa (UNISA) (Annexure A), the proposal and ethical clearance certificate were submitted to Dilla University, Research and Dissemination Office. Upon approval by Dilla University, Research and Dissemination Office (Anexure D), ethical approval and permission was also obtained from Southern Nations, Nationalities and Peoples Regional State of Ethiopia Health Bureau Health Research and Technologies Transfer Office (Annexure E).Each and every healthcare sector could not allow for data collection before the permission of Regional Health Bureau Health Research and Technologies Transfer Office despite the fact that one granted permission for ethical clearance certificate before the approval of Regional Health Bureau Health Research and Technologies Transfer Office.

Following approval of Regional Health Bureau Health Research and Technologies Transfer Office as stated above, the study was conducted at sampled healthcare sectors. As indicated above, data collection was conducted concurrently. The researcher approached zonal health department head, district health office head, as well as the head of health centers and hospital medical directors and described the purpose of the study.

In both health service facilities, the concerned management officials introduced the researcher to the health professionals and informed them of the purpose of the study.

Recruitment of both male and female health professional leaders and those having no leadership role was performed after obtaining permission from Sidama Zonal Health Department (Annexure F) and Hawassa City Administration Zonal Health Department (Annexure G). The researcher invited each participant to an office to explain the purpose of the study and provide them with information sheet to read over 24 hours. Ethical considerations for participants are discussed later in section 3.11.

3.7.3 Sample Size

Sample size (n) was determined using single population proportion formula based on the following assumption.

- 50% proportion (p) was considered because no documented study known to the researcher.
- 5% margin of sampling error tolerated.
- 95% confidence interval, and $\left(Z_{\left(\frac{\alpha}{2}\right)}\right)^2$ is the value of the standard normal distribution corresponding to a significant level of alpha $\alpha = 0.05$ which is 1.96.

$$n = \frac{\left(Z_{\left(\frac{\alpha}{2}\right)}\right)^2 P\,(1-P)}{d^2} = \frac{(1.96)^2 0.50\,(1-0.50)}{(0.05)^2} = 384$$

- A further 10% of the sample was added to allow for participants attrition & incomplete questionnaires.
- Hence the final sample size was 384+38=422.

3.8 DATA COLLECTION INSTRUMENTS

For cross-sectional study, a modified data collection instrument from gender audit survey tools developed by InterAction 2011 was used to collect quantitative data. To conduct an in-depth interview for qualitative study, a semi-structured interview guide was also designed in English containing open questions. Care has been taken in developing interview guide to allow for the collection and analysis of valid data, and ultimately the development of a sound dissertation report and summary presentation.

Exploratory and descriptive cross-sectional research design was used in this study. In exploratory and descriptive research, a semi-structured and structured or well thought data collection instrument was used respectively. The main focus of exploratory research was formulating a problem for more precise investigation of research questions from an operational point of view but descriptive research concerned with specific predictions, describing facts and characteristics concerning gender disparity in healthcare sector leadership positions (Kothari & Garge 2014:34-37).

3.8.1 Pilot Testing of Data Collection Instruments

A pilot study is a small-scale study conducted prior to the main study on a limited number of participants who are not part of the sample (Brink et al 2018:161). A pilot study is a small-scale study performed with the same study population, the same study setting, the same data collection and analysis techniques to determine their quality (Gray et al 2017:54; Grove et al 2015:45). According to Gray et al (2017:54); Brink et al (2018:161), the following are the purpose of pre-testing data collection instruments.

- To determine the effectiveness of the proposed methods in collecting useful information.
- To determine how much time is required to collect data from one study subject.
- To investigate ambiguity of instructions or wording of data collection instruments.
- To determine whether the variable defined by operational definitions are measurable.

Pilot study or field-testing was conducted in a similar setting to ascertain feasibility of the study. For conducting pilot study, the researcher piloted data collection instruments by identifying 21 health professionals working in Gedeo Zonal Health Department and health centers who meet the eligibility criteria and they were not be part of the actual study.

Data obtained from the pilot study was analyzed using Statistical Package for Social Sciences (SPSS version 24.0 for windows) and presented to the supervisors. The revised data collection instruments were also presented to the supervisors and used in the actual study.

The researcher also identified female health professional leaders not included in the quantitative study to take part in an in-depth interview for the qualitative strand of the study. The same concepts were addressed in both the quantitative and qualitative data collection so that the two data sets were merged and the results were compared. Qualitative data was analyzed using Collaizze seven steps descriptive phenomenological data explicitation (Morrow, Rosie, Rodriguez, Alison & King Nigel 2015:643-644).

3.8.2 Participants

Research participants or study subjects and informants are used in the context of the naturalistic paradigm of qualitative and mixed methods research (Gray et al 2017:330). Study participants are individuals serving as a data source for the research and their autonomy and agency was acknowledged by the researcher in contributing to the research activity (Robson 2014:86). The target population for the study includes 3,361 male and female health professionals currently working in the public healthcare sectors

who assigned at healthcare sector leadership and junior decision-making positions in Southern Nations, Nationalities and Peoples Regional State of Ethiopia.

3.9 DATA COLLECTION PROCESS

A triangulation of data collection methods including individual in-depth interview and interviewer administered structured questionnaires was employed for qualitative and quantitative research methods respectively. The researcher administerd structured questionnaire prepared in English for 422 participants to collect quantitative data from health professionals working in health centers and hospitals while in-depth interview for qualitative data was captured by audio-tape from health professionals working in district and zonal health offices. The researcher collected completed and enveloped questionnaire from the participants. To ensure confidentiality participants were informed that information obtained and interview response was not divulged to the public and their identity remains anonymous during presentation of the study findings. An in-depth interview was conducted using a semi-structured interview guide containing open questions. All study participants were interviewed using a central opening question ''Tell me your view regarding gender disparity in healthcare leadership'' The central question was followed by probing questions based on their response.

The researcher liaised with the South Region Health Bureau by explaining the purpose and the significance of the proposed study for ease of access to female healthcare sector leaders in their natural setting to request permission to conduct the study at health sectors found in Southern Nations, Nationalities and Peoples Regional State of Ethiopia.

On the specific data collection days, the prospective study participants were met in their office, given the information letter. After this, a consent form was given to those participants who were willing to participate in the study for signature or endorsement. The study was deemed to have no anticipated risks and harm to the study participants' attributable to their participation in the study.

3.9.1 Inclusion Criteria

Inclusion criteria are characteristics that the study subjects possess eligibility criteria to be part of sampled population (Gray et al 2017:331). Both male and female senior, intermediate and junior officers were included in the study.

3.9.2 Exclusion Criteria

Exclusion criteria are characteristics that cause subjects to be eliminated or excluded from the study (Gray et al 2017:331). Health extension professionals working in the community health posts were excluded because they are all females. Health professionals working at the public Universities which are not governed and supervised by regional health bureau management were also excluded from the study.

3.10 DATA PROCESSING AND ANALYSIS

3.10.1 Quantitative Data

The quantitative survey data collected was entered into EpiData version 3.1 and exported to Statistical Package for Social Science (SPSS) version 24.0 for data cleaning and further analysis. Descriptive statistics were computed to summarize and describe the data in the form of numbers, charts, frequency distribution tables, percentages and proportions. To test the association between variables under study, the odds ratios and confidence intervals were calculated. Odds ratios are a measure of the association between the predictor and the dependent variable having dichotomous values (Gray et al 2017:561). It is the ratio of the odds of an event occurring in one group to the odds of

occurring in another group. In this study, level of women representation in healthcare sector leadership positions as the outcome variable and odds ratio indicated the likelihood that women representation would occur given the presence of certain exposures particularly demographic and socio-economic characteristics. The 95% confidence interval indicates that the population mean would fall within this interval, and used to estimate the degree of variation that the point estimate is expected to have from sample to sample (Grove et al 2015:334; Maree 2016:223). According to Maree (2016:223), the level of precision of the odds ratio with wide confidence intervals indicating low precision and small confidence intervals representing high precision of the odds ratio.

3.10.2 Qualitative Data

Data collected during the qualitative study was the transcripts from the digital audio recordings of an in-depth interview and field notes (Gray et al 2017:268). Qualitative data analysis occured concurrently with data collection rather than sequentially as a quantitative approach. Therefore the researcher was attempting collected, managed, and interpreted large volume of qualitative data simultaneously, which required the researcher to have a plan for labeling electronic files, and storing them in a secured place so that specific data can be retrieved as needed (Grove et al 2015:88).

Data was analyzed according to Collaizze seven steps of managing qualitative data (Morrow et al 2015:643-644). In exploratory-descriptive qualitative studies, the researcher analyzed the content of the text using concepts from guiding theories developed earlier during the study (Gray et al 2017: 272).

3.10.3 Qualitative Data Coding

A code refers to the symbols or abbreviations used to label electronic files in the raw qualitative data elements, which allows the researcher to find prominent themes and patterns (Gray et al 2017:271). Because of the volume of the data acquired in a qualitative research, the researcher focused on reducing the large masses of the qualitative data in to smaller, more manageable segments so as to effectively analyze the data. Data coding in a qualitative study involves the reduction of data so as to attach meaning to words and symbols. Coding is the process of transforming raw qualitative data elements into standardized form which allows the researcher to process and analyze it (Polit & Beck 2014:376).

The researcher used descriptive, analytical and hierarchical coding. Descriptive coding is the first level of coding, and the researcher used participants' viewpoint as a label, also in vivo coding (Gray et al 2017:271). Analytic coding involved breaking down large volume of data elements into smaller units, labeling and naming the units according to the content presented, and grouping coded materials based on shared concepts (Polit & Beck 2014:306). Then the researcher used clustering based on similarities among units of analysis and hierarchies that conceptualize the text on different level of abstraction (Polit & Beck 2014:306).

3.11 ETHICAL CONSIDERATION

Research ethics is the standards of conduct for the researcher in his professional endeavors. These diverse set of values, norms and institutional relationship help to plan, imply and regulate scientific activity (Prathapan 2014:233). Rea & Parker (2014:34) explained that when the researcher conducts their study, they are highly expected to adhere to a variety of ethical standards. The researcher must ensure that study participants are included by their own free will and their participation was voluntarily, and they have been advised of their right to withdraw from the study at anytime without penalty if any discomfort happens during the study.

3.11.1 Permission to Conduct Research

In order to safeguard study participants' rights the principle of beneficence requires the researcher to do good and avoid causing harm is ethical principle relevant to research involving human subjects were observed (Gray et al 2017:161). The approval for the study was sought from several ethics committees before commencement of data collection. The initial ethical clearance certificate was sought from Ethics and Higher Degree Committee of the Department of Health Studies, University of South Africa (Annexure A). Ethical approval and permission was also obtained from Southern Nations, Nationalities and Peoples Regional State Health Research and Technologies Transfer Office (Annexure E).

3.11.2 Access to Healthcare Sectors

Meetings were held with the management team of healthcare sectors found in the study setting to gain entry into the institutions and ease access of study participants. The researcher obtained information from the study participants concerning quantitative and qualitative study. The head of healthcare sectors had an extensive knowledge and established relationship with the healthcare professionals and therefore had detailed understanding of the local situations. This helped the researcher to get trust and build rapport with the health professionals. The head of healthcare sectors also offered a safe place for female health professionals and allowed ease of access in identifying eligible study participants who meet inclusion criteria.

3.11.3 Self Determination

The right to self-determination is based on the ethical principle of respect for persons and indicates that humans are capable of self-determination and should be treated as autonomous agents to make their own decision to participate freely in the study (Gray et al 2017:162). The study participants were granted the right to privacy, anonymity and confidentiality, and right to fair selection and treatment (Gray et al 2017:168-172; Grove et al 2015:105-107). To protect anonymity and maintain confidentiality of study subjects, code numbers were given to each study participants, and master list of their code numbers were kept into a locked cupboard (Gray et al 2017:170). The researcher ensured that there were no explicit or implicit threats of penalty from failing to participate in a study or agreeing and granting incentives to participate (Polit & Beck 2014:84).

3.11.4 Informed Consent

Informed consent is the transmission of specific information and contents from the researcher to the prospective study participants and agreement made by the participant voluntarily to participate in a study (Grove et al 2015:111). Informed consent is the first principle of the Nuremburg Code (1949) in which the person should have legal capacity to give consent, exercise freedom of choice without any intervention, should have sufficient knowledge and comprehension of the purpose of the study to enable him to make an understanding and make decision (Gray et al 2017:176).

In order to obtain informed consent, the researcher explained the purpose and significance of the study; risks, discomfort and benefits of participation; emphasized that participation was voluntarily and refusal to participate involve no penalty and option to withdraw from a study (Grove et al 2015:111-112). This information enabled the participants to make an informed decision about participating and seeking any clarification about the study. If the participants agreed to take part in the study, they were asked to sign an informed consent form before commencing the study (Annexure H). The researcher arranged convenient times at the health service facilities for the study. The

participants were informed the right to withdraw at any stage of the study without any reason and there were no penalty or sanction for withdrawal (Annexure H).

3.11.5 Confidentiality

Gray et al (2017:170) described confidentiality as the researcher's management of private information shared by a study participant that must not be divulged to the public without the authorization of the respondents (Annexure I). According to Grove et al (2015:107), confidentiality is the researcher's safe management of data shared by a study subject to ensure that the data collected was kept private from others. To ensure confidentiality, a study subjects were informed that the information obtained from them and their responses was kept confidential and their identities remain anonymous during reports, presentations, and publications of the study findings (Gray et al 2017:177). According to Grove et al (2015:107), confidentiality is grounded in the following assumptions.

- Individuals can share their personal information to the extent that the study subjects wish and entitled to have secret.
- The researcher can choose the organization or the institution to share the information obtained from the study subject.
- Those accepting the information should have an obligation to maintain confidentiality.

A promise of confidentiality is a pledge that any information the study participants provide was not publicly divulged in a manner that identifies the subjects and was not made accessible to others (Pilot & Beck 2014:89). To develop and ensure confidentiality procedure according to Pilot & Beck (2014:89), securing confidentiality assurances from those having access to the research data, maintain information obtained from study subjects in a computer access protected by password, assigning code numbers instead of capturing participants' name to prevent accidental breach of confidentiality, and

reporting only aggregate data during presentation of the study findings (Polit & Beck 2014:89).

3.11.6 Risks

The researcher had assessed the type and severity of anticipated risks and harm to the study subjects attributable to their participation in the study or improve to the satisfaction of the supervisors (Gray et al 2017:175). This research required study subjects to complete questionnaires or participate in an in-depth interviews according to Gray et al (2017:173), which involve minimal risk including physical discomfort that is fatigue and headache, emotional and social risks like anxiety or embarrassment associated with responding to certain questions, time spent by the subjects participating in the study was also considered as an economic risks.

3.11.7 Adverse Events

There were no adverse events to the study participants' but if the study participants' experienced any emotional discomfort attributable to their participation in the study and need further support. The researcher would referr the study participants to a qualified counselor and social worker to the nearest available health facilities.

3.12 RIGOR AND TRUSTWORTHNESS

3.12.1 Rigor

The rigor or strength of a qualitative study is the extent to which the identified meanings accurately reflect the viewpoints of the study participants (Grove et al 2015:67). According to Grove et al (2015:36), a rigorously conducted quantitative study has a precise data collection tools, a representative sample, and a tightly controlled study design. According to Gray et al (2017:43), rigor implies the following:

- The choice of sample was based on predetermined inclusion criteria.
- Measurements are made accurately with a standard data collection instruments.
- Data are recorded precisely.

3.12.1.1 Validity of the Instruments

The validity of data collection instrument refers to the extent to which the instrument measures what it is designed to measure (Maree 2016:239). The validity of an instrument is a determination of how well the instrument reflects the abstract concepts under investigation (Grove et al 2015:290). According to Gray et al (2017:375), the validity of an instrument indicates the extent to which the instrument reflects or able to measure the construct being examined. In order to investigate validity, the evidence based on the content and internal structure of data collection instrument, response process, and relationship of study variables was examined (Gray et al 2017:375). Babbie (2016:148) described validity as the extent to which an empirical measure adequately reflects the real meaning of the concepts under investigation. In this study, internal validity and external validity were important.

3.12.1.1.1 Internal Validity

Internal validity reflects design-embedded decisions about how dependent variables and independent variables are measured, and it is an assessment of the degree to which the measured relationships among variables is accurate due to their interaction (Gray et al 2017:198). The researcher ensured that factors which compete with the independent

variable as a cause of the dependent variable that could potentially affect the study findings were ruled out as competing explanations for any observed association between the dependent and independent variables(Polit & Beck 2014:168).

3.12.1.1.2 External Validity

External validity, which is defined by quantitative researchers as the degree to which the findings of the study can be generalized to other setting or samples, is usually referred to as "transferability" and "fittingness" in qualitative research (Brink et al 2018:111). External validity is the extent to which study findings can be generalized outside the specific research setting beyond the sample included in the study (Gray et al 2017:199). According to Gray et al (2017:199), external validity reflects design-resultant decisions that determine the population to which research findings can be generalized. Polit & Beck (2014:169) explained concept relevant to external validity is that, the generalizabilty of the study findings can be attained if the results have been replicated in more naturalistic study setting. The researcher ensured external validity by using large random sample to allow generalization of the study findings to the target population (Gray et al 2017:199).

3.12.1.2 Reliability of the Instruments

Reliability refers to the degree to which an instrument yields consistent results if used repeatedly over time by different researchers (Brink et al 2018: 155).
According to Gray et al (2017:370), reliability is concerned with precision, reproducibility, and comparability of the methods of measurement.

According to Maree (2016:238), reliability is the extent to which the same data collection instruments were used at different time or administered to different study subjects from the same population yielding consistent study findings. The three aspects of reliability testing according to Polit & Beck (2014:202) which are considered by the quantitative

researchers are associated with a measure's stability, internal consistency and equivalence.

Stability reliability is concerned with the consistency of repeated measures of the same attribute with a given instrument (Gray et al 2017:370). Test-retest reliability was conducted to examine instrument stability, which reflects the reproducibility of a scale on repeated administration of the questionnaire over time (Gray et al 2017:370).The original approach used to determine **internal consistency** or **homogeneity** is split-half reliability which is according to Gray et al (2017:373) is a method of obtaining test-retest reliability without administering the test twice. **Equivalence reliability** involves examining the consistency of scores between two observers measuring the same events (Gray et al 2017:373).

3.12.2 Trustworthiness

Hedges & Williams (2014:300) describe trustworthiness as the extent to which the researcher has demonstrated that the findings of the qualitative study are an accurate reflection of the participants' view point. Trustworthiness determines the quality and rigor of the qualitative study according to Grove et al (2015:392) is the extent to which a qualitative research is dependable, confirmable, credible, and transferable.

3.12.2.1 Dependability

Babbie (2016:405) proposed dependability as an ''inquiry audit trial'' of assessing the consistency or stability of the observation and the process of observation. Dependability is a criterion to establish trustworthiness of the study and this criterion requires an audit trial according to Brink et al (2018:111), in which the auditor follows the overall process and procedures used by the researcher and determines the acceptability of the study findings. The researcher demonstrates dependability through study design and its implementation, the operational detail of data collection and the interpretation of the study findings (Maree 2016:124).

3.12.2.2 Confirmability

Confirmability is the degree of neutrality in which the study findings reflects the participants view and the interpretations of the data were not biased by the researcher's motivation and interest (Maree 2016:125). Confirmability ensured that the study findings, conclusions and the recommendations are supported by actual information collected and an agreement made between the researcher's interpretations (Brink et al 2016:111). The researcher ensured that the results of this study could be reviewed or verified by other researcher and agrees that the researcher's conclusions are logical (Grove et al 2015:392).

3.12.2.3 Credibility

Credibility is the confidence in the truth value of the information collected and the accuracy of the interpretations of the study findings (Brink et al 2018:158). Grove et al (2015:392) pointed out that credibility involves the confidence of the reader about the extent to which the researcher have produced the study findings that reflect the view of the study participants. Credibility is further enhanced through frequent debriefing sessions, researcher's reflection of field notes and member checking (Maree 2016:123). A prolonged engagement with respondents and data triangulation to obtain rich description of the context also enhanced the credibility of the study (Terrell 2016:173-174).

3.12.2.4 Transferability

Transferability refers to the ability to ensure that qualitative findings are not generalizable, but are relevant and applicable in other settings with similar study participants (Grove et al 2015:392). To ensure transferability of the results, the researcher provided a thick description of the research context and purposeful sampling of the study participants in terms of the context being studied (Maree 2016:124).

3.13 METHODOLOGICAL AND THEORETICAL LIMITATIONS OF THE STUDY

Regarding the methodological limitations the researcher recognizes that the study was conducted in Southern Nations, Nationalities and Peoples Regional State of Ethiopia only. The researcher used purposive sampling technique in the qualitative study. By using purposive sampling to recruit female health professionals in this study might have increased risk of selection bias.The scope and setting of this study determine the sample size of the study participants recruited for this study.

The researcher appreciated that it was impossible to recruit adequate sample from few healthcare sectors found in zonal health departments and districts. In an attempt to achieve a reasonable sample size, healthcare sectors found in Southern Nations, Nationalities and Peoples Regional State of Ethiopia were considered. The researcher decided to use the sampling strategy from the study setting based on his previous experience as a researcher and as a leader in one of the healthcare sector. The sample in qualitative study is not a representative of the target population and this limit the credibility to generalize the findings of the study. The researcher was known in one of the research settings and some measures such as emphasis on voluntary participation and the decision to withdraw from participation were stressed during recruitment of study participants and not any study participant was coerced to take part in the study.

The other methodological issues were those pertaining to the theoretical limitation. Although a modified three steps theoretical model for gender sameness/difference or equity/inequity can be used as a way to understand gender bias in health care settings (Risberg et al 2009:1475-9276). However; this model is documented in few studies on gender disparity in healthcare sector leadership internationally or locally. The researcher decided to use this model because female health professionals have similar experiences and perceptions; these experiences are across a wide range or continuums from top hierarchy to the lowest.

The more compromised leadership status for female health professionals is, the more severe are the male dominated structure and gender stereotype. Male-dominated

leadership models limit women's aspirations to leadership position, as well as their access to leadership roles in healthcare sectors. Diverse healthcare leadership and governance is critical for healthcare sector and it might signal an organization's commitment to its health workforce and senior political leadership commitment to diversify healthcare sector leadership. This can reduce turnover intentions of qualified health workforce. Therefore; the researcher feels this model is appropriate for this study despite that it was used for the first time in this research topic in a study setting.

3.14 CONCLUSION

This chapter described the methodological underpinning of the study, which is convergent parallel mixed methods research. Both quantitative and qualitative research designs are discussed by giving due emphasis on how they were used to answer the research questions. The sampling strategy and selection criteria of the study participants, the instruments used for data collection and pilot-study are described. Data collection procedure and data analysis techniques for this study are discussed in detail. At the end of the chapter, ethical considerations, the strategies to enhance rigor and trustworthiness of this research process and the methodological issues encountered are described. Chapter 4 covers the quantitative and qualitative data analysis, interpretation and study findings.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 INTRODUCTION

This chapter focuses on the presentation and description of the results. The purpose of this study was to develop guidelines for reducing gender disparities in healthcare sector leadership in study setting of South Ethiopia to a minimum. A convergent parallel mixed methods design was used. This is a type of design in which the researcher collected both quantitative and qualitative data and analyzed during the same phase of the research process and merging of the two sets of results occurs into an overall interpretation (Gray et al 2017:315; Terrell 2016:210).

In this study quantitative data was used to describe factors affecting women's role in healthcare sector leadership in health care setting. Qualitative data was used to explore and describe the experiences of gender disparity in healthcare sector leadership in healthcare setting. Both sets of data were used to bring a greater and comprehensive assessment of gender disparity in healthcare sector leadership positions in a study setting.

4.2 QUANTITATIVE DATA MANAGEMENT AND ANALYSIS

Data was captured as per the variables on the questionnaire and cleaned before it was analyzed. Quantitative data was entered into EpiData version 3.1 and exported to Statistical Package for the Social Sciences (SPSS) version 24.0 for windows for further analysis. A statistician was consulted during the data analysis phase and both descriptive

and inferential statistics were computed. A sample size of four hundred and fourteen participants out of the expected four hundred and twenty two responded to the questionnaire. The compliance rate for quantitative aspect of the study was therefore 98%.

There were two objectives for the quantitative aspect of the study:

- Explore and describe gender disparity in healthcare leadership at health sectors in South Ethiopia.
- Determine factors affecting women's role in healthcare leadership at health sectors in South Ethiopia.

4.2.1 Site Characteristics

This section describes the characteristics of the study sites according to districts from which study participants were recruited from hospitals and health centers found under each districts.

4.2.1.1 Districts

The study was conducted in seven (7) districts that are found in Sidama Zone South Ethiopia. The other two (2) districts either did not provide permission for the study to be conducted or were inaccessible due to the topography of Sidama Zone. The Zone was divided into Hawassa city administration and Sidama rural district due to its large size and variability of the healthcare settings. Hawassa city administration consisted of healthcare facilities within the metropolitan area and Sidama rural consisted of healthcare facilities located in rural areas but under management of the Southern Regional Health Bureau. Figure 4.1 shows the distribution of participants from each district. Twenty two percent (n=90) of the participants were from Hawassa city administration; 11% (n=48) from Boricha district; 12% (n=50) from Shebedino district; 20% (n=84) from Dale district; 15% (n=62) from Aleta wondo district; 10% (n=41) from Aleta chuko district and 10% (n=40) from Dara district. The total number of participants was 414 from six districts. Only 22%

(n=90) of the participants were from health facilities found in Hawassa city administration but 78% (n=326) study participants were from district health facilities (Figure 4:1).
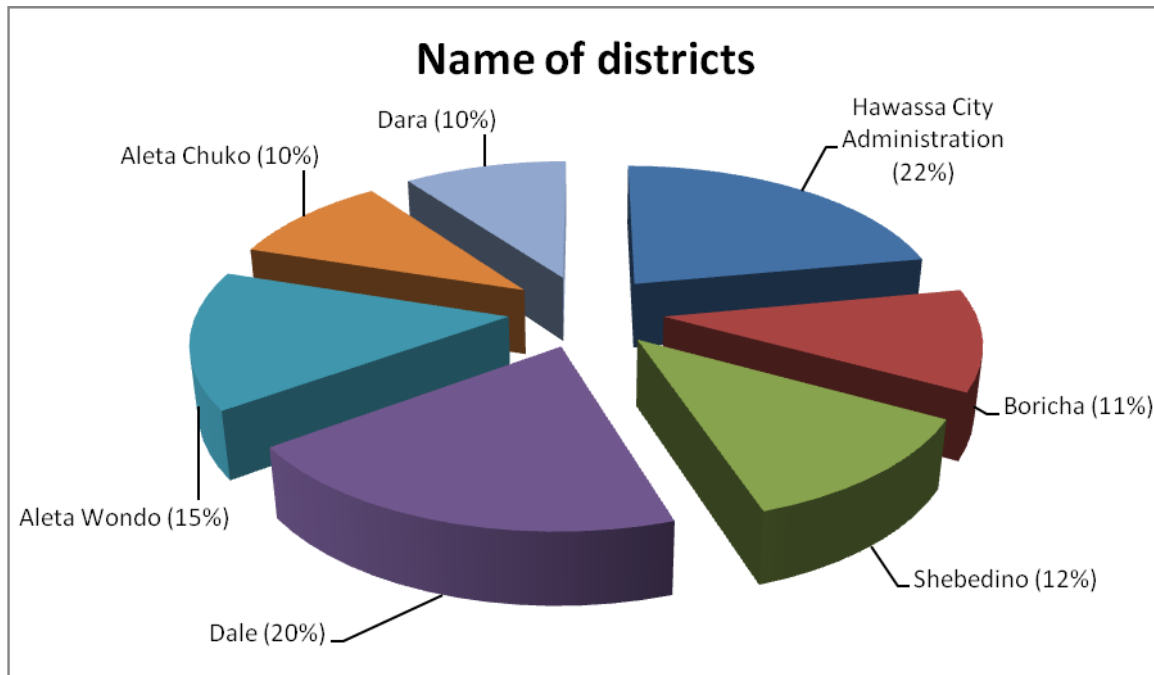
Figure 4:1 Proportion and name of the districts (N=414)

4.2.2. Sample Characteristics

This section describes the study sample according to age, gender, marital status, level of education, professional qualification, health sector organization, employment status, monthly personal income; participants work experience, position, role in health service facility and formal leadership training. Table 4:1 below presents the participants' detailed demographic information. The individual description of demographic characteristics are summarized and presented in tables and graphs.

Table 4:1 Participants' demographic characteristics (n=414)

Participants characteristics	n=414	%
Average age	(28.29) years	
Gender		
Male	192	46.6%
Female	220	53.4%
Marital status		
Single	199	48.4%
Married	212	51.6%
Level of education		
Diploma	203	49%
Bachelor degree	199	48.1%
Master's degree	12	2.9%
Professional qualification		
Registered nurse	216	52.4%
Midwifery	42	10%
Public health officer	64	15.5%
Medical doctor	20	4.9%
Pharmacist	26	6.3%
Laboratory professionals & others	44	10.8%

Table 4:1 Participants' demographic characteristics (continued)

Participants characteristics	n=414	%
Health service organization		
Health center	188	45.6%
Primary hospital	145	35.2%
General hospital	79	19.2%
Employment status		
Full time	386	98.2%
Part-time	7	1.8%
Monthly personal income in ETB		
< 5, 000.00 ETB	229	57%
> 5, 000.00ETB	173	43%
Work experience in years		
Mean work experience	(6.21 years)	
Median work experience	(5 years)	
Standard deviation	(4.56 years)	
< 25 years	398	96%
>25 years	4	1%

Table 4:1 Participants' demographic characteristics (continued)

Participants characteristics	n=414	%
Position of participants in health service facility		
Chief Executive Officer	5	1.3%
Medical Director	9	2.3%
Outpatient Department head	56	14.2%
Pediatrics & Internal Medicine department head	16	4%
Obstetric & Surgery department head	10	2.5%
Maternal & Child Health department head	21	5.3%
Other positions	13	3%
Role of participant in health service facility		
Hospital board member	12	3%
Health center board member	41	10.3%
Senior management member	39	9.4%
I do not have any role	308	77%
Did you ever receive any formal leadership training?		
Yes	48	11.7%
No	363	88.3%

4.2.2.1 Age

Ninety-four percent (n=388) of the participants provided information on their age and 6% (n=26) of the participants did not provide information on their age. The age range was 37 with a minimum of 20 and a maximum of 57 years. The mean age of the participants was 28.29 years and the standard deviation was 5.64. Table 4:1 above shows the frequency distribution of the age of the participants. Sixteen percent (n=66) of the participants` were aged between 20-24 years, 70% (n=290) of the participants` were aged between 25-35 years, 14% (n=58) of the participants aged greater than 36 years (Figure 4:2).
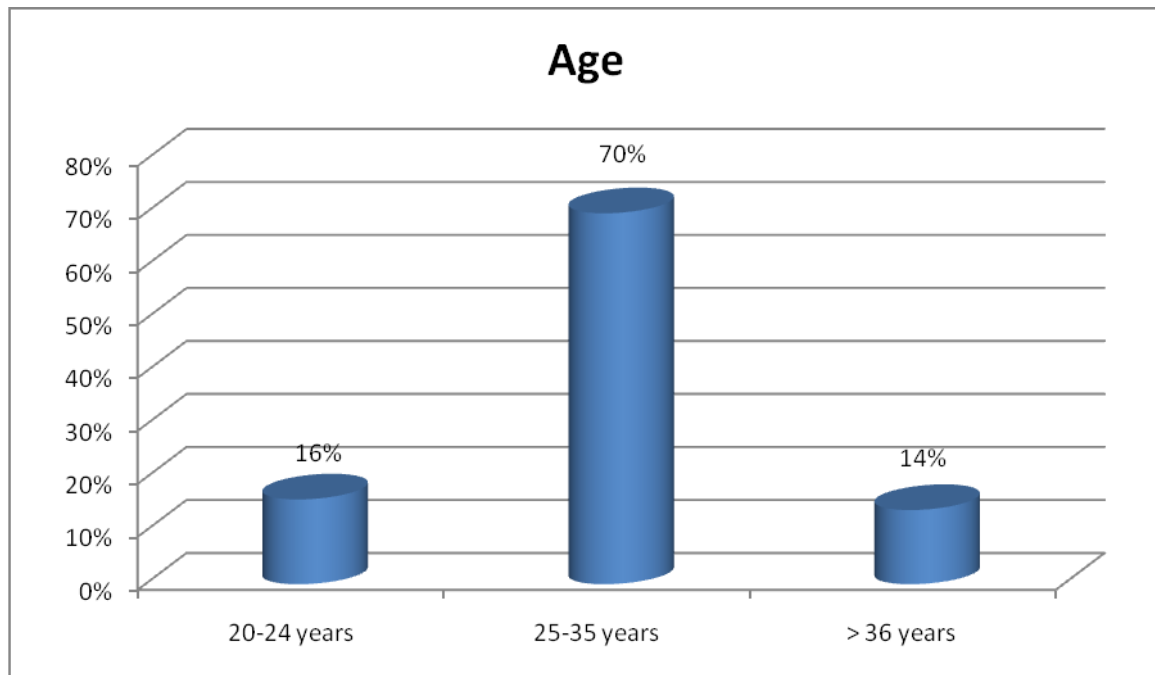
Figure 4:2 Participants' age distribution (N=414)

4.2.2.2 Gender

Information on the gender of the participants was also elicited. Ninety-nine percent (n=412) of the participants provided information on their gender. Only two participants did not provide information on their gender. Forty six percent (n=192) of the participants were males and 53% (n=220) were females (Figure 4:3).
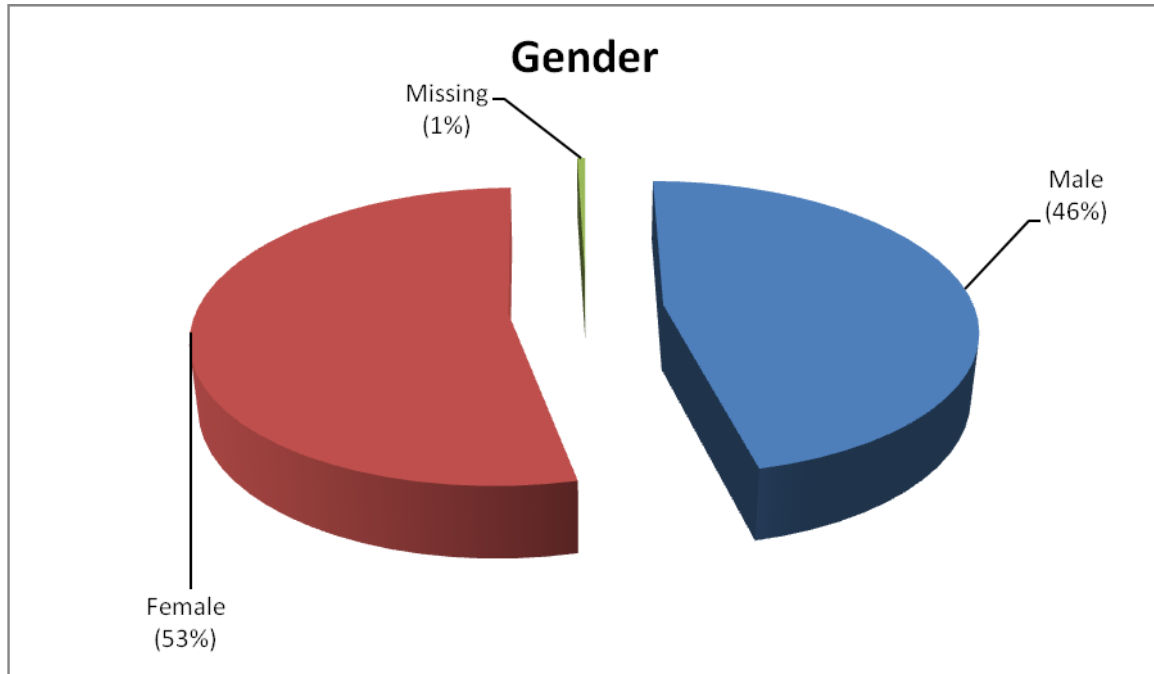
Figure 4:3 Gender of the participants (N=414)

4.2.2.3 Marital Status

Ninety-nine percent (n=411) of the participants provided information on their marital status and 1% (n=3) of the participants did not provide information on their marital status. Of the participants, 48% (n=199) were single, 51% (n=212) were married. According to the Ethiopian Demographic and Health Survey (EDHS 2016:11). One-fourth of women (26%) and two-fifth of men (42%) have never married. Women are more often married or living together with a partner (i.e., in union) than men (65% and 56%, respectively).

Women are also more likely than men to report that they are divorced or separated (6% and 2%, respectively). In this study only one female study participant has reported that she was divorced (Figure 4:4).
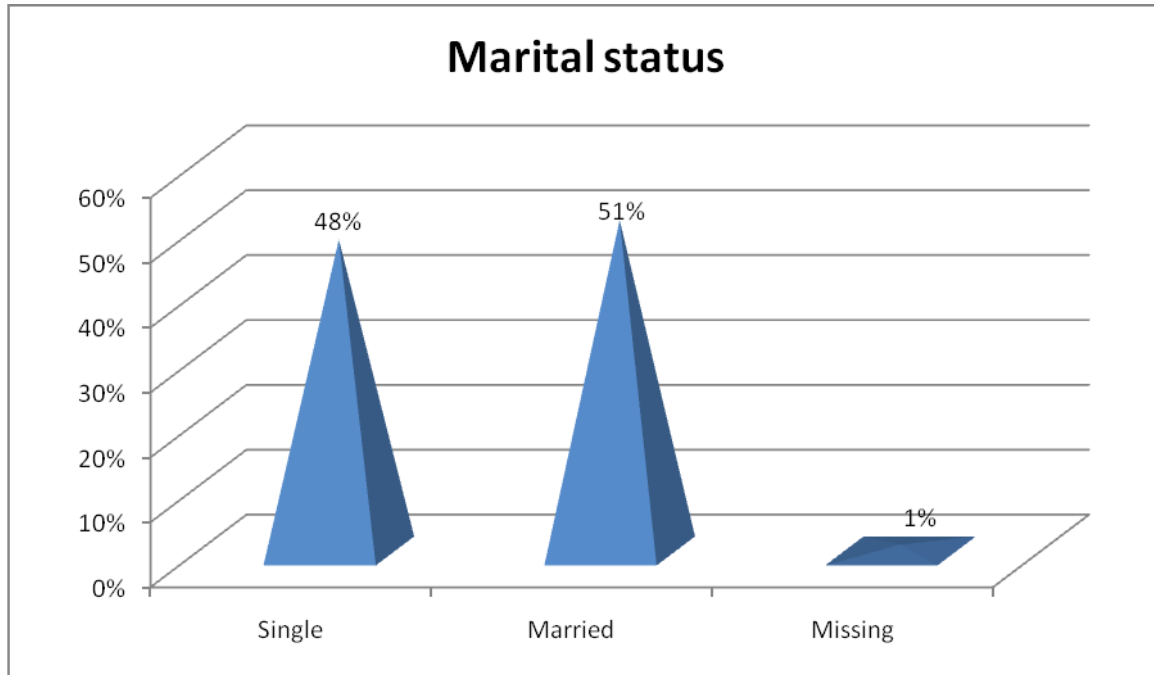
Figure 4:4 Marital status of the participants (N=414)

4.2.2.4 Level of Education

Regarding the participants' educational level, 49% (n=203) had diploma; 48% (n=199) had bachelor degree, only 3% (n=12) had master's degree level of education (Figure 4:5).
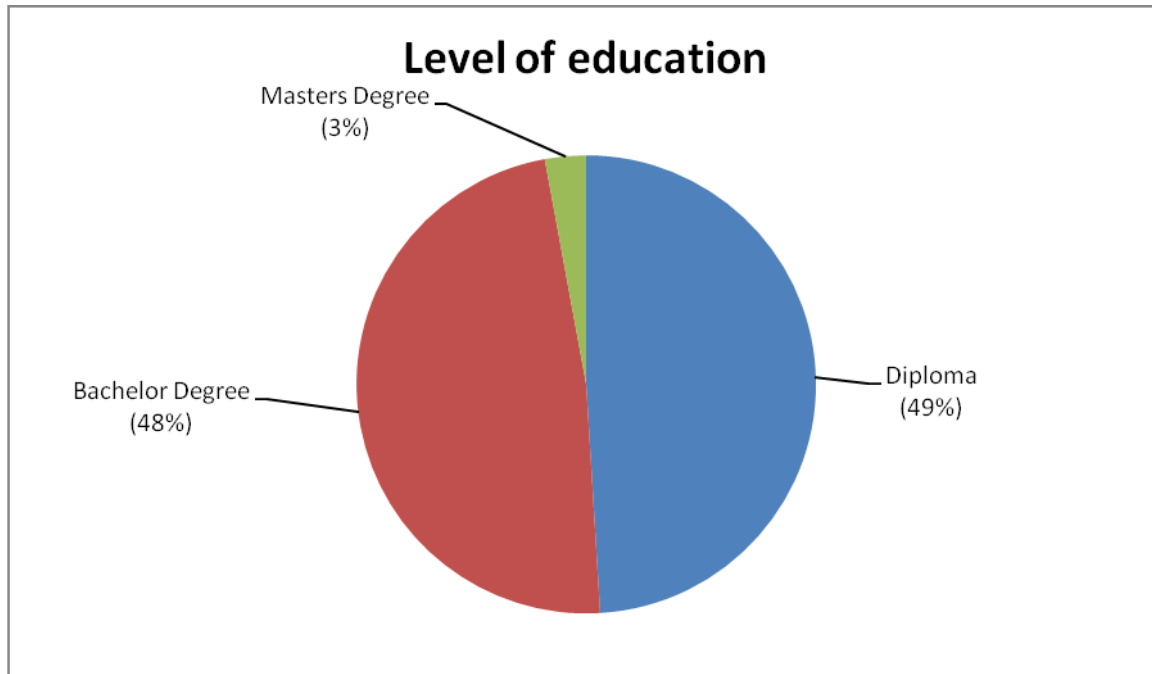
Figure 4:5 Educational level of the participants (N=414)

4.2.2.5 Professional Qualification

Information on the professional qualification of the participants was also elicited. Fifty- two percent (n=216) of the participants were registered nurses, 10.2% (n=42) were midwives, 15.5% (n=64) were public health officers, 6.3% (n=26) were pharmacists, 7% (n=29) were laboratory professionals, 4.9% (n=20) of the participants were medical doctors but the remaining 3.6% (n=15) of the participants were having other professional qualifications like anesthesia, and environmental health (Figure 4:6).
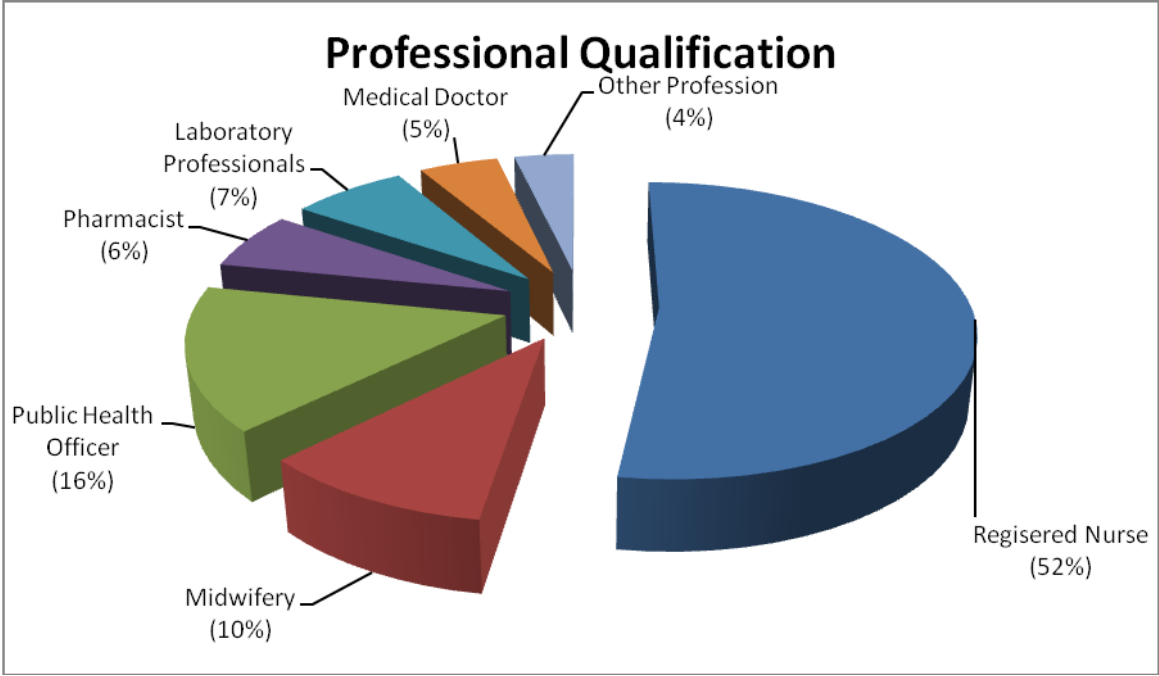
Figure 4:6 Professional qualification of the participants (N= 414)

4.2.2.6 Health Sector Organization Participants Currently Working

Overall, 45.6% (n=188) were working in health center, 35.2% (n=145) were working in primary hospitals and only 19.2% (n=79) were working in general hospital (Figure 4:7).
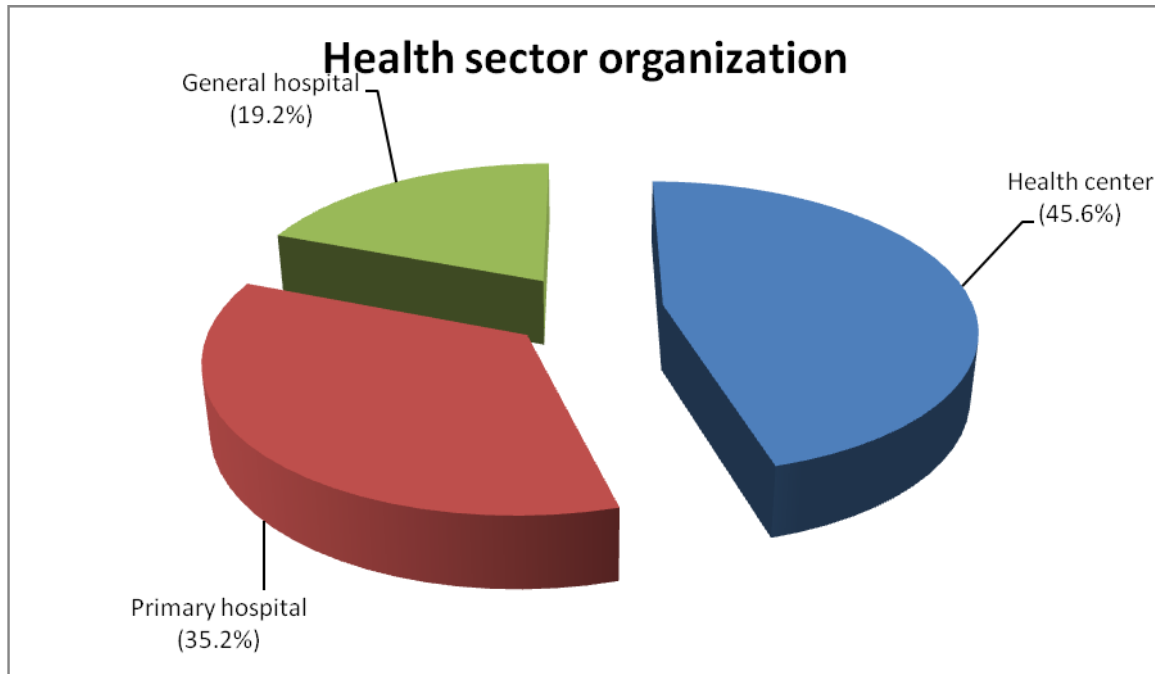
Figure 4:7 Health sector organization the participants currently working (N=414)

4.2.2.7 Employment Status

Ninety-five percent (n=393) of the participants provided information on their employment status however, 21% (n=5) of the participants did not provide information on their employment status. From the total number of employed participants, 98.2% (n=386) were in full-time employment while only 1.8% (n=7) participants in part-time employment status (Figure 4:8).
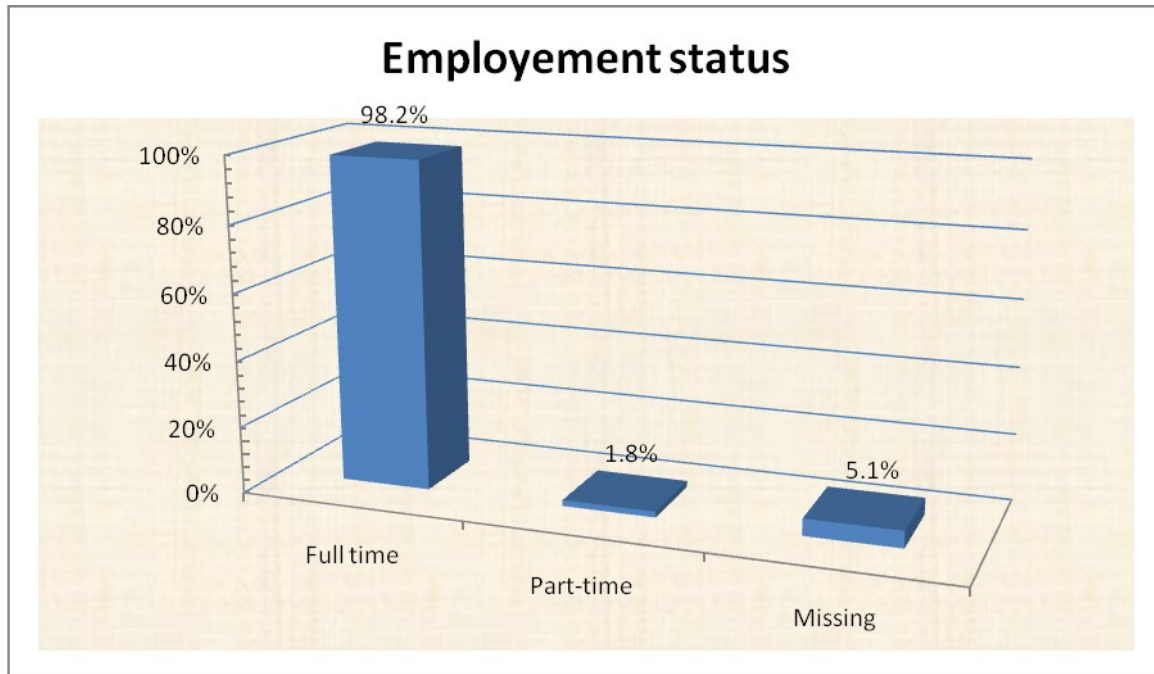
Figure 4:8 Employment status of the participants (N=414)

4.2.2.8 Monthly Personal Income

Of the participants, 57% (n=229) earned below 5, 000 Ethiopian birr (<29 USD) per month, 43% (n=173) earned more than 5, 000 Ethiopian birr (> 29 USD) per month. According to the National Bank of Ethiopia on 15 April 2019, the exchange rate was 1 USD to 29 Ethiopian birr (Figure 4:9).
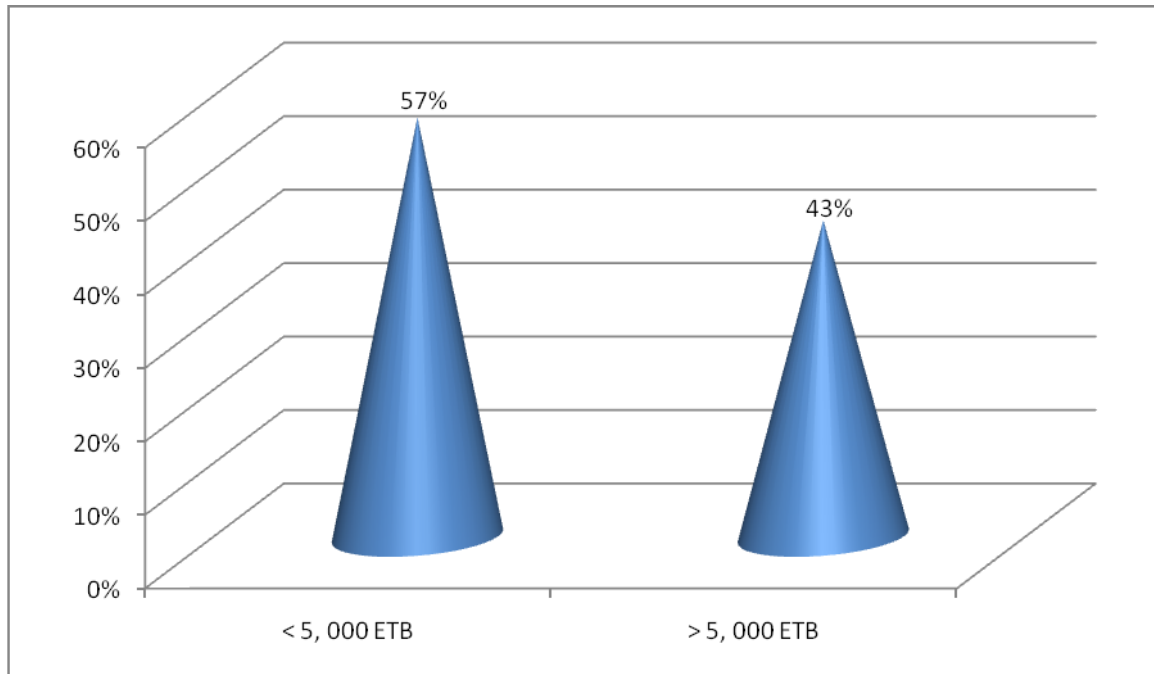
Figure 2:9 Monthly personal income of the participants (N= 414)

4.2.2.9 Work Experience

The mean work experience of the participants was 6.21 years; the median and standard deviation were 5 years and 4.56 years respectively. The minimum work experience of the participants was one year and the maximum was 35 years. Ninety six percent (n=398) have less than 25 years work experience, but only one percent (n=4) of the participants have served for more than 25 years in health service facility (Figure 4:10).

Work experience

12 (3%)

4 (1%)

398 (96%)
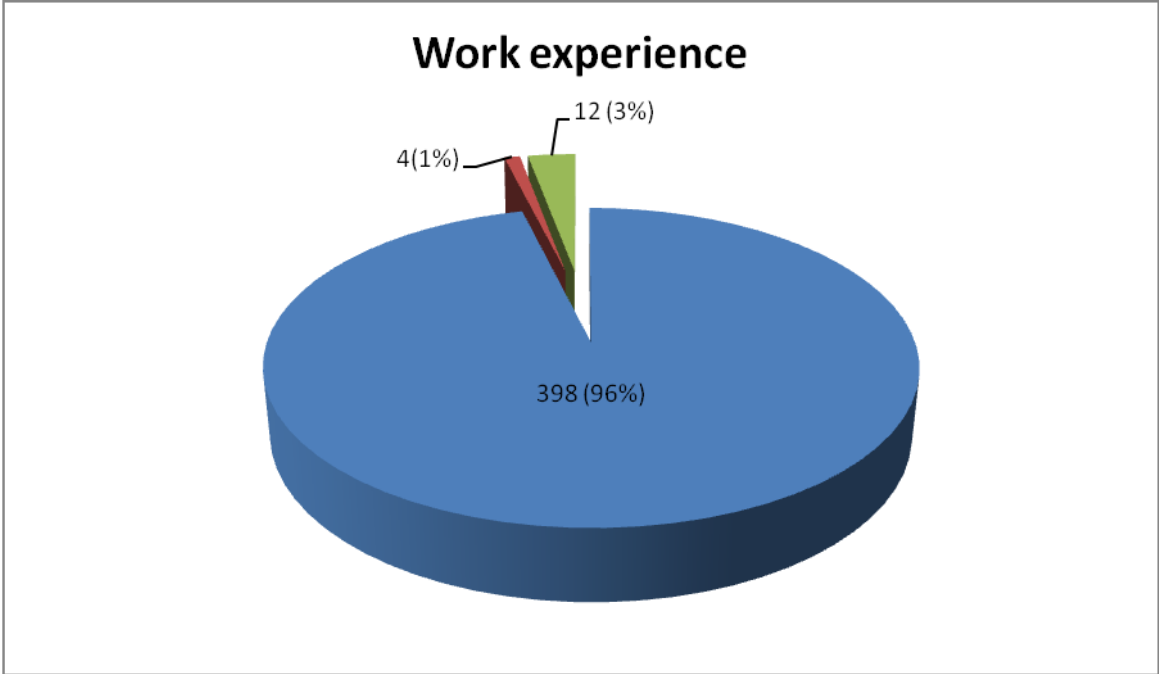
Figure 4:10 Participants' work experience (N= 414)

4.2.2.10 Position of the Participants in their Health Service Facility

About sixty-five percent (n=269) of the participants do not have any position in a health service facility. Thirty percent (n=117) have positions as depicted in figure 4:11 below but three percent (n=13) occupied other positions like tuberculosis focal person, medical supply & logistic officer, and disease prevention & health promotion office (Figure 4:11).
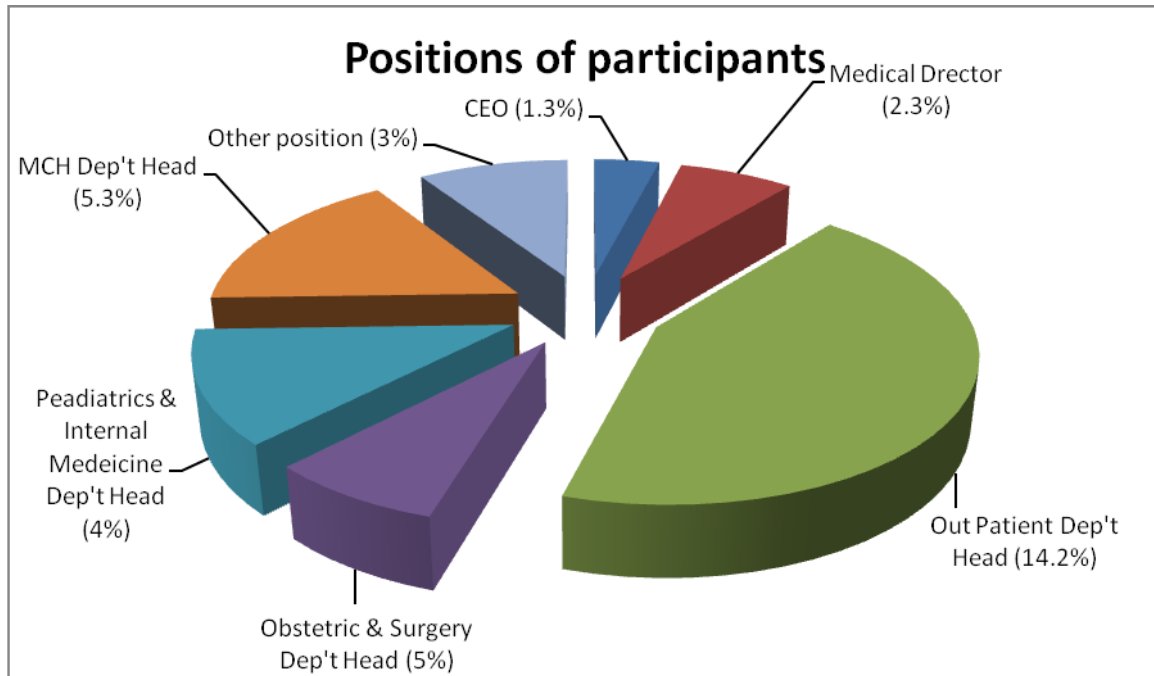
Figure 4:11 Position of the participants in their health service facility (N=414)

4.2.2.11 Role of the Participants in their Health Service Facility

Three percent (n=12) of participants were hospital board members; 10.3% (n=41) percent of participants were health center board members and 9.4% (n=39) percent were in senior management positions (Figure: 12).
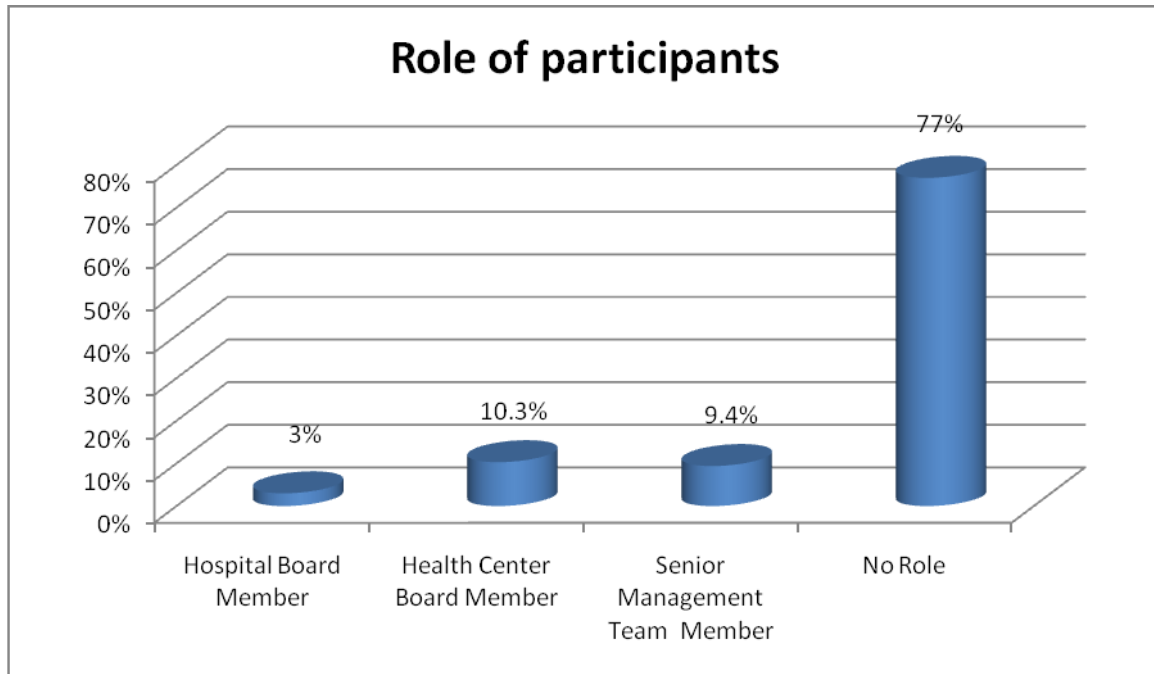
Figure 4:12 Role of the participants in their health service facility (N=414)

4.2.2.12 Formal Leadership Training

Vast majority of study the participants, 88.3% (n=363) did not receive any formal leadership training while only 11.7% (n=48) percent of study participant have been received formal leadership training (Figure 4:13).
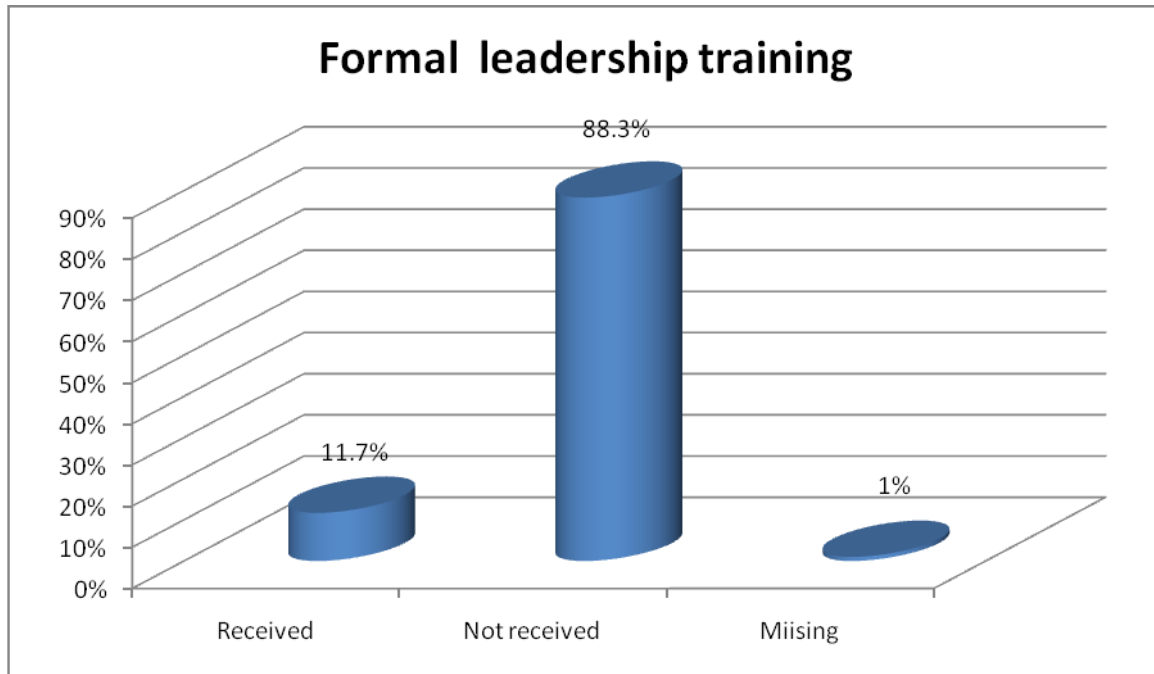
Figure 4:13 Formal leadership training for participants (N=414)

4.3 GENDER EQUITY IN HEALTHCARE SECTOR LEADERSHIP POSITIONS

4.3.1 Representation of Women in Healthcare Sector Leadership Positions

As shown in Table 4:2 below, 26% (n=108) of the participants reported that representation of women in healthcare sector leadership positions in the past few years has been increased, 73.9% (n=306) reported that representation of women in healthcare sector leadership positions did not show any increment.

Table 4:2 Response on the representation of women in healthcare leadership sector positions

Response	Yes	Not at all
%	26% (n=108)	73.9% (n=306)

4.3.2 Inclusion of Gender Equity Goals and Objectives in Strategic Planning

About 41% (n=169) of the participants were reported that gender equity goals and objectives are not included in strategic planning at all, 31.6% (n=131) percent of participants were reported that gender equity goals and objectives are included in strategic planning to a limited extent, 8% (n=33) reported that gender equity goals and objectives are included in strategic planning to a moderate extent. About 12% did not know whether gender equity goals and objectives are included.

4.3.3 Need Assessment and Analysis of Gender Roles and Responsibilities

About 66% (n=271) of the participants reported that no need assessment and analysis of gender roles and responsibilities were conducted at all, 15.7% (n=65) percent of the participants reported that need assessment and analysis of gender roles and responsibilities were conducted to a limited extent, 3.9% (n=16) reported that need assessment and analysis of gender roles and responsibilities were conducted to a moderate extent, few proportion of participants reported that need assessment and analysis of gender roles and responsibilities were conducted to a greater and fullest extent but 5.6% (n=23) participants did not know about need assessment and analysis of gender roles and responsibilities.

4.3.4 Availability of Written Guideline in Health Service Facility that Affirms Commitment to Gender Equity

Over 69% (n=245) of the participants reported that there is no written guideline in health service facility that affirms commitment to gender equity at all, 10.1% (n=42), 6.5% (n=27), 3.9% (n=16), and 3.6% (n=15) percent reported that written guideline in health service facility that affirms commitment to gender equity is available to a limited extent, to a moderate extent, to a greatest extent and to a fullest extent respectively, but 16.7% (n=69) percent of participants reported that they do not know the availability of written guideline in health service facility that affirms commitment to gender equity.

4.3.5 Implementation of Proactive Strategies to Promote Women into Senior Health Management Positions

Sixty three (n=260) percent of the participants reported that there is no proactive strategies being implemented to promote women into senior management position at all, whilst 18.2% (n=76) of the participants said that proactive strategies being implemented to promote women into senior management positions to a limited extent, 5.3% (n=22), 2.4% (n=10), and 2.9% (n=12) of the participants reported that proactive strategies being implemented in promoting women into senior management position to a limited extent, to a moderate extent and to a fullest extent respectively, but 8% (n=33) percent of participants did not know about such strategies.

4.3.6 Serious and Open Discussion of Gender Issues by Men and Women in Health Service Facility

About 66% (n=273) reported that gender issues are not discussed openly by men and women in health service facility at all, 17.9% (n=74) reported that gender issues are openly discussed by men and women in health service facility to a limited extent, while 5.6% (n=23), 2.7% (n=11), and 2.9%(n=12) said that gender issues are openly discussed by men and women to a moderate extent, to a greater extent and to the fullest extent

respectively but 5.1% (n=21) percent of participants did not know about open discussion of gender issues by men and women in health service facility.

4.3.7 Men's and Women's View on Gender Issues in Health Service Facility

About 44% (n=179) of the participants reported that views of gender issues by men and women in health service facility differ to a limited extent but 13.6% (n=56) of the participants said that there is no significant difference in views of gender issues by men and women in health service facility, whereas 11.7%(n=48), 14.6% (n=60), and 8.3% (n=34) of the participants reported that views of gender issues by men and women in health service facility differ to a moderate extent, to greater extent and to the fullest extent respectively, similarly 8.3% (n=34) of the participants did not know the difference between men's and women's view on gender issues in health service facility.

4.3.8 Thought of Staff in Health Service Facility about Fitness of Gender Equity and Organizational Vision

About 33% (n=143) of the participants reported that staff in health service facility think gender equity do not included into the organizational vision at all, 24.8% (n=117) of the participants reported that thought of staff in health service facility about the inclusion of gender equity into the organizational vision to a limited extent, 8.3% (n=14), 11.9% (n=49), and 7.8% (n=39) of the participants were reported to a moderate extent, to a greater extent and to the fullest extent respectively, only 8.8% (n=36) of the participants do not know whether gender equity was included into organizational vision or not.

4.3.9 Inclusion of Gender Awareness in Job Descriptions

About 61% (n=252) of the participants reported that gender equity is not included in job descriptions at all followed by 19.7% (n=81) percent of the participants reported that gender equity is included in job descriptions to a limited extent, 6.3% (n=26) percent of

the participants reported that gender equity is included in job descriptions to a moderate extent but a few proportion of the study participants, 4.9% (n=20) and 3.2% (n=13) were reported that gender equity is included in job descriptions to a greater extent and to the fullest extent respectively, only 4.9% (n=20) percent of participants do not know about the inclusion of gender equity in job descriptions of staff members.

4.3.10 Inclusion of Gender Awareness in Performance Based Evaluation Criteria

About 64% (n=264) reported that gender equity is not included in performance based evaluation criteria at all followed by 12.9% (n=53) percent of the participants who reported that gender equity is included in performance based evaluation criteria to a limited extent, 3.9% (n=16) percent of participants reported that gender equity is included in performance based evaluation criteria to a moderate extent, only a few proportion of the study participants, 3.4% (n=14) and 4.1% (n=17) percent of the participants reported that gender equity is included in performance based evaluation criteria to a greater extent and to the fullest extent respectively, only 11.2% (n=46) percent of the participants do not know about the inclusion of gender equity in performance based evaluation criteria.

4.3.11 Monitoring and Evaluation of the Impact of Gender Inequality in Organizational Performance

Over 70% (n=289) were reported that the impact of gender inequality in organizational performance was not monitored and evaluated at all, 10.9% (n=45) and 2.4% (n=10) percent of the study the participants reported that the impact of gender inequality in organizational performance is being monitored and evaluated to a limited extent and to a moderate extent respectively, whereas a few proportion of study the participants, 3.6% (n=15) and 4.4% (n=18) of the participants reported that the impact of gender inequality in organizational performance is being monitored and evaluated to a greatest extent and to the fullest extent respectively, but 8.3% (n=34) percent of participants do not have any

idea about monitoring and evaluation of the impact of gender inequality in organizational performance.

4.3.12 Health Service Facility's Gender Disaggregated Data Collection and Analysis for Healthcare Leadership Positions

About 60% (n=249) of the study participants reported that health service facility's gender disaggregated data for healthcare leadership positions are not collected and analyzed at all, 12.1% (n=50) percent reported that health service facility's gender disaggregated data for healthcare leadership positions are collected and analyzed to a limited extent, whereas a few proportion of the study participants, 5.1% (n=21), 4.1% (n=17), and 3.6% (n=15) reported that health service facility's gender disaggregated data for heathcare leadership positions have been collected and analyzed to a moderate extent, to a greater extent and to the fullest extent respectively, but 14.8% (n=61) percent of the study participants do not have any information about health service facility's gender disaggregated data on leadership positions.

4.3.13 Department or Division Responsible for Gender Issue in Health Service Facility

About 77% (n=317) of the participants reported that there is no department or division responsible for gender issue in health service facility at all, whereas a few proportion of the study participants, 4.1% (n=17), 13.4% (n=14), 5.1% (n=21), and 3.6% (n=15) reported that a department or division responsible for gender issue in health service facility is available to a limited extent, to a moderate extent, to a greater extent and to the fullest extent respectively but 7% (n=29) percent of the study participants do not know about the availability of department or division responsible for gender issue in health service facility.

4.3.14 Assigned Responsible Staff in Health Service Facility for Gender Integration in Different Departments

About 60% (n=272) the study participants reported that there is no assigned responsible staff in health service facility for gender integration in different department at all, 11.1% (n=46) percent of the study participants reported that responsible staff in health service facility for gender integration in the different departments has been assigned to a limited extent, 4.6% (n=19), 6.1% (n=25), and 3.9% (n=16) percent of the study participants reported that there is a responsible staff in the health service facility for gender integration in different department has been assigned to a moderate extent, to a greater extent, and to the fullest extent respectively, but 8.2% ((n=34) percent of the study participants do not know the availability of assigned responsible staff in health service facility for gender integration in different department.

4.3.15 Staff Training Program on Gender Planning and Analysis

About 76% (n=315) of the study participants reported that staff training program on gender planning and analysis is not conducted at all, whereas a few proportion of the study participants, 7.0% (n=29), 2.9% (n=12), 2.9% (n=12), and 3.1% (n=13) reported that staff training program on gender planning and analysis was conducted to a limited extent, to a moderate extent, to a greater extent and to the fullest extent respectively, but 8% (n=33) percent of the study participants do not have any idea about staff training program on gender integration and analysis.

4.3.16 Men in Health Service Facility Tend to Dominate during Staff Meeting

 As detailed in Table 4.3 below, (20%, n=83) of the participants strongly disagreed that men in health service facility tend to dominate during staff meeting, 22.5% (n=93) of the participants disagreed that men tend to dominate during staff meeting, 6% (n=25) of the

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participants were neutral, but 34.5%(n=143) of participants agreed that men tend to dominate during staff meeting, but 16.9% (n=70) of the participants strongly agreed that men in health service facility have influence over staff meeting.

Table 4:3 Response on dominance of men in health service facility during meeting

Response	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
N(%)	83(20%)	93(22.5%)	25(6%)	143(34.5%)	70(16.9%)

4.3.17 Effort of Health Service Facility to Institutionalize Gender Equity

As depicted in Table 4.4 below, (28.7%, n=119) of the participants strongly disagreed that their health service facility is currently doing much more to institutionalize gender equity, 33.8% (n=140) of the participants disagreed that their health service facility is currently doing much more to institutionalize gender equity, 14% (n=58) of the participants were neutral on the effort of their health service facility to institutionalize gender equity, 16.7% (n=69) of participants agreed that their health service facility is currently doing much more to institutionalize gender equity, 6.8% (n=28) of the participants strongly agreed that their health service facility is currently doing much more to institutionalize gender equity.

Table 4:1 Response on the effort of health service facility to institutionalize gender equity

Response	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
N(%)	119(28.7%)	140(33.8%)	58(14%)	69(16.7%)	28(6.8%)

4.3.18 Positive Impact of Gender Diversity on Health Facilities' Performance and Long-Term Improvement

About 17% (n=69) of the participants strongly disagreed on positive impact of gender diversity on health facilities' performance & long-term improvement, 7.3% (n=30) of the participants disagreed on positive impact of gender diversity on health facilities' performance & long-term improvement, similarly 7.3% (n=30) of participants were neutral on positive impact of gender diversity on health facilities' performance & long-term improvement, 37.3% (n=154) of participants agreed that gender diversity has positive impact on health facilities' performance & long-term improvement but 31.5% (n=130) of participants strongly agreed that gender diversity has positive impact on health facilities' performance & long-term improvement.

Table 4:5 Response on positive impact of gender diversity on health facilities' performance & long-term improvement

Response	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
N(%)	69(16.7%)	30(7.3%)	30(7.3%)	154(37.3%)	130(31.5%)

4.4 RESULTS OF STATISTICAL TESTS ON THE RELATIONSHIP BETWEEN DEMOGRAPHIC CHARACTERISTICS AND SELECTED DEPENDENT VARIABLES

The dependent variable was level of women representation in healthcare sector leadership positions defined as the extent to which women's representation were constructed and communicated to the community at large and this representation reinforced dominant ideologies of gender difference and the qualities of ideal-type femininity and the independent variables were age in years, gender, marital status, educational level, professional qualification, health sector organization, employment status, monthly personal income, work experience in a year, position, role of participants in health service facility and formal leadership training.

Logistic regression model was used to determine the contribution of the socio-demographic factors with the level of women representation as the outcome variables. For bi-variate and multi-variate analysis, the dependent variable was dichotomized into represented and not represented. In bi-variate analysis, variables having p-value ≤ **0.25** was the candidate for multivariate logistic regression models. Odds Ratio with 95% confidence interval was computed to measure the strength of associations between dependent & independent variables. The variables considered significant across dependent variables were identified and the researcher set the level of statistical significance at p-value **≤ 0.05.**

4.4.1 Overview of Research Findings

Of the socio-demographic characteristics of the participants, gender, level of education, professional qualification, health service organization where study participants are currently working, monthly personal income, role of study participants in their health service facility, and formal leadership training was independent predictor of women representation in healthcare sector leadership positions at p-value **≤ 0.25** in binary logistic regression analysis (Table 4:6)

Table 4:6 Binary Logistic Regression Analysis of Participants' Demographic Factors (n=414)

Variables	Category	N (%)	COR(95%CI)	p-value
Age in a year	20-24 years	66 (16%)	0.94 [0.391, 2.263)	0.891
	25-30 years	290 (70%)	1.52 [0.775, 3.047]	0.218
	>36 years	58 (14%)	1	
Gender	Male	192 (46.6%)	1	
	Female	220 (53.4%)	0.68 [0.437, 1.056]	**0.086**
Marital status	Single	199 (48.4%)	1	
	Married	212 (51.6%)	1.0 [0.670, 1.619]	0.856
Level of education	Diploma	203 (49.0%)	1	
	B.Sc. degree	199 (37.2%)	1.9 [1.230, 3.084]	**0.004**
	Master's degree	12(2.9%)	4.2 [(1.287, 13.743]	**0.017**
Professional qualification	Nurse	216 (52.4%)	0.57 [0.240, 1.359]	**0.21**
	Midwifery	42 (10.2%)	0.73 [0.369, 1.439]	0.36
	Public health officer	64 (15.5%)	1.05 [0.420, 2.637]	0.91
	Pharmacy	26 (6.3%)	0.91 [0.368, 2.243]	0.84
	Laboratory	29 (7.0%)	3.52 [1.375, 8.869]	**0.009**
	Medical doctor	20 (4.9%)	1.43 [0.468, 4.360]	0.53
	Other profession	15 (3.6%)	1	
Health service organization	Health centre	188 (45.6%)	0.46 [0.264, 0.809]	**0.007**
	Primary hospital	145 (35.2%)	0.39 [0.219, 0.777]	**0.003**
	General hospital	79(19.2%)	1	

Table 4:6 Binary Logistic Regression Analysis of Participants' Demographic Factors (continued)

Variables	Category	N (%)	COR(95%CI)	p-value
Employment status	Full-time	386 (98.2%)	0.45 [0.103, 2.119]	0.323
	Part-time	7 (1.8%)	1	
Monthly personal income	<5000 ETB	229 (57.0%)	1	
	>5000 ETB	173 (43.0%)	1.7 [1.085, 2.263]	**0.021**
Work experience	<25 years	398 (99.0%)	1.06 [0.109, 10.315]	0.959
	>25years	4 (1.0%)	1	
Role of participants	Hospital board member	12 (3.0%)	4.35 [1.341, 14.109]	**0.014**
	HC board member	41 (10.3%)	2.43 [1.245, 4.749]	**0.009**
	SMT member	39 (9.8%)	0.57 [0.228, 1.400]	**0.218**
	No role	308 (77.0%)	1	
Formal leadership training	Yes	48 (11.7%)	1.7 [0.905, 3.245]	**0.098**
	No	363 (88.3%)	1	

4.5 ANALYSIS OF DEMOGRAPHIC FACTORS AND WOMEN REPRESENTATION IN HEALTHCARE SECTOR LEADERSHIP

Participants' level of education, health service facility and role of participants in health service facility were retained their statistical significance after adjusting for dependent variables. There is a marginal significant association (**p-value = 0.05**) between women representation and bachelor degree level of education after adjusting for the confounders.

Study participants having bachelor degree level of education in any health science field of study is 2.3 times more likely to be represented in healthcare sector leadership positions than those participants having master's degree and diploma [**AOR=2.34, (95% CI: 1.289, 4.252)].** Participants working in primary hospital setting are 74% more likely to be represented in healthcare sector leadership positions when compared to participants working in health centre [**AOR=0.26, (95% CI: 0.126, 0.552)**].

Participants who represented in healthcare sector leadership positions are 2.9 times more likely to become health centre board member when compared to participants having hospital board and senior management team member roles [**AOR=2.9, (95% CI: 1.347, 6.468)].**

Multi-variable logistic regression analysis clearly point out that there are a significant association between participants level of education (**p-value=0.005**), health service organization they are currently working (**p-value=0.000**) and the role of participants in their health service facility **(p-value=0.007)** and women representation in healthcare sector leadership position (Table 4:7).

Table 4:72 Multivariable Logistic Regression Analysis of Participants' Demographic Factors (n=414)

Variables	Category	N (%)	AOR(95%CI)	p-value
Level of education	Diploma	168(49.9%)	1	
	B.Sc. degree	159(47.2%)	2.3 [1.289, 4.252]	**0.005****
	Master's degree	10(2.9%)	6.6 [(1.283, 33.566]	**0.024**
Health service facility	Health centre	162(48%)	0.44 [0.221, 0.880]	0.02
	Primary hospital	119(36.4%)	0.26 [0.126, 0.552]	**0.000****
	General hospital	56 (16.6%)	1	
Role of participants	Hospital board member	7(2.0%)	2.05[0.409, 10.333]	0.38
	Health centre board member	34 (10.1%)	2.9 [1.347, 6.468]	**0.007****
	Senior management team member	39 (11.6%)	0.5 [0.183, 1.424]	0.199
	No role	257 (76.3%)	1	

4.6 GENDER EQUITY VARIABLES AND LEVEL OF WOMEN REPRESENTATION IN LEADERSHIP

The independent variables were inclusion of gender equity goals in strategic planning, need assessment and analysis of gender role and responsibilities, availability of written guideline, implementation of proactive strategies to promote women into senior health management positions, open discussion of gender issue by men and women, views of men and women about gender issue, thought of staff about fitness of gender equity and organizational vision, inclusion of gender awareness in job description, inclusion of gender awareness in performance based evaluation criteria, monitoring and evaluation of the impact of gender inequality in organizational performance, collection and analysis of gender disaggregated data for healthcare leadership positions, availability of department responsible for gender issue, availability of assigned responsible staff for gender integration in different department, staff training program on gender planning and analysis, dominance of men during staff meeting, effort of health service facility to institutionalize gender equity and positive impact of gender diversity on health facility performance and long-term improvement.

Of the gender equity related variables:

- Inclusion of gender equity goals in strategic planning,
- Availability of written guideline in health service facility,
- Implementation of proactive strategies to promote women into senior health management positions,
- Open discussion of gender issue by men and women,
- Inclusion of gender awareness in job description,
- Availability of assigned responsible staff for gender integration in different department,
- Dominance of men during staff meeting,
- Effort of health service facility to institutionalize gender equity,
- Positive impact of gender diversity on health facility performance and long-term improvement were independent predictor of women representation in healthcare sector leadership positions at p-value ≤ 0.25 in binary logistic regression analysis (Table 4:8)

Table 4:8 Binary Logistic Regression Analysis of Gender Equity Variables (n=414)

S.N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
1.	Are gender equity goals and objectives included in strategic planning?	Not at all	169 (40.8%)	0.99 [0.451, 2.186]	0.985
		To a limited extent	131 (31.6%)	1.79 [0.816, 3.941]	0.146
		To a moderate extent	33 (8.0%)	1.216 [0.422, 3.502]	0.717
		To a greater extent	15 (3.6%)	3.33 [0.971, 11.382]	**0.056***
		To the fullest extent	18 (4.3%)	1.90 [0.571, 6.323]	0.295
		Do not know	48 (11.6%)	1	
2.	Is there a need assessment, and analysis of gender roles and responsibilities?	Not at all	271 (65.5%)	0.81 [0.304, 2.134]	0.664
		To a limited extent	6515.7%)	1.66 [0.576, 4.779]	0.349
		To a moderate extent	16 (3.9%)	0.94 [0.218, 4.088]	0.939
		To a greater extent	19 (4.6%)	2.60 [0.698, 9.311]	0.157
		To the fullest extent	20 (4.8%)	0.94 [0.239, 3.735]	0.935
		Do not know	23 (5.6%)	1	
3.	Does your health service facility have a written guideline that affirms commitment to gender equity?	Not at all	245 (59.2%)	0.82 [0.443, 1.518]	0.528
		To a limited extent	42 (10.1%))	1.13 [0.480, 2.674]	0.775
		To a moderate extent	27 (6.5%)	3.05 [1.208, 7.707]	**0.018***
		To a greater extent	16 (3.9%)	1.70 [0.540, 5.347]	0.364
		To the fullest extent	15 (3.6%)	0.71 [0.179, 2.800]	0.623
		Do not know	69 (16.7%)	1	

Table 4:8 Binary Logistic Regression Analysis of Gender Equity Variables (continued)

S.N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
4.	Are there proactive strategies implemented to promote women into senior health management positions?	Not at all	260 (63.0%)	0.49 [0.222, 1.071]	**0.074***
		To a limited extent	76 (18.4%)	1.04 [0.438, 2.470]	0.929
		To a moderate extent	22 (5.3%)	1.14 [0.369, 3.540]	0.817
		To a greater extent	10 (2.4%)	4.67 [1.006, 21.637]	**0.049***
		To the fullest extent	12 (2,.9%)	1.43 [0.368, 5.448]	0.606
		Do not know	33 (8.0%)	1	
5.	Are gender issues taken seriously and discussed openly by men and women in your health service facility?	Not at all	273 (65.9%)	0.34 [0.137, 0.829]	**0.018***
		To a limited extent	74 (17.9%)	0.44 [0.161, 1.178]	0.102
		To a moderate extent	23 (5.6%)	0.39 [0.110, 1.375]	0.143
		To a greater extent	11 (2.7%)	0.11 [0.012, 1.020]	**0.052***
		To the fullest extent	12 (2.9%)	1.10 [0.266, 4.547]	0.895
		Do not know	21 (5.1%)	1	
6.	Do men and women in your health service facility differ in their views of gender issues?	Not at all	56 (13.6%)	1.43 [0.556, 3.657]	0.460
		To a limited extent	179 (43.6%)	0.99 [0.431, 2.272]	0.979
		To a moderate extent	48 (11.7%)	1.03 [0.382, 2.785]	0.951
		To a greater extent	60 14.6%)	0.43 [0.147, 1.240]	0.118
		To the fullest extent	34 (8.3%)	1.33 [0.466, 3.786]	0.595
		Do not know	34 (8.3%)	1	

Table 4:8 Binary Logistic Regression Analysis of Gender Equity Variables (continued)

S. N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
7.	Do staffs in your health service facility think that gender equity fits into the organizational vision?	Not at all	143 (34.8%)	0.51 [0.221, 1.154]	0.105
		To a limited extent	117 (28.5%)	0.89 [0.395, 2.018]	0.785
		To a moderate extent	34 (8.3%)	1.08 [0.396, 2.983]	0.871
		To a greater extent	49 (11.9%)	0.82 [0.317, 2.125]	0.684
		To the fullest extent	32 (7.8%)	1.56 [0.572, 4.228]	0.387
		Do not know	36 (8.8%)	1	
8.	Is gender awareness included in all job descriptions?	Not at all	252 (61.2%)	0.54 [0.207, 1.426]	0.215
		To a limited extent	81 (19.7%)	1.09 [0.393, 3.040]	0.866
		To a moderate extent	26 (6.3%)	0.68 [0.193, 2.419]	0.556
		To a greater extent	20 (4.9%)	0.21 [0.037, 1.159]	**0.073***
		To the fullest extent	13 (3.2%)	1.16 [0.273, 4.932]	0.840
		Do not know	20 (4.9%)	1	
9.	Is gender awareness included in Performance Based Evaluation criteria?	Not at all	264 (64.4%)	0.86 [0.429, 1.737]	0.680
		To a limited extent	53 (12.9%)	1.00 [0.417, 2.408]	0.996
		To a moderate extent	16 (3.9%)	0.36 [0.072, 1.823]	0.218
		To a greater extent	14 (3.4%)	1.01 [0.270, 3.821]	0.982
		To the fullest extent	17 (4.1%)	1.76 [0.557, 5.666]	0.331
		Do not know	46 (11.2%)	1	

Table 4:8 Binary Logistic Regression Analysis of Gender Equity Variables (continued)

S.N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
10.	Is the impact of gender inequality in organizational performance monitored and evaluated?	Not at all	289 (70.3%)	0.91 [0.403, 2.029]	0.808
		To a limited extent	45 (10.9%)	1.13 [0.416, 3.061]	0.812
		To a moderate extent	10 (2.4%)	0.69 [0.124, 3.904]	0.679
		To a greater extent	15 (3.6%)	1.34 [0.372, 5.181]	0.625
		To the fullest extent	18 (4.4%)	2.22 [0.668, 7.393]	0.193
		Do not know	34 (8.3%)	1	
11.	Is gender disaggregated data of your health service facility collected and analyzed for healthcare leadership position?	Not at all	249 (60.3%)	0.69 [0.371, 1.270]	0.231
		To a limited extent	50 (12.1%)	0.86 [0.378, 1.955]	0.718
		To a moderate extent	21 (5.1%)	0.69 [0.221, 2.162]	0.525
		To a greater extent	17 (4.1%)	1.55 [0.511, 4.684]	0.440
		To the fullest extent	15 (3.6%)	0.80 [0.227, 2.851]	0.735
		Do not know	61 (14.8%)	1	
12.	Is there a department or division responsible for gender issue in your health service facility?	Not at all	317 (76.8%)	0.65[0.291, 1.460	0.299
		To a limited extent	17 (4.1%)	1.33 [0.388, 4.562]	0.650
		To a moderate extent	14 (3.4%)	0.52 [0.117, 2.296]	0.387
		To a greater extent	21 (5.1%)	0.45 [0.118, 1.693]	0.236
		To the fullest extent	15 (3.6%)	0.46 [0.108, 2.084]	0.324
		Do not know	29 (7.0%)	1	

Table 4:8 Binary Logistic regression Analysis of Gender Equity Variables (continued)

S. N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
13.	Is there assigned responsible staff in your health service facility for gender integration in different departments?	Not at all	273 (66.1%)	0.52 [0.244, 1.085]	**0.081***
		To a limited extent	46 (11.1%)	0.64 [0.248, 1.635]	0.348
		To a moderate extent	19 (4.6%)	0.94 [0.295, 3.008]	0.920
		To a greater extent	25 (6.1%)	0.51 [0.162, 1.610]	0.251
		To the fullest extent	16 (3.9%)	0.37 [0.089, 1.563]	0.117
		Do not know	34 (8.2%)	1	
14.	Is there a staff training program on gender planning and analysis?	Not at all	315 (76.1%)	0.59 [0.274, 1.280]	0.183
		To a limited extent	29 (7.0%)	1.05 [0.367, 3.019]	0.924
		To a moderate extent	12 (2.9%)	2.00 [0.522, 7.663]	0.312
		To a greater extent	12 (2.9%)	1.43 [0.368, 5.548]	0.606
		To the fullest extent	13 (3.1%)	0.89 [0.223, 3.542]	0.867
		Do not know	33 (8.0%)	1	

Table 4:8 Binary Logistic Regression Analysis of Gender Equity Variables (continued)

S. N	Gender equity variables	Category	N(%)	COR (95% CI)	P-value
15.	Men in your health service facility tend to dominate during staff meeting.	Strongly disagree	83 (20.0%)	1	
		Disagree	93 (22.5%)	1.13 [0.585, 2.199]	0.709
		Neutral	25 (6.0%)	1.08 [0.397, 2.931]	0.883
		Agree	143 (34.5%)	1.15 [0.629, 2.133]	0.645
		Strongly agree	70 (16.9%)	0.46 [0.202, 1.058]	**0.068***
16.	My health service facility is currently doing much more to institutionalize gender equity.	Strongly disagree	119 (28.7%)	1	
		Disagree	140 (33.8%)	1.10 [0.615, 1.979]	0.742
		Neutral	58 (14.0%)	2.03 [1.018, 4.047]	**0.044***
		Agree	69 (16.7%)	1.57 [0.799, 3.065]	0.192
		Strongly agree	28 (6.8%)	1.192 [0.457, 3.113]	0.719
17.	Gender diversity has positive impact on health facilities' performance & long-term improvement.	Strongly disagree	69 (16.7%)	`1	
		Disagree	30 (7.3%)	0.90 [0.311, 2.603]	0.846
		Neutral	30 (7.3%)	1.15 [0.395, 3.042]	0.861
		Agree	154 (37.3%)	1.78 [0.918, 3.460]	**0.088**
		Strongly agree	130 (31.5%)	1.03 [0.510, 2.093]	0.927

4.7 MULTI-VARIABLE LOGISTICREGRESSION ANALYSIS OF GENDER EQUITY VARIABLES AND LEVEL OF WOMEN REPRESENTATION IN HEALTHCARE SECTOR LEADERSHIP POSITIONS

Among the gender equity related variables, inclusion of gender equity goals in strategic planning, availability of written guideline in health service facility, and implementation of proactive strategies to promote women into senior health management positions in health service facility retained their statistical significance after adjusting for dependent variables. There is a marginal significant association (**p-value = 0.05**) between women representation and inclusion of gender equity goals in strategic planning, availability of written guideline in health service facility after adjusting for the confounders but implementation of proactive strategies to promote women into senior health management positions in health service facility has statistical significant association at **p-value = 0.009.**

Study participants responding the inclusion of gender equity goals in strategic planning to the fullest extent were 4.2 times more likely that women were represented in healthcare sector leadership positions than those participants providing other responses [**AOR=4.2, (95% CI: 0.997, 17.730)].**

Similarly, study participants responding written guideline in health service facility is available to a moderate extent were 3.6 times more likely that women were represented in healthcare sector leadership positions than those participants providing other responses [**AOR=3.6, (95% CI: 1.001, 12.884)**] but study participants providing a response on the implementation of proactive strategies to promote women into senior health management positions in health service facility to a moderate extent were 10.8 times more likely to represent women in healthcare sector leadership positions [**AOR=10.8, (95% CI: 1.834, 63.733)].**

Multi-variable logistic regression analysis clearly point out that there are a significant association between inclusion of gender equity goals in strategic planning (**p-value=0.05**), availability of written guideline in health service facility (**p-value=0.05**), and implementation of proactive strategies to

promote women into senior health management positions in health service facility (**p-value=0.009**) and women representation in healthcare sector leadership position (Table 4:9).

Table 4:9 Multivariable Logistic Regression Analysis of Gender Equity Variables (n=414)

S.N	Gender equity variables	Category	N(%)	AOR (95% CI)	P-value
1.	Are gender equity goals and objectives included in strategic planning?	Not at all	169 (41.1%)	1.94 [0.619, 6.097]	0.255
		To a limited extent	130 (31.6%)	2.66 [0.884, 7.446]	0.083
		To a moderate extent	33 (8.0%)	1.12 [0.310, 4.046]	0.864
		To a greater extent	14 (3.4%)	9.0 [1.302, 63.662]	0.026
		To the fullest extent	18 (4.4%)	4.2 [0.997, 17.730]	**0.05***
		Do not know	47 (11.4%)	1	
2.	Does your health service facility have a written guideline that affirms commitment to gender equity?	Not at all	244 (59.4%)	1.02 [0.357, 2.921]	0.968
		To a limited extent	42 (10.2%)	0.94[0.293, 3.032]	0.921
		To a moderate extent	27 (6.6%)	3.6 [1.001, 12.884]	**0.05***
		To a greater extent	15 (3.6%)	1.02 [0.148, 7.068]	0.982
		To the fullest extent	15 (3.6%)	0.25 [0.034, 1.851]	0.175
		Do not know	68 (16.5%)	1	
3.	Are there proactive strategies implemented to promote women into senior health management positions?	Not at all	259 (63.0%)	2.4 [1.184, 5.047]	**0.016***
		To a limited extent	75 (18.2%)	2.4 [0.685, 8.391]	0.171
		To a moderate extent	22 (5.4%)	10.8 [1.834, 63.733]	**0.009***
		To a greater extent	10 (2.4%)	1.8 [0.403, 7.662]	0.453
		To the fullest extent	12 (2.9%)	1.95 [0.584, 6.554]	0.277
		Do not know	33 (8.0%)	1	

4.8 GENDER EQUITY RELATED QUALITATIVE RESPONSES

4.8.1 Characteristics of Ideal Health Professionals

In this study, participants were asked to describe the characteristics of ideal health professionals in health service facilities. Out of the 414(100%) percent of the participants (82%; n=339) provided a written response when asked to provide the characteristics of ideal health professionals. Table 4:16 depict the proportion of participants who commented on the features of ideal health professionals working in health service facilities.

4.8.1.1 Caring, Respectful and Compassionate Health Professionals

One-hundred-seven (32%) of the participants mentioned that health professionals who provide timely care without delay, with a kind approach, in a friendly manner, and without discrimination in terms of race, sex, geographic location, and income status while (58%, n=195) percent of the participants explained the following characteristics of ideal health professionals: those who respect every clients demanding health service as a basic human right, including respect for clients autonomy, dignity, feeling, choice and preferences, treating clients with respect as an individual, communicating with clients in a language that the clients can understand and calling clients by his/her name; (14%, n=49) percent of the participants cited the need to emphasize compassionate health care practice like responding to clients suffering and need whether or not they asked, health professionals who are willing to show his/her concern and empathy to every clients were also cited.

4.8.1.2 Respecting duties

Fifty-one articipants (15%) of the participants explained that health professionals who accomplish his or her duties well as per the operational standards; (3%; n=10) percent of the participants cited health professionals who follow treatment guideline; (7%; n=25) percent of the participants explained that health professionals who respect the rules and the regulations of health service facilities; (6%; n=19) percent of the participants said that health professionals who accomplish his or her duties without command; (19%; n=63) percent of the participants mentioned the following characteristics of ideal health professionals; those who respects his or her immediate supervisors, knowing his or her duties and responsibilities, respecting office hour and punctual.

4.8.1.3 Professional ethics

Seventy-five (22%) of the participants mentioned that health professionals who maintain confidentiality and maintain professional secrecy, fight corruption, free from addiction (drugs and alcohol), dressed and groomed well; (26%, n=89) percent of the participants explained that health professionals who cooperate with his or her co-workers, and believe in team work, demonstrate professional code of conduct like integrity, honesty, responsive to clients need; (12%, n=39) percent of the participants said that health professional who is having good relationship with his or her immediate supervisors, co-workers, and clients to be served as well as with clients relatives or patient attendants.

4.8.1.4 Positive attitude towards self, organizational change and long-term improvement

Forty-nine (14%) of the articipants mentioned that health professionals who are wiiling to accept organizational reforms and changes, open-minded, ready for innovation, (19%, n=64) percent of the participants cited the significance of opportunities for further education for health professionals.

Table 4.10: Characteristics of ideal health professionals in health service facilities

Characteristics	
Caring, respectful and compassionate	Provide care with a kind approach
	Provide care in a friendly manner
	Provide timely care without delay
	Provide discrimination free care
	Respect clients' autonomy
	Respect clients' choice and preferences
	Communicate with clients' in a language he/she can understand
	Call clients' with his/her name
	Respond to patients' suffering
	Show concern and empathy
Takes his/her duties seriously	Know duties and responsibilities
	Accomplish duties as per the operational standards & guidelines
	Respect rules and regulations of health service facilities
	Accomplish duties without command
	Respect immediate supervisors
	Respect office hours
Professional ethics	Maintain confidentiality and keep patients' secret
	Free from drugs or alcohol addiction
	Dressed and groomed well
	Cooperate with co-workers
	Believe in team work
	Honest, and responsive to clients' need

	Good relationship with immediate supervisors, co-workers, patients and patient attendants
Positive attitude towards self and organizational change	Accept organizational change and reforms
	Open-minded and ready for innovation
	Opportunities for further education

4.8.2 Challenges Experienced Regarding Gender Inequality

In this study, participants were asked to describe the challenges that were being experienced gender inequality in health service facilities. The challenges mentioned by the participants were not different from the ones already described. Eight nine percent (89%, n=367) out of the 414(100%) participants provided a written response when asked to describe challenges they face in gender inequality in health service facilities.

4.8.2.1 Family responsibilities

Figure 4.14 shows the proportion of the participants who cited family responsibility as a challenge and (34%, n=125) percent of the participants explained that house hold work overload coupled with caring for husband and children impede women health professionals aspiration to leadership positions; (23%, n=83) percent of the participants explained that women are more concerned about their families than leadership positions; (15%, n=54) percent of the participants attributed culturally long standing division of labor as men's and women's role in to house hold and in health service facilities; (26%, n=95) percent of the participants mentioned that household roles and caring for husband and children are considered by the community as the responsibilities of women; (4%, n=15) percent of the participants cited fear of geographical location if women health professionals were appointed to leadership positions far away from their families because of family attachment.
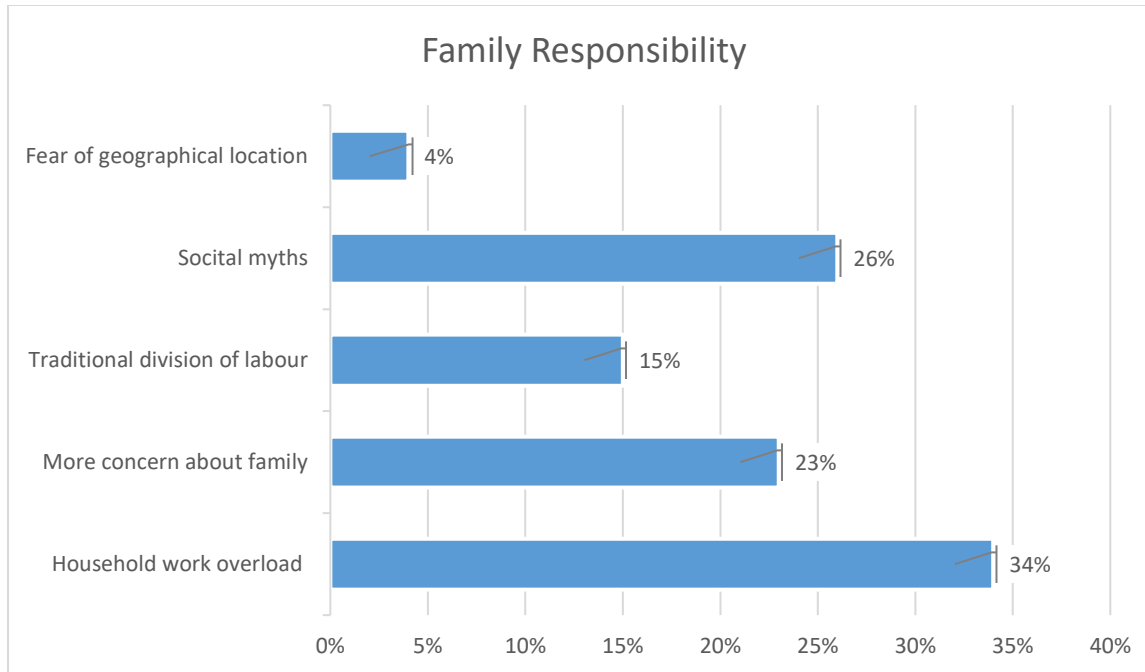
Figure 4.14: Proportion of participants who cited family responsibility as a challenge (N=367)

4.8.2.2 Lack of self confidence or self esteem

Figure 4.15 shows the proportion of participants who cited lack of self-confidence as a challenge and (28%, n=102) percent of the participants cited the outdoor and indoor superiority of men resulted in lack of self-confidence; (16%, n=59) percent of the participants explained that burden associated with family and office responsibility; (19%, n=68) percent of the participants explained that societies consider women as a weak creature and they are not strong enough like men; (10%, n=35) percent of the participants mentioned that selfishness and male dominated leadership environment resulted in the lack of women's self-confidence; (8%, n=29) percent of the participants cited that women fail to speak out their feelings because of self-confidence; (5%, n=18) percent of the participants explained that majority of women health professionals were assigned in lower-end jobs and the absence of role models resulted in women's lack of self-confidence; (3%, n=11) percent of the participants mentioned fear of challenges and problems associated with leadership positions in health service facilities.
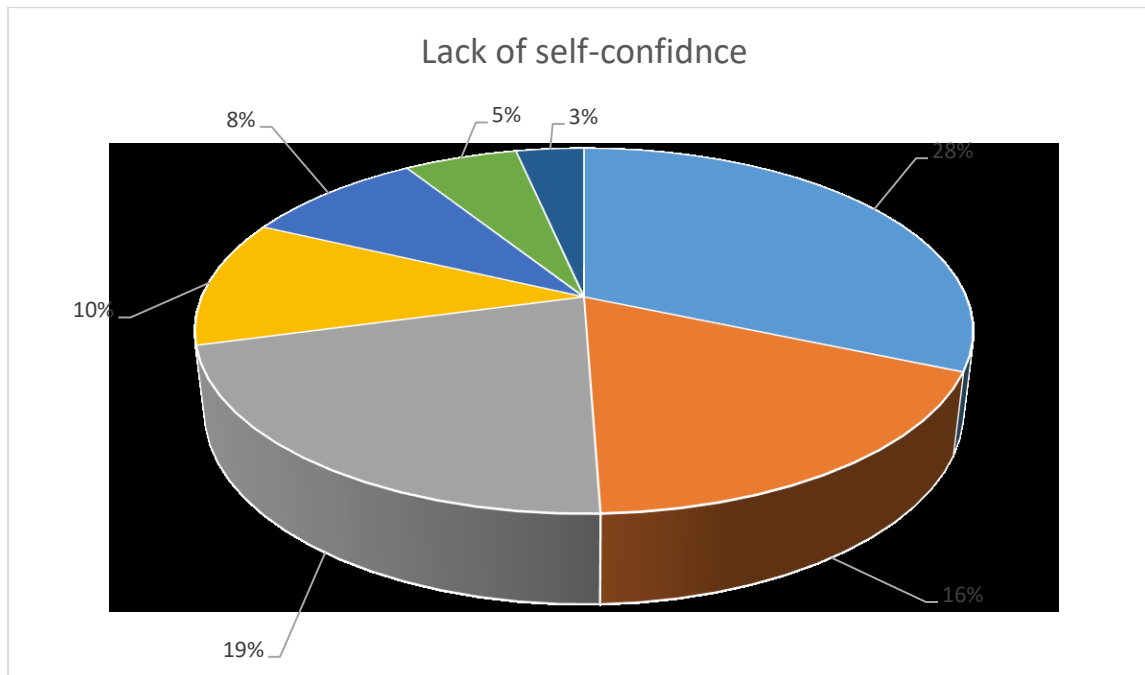
Figure 4.15: Proportion of participants who cited lack of self-confidence as a challenge (N=367)

4.8.2.3 lack of support

Figure 4.16 shows the proportion of participants who cited lack of support as a challenge and (4%, n=16) percent of the participants explained that women healthcare sector leaders take more time off work to care for their children because of lack of support from husband; (22%, n=81) percent of the participants cited that there are no opportunities for women to develop educational career path; (19%, n=70) percent of the participants explained that political leaders prefer men to women healthcare sector leader because of long standing cultural preference of baby boy than baby girl; (7%, n=23) percent of the participants cited subtle racism and ethnic prejudices resulted in non-merit-based promotion of male health professionals into leadership positions; (24%, n=89) percent of the

participants explained that wrong perception of the community about women's leadership potential that we inherit from our ancestors.
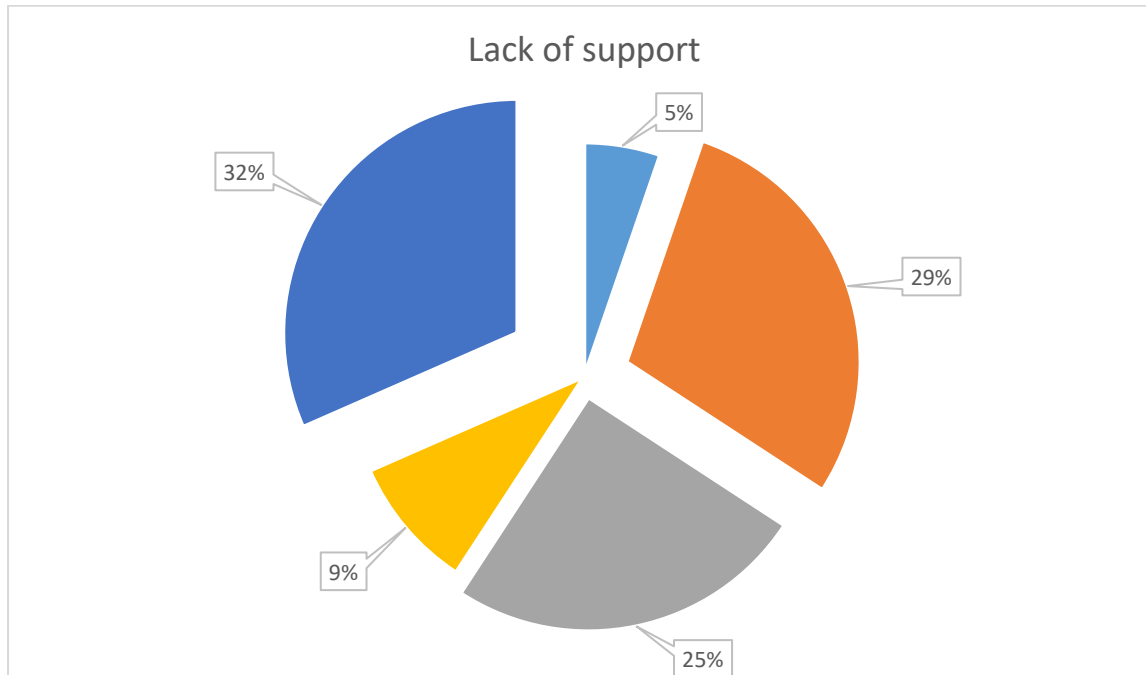
Figure 4.16: Proportion of participants who cited lack of support as a challenge (N=367)

4.8.2.4 lack of written guidelines

Figure 4.17 shows the proportion of participants who cited lack of written guidelines that affirms commitment to gender equity in health service facilities as a challenge and (27%, n=99) percent of the participants explained that there are no written directives and guidelines about gender equity in health facilities; (17%, n=61) percent of the participants mentioned that lack of decentralization of written guidelines about gender equity from Federal Mistry of Health or regional health system to the peripheral health service facilities (hospitals & health centers); (11%, n=42) percent of the participants explained that there was no written information concerning gender equity in health service facilities;

(8%, n=31) percent of the participants explained that lack of written and documented information elaborating selection criteria to assign health professionals into senior level managerial positions.
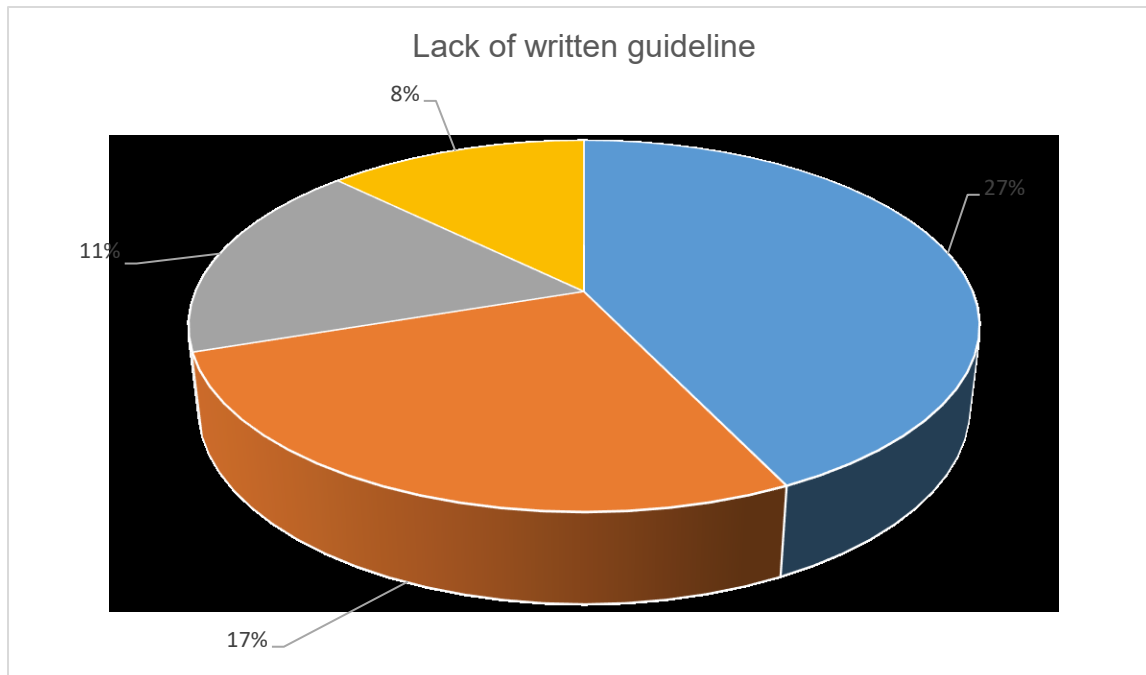
Figure 4.17: Proportion of participants who cited lack of written guideline as a challenge (N=367)

4.8.2.5 Lack of department or division responsible for gender issue

Figure 4.18 shows the proportion of the participants who cited lack of department or division responsible for gender issues in health service facilities as a challenge and (9%, n=33) percent of the participants explained that there was no concern by political leaders of district health office about gender equity; (7%, n=27) percent of the participants explained that health center managers

themselves do not have leadership skill and capabilities to worry about gender issue; (11%, n=41) percent of the participants explained that lack of hospital senior management team members awareness about the importance of gender office; (5%, n=20) percent of the participants explained that lack of knowledge of hospital board members about the department concerning gender issue; (6%, n=22) percent of the participants explained that the entire health professionals' lack of information about the significance of gender office as a separate entity.
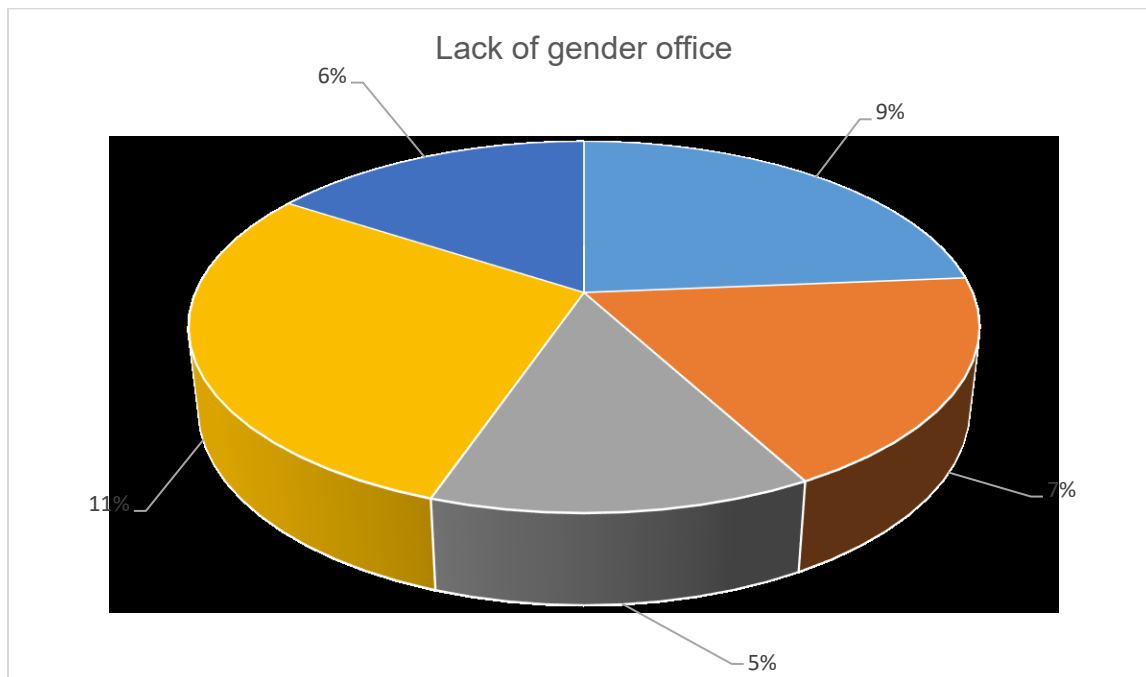
Figure 4.18: Proportion of participants who cited lack of gender office as a challenge (n=367)

4.8.2.6 Lack of Assigned Responsible Staff

Figure 4.19 shows the proportion of participants who cited lack of assigned responsible staff in health service facility for gender integration in different departments as a challenge and (12%, n=46) percent of the participants explained that there was no responsible staff to implement proactive strategy to ensure and promote women into senior leadership positions in heath service facilities; (14%, n=51) percent of the participants explained that lack of responsible gender officer resulted in gender

inequality; (13%, n=48) percent of the participants mentioned that there is no any professional specifically qualified in gender; (15%, n=55) percent of the participants explained that there was no responsible person facilitating open discussion during staff meeting about gender issue, (10%, n=37) percent of the participants cited that lack of gender officer resulted in failure to include gender issue into strategic and annual plan of the health service facilities; (8%, n=29) percent of the participants mentioned that lack of women health professionals network who concerned about gender equality in health service facilities; (7%, n=24) percent of the participants explained that lack of independent team who conduct periodic gender audit in health service facilities; (5%, n=20) percent of the participants explained that the absence of gender officer resulted in lack of monitoring and evaluation of the impact of gender inequality in organizational performance and long-term improvement; (6%, n=22) percent of the participants cited that lack of inclusion of gender awareness in to job description resulted in role confusion.
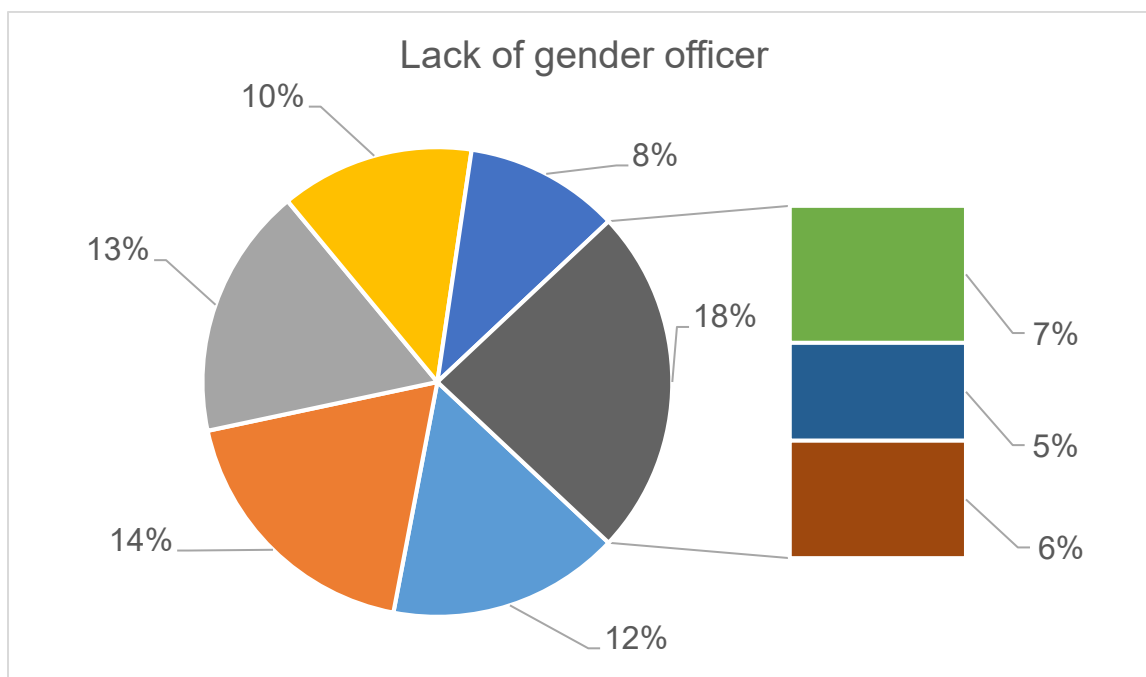
Figure 4.19: Proportion of participants who cited lack of gender officer as a challenge (N=367)

4.8.2.7 Lack of Formal Leadership Training

Figure 4.20 shows the proportion of participants who cited lack of leadership training program on gender planning and analysis in health service facilities as a challenge and (16%, n=57) percent of the participants explained that poor awareness of the community at household level resulted in gender bias in connection with culture; (12%, n=44) percent of the participants mentioned that lack of awareness of district health office senior management team about gender equity; (8%, n=31) percent of the participants explained that the entire health professionals in health service facilities do not have adequate information about gender equity; (11%, n=42) percent of the participants mentioned that women health professional themselves have huge knowledge gap about gender issue; (6%, n=23) percent of the participants explained that lack of gender mainstreaming into the entire activities of health service facilities.
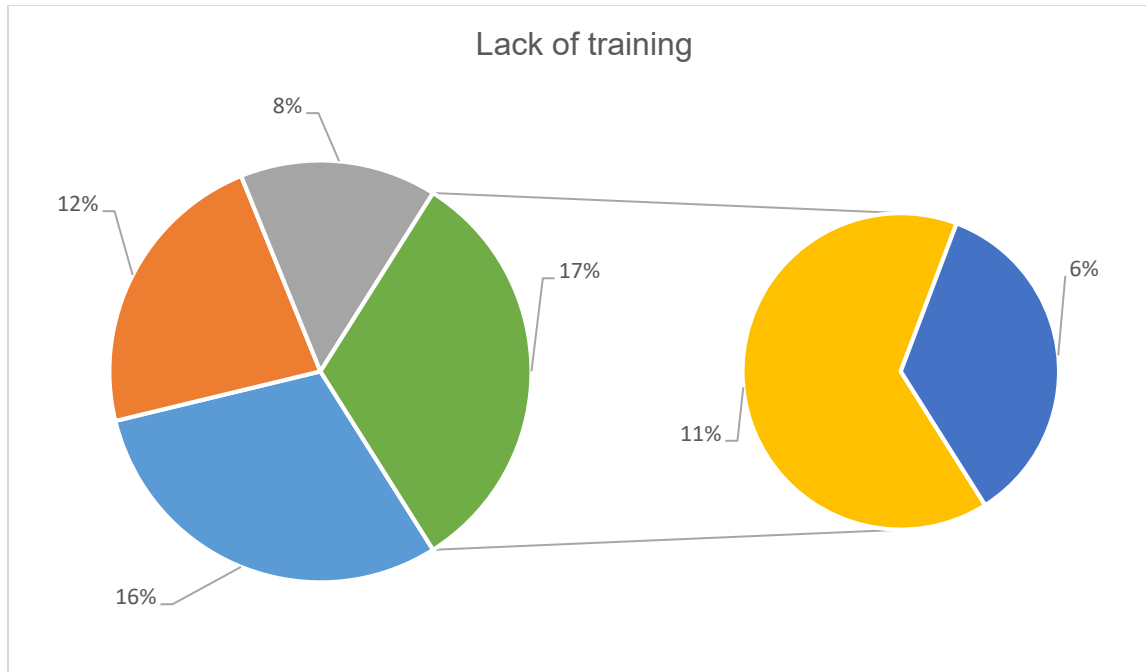
Figure 4.20: Proportion of participants who cited lack of training as a challenge (N=367)

4.8.2.8 Wrong Perception of Women Themselves

Figure 4.21 shows the proportion of the participants who cited wrong perceptions of women themselves about gender equality as a challenge and (16%, n=59) percent of the participants explained that women health professionals downgrade their own leadership potential; (13%, n=47) percent of the participants explained that non-conducive leadership environment for women impede their aspiration; (19%, n=68) percent of the participants explained that demarcation made by community between women's and men's role discourage them to look for leadership positions; (10%. n=35) percent of the participants explained the lack of recognition of women manager to inspire the followers leads to lose of hope in looking for leadership positions; (7%, n=26) percent of the participants explained that the appointments of hospital leadership positions is not merit-based, (11%, n=41) percent of the participants mentioned that lack of support and involvement of women in gender related affairs make women to regret; (8%, n=31) percent of the participants explained that lack of

good governance practices like transparency and openness causes loss of morale; (17%, n=64) percent of the participants mentioned that lack of opportunities for further education create frustration; (12%, n=43) percent of the participants cited the perception of difference in power of influence impede women's aspiration to leadership positions.

Wrong perception of women's themselves
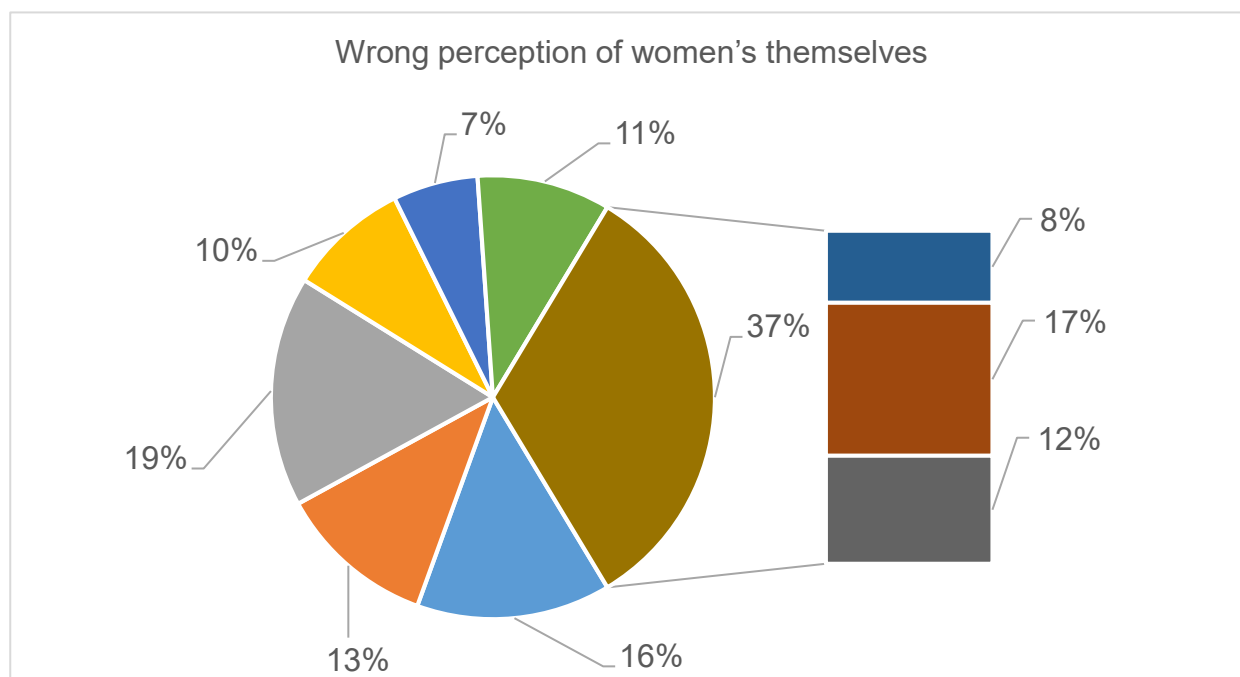
Figure 4.21: Proportion of participants who cited wrong perception of women's themselves as a challenge (N=367)

4.8.3 Suggestions for Improvement

In this study, participants were asked to provide suggestions for improving health service facility's action on gender equity and the process of gender integration. Only (63%; n=291) of the participants provided suggestions to improve gender equity in health service facilities. The following narratives shows the suggestions that participants made with regard to the gender equity.

4.8.3.1 Balancing Office Responsibilities with Family Obligations

Five percent (n=15) of the participants suggested the establishment of day-care center in the hospital or health centers to avoid the concentration of women health professionals on looking after their children; (2%; n=7) percent of the participants said that there is a need to provide advice and counseling for women health professionals to look for healthcare leadership positions away from their husband and children; (2%; n=6) percent of the participants cited the need to assign women health professionals on top leadership positions in health service facilities that is geographically accessible; (7%; n=20) percent of the participants said that husband must share women health professionals' household responsibilities,

4.8.3.2 Improve Self Confidence

Seven percent (n=19) of the participants recommended that there is the need to identify role models and mentors that can inspire female health professionals; (9%, n=25) percent cited the need to engage all female health professionals in gender related issues; (12%, n=35) percent emphasized the importance of reducing cultural bias and discrimination of female health professionals; (15%, n=45) percent mentioned the importance of enhancing female health professionals' self-confidence by giving in-service leadership training; (7%, n=21) percent mentioned the importance of public recognition of female health professionals so as to inspire others; (11%, n=31) percent mentioned the provision of opportunities for further education for female health professionals.

4.8.3.3 Increase Support

Seven percent (n=19) of the participants suggested the need to encourage participation of women and support for female health professionals to attend gender related meetings, and training workshop, (5%, n=14) percent of the participants suggested the empowerment and support of women health professionals to look for leadership positions; (13%, n=37) percent of the participants cited the importance of supporting women health professionals to make them to say loudly ''*we can deserve leadership positions!*'' (8%, n=22) percent of the participants emphasized health systems' support for women's health professionals to climb into top leadership positions; (9%, n=27) percent of the participants stated the need to create conducive work climate for women health professionals; (4%, n=11) percent of the participants cited the need to establish women health professionals network in health service facilities; (8%, n=24) percent of the participants suggested the development of selection criteria to assign health professionals in top leadership positions; (7%, n=20) percent of the participants explained that hospital CEO and medical director leadership positions appointment should be merit-based so competent women health professionals hopefully aspire to the positions.

4.8.3.4 Develop Written Guidelines

Thirteen percent (n=39) of the participants suggested the need to develop written guidelines and directives that affirm the commitment of gender equity in health service facilities; (9%, n=26) percent of the participants cited the inclusion of gender issues in organizational strategic plan and written guidelines; (5%, n=13) percent of participants suggested that written guidelines should incorporate gender mainstreaming; (14%, n=41) percent of the participants said that health service facilities should develop either their own guidelines or decentralization of written guidelines that have been developed and utilized by Federal Ministry of Health.

4.8.3.5 Establish Department or Division Responsible for Gender Issue

Twenty-one percent (n=62) suggested the need to establish gender office in health service facilities as a separate entity.

4.8.3.6 Assign Responsible Staff

Twenty-nine percent (n=85) of the participants suggested the importance of responsible individual about gender issue in health service facilities; (24%, n=71) percent of the participants cited the importance of assigning qualified professional and competent gender officer who is concerned about gender issues; (21%, n=62) percent of the participants explained that establishment of independent team responsible to monitor and evaluate gender equity in health service facilities.

4.8.3.7 Provision of Leadership Training

Thirty-three percent (n=95) of the participants suggested the need to create community awareness about gender equity so as to change their attitudes and beliefs on cultural influence; 30%, n=88) percent of the participants cited the provision of in-service leadership training to the entire health professionals; (30%, n=90) percent of the participants explained the importance of leadership training for political leaders and senior management team of the hospital and health centres.

4.8.3.8 Improve Women's Perception

Twenty-six percent (n=77) of the participants suggested the need to educate the community in order to reduce myths and misconception about women's leadership potential; (32%, n=93) percent of the participants cited the need to influence women from an early age to believe on their leadership potential; (20%, n=59) percent of the participants suggested that women health professionals should

not be assigned in a lower-end jobs and weaker position so as to alter traditional and cultural attributes of the communities.

4.9 QUALITATIVE FINDINGS

The previous section discussed the quantitative data analysis and this section presents the transcription, explicitation, presentation and interpretation of qualitative data.

4.9.1 Demographic Characteristics of Participants

Table 4: 11 Demographic characteristics of participants (n=21)

Participants characteristics	n=21	%
Average age	(27.85) years	
Gender		
Male	9	42.9%
Female	12	57.1%
Marital status		
Single	5	23.8%

Married	**16**	**76.2%**
Level of education		
Diploma	**2**	**9.5%**
Bachelor degree	**16**	**76.2%**
Master's degree	**3**	**14.3%**
Professional qualification		
Nurse	**6**	**28.6%**
Midwives	**1**	**4.8%**
Public health officer	**9**	**42.9%**
Pharmacist	**3**	**14.3%**
Laboratory professional	**2**	**9.5%**
Health service organization		
Zonal health department	**1**	**4.8%**
District health office	**13**	**61.9%**
Town health office	**7**	**33.3%**
Monthly personal income in ETB		
3, 500 – 5, 000 ETB	**1**	**48%**
5, 001 – 6, 500 ETB	**6**	**28.6%**
6, 501 – 8, 000 ETB	**9**	**42.9%**
>8, 000 ETB	**5**	**23.8%**

Participants characteristics	n=21	%
Average work experience in years	**(11) years**	
5-10 years	**13**	**61.9%**
11-16 years	**6**	**28.6%**
>17 years	**2**	**9.5%**
Position of participants in health service facility		
District health office head	**2**	**9.5%**
Disease prevention & health promotion coordinator	**3**	**14.3%**
Medical service officer	**5**	**23.8%**
Public health emergency officer	**1**	**4.8%%**
Multi-sectoral & HIV prevention & control officer	**2**	**9.5%**
Maternal & child health & nutrition officer	**2**	**9.5%**
Medical supply & logistics officer	**6**	**28.5%**
Role of participant in health service facility		
Hospital board member	**0**	**0%**
Health centre board member	**2**	**9.5%**
Senior management member	**5**	**23.8%**
I do not have any role	**14**	**66.7%**

Did you ever receive any formal leadership training?		
Yes	**10**	**47.6%**
No	**11**	**52.4%**

4.9.1.1 Demographic Profiles of Participants who Took Part in the Interviews

4.9.1.1.1 Age

The average age of the study participants was 27.85 years with the youngest interview participants being 25 years old and the oldest was 43 years.

4.9.1.1.2 Gender

Of the interview participants, 42.9% (n=9) were male, and 57.1% (n=12) were female health professionals.

4.9.1.1.3 Marital Status

Of the interviewed participants, 23.8% (n=5) were single, and 76.2% (n=16) were married.

4.9.1.1.4 Level of Education

Of the interviewed participants, 9.5% (n= 2) were having diploma, 76.2% (n=16) were having bachelor degree, and only 14.3% (n=3) were having master's degree.

4.9.1.1.5 Professional Qualification

Of the interviewed participants, 28.6% (n= 6) were nurse by profession, 4.8% (n=1) were midwives, 42.9% (n=9) were public health officer, 14.3% (n=3) were pharmacist, and 9.5% (n=2) were having other professions like health service management.

4.9.1.1.6 Health Service Organization where the Study Participants are Currently Working

Of the interview participants, only 4.8% (n=1) is working at zonal health department, 61.9% (n=13) were working at district health office, and 33.3% (n=7) were working at town health office.

4.9.1.1.7 Monthly Personal Income in ETB

The minimum monthly personal income of the interview participants was 3, 579.00 ETB with a maximum of 9, 028.00 ETB. Of the interview participants, 4.8% (n=1) have monthly personal income ranging from 3, 500 – 5, 000 ETB, 28.6% (n=6) have monthly personal income ranging from 5, 001 – 6, 500 ETB, 42.9% (n=9) interview participant fall in the range of 6, 501- 8, 000 ETB monthly personal income but 23.8% (n=5) were paid more than 8, 000 ETB.

4.9.1.1.8 Work Experience in YearS

The average work experience of the interview participants in various health service organizations was 11 years with the minimum of 7 and the maximum was 22 years. Of the participants, 61.9% (n=13) participants work experience ranges from 5-10 years, 28.6% (n=6) participants served between 11-16 years but only 9.5% (n=2) have more than 17 years' work experience.

4.9.1.1.9 Position the of Participants in their Organizations

All those interviewed did not have leadership position in their health service facilities, only 9.5% (n=2) male participants were district health office heads but the remaining vast majority interview were assigned to positions below top healthcare leadership.

4.9.1.1.10 Role of Participant in Health Service Facility

Of the interview participants, 66.7% (n=14) do not have any role in their health service facility, none of the participants were hospital board member but 23.8% (n=5) interview participants were senior management team member, only 9.5% (n=2) interview participants were health center board member

4.9.1.1.11 Formal Leadership Training

About 48% percent (n=10) of the participants received formal leadership training while 52.4% (n=11) did not.

4.9.2 METHOD OF QUALTATIVE DATA ANALYSIS

As this study is paradigmatically naturalistic, the phrase "data analysis" is being intentionally avoided instead explicitation of data is being preferred. Data collected was done through semi-structured face to face interview, during the period of three (3) months from 1st February to 30th April 2019. In qualitative study data explicitation was done simultaneously with data collection using the Collaizze seven steps of explicitation (Morrow et al 2015:643-644). Data were analyzed, categorized and organized into nine (9) themes, sub-themes that emerged through coding processes. Each theme and sub-theme were discussed and supported by direct quotes from the transcripts. The quotes from

the participants are indicated in italics in the discussion of themes and sub-themes. The following seven steps in Colaizzi's descriptive phenomenological data analysis were used.

Familiarisation: The researcher read through the information gathered from the participants several times to familiarise himself with the research data (Morrow et al 2015:643-644). For this study, the researcher read and listened repeatedly transcribed interviews to understand the subject.

Identifying significant statements: The researcher identified all statements in the accounts that were of directly relevant to the phenomenon under investigation (Morrow et al 2015:643-644). To identify significant statement, the researcher read and listened repeatedly to the transcribed interviews participants' information, formulated statement pertaining to the experience of gender disparity and extracted key words described gender disparity in healthcare leadership. Face to face interview was conducted, statement made by participants were recorded and transcribed verbatim. Coding of data was done once all the data was fully transcribed and analysed by the researcher himself.

Formulating meanings: The researcher identifies meanings relevant to the phenomenon that arise from a careful consideration of the significant statements (Morrow et al 2015:643-644). The researcher must reflexively "bracket" his or her pre-suppositions to stick closely to the phenomenon as experienced, though Colaizzi recognises that complete bracketing is never possible (Morrow et al 2015:643-644).

Clustering themes: The researcher clusters the identified meanings into themes that are common across all accounts. Again, bracketing of pre-suppositions is crucial, especially to avoid any potential influence of existing theory (Morrow et al 2015:643-644). In this study, the researcher explored and described experiences and challenges that female health professionals face in gender disparity in healthcare sector leadership in health service facilities. The data saturation point was reached when all 21 participants were interviewed, and participants started to repeat same information repeatedly during the interview.

Developing an exhaustive description: The researcher writes a full and inclusive description of the phenomenon, incorporating all the themes produced at step 4 (Morrow et al 2015:643-644). Researcher developed themes based on the information given by participants during interview, themes were named according to key words extracted and transcribed.

Producing the fundamental structure: The researcher condensed the exhaustive description down to a short, dense statement that captures just those aspects deemed essential to the structure of the phenomenon (Morrow et al 2015:643-644). In this study, the researcher collected information and transcribed it as a draft document and made comments, the data was filtered and preserved.

Seeking verification of the fundamental structure: The researcher returns the fundamental structure statement to all participants (or sometimes a sub-sample in larger studies) to ask whether it captures their experience (Morrow et al 2015:643-644). He or she may go back and modify earlier steps in the explicitation in the light of this feedback (Morrow et al 2015:643-644). For this research, the researcher revisited the original transcripts, audio tapes and other transcripts to validate his findings.

Data saturation was reached with all themes and sub-themes. Saturation was based on the verbatim excerpts from the transcriptions and voice recordings provided but theme 4, 6. 7 and 9 have not reached saturation because only 1 sub-themes emerged. Table 4.12 depicts the themes and sub-themes which were agreed upon by the researcher and independent coder which serves as the findings of the study.

4.9.3 Qualitative data transcription

In naturalistic study, transcription is part of the data explicitation. Transcription refers to the process of reproducing the spoken words from the audio tape into written text. As the paradigmatic stance of this study is naturalistic, the researcher transcribed and translated the data set with the purpose of staying close to the data. During this process, notes were separated and grouped according to similarity.

The findings are presented in a narrative format whereby after the descriptions of the findings were presented. Verbatim excerpts of the participants are presented and relevant literature to support the findings was described. The findings of this study are discussed based on the themes and the sub-themes that have emerged during data explicitation based on the individual semi-structured interviews conducted. The main objective of the chapter is to provide critical reasoning and

presentation of the results in order to provide the foundation how participants viewed the experience they face with regard to gender disparity in health service facilities.

4.9.3.1 Transcription Quality and Trustworthiness

To begin with, the researcher prepared for the interview in this way:

Audiotape

- The full battery – to avoid interruptions during recording.

- Dates settings- for easy retrieval of the data.

- The closeness of the tape to the participant to avoid missing words.

- The closeness of the tape to the interviewer to avoid unclear questions.

- Checked if the tape is working.

Environment

Whilst observing the maintenance of the natural environment, the researcher ensured the conducive environment for the purpose of quality during the interview.

- Quiet place, closed door, sometimes closed parked vehicle.

- No interruptions from anything around.

- No noisy pages from field notes notebook.

- Researcher speaks loud and encouraged the participant to speak louder also.

- The researcher did not transcribe the data verbatim but to ensure quality the researcher transcribed as close to verbatim accounts of the interview conversations as possible. The researcher transcribed the data in small bits to avoid being overwhelmed by excessive material to be analyzed.

4.9.4 THE Themes and Sub-themes

The analysis for the qualitative data was carried out according to the questions in the interview guides. The interview guide covers experience issues on gender disparity, availability of written guideline, men's and women's view about gender issues, effort of health service facilities to institutionalize gender equity, monitoring and evaluation of the impact of gender inequality, availability of department responsible for gender issue, and perceived impact of gender diversity in organizational performance.

The researcher developed themes that emerged from the data analysis. The findings are therefore presented in relation to the themes that emerged from the data explicitation. Sub-themes were also developed from within the themes. Direct quotes from the participants provide a thick description of the findings. Participants age and work experience in a year were used to protect the participants' identities and to maintain confidentiality.

The following nine major themes and sub-themes emerged from the data analysis using Collaizze seven steps.

Table 4:12 The Themes and Sub-Themes

S. No	Themes		Sub-themes
4.9.3.1	Family responsibilities	4.9.3.1.1	Family attachment
		4.9.3.1.2	Cultural conditioning
		4.9.3.1.3	Wrong belief on women's potential
4.9.3.2	Lack of self esteem or self confidence	4.9.3.2.1	Gender stereotype
		4.9.3.2.2	Social influence
		4.9.3.2.3	Fear of challenges or problems

4.9.3.3	Inadequate support	4.9.3.3.1	Gender discrimination
		4.9.3.3.2	Gender imbalance
		4.9.3.3.3	Career promotion is not merit-based
4.19.3.4	Organizational factors that impede gender equity	4.9.3.4.1	Lack of written guideline
4.9.3.5	Views of men & women about gender issue	4.9.3.5.1	Men and women do not have equal power of influence
		4.9.3.5.2	Lack of opportunity for further education
		4.9.3.5.3	Downgrading women's own potentials
4.9.3.6	Barriers to institutionalize gender equity	4.9.3.6.1	Lack of department or division responsible for gender issue
4.9.3.7	Essential to enhance organizational performance but not conducted	4.9.3.7.1	Lack of knowledge to monitor & evaluate gender equity
4.9.3.8	Staff adequacy	4.9.3.8.1	Shortage of staff responsible for gender issue
		4.9.3.8.2	Non-functional department or division
4.9.3.9	The impact of gender diversity	4.9.3.9.1	Gender diversity positively impact organizational performance

4.9.5 PRESENTATION of the findings

The themes and sub-themes are discussed individually at the beginning of each section. The data was classified in order to facilitate data integration and comparison of the qualitative and quantitative result. Verbatim quotations from the interview participants were cited as indicated below.

The interviewee participants in the qualitative component shared a wide range of experiences and views regarding gender disparity in healthcare sector leadership positions. The shared experiences and views revealed that the interviewee participants' had experienced gender disparity in different aspects and in many instances more than one factors play a role. The interconnectedness of these

factors was vivid. The interviewee participants' narratives highlighted that no single factor resulted in gender disparity in healthcare sector leadership positions, but a number of factors were often at play.

All the interview participants (100%, n=21) reported their experiences and views of gender disparity in top healthcare sector leadership positions includes emerged themes of family responsibilities, lack of self-esteem or self-confidence, and lack of support. The researcher observed the participants to be rather very excited, showed enthusiasm and confidence when providing the response.

4.9.5.1 Theme: Family Responsibilities

The experiences of the interviewees with regards to family responsibilities played a crucial role in understanding gender disparity in the healthcare sector. This was a common thread in the narratives of the men and women health professionals. This indicates that family responsibilities came about as a result of difficulties associated with family attachment, cultural conditioning and wrong belief on women's potential as they adversely affect leadership role of women health professionals.

4.9.5.1.1 Sub-Theme: **Family Attachment**

This sub-theme refers to an interview participants randomly stating their experience on family attachment as an underlying cause hindering the propagation of women representation in healthcare sector leadership positions. One interview participants stated different reason advanced by women health professionals for not taking up leadership positions.

Female public health officer aged 29 years with5 years' work experiences mentioned the following about family attachment:

"We do not want to become healthcare sector leader perhaps if I will be posted somewhere far away from my family. That is the major reason why I talked to a friends of mine, women health professionals who are now qualified to be the heads of the health centres in our district and they were saying they are not eager to take leadership positions because of the geographical location and distance of the health centre from my home place."

The above response suggests that preference for staying with one's family discouraged some women health professionals from looking for healthcare sector leadership posts.

As explained by Dhatt et al (2017:5), human resource managers in Zimbabwe prefer to deploy men to rural areas believing that men will stay longer in rural district health facilities and will not request transfers, and other positive aspect of rural posting is that, men healthcare leadership will gain professional experiences and in turn rural posting is valued by men in terms of future access to professional development opportunities, invitations to international workshops, and promotion

Silver (2018:12) observed that lack of the provision of appropriate support and intentional effort to hire women health professionals in leadership positions many might be a proven obstacles to the advancement of women health professionals to leadership positions.

Similarly, a midwife aged 30 years with 6 years' work experience expressed why she did not initially want to become healthcare sector leader and she mentioned that:

''I asked myself how I was going to manage my family, I also wanted my husband stay near me………I asked my friend who is female health professional and replied to me………husband should never be left alone. You are going to break your marriage and family relationship"……..Do you want power on the expense of your families? You need to take a moment and think about the issue"

In their field of study in Cambodia Dhatt et al (2017:5) noted the challenges women health managers faced in family responsibilities, including breastfeeding, child raising and domestic chores, and their

final decisions tended to prioritize families rather than their career……….. A 44 years-old health manager in Cambodia augmented that…….. *The hardest thing for women was when I had meeting at province. I had to bring both my husband and children to go with me. After the meeting, I had to rush to breast-feed my children. If men have mission at province, they will go alone."*

A midwife aged 30 years with 6 years experience also reiterated that:

"I started to ask myself and think, if I got leadership positions in one primary hospital or health centre away from my family, this is an advantage to my career advancement but a disadvantage to my family. When I am frequently away from your family for a long period of time for monthly review meeting, seminars and training workshop, may be my husband at times start going out with other women and look for replacement. Automatically I get frustrated and I may end up in dilemma."

This interview clearly demonstrate the dilemma that woman health professionals face working far away from their families fearing that her husband might be tempted to go for other women during her absence.

4.9.5.1.2 Sub-Theme: **Cultural Conditioning**

The interviewee participant is willing to get the promotion but, *"cultural conditioning"* is an impediment to her decision to take up leadership position in healthcare sector. Moreover; since she was already a healthcare sector leader, she felt that she did not make a wise decision in taking the leadership positions in healthcare sector.

Another female nurse aged 26 with two years' work experience also pointed out similar reasons why women health professionals do not look up for leadership positions in health care facilities. The following explanation emerged from interview.

"In our community, children will not be well cared by husbands, Ethiopian husband cannot take good care of his children and home …….yes, that is why small proportions of women health professionals get promoted because culturally women take a time to concentrate on looking after their families, husband and children."

The above interview response suggested that some women believe that the role of looking after children are mainly for women and men cannot look after children. As a result, women found it difficult to continue their further education and look for healthcare leadership positions away from their husbands and children.

Hyde & Hawkins (2017:2) cited conflicting ideas pertaining family responsibilities versus career advancement, and he explained that Cambodian women who had children valued their partners' support in being able to continue their further education, in spite of challenges. Some husband shared household responsibility and childcare.

The following ideas were mentioned by a female nurse aged 30 years with six years' work experience:

"*As a woman, I accept the notion that women should take care for their families and homes, but I will reject and never and ever accept the idea that family responsibility is the primary and the only role for women, women can lead health care facilities well.*"

Female nurse aged 40 years with ten years work experience noted the following traditional notions:

"I think, in addition to the traditional culture, another religious issue for the protestant women who is Christian and the fact that men are described in the Bible as superior to women and the head of the house hold, this traditional culture puts women in a lower-end jobs and weaker positions."

In his study Carbajal (2018:1) described the perspective of patriarchal society in relation to biblical notion as follows……….Genesis 2:18 states, *"The Lord God said, 'It is not good for the man to be alone; I will make him a **helper** suitable for him.* ''The interpretation of the word "helper" is assumed to convey inferiority. Based on the biblical interpretations, this perception has highly influenced women to be considered inferior to men and this perception is a fallacious assumption and an adulterated understanding of women themselves (Carbajal 2018:2).

Carbajal (2018:15) argued that, the construct of women being perceived as inferior to men is the problem of women's leadership aspiration and biblically the notion of women being inferior to men is not supported.

4.9.5.1.3 Sub-Theme: **Wrong Belief on Women's Potential**

To the contrary,a midwife aged 28 years with four years' work experience reflects the following wrong belief on women's potential and concern of political leaders:

"I thought that women are not given top leadership positions in healthcare sector in our district because political leader or cabinet who is responsible to appoint health professionals to higher healthcare sector leadership positions are concerned that women will have or already have families or children and will take more time off from work to care for them and her husband, this is therefore; political leaders assumptions are not as committed to the top healthcare leadership positions as someone with no children and families."

Some interview participants in the sample claimed that women were discriminated against and kept from promotion by health system just because they were women. They felt that discrimination was implicit in the organizational structure or in the attitude of those in authority like cabinet members.

In their field of study, Dhatt et al (2017:5) cited supporting ideas of the above interview response from Kenya and they explained that: "*When appointing a health manager…if she is female higher officials have to consider if she has children or not……if she is married, then after working for only a few months, she became pregnant and go off on maternity leave. Also once if she has a child, the women health professionals tend to become irregular with work, there is no more commitment to leadership positions when compared to her male counterparts…*"

Female pharmacist aged 41 years with 12 years' work experience said the following:

"*Social norms influence women to think more about her families and children than men. Their justification was that having a family and leadership positions in healthcare sector is difficult. If women health professionals have a families, they need to decide how they are going to manage the family and her leadership positions. This questioning of women's ability to become healthcare sector leader because her duty to have a family highlights the discrimination that continue to exist against women till the next generation unless well addressed.*"

The researcher was not able to find any statistics supporting the discrimination female health professionals faced but many female health professionals begun to speak out and explain the reasons why they feel wrongly mistreated.

Walker (2017:2) explained the root cause of gender discrimination as a societal challenge which is multifaceted and nearly impossible to pin on one factor. But gender stereotypes still play a role, concerning balancing family responsibilities and work schedules.

Female laboratory manager aged 37 years with 11 years' work experience viewed wrong belief of the society on women's leadership potential to be a result of lack of understanding and she described the following:

"I feel bad when I heard the statement that leadership positions have always been traditionally deemed by the society as a male's dominant role while housekeeping affairs has been always considered to be female role. However; as few women health professionals have begun to enter the world of leadership positions in healthcare sector in our district, they have been faced with some harsh criticism from both their co-workers and the communities.''

The following quotes from a 58-year-old married woman support the perspective of some women that they were considered themselves suited to leadership positions…………..*"I always perceive that whatever men can do, women can also do it. I always want to show my output and results to others."* (Hyde & Hawikns 2017:3).

This was augmented by female nurse aged 35 years with 9 years' work experience as follows:

"The potential of women is seriously questioned even from very beginning of her professional career. Many question women's ability to be a leader, even if she is good at leadership positions and well qualified than their male counterparts, especially for women that are not the native of the districts. As a result, we feel that we are at a disadvantage when it comes to promotion in top leadership posts in health service facility. This might be considered by the society to the fact that women health professionals always experience less hands on leadership activities than their male counterparts.''

Silver (2018:7), identified perpetuating myths most commonly mentioned by the society is that *"there are not enough qualified women, or females are not as skilled or dedicated in leadership positions as their male counterparts."* and the above myths was argued by author…….*"There is no lack of qualified and interested women health professionals suitable for leadership positions in health service facilities rather the selection process is flawed."* (Silver 2018:12).

Female nurse aged 26 years with two years' work experience described the following regarding wrong beliefs of the society about the reasons underlying their employment:

"Some individuals argue that, why women are employed? Unless for the financial need, men are expected to work in office to make money and support his wife and children, while women are expected to remain at home attending to their husband, children, and families."

As explained by Hyde & Hawkins (2017:2), there was social tendency which restrict girls in Cambodia not to study much and as they would still become someone's wife in the future and women were encouraged to stay at home rather than getting employed.

As evident, gender biases exist in both genders in many work environments. The field of healthcare industry is going to be rapidly changing and becoming more diversified, but this does not mean the biases have vanished.

Female nurse aged 30 years with six years' work experience also stated that:

"At present, in our region gender diversity is not yet ensured, hopefully with time, we (female health professionals) feel more comfortable and will hold more than 50% of leadership posts in health service facilities and this will be realized in near future."

The above interview response is supported by the presence of role models which inspire successful women health professionals who aspire to advance in top leadership positions (Hyde & Hawkins 2017:2), evidenced by the representation of 50% of women ministers in central Ethiopian government department (EBC 1, The news on 18 February 2018, 8:00 p.m).

Female public officer aged 27 years with three years' work experience particularly emphasis the following:

"I had to prove myself and my suitable potential of the leadership in healthcare sector that I have. I had to fight to overcome gender stereotype and common misconception of the society as well as my co-workers that women are not committed to their leadership positions because of their commitment to their husbands, children, and families."

The above response is supported in terms of cyborg leadership approach according to Carbajal (2018:7), which is important to counter the patriarchal societal perspective, thus cyborg leadership approach creates a "super-leader" persona that top women healthcare leaders take on "to fight gender stereotype and break the glass ceiling."

4.9.5.2 Theme: Lack of Self Confidence or Self Esteem

Many women health professionals experience self esteem or self confidence problems that impede their ability to pursue leadership opportunities or the ability to lead effectively in male dominated environment. Interestingly, gender stereotype or preconceived opinion that is not related to the actual experiences, abilities and attitudes of women, social influence and fear of challenges or problems were sub-theme emerged from the interview and identified obstacles encountered for under-representation of women in top healthcare sector leadership positions that induce a glass ceiling over the female health professionals.

4.9.5.2.1 Sub-Them: **Gender Stereotype**

In their large field of managerial study Eriksson et al (2017:1) observed:

…...many women have to a certain degree internalized the attitudes and role expectations about women, and male healthcare sector leaders on average tend to have stronger gender stereotype views with respect to the role as a successful leader than their female counterparts, that women have learnt to fit neatly into the stereotypes. This can be a major handicap in the development of their individual personalities, their abilities and leadership potential. A response from interview participant precisely illustrates this pattern, as discussed here:

Female laboratory manager aged 39 with 14 years' work experience mentioned that:

''Women *are not courageous enough to accept big roles because of multiple responsibilities in their home like caring her children and husband.''*

Women view collaboratively driven discussions to empower and lead health workforce but men perceive a woman as being not good at leadership position or unclear about their role (Wyman 2019:9), the problem of women's leadership aspiration include unconscious bias and wrong perceptions resulted in misinterpretations or skewed evaluations of women by men (Carbajal 2018:10).

The following sentiments also emerged from female public health officer aged 31 years with seven years' work experience:

"Social norms in our community has a major influence, women have multiple roles in their home, and for example, women are wife, mother of the children, government employee, and attendants of social life……..visiting the sick, attending funeral ceremony if any etc, we grew up in societies where women were not leaders in a public sector. So this affects us. We feel we should be led by men always. Women are naturally not confident. Women feel inferior naturally and believe that men should be leaders in top leadership positions in any government organization."

The above sentiment was viewed and explained by Carbajal (2018:12) "…the more women considered themselves as suitable for traditional feminine gender stereotype, the less likely they were to report leadership aspirations" This view is impeding factors of their leadership aspirations.

In addition, the following was also mentioned by female nurse aged 21 years with 6 years' work experience:

"Women health professionals feel that top position in healthcare sectors are men's roles. Culturally we should be lower in leadership positions but we are not deficient in leadership qualities as expected by the societies. They thought that women do not want to have higher leadership positions than their husbands."

As explained by Bismark et al (2015:4), even if women were sufficiently qualified, they were still not considered by the society suitable for leadership positions and not stereotypically consistent with being a leader.

The above responses point out that the stereotypes embedded in the way women are socialized hinder their advancement into healthcare sector leadership positions. The responses mentioned above reflect that the society think leadership roles as something not meant for women.

4.9.5.2.2 Sub-Theme: **Social Influence**

This sub-theme was described by the interviewee participants to be the major reason why women health professionals lack self-esteem or self-confidence to advance into healthcare sector leadership positions in health service facilities.

As explained by male pharmacist aged 29 years with four years' work experience:

''From an early age, women are prepared for their marriage roles of wife, mother of the children and food provider for the husband and children …….and they are significantly influenced from an early age to believe that a women is inferior to a men and that her place is in the home.''

Female public officer aged 28 years with 3 years' work experience also mentioned the following:

"I am always questioned by my society on whether I am suitable to lead healthcare sector and make decisions, they think that women are not good at decision-making process and are emotional."

Female nurse aged 33 years with five years' work experience noted that:

"People always question me on whether I am a good manager because I am a woman. There is a common misconception by the society that women are not able to become decision-maker because they are emotional and very sensitive."

A midwife aged 29 years with five years' work experience having leadership influence in one of the district health service facility mentioned that:

"I have been told that majority of the co-workers of mine do not want me as the head of the core process on the grounds that leadership is a man's job. I was always excluded from the networking activities at my work place. Does the leadership positions are always about the men? I am always feeling bad while I am thinking about this demarcation."

A 43 years old female nurse with more than 20 years' work experience described the reason why women health professionals avoid promotion to leadership positions as detailed below:

"……..why we avoid promotion to leadership positions is in fear of being viewed negatively in suspicion by my husband and our communities, for example if I were healthcare sector leader, I will be expected to spend more than 56 hours a week in office including night and week-end meeting when compared to the one with no leadership influence, who is expected to spend only 39 hours a week, therefore; my husband and our neighbour community could not understand and believe me whether I have been in office or into other affairs."

Hyde & Hawkins (2017:2) emphasize the constraint of gender norms………women health professionals were facing disapproval from husband and the community as well as undervalued by male counterparts when they were assigned to night shift in health centre or hospital.

4.9.5.2.3 Sub-Theme: **Fear of Challenges or Problems**

Female nurse aged 31 years with six years' work experience as a reproductive health expert mentioned that:

"………I have been assigned as a deputy district health office before the past four years and I accomplished the duties of top healthcare leader (male) for one year, but male co-workers including my immediate supervisor were not interested and did not believe in my leadership potential, they did not support me, rather they discouraged me, they thought as if I am not good at healthcare sector leadership rather I am good at management of household affairs, so the impact that I have been experienced during my previous appointment have eroded my self-confidence, and the potential to lead effectively in male dominated health service facility. But if I were given top leadership positions, I will never and ever accept the post."

As described by Carbajal (2018:5), women health professionals feel pressure from male managers to live up to the expectations stemming from what the wives were expected to do and women were not judged for their leadership potential and capabilities but instead viewed as mothers of children or house wives.

Female nurse aged 33 years with eight years' work experience who previously given leadership positions as a head of district health office mentioned her experience and why she was fired from her post after thorough evaluation made by political leader as follows:

"……..women frequently have to take more working hours away from office due to care giving responsibilities for their children and husband and face serious challenges in their careers as a result of family responsibilities. One such consequence is that women attempt and fail to balance their office responsibilities with family obligations may delay them from advancing through higher leadership ranks."

Political leaders preserve wilful ignorance about the problem and they do not know the evidence-base on healthcare workforce disparities and they have perpetuating critical thinking deficiencies (Silver 2018:7).

A midwife aged 30 years with six years' work experience mentioned potential challenges and problems anticipated as follows:

"……..If I were given leadership positions in one of the district health office, I will fight against corruption but male health professionals and other co-workers demand financial incentives without any contribution to health service facility's performance improvement but if I refused to sign up on their request and fail to approve the payment to be effective, they may beat me on the way and I afraid that."

Female nurse aged 37 years with ten years work experience had this to say about the fear of challenges or problems in leadership positions:

"As a women, I personally need to prioritize family responsibilities over leadership position as a potential challenge that I am anticipating, therefore; I prefer to practice clinical activities to leadership post, which demand only 39 hours per week."

4.9.5.3 Theme: Inadequate Support

This theme involves health professionals attesting to inadequate support as a result of gender discrimination, gender imbalance, and career promotion is not merit-based.

4.9.5.3.1 Sub-Theme: **Gender Discrimination**

This sub-theme refers to participants explaining their views that there was gender discrimination amongst healthcare professionals regarding top leadership positions. Unlike other fields where one gender is clearly given a priority and an advantage over the other, so healthcare industry is more blurry.

Female nurse aged 40 years with more than seventeen years work experience explained that:

"To most people, there seems to be no gender disparity in health care facility in South Ethiopia. Most of the health professionals "I work with" in this health centre are women, and I rarely blink twice about whether I am looking female or male health professionals, and discrimination against female health professionals is a sad fact of the past several decades and still persisting, and women health professionals are still feeling setbacks in the success of their career and level of leadership roles they play in health care facilities but recent information from Federal government is promising and shows that gender discrimination is reduced hopefully."

According to Kuhlmann et al (2017:1), the above sentiment is correct because women's representation in healthcare leadership positions and the need for gender equity in healthcare and other institutions are increasingly recognized, yet little attention is paid to leadership and management positions in large publicly funded health centres and hospitals.

Public officer aged 37 years with 12 years' work experience remarks relating to the above aspect:

"According to the assumption of what is going to be proved in near future, and if applied in healthcare industry, the vast improvement in the representation of women as a head of Ethiopian government department (minister) will not be promising but also inspiring for female health professionals."

Female nurse aged 32 years with seven years' work experience further reiterated on this view as described here:

"While a list of progress has been made by Federal government in ensuring that women feel comfortable and are able to pursue a career in government department, a lot of barriers pertaining to gender roles were going to be broken down in the present and we can truly declare that there is no more gender discrimination among female healthcare professionals in health service facilities top leadership positions."

Gender equity will be ensured if the following major strategies were implemented..........equal opportunity to men and women during recruitment, periodic monitoring of gender equality, career development workshops and seminars, gender-sensitive appointment and promotion criteria, support during career development, flexible working hour arrangements, mentoring programs and networking for women, diversity training for all health professionals, and inclusion of gender issues in teaching curriculum is important to ensure gender equity (Kuhlmann et al 2017:1).

Female laboratory manager aged 34 years with ten years work experience mentioned that:

"There is no reason that healthcare sector leadership positions should be associated with men health professionals roles only or lower-end jobs for women because both genders are capable of managing healthcare sector, I can lead healthcare sector even better than men, If I were given the position."

Male and female characteristics can be balanced when both are held together in harmony (Carbajal 2018:12), but one is not better than the other, rather they are complementary.

Female nurse aged 27 years with only two years' work experience had this to say:

"It is hard to believe that there is such a huge gap in the ratio of women to men healthcare sector leaders. I hope it will fix itself over time though as more women were given the leadership post in near future. Overall it really made me inspired."

4.9.5.3.2 Sub-Theme: **Gender Imbalance**

Quite a number of interview participants pointed out that gender imbalance in healthcare sector leadership is caused by the fact that women are not getting the necessary support from their families

and from the health system itself. That is why some of them did not apply for top leadership positions or if they were given, they did not accept the post. Following are the suggestions of nurse aged 27 years with two years' work experience pertaining to the above aspect:

"I have worked in one of the primary hospital for the past one year but my husband does not want to allow me to become nurse practitioner in hospital, and he forced me to be transferred into district health office after a period of a year clinical practice. At times it is not mentioned to the public but when I go to hospital during the weekend or night duty assignment my husband feelsl that I will get into other affairs rather than going to hospital."

Hyde & Hawkins (2017:2) emphasize the constraint………husbands will never accept and approve when wives assigned to night shift in health centre or hospital.

Equally, men cultural domination has been observed to contribute to women's lack of support in seeking leadership roles in healthcare sectors.

A midwife aged 28 years with three years' work experience mentioned that:

'It is difficult to change long-existing system? That is to look for leadership positions in health service facilities."

Another female public officer aged 36 years with two years' work experience as a head of district health office said that:

"My husband is not always happy when I go to the big city for meeting, training workshop, review meeting and other demanding duties because he wants me to stay home during week-end and non-working days and he does not tolerate off time duties."

The above interview participants clearly attributed lack of support from her husband as one of the factors contributed to persistent under-representation of women in leadership positions in health service facilities.

Female public officer aged 30 years with six years' work experience described that:

"In our region, gender imbalance in healthcare sector leadership positions was there for the last several decades, and still persistent, but recently the effort of our Prime Minister offered female health professionals an optimistic outlook."

4.9.5.3.3 Sub-Theme: **Career Promotion is not Merit Based**

In Southern Ethiopia health service facilities in general, career promotion in top healthcare sector leadership positions for women health professionals is not merit-based, and males were more promoted than female.

Female pharmacist aged 29 years with four years' work experience reflected that:

"The district health office that I am working in currently prefers male health professional leaders and therefore promotes males more than females".

A female nurse aged 28 years with three years' work experience briefly mentioned that:

"One of the reasons I was initially so doubtful about my interest in healthcare sector leadership positions is that I afraid that it was not my field of interest where trust was the norm." She also described how *"in my opinion, the absence of female role models resulted in not having leadership aspirations for upcoming female healthcare sector leaders."*

Laboratory manager aged 39 years with fifteen years work experience augments the above aspect as follows:

"What remains unclear to me is whether male leaders preference by authorized political leaders is the result of discouragement women health professionals who aspire to healthcare sector leadership positions or a lack of belief in the leadership potential of women I think."

Public officer aged 56 years with 30 years' work experience argued and reflected up on merit-based selection and recruitment of female leaders, his narratives revealed that:

"Female health professionals typically do not intentionally look for leadership positions because of the fear of deliberate appointment of male leaders by authorized political official provided that they may have equal or higher educational preparation than their male counterparts, hence chance should be offered for them to compete with their male counterparts, and affirmative action must be considered for women health professionals as per the civil service directives."

4.9.5.4 Theme: Organizational Factors that Impede Gender Equity

This theme refers to interview participants describing their experiences regarding the organizational factors that impede gender equity, and written guideline is not available emerged as one sub-theme from the interview.

4.9.5.4.1 Sub-Theme: **Guideline is not Available**

This sub-theme refers to interviewee participants' elaborating how the lack of written guideline affected formal declaration of gender equity in health service facility, as described by male nurse aged 34 years with nine years work experience:

"There is no written guideline available here in our district health office, I did not hear about guideline related to gender issue rather than other treatment guidelines, may be written guideline pertaining gender issues is available at regional health bureau or zonal health department level."

Female nurse aged 41 years with 17 years' work experience also mentioned that:

"What you are asking me about written guideline to ensure gender equity may be available at zonal or regional level health unit, but I did not hear about it in this district health office."

Male nurse aged 36 years with nine years work experience also briefly cited that:

"District Health Management Team as the government entity has the responsibility to develop guidelines that affirm gender equity if it is necessarily a must, but I think…….I am not quite sure that zonal health department might be using written guideline to monitor and evaluate gender equity."

Male public officer aged 33 years with eight years' work experience suggested that:

"District health office need to adopt its own from national guideline or regional one, and to be operationalized by respective health service facilities."

4.9.5.5 Theme: Views of Men and Women about Gender Issues

This theme refers to interviewee participants elaborating the difference in views of gender issues by men and women in their respective health service facility: The majority of the interview participant mentioned that the difference in the view of gender issue by men and women in their respective health service facilities have individual variation, but the differentials are covert.

The sub-theme of men and women has different power of influence, lack of opportunity to make career development, and downgrading women's own potentials emerged from the interview.

4.9.5.5.1 Sub-Theme: **Men and Women have Different Power of Influences**

This sub-theme refers to interviewee participants explaining their views that one's gender identification has a great influence on behaviour, perceptions and effectiveness on their roles.

Female nurse aged 31 years with six years' work experience had this to say:

"I will accept the difference regarding biological make-up and dichotomies about men and women as a social reality but I do not agree with the notion that men and women are different in leadership

qualities, even I declare that we have equal power of influence with male counterparts in leading health service facilities in higher positions.”

Male nurse aged 28 years with four years' work experience further explained that biological make-up of men and women do not determine leadership potential, and he concluded that:

"The difference between men and women response from the way in which society behave and accept to judge the differences in power influence between males and females .”

Female public officer aged 33 years with nine years work experience also stated variety of underlying assumptions as described below:

"Men and women health professionals can function equally well in health care leadership positions of whatever level it may be because both of them have the same foundation as a human being.”

Female nurse aged 27 years with three years' work experience explained divergent assumption about men and women and her views regarding the prerequisite to become healthcare sector leader:

"I think……on top of professional qualification that have been acquired from the colleges or Universities natural gift and intelligence is required to lead healthcare sector but this intelligence is equal for men and women but no deference.”

Female pharmacist aged 29 years with five years' work experience mentioned that:

"Men and women differ very little in the abilities and potential to lead, but leadership qualities that are most suitable and relevant to lead health service facilities outweigh for women than men which is transformational leadership qualities.”

Female interview participant also stated differentials in effective judgment against the abilities and talents of men and women healthcare sector leaders.

A female nurse aged 26 years with three years' work experience elaborated that:

"In South region health system in general and in our district health office in particular, health facilities including hospitals and health centres were managed in the same way as they were managed several decades ago because authorized political officials prefer male leaders than female which favours the traditional command and control leadership style, and they do not appreciate the value of gender diversity……..their thought support the difference in power of influence between men and women."

Female participant added the view of the need to incorporate feminine qualities of leadership style for better performance of health service facilities:

Female public officer aged 39 years with fifteen years work experience explained that:

"I acknowledge naturally acquired skill difference between men and women, and women are more collaborative, not emotional and sensitive like that of men counterparts, we are good at networking relationship and communication with co-workers, if women health professionals were given top leadership positions, we have greater opportunities to improve the performance of health service facilities."

Female interviewee participant suggested the origin of differences in men's and women's role which arises from the process of conditioning from early age:

Female nurse aged 40 years with more than ten years work experience explained that:

"I personally acknowledge gender role difference but as expected features of being female, women are more passive and do not involve themselves into the risks of men's role, like exercising duties that demand hard ship.............. this may be assumed to be the difference in power of influence between men and women."

4.9.5.5.2 Sub-Theme: **Lack of Opportunity for Further Education**

This category refers to interviewee participants' view about the lack of focus on female career development based on persistent stereotypes regarding women leaders is a major deterrent factors to advancing women to top leadership positions in health service facilities.

Female nurse aged 31 years with six years' work experience said that:

"I did not encounter and hear about leadership development program in this health service facility, even women health professionals most of the time are not given the opportunities to participate in in-service clinical skill training, the head of the health facility is frequently called for the training."

Female nurse aged 39 years with thirteen years work experience explained that:

"District health office as yet the head of the health facility that I am working in frequently invites individual health facility leaders already given top leadership positions for leadership skill development and leadership competency training but women health professionals were not invited

because such opportunities are very important in order to cultivate women as potential future leaders.”

Another participant further reiterated on this view that the development of women's leadership career will results healthcare sector's ability to create and sustain competent leadership teams.

Female public officer aged 30 years with six years' work experience augmented that:

"The development of leadership competencies focusing on individuals' skill is not utmost important to enhance the leadership capacity of women health professionals team of future leaders.”

Another interviewee participant explained that lack of opportunities for father education to female health professionals' results in large disparities in healthcare sector leadership over time.

Female nurse aged 41 years with fifteen years work experience had this to say:

"The reason why there is negative impact on the performance of health service facilities and long term improvement because female leaders are not well equipped and recognized to assume leadership roles.”

Another female interviewee participant explaining her view on the lack of opportunities for further education and also cited the absence of district health's vision to develop women health professionals.

Female nurse aged 38 years with thirteen years work experience stated that:

"In my view, creating a vision for health care leadership development opportunities are very important for any work environment other than health care industry but healthcare leadership is facing new challenges of 21ˢᵗ century mixed with unresolved challenges carried over the past several decades in Ethiopia in general and in Southern Ethiopia in particular."

4.9.5.5.3 Sub-Theme: **Downgrading Women's own Potentials**

This category refers to interviewee participants' view regarding the divergent assumptions about the inequality and difference between men and women in their characteristics. This was viewed to have resulted in a number of factors which impede women health professionals promotion into leadership positions indicated that women are considered to be their own enemy. They sometimes placed limitations on their own potentials as was explained by female pharmacist aged 38 years with 16 years' work experience who said:

"Women health professionals lack self-confidence to become healthcare leaders, even if they have equivalent or higher educational preparation than their male counterparts……..they perceive that leadership positions in health service facilities are challenging and have many problems."

Female nurse aged 43 years with 19 years' work experience stated that:

"We do not have self-confidence and assume that only men should have to possess higher leadership positions than ourselves, the spill over effect of this negative assumptions are still there and should be avoided"

Another male public officer, aged 30 years and 7 years' work experience had this to say:

"We have many leadership qualities inherited naturally, but we fail to realize our strength until some other individuals observe and identify us."

Qualitative data from health professionals reveals that women lack personal initiatives that will help promote their advancement into top leadership positions in health service facilities. They feel that existing obstacles in district health office coupled with the barriers that women put upon themselves negatively affect them to take responsibility for their leadership development path.

4.9.5.6 Theme: Barriers to Institutionalize Gender Equity

This theme reflects the experience of interviewee participants about the effort made by health service facilities to institutionalize gender equity which is a key point to be addressed by concerned higher officials. Under this theme one sub-theme of lack of gender office is emerged from the interview.

4.9.5.6.1 Sub-Theme*:* **Lack of Department or Division Responsible for Gender Issue**

Health professionals working in various district health offices agreed that it is the senior management team's responsibility to do much more to establish department or division responsible for gender issue so as to institutionalize gender equity in all health service facility irrespective of their level.

Male public officer district health office manager, 35 years and with 5 years managerial experience stated that:

"As we all know that despite huge gender gap in healthcare sector leadership positions, lack of department or division responsible for gender issue contribute to failure of significant proportion of women health professional to reflect their concern about gender equity issues, but bench marking and utilization of regional health bureau standard is important and should be operationalized in facilities gender office."

To concur with the public health officer district health office manager, another female nurse aged 38 years and with 11 years' work experience stated that:

"I have working for the last 11 years, but since then I did not observe any efforts made by district health office to institutionalize gender equity, so the best should be to look for best practice."

Female nurse aged 28 years with 6 years' work experience had this to say:

"When our district health office head is invited to leave for workshop training, biannual or annual review meeting or other affairs for a week period or more for example, he prefer to delegate his male friends rather than female nurses or other."

Female nurse aged 40 years with 18 year work experience augmented the above concern as follows:

"Understanding best should be if pairing women health professionals with male healthcare leader was made to encourage and motivate future women leader…………..maybe considered as leadership post exercise and early support that enable women to develop leadership confidence and credibility in case she became healthcare sector leader in the future."

The above response show that gender equity is required at all levels of health systems to eliminate gender bias and discrimination, support and full participation of all genders and ensure equal access to leadership opportunities.

4.9.5.7 Theme: Essential to Enhance Organizational Performance but not Conducted

This theme refers to interviewee participants explaining their experiences about the significance of monitoring and evaluation of the impact of gender inequality in organizational performance and one sub-theme of lack of knowledge to monitor & evaluate gender equity emerged from an interview.

4.9.5.7.1 Sub-Theme: **Lack of Knowledge to Monitor and Evaluate Gender Equity**

This sub-theme involves health professionals explaining their experience about monitoring and evaluation of the impact of gender inequality in organizational performance in their respective district health offices but knowledge deficit in the area have been mentioned as follows:

Female nurse aged 35 with seven years' work experience said this:

"In this district health office that I have been currently working as a medical service core process head for the last seven years, there is no monitoring and evaluation of the impact of gender inequality in organizational performance, nobody cares."

Female nurse aged 32 with five years' work experiences also reiterated that:

"District health management team conducting evaluations of health service activities performance every quarter do not monitor and evaluate the impact of gender inequality in organizational performance…..I did not hear about this."

Female public officer aged 26 years with just two year work experience had this to say:

"I know from training acquired from the University that monitoring and evaluation is important, but I did not see such practice in this district health office……there is no one concerned about gender inequality, how this impacted organizational performance and why the advancement of women health professionals has been low in leadership positions."

Male laboratory technologist aged 39 years with more than 13 years' work experience had this to say:

"The most critical area that district health offices need to address is monitoring and evaluation of the impact of gender inequality in organizational performance because gender diversity in leadership is important to enhance health service facilities performance and long-term improvement."

Female nurse aged 40 years with 15 years' work experience mentioned that:

"I personally think that people assigned to top healthcare leadership positions satisfy their personal interests……………nobody gives attention to the impact of inequality.

4.9.5.8 Theme: Staff Adequacy

This theme refers to interviewee participants explaining their views and experiences in the staffing adequacy and functionality of the department or division responsible to strengthening gender equality in health service facility. One sub-theme of shortage of staff responsible for gender issue and non-functional department or division responsible for gender issue emerged from an interview.

4.9.5.8.1 Sub-Theme: **Shortage of Staff Responsible for Gender Issue**

Interviewee participants realized that it is important for each and every district health office to recruit qualified staff responsible for gender issue after establishing well functional gender department or division in order to strengthen gender equality in health service facility, but described the fact that gender officer spend time doing nothing, it is short staffed and this does not always allow for the realization of the intended goal of ensuring gender equality.

Male public officer aged 32 years with four years of district health office leadership position experience mentioned that:

"There is only one female gender officer assigned before two to three years but gender office staffing is inadequate, shortage of qualified gender staff is one of the obstacles in promoting gender equity in the health service facilities. Without the full participation of women achieving the global sustainable development goals five is not realized."

Female nurse aged 43 years with six years' work experience stated that:

"Adequately qualified gender staff in district health office is very important to ensure gender equity, with the aim that relate to end gender-based discrimination so as to support women aspiration into leadership positions in health service facilities."

Female nurse aged 29 years with five years' work experience explained that:

"I personally think qualified gender officers must be adequately deployed and staffed to ensure gender equity in decision-making structures in public health service facilities but I did not hear and see any contributions of the gender officer assigned in our district health office before three years."

Female nurse aged 35 years with eight years' work experience described that:

"As far as my understanding concerned, gender equality means equal access and equal opportunities represent women in leadership positions, equal power, equal rights and equal influence between

gender, but qualified and adequate gender officers must be required to monitor and ensure these equality by comparing the number of men and women in leadership positions in the district health offices."

4.9.5.8.2 Sub-Theme: **Non-Functional Department or Division Responsible for Gender Issue**

This category refers to interviewee participants explaining their views about non-functional department or division responsible for gender issue in the district health offices in which qualitative interview were conducted resulted in lack of responsible individual who recognize and increase the visibility of women's leader in health service facilities.

One quote that summarized most of the feelings of interviewee participant is:

Male pharmacist aged 40 years with seven years' work experience had this to say:

"Adequately staffed and fully functional department or division responsible for gender issue is needed to develop enabling environment for women health professionals to share their experience among themselves allowing validation of their leadership experiences, such environment will contribute institutional re-structuring that provide support for women health professionals to aspire into leadership positions in health service facilities."

4.9.5.9 Theme: The Impact of Gender Diversity

This theme refers to interviewee participants explaining their experiences and perceptions of the positive impact of gender diversity on health facilities performance and long-term improvements. One sub-theme of improved organization performance emerged from an interview.

4.9.5.9.1 Sub-Theme: **Gender Diversity Positively Impact Organizational Performance**

District health office manager felt that gender diversity has positive impact on health facilities' performance & long-term improvement. The inclusion of women in healthcare sector leadership positions has significantly improves health service outcomes.

Male public officer aged 37 years old with four years managerial experience stated that:

"I absolutely agree that gender diversity has a positive impact on health facilities performance and long-term improvement because as a district health office manager, I have evaluated and conducted performance audit of institutional delivery service in six health centre under the management of our district health office which are led by female and male health professionals, and two of the health centres led by women achieve institutional delivery service performance of 65% and 60% annually but three of the health centres led by men achieve 24%, 35% and 50% only."

A study conducted by Wyman (2019:5) have shown that diversity makes teams question their default assumptions in a way that gender diversity produces better outcomes, more innovation, more creative solutions to intractable problems, and ultimately better financial outcomes.

Female nurse aged 44 years with sixteen years work experience replied the following for the question asked by the researcher……..……..do gender diversity positively impact health facilities performance and long-term improvements? Her automatic response for the question is ……..*"The answer is yes. ."*She further described important points as follows:

"To improve health facilities performance, gender diversity is the key but district health office still have to work at achieving gender diversity, this is what the concerned political leaders are most lacking."

Female laboratory manager aged 39 with 14 years' work experience reiterated the following:

"On top of ensuring gender diversity in healthcare leadership position, promotion of women in executive posts and decision-making structure will cultivates an empowered workforce and this effort will contribute to enhance health facilities performance and its long-term improvement."

A midwife aged 32 with eight years' work experience explained that:

"The government of Ethiopia set targets for the advancement of women health professionals to senior healthcare leadership positions in hospitals and health centres found throughout Ethiopia, which will be expected to be realized in near future but diversity management and promotion system by political leaders is not as such strong enough, because they have the responsibility of assigning healthcare sector leaders in top positions."

4.9.6 DATA INTEGRATION

This section presents integration of the quantitative and qualitative results from the mixed methods approach used. The researcher discussed the study results in relation to the research questions and main themes emerged from the interview. In this section, the researcher discussed the quantitative and qualitative data analysis and results separately to clarify the datasets prior to merging the quantitative and qualitative results. This, in turn, facilitated the development of linkages and allowed for substantiation of results, comparing and contrasting the two data sets, and the extension of the dialogue to the development of guidelines. Data integration was guided by the research objectives and according to the foundation of the mixed methods approach.

As described in Gray et al (2017:315), quantitative and qualitative data analysis in mixed methods research was conducted to integrate the results by comparing the two data sets. In this study both qualitative and quantitative data was collected concurrently using the same or parallel variables, constructs, or concepts and analysis was made separately, and then both qualitative and quantitative results were merged and compared to see if the findings confirm or disconfirm each other(Creswell 2014:269). The combination of quantitative and qualitative data provide different information from the

detailed views of participants qualitatively and numeric scores on data collection instruments quantitatively and together they yield results that should be the same (Creswell 2014:269).

According to Creswell (2014:273), the description of convergent parallel mixed method design indicate that the two data sets are analyzed separately and then brought together for data integration. There are several ways of merging the two data sets (Creswell 2014:273).

- The first approach is a side-by-side comparison of two data sets. In this approach, the researcher first report the quantitative statistical findings and then discuss the qualitative findings or themes that either confirm or disconfirm the statistical findings. Alternatively, the researcher might start with the qualitative findings and then compare them to the quantitative results. Mixed methods researcher use side-by-side approach because the researcher makes the comparison within a discussion, presenting first one set of findings and then the other.

- The second procedure is joint display of data. In this approach, the researcher integrate both quantitative and qualitative forms of data sets in a table or a graph. This method might use a table with key concepts on the vertical axis and then two columns on the horizontal axis indicating qualitative responses and quantitative findings to the concepts.

- The final approach is data transformation. In this procedure the researcher merge the two data sets by changing qualitative codes or themes into quantitative variables and then combining the two quantitative data sets. The researcher takes the qualitative themes or codes and counts or groups them to form quantitative measures.

As shown below, mixed methods design was used in this study as the researcher envisaged to collect both qualitative and quantitative data to answer separate but related research questions which are:

- What factors have contributed to the lack of advancement of women to the healthcare sector leadership position?
- What are the experiences and views of gender disparity in healthcare sector leadership positions?

4.9.6.1 Family Responsibility

In quantitative data analysis result, majority of the participants, 102% (n=372) percent reported the following factors associated with family responsibilities that impede women health professionals' aspiration to leadership positions: domestic chores overload coupled with caring for husband and children, the concern of women health professionals about their families than leadership positions, long standing cultural divisions of labour as men's and women's role into the house hold and in health service facilities, household roles and caring for husband and children are considered by the community as the only responsibilities of women, and fear of geographical location if women health professionals were assigned in top leadership position far away from their families because of family attachment whilst qualitative results revealed a theme of family responsibilities had three sub-themes of family attachment, cultural conditioning, and wrong belief on women's leadership potential. Both sets of results are therefore conclusive that family attachment, cultural conditioning, and wrong belief on women's leadership potential in connection to family responsibilities impede women health professionals' aspiration to leadership positions.

4.9.6.2 Lack of Self Confidence or Self Esteem

In quantitative data analysis result, 88% (n=322) percent of the participants cited the following root causes of women's lack of self-confidence to look for top leadership positions: outdoor and indoor superiority of men, fear of burden associated with family and office responsibility, wrong perception of the community about women – they are a weak creature and they are not strong enough like that of men, selfishness and male dominated leadership environment, women fail to speak out their feelings, lower-end job positions for women health professionals, and the absence of role model, fear of challenges and problems associated with leadership positions resulted in women's lack of confidence or self-esteem to look for leadership positions in health service facilities whilst qualitative

results revealed a theme of lack of self-confidence had three sub-themes of gender stereotype, social influence, and fear of challenges or problems associated with leadership positions.

Both sets of results are therefore conclusive that lack of self-confidence or self-esteem impede women health professionals' aspiration to leadership positions.

4.9.6.3 Lack of Support

In quantitative data analysis result, 76% (n=279) percent of the participants mentioned the following points associated with lack of support: opportunities for further education to women health professionals is not in place, political leaders prefer men to women health manager because of cultural preference of baby boy than baby girl, subtle racism and ethnic prejudices resulted in non-merit-based promotion of male health professionals into leadership positions, wrong perception of the community about women's leadership potential that we inherit from our ancestors, and women were considered to take more time off work to care for their children because of lack of support from husband whilst qualitative results revealed a theme of lack of support had three sub-themes of gender discrimination, gender imbalance, and non-merit based career promotion. Both sets of results are therefore conclusive that lack support from family members, co-workers, and the community as well as from health system impede women's aspiration into leadership positions in health service facilities.

4.9.6.4 Organizational Factors that Impede Gender Equity

In quantitative data analysis result, 59.2% (n=245) percent of the participants reported different factors considered to compromise gender equity: lack of written directives and guidelines about gender equity, lack of decentralization of written guidelines about gender equity from Federal Mistry of Health or regional health system to the peripheral health service facilities (hospitals & health centers), lack of any written information concerning gender equity, lack of clearly written and documented information about merit-based selection criteria of health professionals to assign in senior level managerial positions whilst qualitative results revealed a theme of organizational factors that impede gender equity had only one sub-theme of no written guideline.

Both sets of results are therefore conclusive that lack of written guidelines that affirms commitment to gender equity in health service facility is a factor associated with gender disparity in healthcare sector leadership positions.

4.9.6.5 Views of Men and Women about Gender Issue

In quantitative data analysis result, 43.6% (n=179) percent of the participants explained that views of men and women health professionals about gender issues in health service facility differ to a limited extent, but the following points were supplemented by the participants: perception of the co-workers regarding the difference in power of influence impede women's aspiration to leadership positions, demarcation made by community between women's and men's role discourage them to look for leadership positions, non-conducive leadership environment for women favoring men , lack of recognition for women health professional contributions cause to lose hope in looking for leadership positions, hospitals and health centers leadership positions were held by more men than women, lack of support and involvement of women in gender related affairs make women health professionals to regret, lack of good governance practices like transparency, openness and participation of women's health professionals in decision-making positions, lack of opportunities of further education for women health professionals create frustration, and women health professionals put glass ceiling on themselves and downgrade their own leadership potential. Qualitative results revealed a theme of views of men & women about gender issue had three sub-themes of men and women do not have equal power of influence, lack of opportunity of further education, and downgrading women's own potentials. Both sets of results are therefore conclusive that men and women health professionals are the same but there is inequality between them, emanating from differences in position, downgrading of women's leadership potential and their characteristics leading to gendered experience and life conditions.

4.9.6.6 Barriers to Institutionalize Gender Equity

In quantitative data analysis result, 76.8% (n=317) percent of the participants reported that there is no any department or division responsible for gender issue in health service facility at all, but 39%

(n=143) percent of interviewee participants explained the following limitations of health service facility's to institutionalize gender issues: lack of concern by district health office political leaders about gender equity, health centre managers themselves do not have leadership skill and capabilities to worry about gender issue, lack of hospital senior management team members awareness about the importance of gender office, lack of hospital board members knowledge about the department concerning gender issue, and the entire health professionals' do not have information about the significance of gender office as a separate unit. Qualitative results revealed a theme of barriers to institutionalize gender equity had one sub-theme of lack of department or division responsible for gender issue. Both sets of results are therefore conclusive that department or division responsible for gender issue in health service facility is important to ensure gender equity.

4.9.6.7 Essential to Enhance Organizational Performance but not Conducted

In quantitative data analysis result, 70.3% (n=289) of the participants reported that the impact of gender inequality in organizational performance and long-term improvement is not monitored and evaluated at all. Qualitative results revealed a theme essential to enhance organizational performance but not conducted had one sub-theme of lack of knowledge to monitor and evaluate the impact of gender inequality in organizational performance. Interviewee participants from qualitative study cited the significance of monitoring and evaluating the impact of gender inequality in organizational performance, and lack of assigned responsible individuals who ensure gender equity. Both sets of results are therefore conclusive that lack of knowledge to monitor and evaluate gender inequality have negative impact on organizational performance and long-term improvement.

4.9.6.8 Staff Adequacy

In quantitative data analysis result, 66.1% (n=272) percent of the participants reported that there is no assigned responsible staff in health service facility for gender integration in different departments at all but 91% (n=332) percent of the participants explained that lack of *a*ssigned responsible staff, and lack of professionals specifically qualified in gender resulted in failure to facilitate open discussion during staff meeting about gender issue. The same proportion of the participants also supplemented lack of women health professionals' network and independent team resulted in failure to conduct

periodic gender audit and lack of concern about gender equality. Qualitative results revealed a theme of staff adequacy had two sub-themes of shortage of responsible staff and non-functional gender department or division. Both sets of results are therefore conclusive that lack of department or division responsible for gender issue resulted in shortage of assigned responsible staff in turn leads to failure to include gender issue into strategic and annual plan of the health facilities, lack of monitoring and evaluation of the impact of gender inequality in organizational performance and long-term improvement, and lack of inclusion of gender awareness in to job description resulted in gender disparity in healthcare sector leadership positions.

4.9.6.9 The Impact of Gender Diversity

In quantitative data analysis result, 37.3% (n=154) and 31.5% (n=130) percent of the participants agreed and strongly agreed on the positive impact of gender diversity in health facilities' performance & long-term improvement respectively. But qualitative results revealed a theme of the impact of gender diversity had one sub-theme of gender diversity positively impact organizational performance. Both sets of results are therefore conclusive that gender diversity has positive impact on health facilities' performance & long-term improvement and the inclusion of equal proportion of men and women in healthcare sector leadership positions will significantly produce better health service outcomes, more innovation, more creative solutions to intractable problems, and ultimately better financial outcomes.

4.9.7 CONCLUSION

This chapter discussed the research results and gave a description of the data analysis methods used in the study. It presented the quantitative and qualitative research findings separately. Both sets of data were then merged to give an overall description of the results of the study.

CHAPTER 5

DISCUSSION OF MAJOR FINDINGS

5.1 INTRODUCTION

The previous chapter focused on the presentation and description of the study findings that aimed to develop guidelines for reducing gender disparities in healthcare sector leadership positions to a minimum in a study setting in Southern Ethiopia. This chapter discusses the major findings of the study based on the modified three steps theoretical framework (gender theory) for gender disparity used in this study (Risberg et al 2009:1475-9276).

5.2 MAJOR FINDINGS OF THE STUDY

Majority of the top leadership positions oocupied by the participants were at departmental level, only 1.3 % CEO positions and 2.3% medical director positions were reported but no women health professionals hold CEO and medical director leadership positions in health service facilities in Southern Ethiopia. A study conducted by Kalaitzi et al (2017:280-285) revealed that only 15% of the supervisory boards and 7% of CEOs positions in Poland were held by women. Similar figures apply in other parts of the world, where women representation in higher leadership position reaches only 15.7% in the United States, 10.9% in Australia and 10.3% in Canada (Kalaitzi et al 2017:280-285), this observation was true and much higher when compared to the current study.

In the USA, only 3% of healthcare CEOs are women, 6% are department chairs, 9% are division chiefs, and 3% are serving as chief medical officers. This is despite the fact that, women comprising

80% of the healthcare workforce evidenced that women in upper management positions is associated with improved financial performance of an organization and enhanced accountability (Rotenstein 2018:1).

In this study the following challenges responsible for gender disparity in healthcare managerial positions were reflected in the qualitative findings: family responsibilities, inadequate support from family members and health system, lack of self-esteem or self confidence, organizational factors (unavailability of written guideline), differences in views of gender issue by men and women, barriers to institutionalize gender equity, lack of monitoring and evaluation of the impact of gender equity in organizational performance, shortage of assigned responsible staff in gender office, and impact of gender diversity.

Bismark et al (2015:5) stated that personal, interpersonal and structural barriers impacting women health professionals' potential and their advancement to the higher leadership positions in health service facilities were interrelated.

5.2.1 Representation of Women in Healthcare Leadership Positions

According to Mulatu (2016:24-37), the level of women's representation is defined as the degree to which participation of women in higher leadership and decision-making positions increases. The vast contribution of women health professionals and the integral role they play as a large part of the health-care workforce in health service facilities is often underappreciated and under-recognized (Dhatt et al 2017:3). Increasing women's representation in top healthcare sector leadership positions within a global health is an opportunity to further health system strengthening and system responsiveness (Dhatt et al 2017:1) as well as a means to promote the fifth Sustainable Development Goals (SDGs) which is achieving gender equality and empowering all women and girls (Loewe & Rippin 2015:126).

In order to address gender disparities in healthcare sector leadership positions, certain mechanisms should be in place such as frequent promotion of women health professionals, offering opportunities for further education, recognition for better performance, developing comprehensive gender-sensitive health workforce monitoring systems and comparing progress across health facilities (Silver 2018:2;Kuhlmann 2017:1).

Focus group discussion involving male and female health managers and health professionals in Zambia and Uganda suggested that, evidence of pro-male bias and a 'discriminatory animus' toward women health service facility managers manifested in gender stereotypes of women's emotionality, tendency to make mistakes, lesser productivity, inability to handle power, weakness, indecisiveness, and incompetence (Newman 2014b: 3).

In this study, qualitative results described above show gender stereotype as one of the major causes of persistent under-representation of women in healthcare leadership positions. In this study, the influence of gender role stereotypes was found to manifest in the form of low self-esteem, lack of confidence and the women's perception that their role in the family overrides all other roles and lack of support from family members at home and work place. How gender stereotypes influence each of these findings is discussed below.

5.2.2 Family Responsibilities and Stereotypes

According to Newman (2014b:3), small-scale multimethod studies conducted in gender discrimination and inequality in the public and private health professionals' employment system in Zambia and Uganda found that, lack of policy responsiveness to life course event for health professionals with family responsibilities as well as evidence of gender bias are considered to be deterrent factors for gender inequity in healthcare leadership positions. This was also a common problems in Southern Ethiopia, and the experiences of the interviewee participants' family responsibilities in a study played a crucial role in interpreting gender disparity in healthcare sector leadership positions. This indicates that family responsibilities came about as a result of difficulties associated with family attachment,

cultural conditioning and wrong belief of the community about women's leadership potential as they adversely impact leadership role of women health professionals.

In their field of study in Cambodia Dhatt et al (2017:5) observed that, challenges women health managers are faced with family responsibilities including breastfeeding, raising children and domestic chores, and women health professionals' final decisions tended to prioritize families rather than their career.

According to Creswell (2014:273), the researcher discusses the findings by counting or grouping qualitative codes by transforming them into quantitative variables to form quantitative measures.

Out of 367 interviewee participants, (98%, n=357) percent explained that household work overload coupled with caring for husband and children, more concern of women health professionals about their families than leadership positions, and culturally long standing division of labour by the community as men's and women's role in to house hold and in health service facilities impede women health professionals aspiration to leadership positions, and interview participants stating their experiences on family attachment as an underlying cause hindering the propagation of women representation in healthcare sector leadership positions.

These findings were supported by the study conducted by Dhatt et al (2017:5) and human resource managers in Zimbabwe that do not prefer to deploy women health professionals to rural areas believing that women will never stay longer in rural district health facilities and will frequently request transfer to the urban health facilities because of family attachment.

Women are willing to get the promotion but, ''*cultural conditioning''* is an impediment for their decision to take up leadership positions in healthcare sector. Moreover they were already healthcare sector leaders, women felt they did not make a wise decision in taking the leadership positions in healthcare sector. ''In Ethiopia, children are not cared well by husbands, and Ethiopian husband cannot take good care of his children and home, that is why small proportions of women health professionals get promoted because culturally women take more time to concentrate on looking after their families,

husband and children. ''This interviewee response suggested that some women believe that the role of looking after children are mainly for women and men cannot look after children. As a result, women found it difficult to continue their further education and look for healthcare leadership positions away from their husbands and children. The above findings were supported by the study conducted by Hyde & Hawkins (2017:2), who cited conflicting ideas pertaining family responsibilities versus career advancement, and he explained that Cambodian women who had children valued their partners' support in being able to continue their further education and aspire to leadership positions in health service facilities. In spite of the challenges, some husband shared household responsibility and childcare.

Interviewee participants explained that, religious view for the protestant women who are Christian and the fact that men are described in the Bible as superior to women and the head of the house hold, this traditional culture puts women in a lower-end jobs and weaker positions, in his study Carbajal (2018:1) described the perspective of patriarchal society in relation to biblical notion described under Genesis 2:18 stated that, *"The Lord God said, 'It is not good for the man to be alone; I will make him a **helper** suitable for him.*

The interpretation of the word "helper" is assumed to convey inferiority. Based on the biblical interpretations, this perception is highly influenced women to be considered inferior to men and this perception is a fallacious assumption and an adulterated understanding of women themselves (Carbajal 2018:2). Carbajal (2018:15) also argued that, the construct of women being perceived as inferior to men is the problem of women's leadership aspiration and biblically the notion of women being inferior to men is not supported.

Women are not given top leadership positions in health service facilities in a study setting because political leaders or cabinet responsible for appointing health professionals to higher positions are concerned that women who had families or children take more time off from work to care for them and their husband, this is therefore; political leaders assumed that women are not as committed to the top healthcare leadership positions as someone with no children and families. Some interview

participants in the sample claimed that women were discriminated against and kept from promotion by health system just because they were women. They felt that discrimination was implicit in the organizational structure or in the attitude of cabinet members.

In their field of study, Dhatt et al (2017:5) cited supporting ideas of the above findings from Kenya and they explained that: "When appointing a health manager…if she is a women health professionals, the cabinets have to consider whether she has children or not……if she is married, then after working for only a few months, she becomes pregnant and go off on long maternity leave. Also once if she has a child, women health professionals tend to become irregular with work, and there is no more commitment to leadership positions when compared to her male counterparts…"

Social norms influence women health professionals to think more about their families and children than men. Their justification is the difficulties associated with family and leadership positions in health service facilities. But if women health professionals have a family, they need to decide on how they are going to manage their families and their leadership positions, this questioning of women's ability to become healthcare sector leader because their duty to have a family highlights the discrimination that continue to exist against women till the next generation unless well addressed. The researcher cited the following literatures supporting the discrimination female health professionals faced but many women health professionals begin to speak out and explain the reasons why they feel wrongly mistreated.

Walker (2017:2) explained the root cause of gender discrimination as a patriarchal challenge of the society which is multifaceted and nearly impossible to pin on one factor. Gender stereotypes still play a role, concerning balancing family responsibilities and work schedules.

A qualitative study conducted in Rewanda cited interviewee participants remark about the leadership capabilities of women ''…………..*women are not even capable of pulling out a tooth''* (Newman 2014:4).

A study conducted by Hyde & Hawikns (2017:3) found supporting quote from female interviewee participants who consider themselves suited to leadership positions…………..''I always perceive that whatever men can do, women can also do it. I always want to show my output and results to others." This finding is quite similar with the experience of female laboratory manager, ''……. Leadership positions traditionally deemed by the community as a male's dominant role while domestic chores has been considered to be female role. However; as few women health professionals have begun to enter the world of leadership positions in healthcare sector in our district, they have been faced with some harsh criticism from both their co-workers and the communities.''

The community in a study setting question women's ability to be health manager, even if they are good at leadership positions and well qualified than their male counterparts, this might be considered by the community to the fact that women experience less hands-on leadership activities than their male counterparts. Silver (2018:7), identified perpetuating myths explained by the community is that *''there are not enough qualified women, or women are not as skilled or dedicated in leadership positions as their male counterparts.''* and the above myths was argued by Silver (2018:12), who cited there is no lack of qualified and interested women health professionals suitable for leadership positions in health service facilities rather the selection process is flawed.

The response from the participants suggest that their role is aimed at keeping women at home attending their husband, children, and families augmented by Hyde & Hawkins (2017:2), there was a social tendency which restrict girls in Cambodia not to study much and as they would still become someone's wife in the future and women were encouraged to stay at home rather than getting employed.

 In Southern region gender diversity is not yet ensured but women health professionals hopefully feel comfortable to hold more than 50% of leadership positions in health service facilities and this will be realized in near future. This finding is supported by a study conducted by Hyde & Hawkins (2017:2), emphasize the presence of role models to inspire successful women health professionals who aspire

to advance in top leadership positions evidenced by the representation of 50% of women ministers in Ethiopian government department (EBC 1, The news on 18 February 2018, 8:00 p.m).

Carbajal (2018:7) in his study cited the significance of cyborg leadership approach which counter the patriarchal societal perspective, thus creates a "super-leader" persona that women health manager fight gender stereotype and break the glass ceiling. This finding is consistent with interview response of female public health officer who promised to prove her leadership potential in healthcare sector, fight to overcome gender stereotype and misconception of the community, and deemed lack of women's commitment to their leadership positions because of their commitment to their husbands, children, and families.

5.2.3 Low Esteem and Stereotypes

Lack of self esteem or self confidence experienced by women health professionals impede their ability to look for leadership opportunities and the ability to lead health facilities effectively in male dominated leadership environment. Gender stereotype, social influence and fear of challenges or problems associated with leadership positions were some of the identified obstacles for under-representation of women in top managerial positions inducing glass ceiling.

According to Eriksson et al (2017:1) research findings reveal that many women internalized the attitudes and role expectations about themselves, and male health manager on average tend to have stronger gender stereotype views with respect to the role as a successful leader than their female counterparts, but women have learnt to fit neatly into the stereotypes. This can be a major obstacles in the development of their leadership abilities and potential. A response from interview participants precisely illustrates this pattern, as discussed below:

Qualitative interview response transformed into quantitative measures revealed that, (33%, n=120) percent of the root causes of gender stereotype which is outdoor and indoor superiority of men, and

the concentration of women in lower-end jobs as well as the absence of role models resulted in lack of women's self-confidence, but (16%, n=59) percent of the interview participants mentioned fear of burden or problems associated with leadership positions and family responsibility, and (19%, n=68) percent of the interview participants explained misconception of the societies explaining *''women are weak creatures and they are not strong enough like men.''* Whereas fear of women to speak out their feelings are cited by (8%, n=29) percent of the interview participants resulted in lack of women's self-confidence to look for leadership positions.

Because of multiple roles, Ethiopian women are not confident enough and they feel inferior naturally and believe that men should be always a leader in top positions in health service facilities, and the above study finding was viewed by Carbajal (2018:12) "…the more women considered themselves as suitable for traditional feminine gender stereotype, the less likely they were to report leadership aspirations" This view is an impeding factor to their leadership aspirations. Wyman (2019:9) in his study augmented the above sentiments, elaborating the view and collaboratively driven discussions of women to empower and lead health workforce but men perceive that woman as being not good at leadership, unconscious bias and wrong perceptions resulted in skewed evaluations of women by men are major problems of women's leadership aspiration (Carbajal 2018:10).

Gender stereotype is deep-rooted and impede the socialization of women's to advance into leadership positions. Most women perceive leadership positions as men's roles, and culturally they should be lower in leadership positions but women are not deficient in leadership qualities as expected by the societies. On the issue of conditioning, it has been found out that gender stereotypes are so entrenched in the minds of some women that they strongly believe low self-esteem to be a natural thing for women. As explained by Bismark et al (2015:4), even if women were sufficiently qualified, they were still not considered by the society suitable for leadership positions and not stereotypically consistent with being a leader.

 Social influence and fear of being viewed negatively by the communities are major reasons why women have low self esteem and lack of self confidence to advance into leadership positions in health

service facilities, and the response from interview participant reflected that women are groomed for marriage and the society significantly influence them from an early age to believe that women is inferior to men and that their place is in the home, but Hyde & Hawkins (2017:2) emphasize the constraint of gender norms and social influence, and he cited that women health professionals were facing disapproval from the community and undervalued by male counterparts, this results in women's lack of self confidence to look for leadership positions.

5.2.4 Lack of Support and Stereotypes

Lack of support from family members and the health system context was found to be one of the causes of under-representation of women in decision-making positions in health service facilities. The central point in such condition is that males who are socialized to have an upper hand in a patriarchal society tend to exclude women health professionals from areas of managerial power. According to the model of gender theory, differences in position and power between men and women are acknowledged, but those in power, mainly men, tend not to support women for leadership roles rather assuming a risk of assigning women in an inappropriate position to ensure gender equity.

In describing gender role inequalities, Silver (2018:12) explains that lack of provision of appropriate support and exclusion of women by those in charge of promotions might be a proven obstacles to the advancement of women in decision-making positions. To make the problems worse these stereotypes influence both men and women equally and in the process of influence, family members and health system play a role. In such condition, the following questions arise: If family members and cabinet members responsible for promotion are also subjected to gender role stereotypes, will they support promotion of women at the work place? The answer is that women would not get support for promotion to healthcare leadership. For example, Kuhlmann et al (2017:1) observes that, ''stereotypical attitudes have a negative influence on the recruitment, selection, placement and promotion of women to healthcare managerial positions''.

Male cultural domination has been observed to contribute women's lack of support in seeking leadership roles. Bismark et al (2015:2) explained that failure to ensure a fair representation of women

in senior roles, which accurately mirrors their representation in the health workforce, may contribute to cultural and ideological divides between those in leadership position and other health professionals with no leadership role.

5.3 CONCLUSION

This chapter discussed the findings of the study under a modified three steps theoretical model for gender sameness/difference or equity/inequity. Gender disparity in healthcare leadership positions were used to guide the discussion. The next chapter will give a summary of the entire study findings; provide conclusions, recommendations as well as limitations of the study and implications for gender audit, and future research.

CHAPTER 6

DEVELOPMENT OF GUIDELINES TO REDUCE GENDER DIPARITY IN HEATHCARE LEADERSHIP

6.1 INTRODUCTION

This chapter provides an evidence-based guideline developed from the qualitative, and quantitative study findings with the objective of reducing gender disparity in healthcare sector leadership positions.

The evidence-based guidelines were developed based on the gender theory proposed by Risberg, Johannsson & Hamberg (2009:1475-9276). The proponents of the gender theory posited divergent assumptions about the leadership role of men and women in health care system to have implications on gender bias, such theory must be a situation-producing theory that emphasize differences and accepting gender role stereotype dichotomies about women and men as social realities (Risberg et al 2009:1475-9276). That is to say, such a theory must have the capacity to influence health workforce diversity management in a situation which could incorporate government policies, rules, and regulations to avoid gender discrimination in healthcare leadership positions in Southern Ethiopia. However; workplace gender diversity management is a desirable goal supported by federal and state laws that forbid gender discrimination in all level of management positions (Tessema et al 2017:2372-4951). Through this guidelines, the influence of gender stereotypes on family responsibilities, women's self-confidence, and support from family and workplace as a major causes of persistent under-representation of women in healthcare leadership positions will be represented with minimal words.

Polit & Beck (2014:134) attest that visual or symbolic representations of a phenomenon are helpful in expressing abstract ideas more clearly and minimizes the words used. Schematic or conceptual

guidelines visually represent relationships among phenomena, and are used in both qualitative and quantitative research. Concepts and linkages between them are depicted graphically through boxes, arrows or other symbols (Polit & Beck 2014:133).

The function of a schematic guidelines is to broadly present an understanding of the phenomenon of interest and reflect the assumptions and philosophical views of the development of guidelines. The guidelines can serve as a facilitators for generating hypotheses. The purpose of these guidelines was to provide support for regional health bureau, zonal health department, senior management teams of district health offices, hospitals and health centres to empower both men and women health professionals to actively participate in decision-making positions including those that are traditionally male-dominated leadership positions in a more balanced manner.

6.2 CONCEPTUAL FRAMEWORK OF THE STUDY

6.2.1 Practice Theory

The conceptual framework for this study is premised on the elements of the practice theory which was made popular by Risberg et al (2009:1475-9276) and the proposition made by the authors to reduce gender disparity caused by gendered stereotypes is conceptual thinking on consciousness rising activities and continuous reflection to effect attitude change among the community, family members, entire health professionals, and health system.

The elements in this practice theory include:

(1)   **The goal**: This is to develop a guidelines to reduce gender disparity in healthcare leadership positions.

(2)   **The directive**: This is the prescribed plan of action through which the goal will be achieved, directed toward specific agents.

(3)   **The survey list**: This includes specific activities involved in achieving the goal. They include agent(s), recipient, context, procedure, dynamics and purpose.

Agent(s): These are the individuals or group of people that will be involved in the implementation of the intervention to achieve the stated goal. This will include the researcher, policy makers (national, state and local levels), regional health bureau, zonal health department, district health offices, hospital board members, senior management team of district health office, and health service facilities, and health workforce.

Recipients: These are the individuals that will benefit from the development of the guidelines. In this intervention, the recipients were male and female health professionals who aspire to leadership positions in health system.

Context: This describes the place where the intervention will take place. In the present study, the context was regional health bureau, zonal health department, district health offices, hospitals and health centres. However; the theoretical framework which underpinned the study is gender theory. This framework takes cognizance of the environmental influence of health policies and regulations in eliciting and sustaining desired change in attitude of the community, family members, and health professionals toward gender stereotypes and dichotomous thinking with a view to conduct effective gender audit as an intervention.

Procedure: This emphasizes the principles and methods to follow in order to accomplish the set goal. This element talks about the methodology for the development of the guidelines.

Dynamics: These are the factors that may decline impetus to the uptake of the activities. They are a power source which fuels or drives the activity. They may be physical or psychological amongst others and include political will of the government, women's low self-esteem, lack of support from the community, family members, co-workers, and health system, lack of motivation on the part of the agent, and lack of written guidelines which affirms gender equity in health system, lack of formal leadership training for ill informed leadership, management, and governance practices.

Purpose: This describes the anticipated outcome of the developed guidelines. In this study, the guidelines is expected to reduce gender disparity in healthcare sector leadership positions to a minimum using the vehicles of balancing work and family responsibilities, building women's self-confidence, increasing support, provision of formal leadership training, inclusion of gender equity goals and objectives in strategic planning, inclusion of gender awareness in job descriptions and performance based evaluation, promote the engagement of responsible staff for gender integration in different departments, and gender disaggregated data collection and analysis for healthcare leadership positions.

6.2.2 Gender Diversity - Prospects and Benefits:

According to Cletus et al (2018:35-52) gender diversity as a holistic concept can be described as a collection of conscious practices that require comprehensive understanding and appreciation of the challenges individual, cultural, and institutionalized discrimination creates within an organization. The author states work place gender diversity that transcends the recruitment, equal treatment, and representation of male and female leaders within healthcare organization (Cletus et al 2018:35-52) to meet three potential benefits:

6.2.2.1 Critical Thinking and Problem Solving Skills

The existence of workplace gender diversity can improve critical thinking and problem-solving skills within an organizations (Cletus et al 2018:35-52). Workplace gender diversity provides employees with varied capabilities that can ensure strategic planning and execution of management activities. These skills according to the authors are essential components for enhanced communication, collaboration, and conflict resolution in the workplace (Cletus et al 2018:35-52). The authors' state when the strengths and visions of every individual are harnessed, productivity and better results can be achieved in the long run (Cletus et al 2018:35-52).

6.2.2.2 Employee Growth and Development

Health sector leaders with diverse characteristics can provide a platform for creating and testing innovative ideas. This view is also shared by the authors' who states that gender diversity enhances the approach to troubleshooting and problem-solving within an organizations (Cletus et al 2018:35-52). As a result of the multiple perspectives and approaches, leaders can effectively address the various leadership activities, decipher problems and create innovative solutions in the health service facilities.

6.2.2.3 Unification of Diverse Strengths

Different skills and strengths of health professionals of various backgrounds can be harnessed for better performance and productivity. Similarly, cross-cultural understanding could stimulate better working environment which can go a long way in dispelling stereotypes, prejudices and misconceptions about employees of diverse cultures.

CONCEPTUAL FRAMEWORK OF THE STUDY

Goal concept
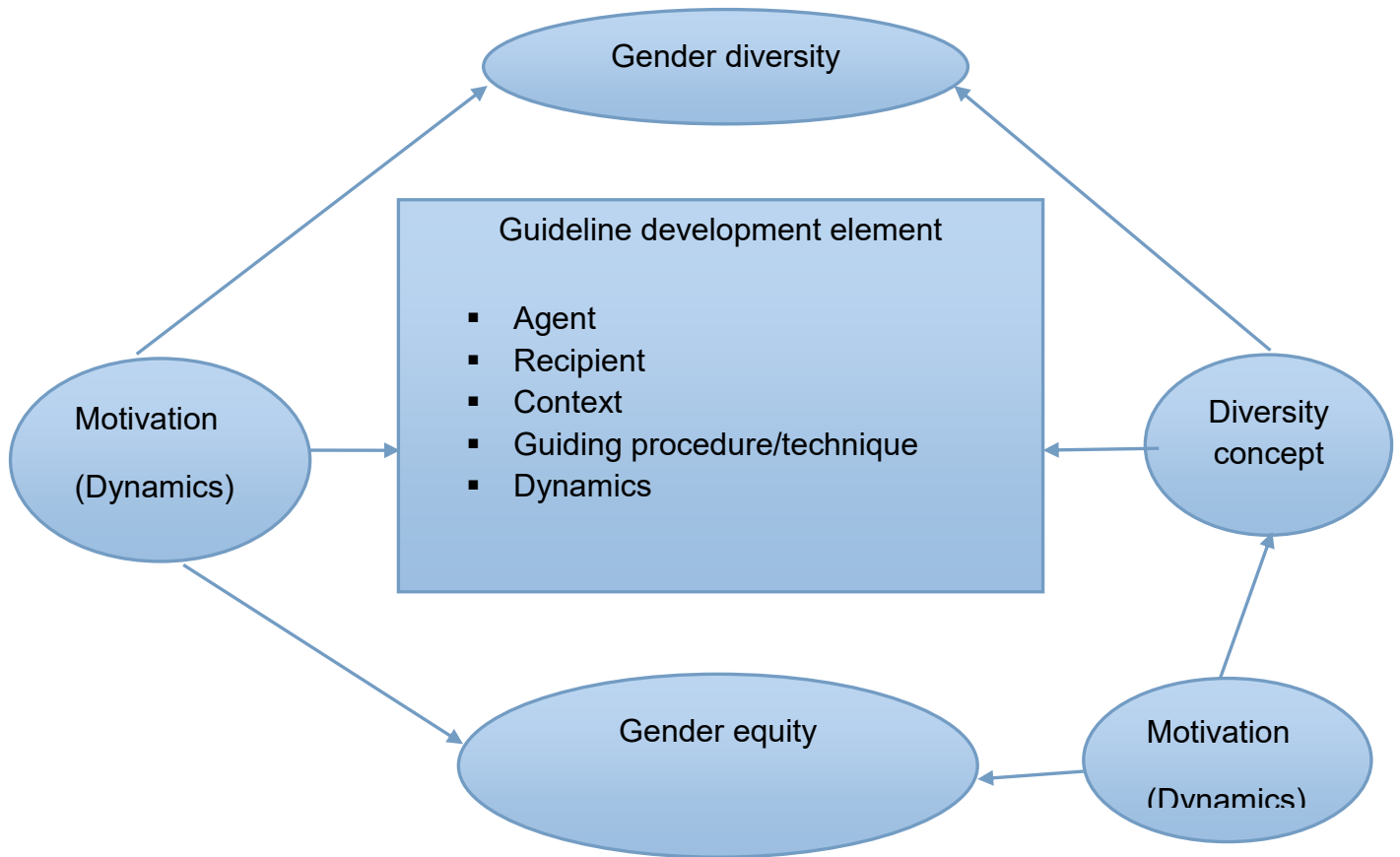
Figure 4.22 Structure of the conceptual framework

Figure 6.1 Structure of the Conceptual Framework

6.2.3 Transfer of Concept into Practice

6.2.3.1 Introduction

The conceptual framework (Figure 4.22) derived a number of elements and components which were pivotal in achieving the goal of reducing gender disparity in healthcare leadership positions. The elements include, 'agents' and 'recipients' while the component include 'motivation', 'gender equity', and 'gender diversity' (Figure 4.22). According to the conceptual framework, the dynamics (energy) that will lead diverse health workforce for critical thinking and problem solving, employee development and unification of diverse strength with in health service facilities while the pathways through which female health professionals and the agents of change can encourage gender diversity in healthcare leadership through work-life balance, developing women's self-esteem, and increasing support.

The developed guidelines draws from the findings of qualitative and quantitative studies embarked in this study. The study findings highlight the constructs of factors associated with gender disparity in healthcare leadership positions which are further corroborated by the elements of practice theory and gender diversity concept.

6.2.3.2 Development Process of the Conceptual Framework and Guideline.

The three key components of the developed conceptual framework are as follows:

a.   **Goal concept**: this is the desired, and expected progress in gender diversity in the target population, which in this case is male and female health professionals.

b.   **Gender diversity concept**: this describes a directive (command) which is given to achieve the conceived, and desired level of leadership role both by male and female health professionals. This concept requires holistic inclusion and development of guidelines to

address challenges currently faced by women health professionals who aspire to healthcare leadership positions. It comprises the use of government policies to meet desired initiative.

c.   **Guideline development elements**: these include agents, recipients, context and dynamics.

    i.   **Agents**: these are stakeholders who will be the change agents. Both qualitative and quantitative phases of the study identified family responsibility, low self-esteem, and lack of support were key factors that impede women's aspiration to leadership positions in health system in the study setting. Recognizing the fact that community, family members, health professionals and health system were identified as the main root for under-representation of women in leadership position. The change agents include family members, community, health care professionals, health system, policy-makers, political leaders, regional health bureau, zonal health department, and district health office and health facilities.

    ii.   **Recipients:** these are primarily male and female health professionals.

    iii.   **Context:** the context in which the action takes place and the developed guidelines will be used, which is the health system.

    iv.   **Guiding procedure/technique:** this entails different ways of carrying out the intervention in the described context. Intervention is carried out through conducting gender audit to determine how responsive the action is to promoting gender equity.

    v.   **Dynamics**: this is the energy source which gives drive to the entire process of achieving desired outcome. This may be achieved through balancing family and office responsibilities, improving support and enhancing self-esteem.

Change agents were driven to achieve desired action through motivation for the realization of set goal and by providing formal leadership training.

6.2.4 Developed Guidelines

This guidelines are based on the premise that the provision of information on how the division responsible for gender equity can support the change agents in gender audit and reaching their gender diversity targets. These guidelines are also designed to provide a description of the requirements that can be used by Regional Health Bureau to qualify health service facilities for the varying levels of gender equity certification.

Empowerment strategies: Despite the outlined persistent under-representation of women in healthcare leadership positions and several challenges associated with gender disparity in health service facilities, the natural obstacles to embracing and implementing gender diversity in health service facilities require organizations to take the lead and the identification of impeding factors in the increasingly competitive world of local and international business. It is no longer just the question is how can the problem of gender disparity be resolved, but what steps, programs and strategies are required in the present and near future. The problems of workplace gender disparity can be resolved by the following empowerment strategies:

1. Given its importance, Regional Health bureau, in collaboration with zonal health department, and district health offices must be required to empower the policies, guidelines and legislation of health service facilities on workplace gender diversity.

2. Regional Health Bureau of Southern Ethiopia should make concerted efforts in improving self efficacy and leadership competencies of female health professionals. This may be done through formal leadership, management, and governance training and facilitating conducive work environment for the women leaders. The result of this step will enhance women's leadership experience and self-regard and relating to others reliably; all impacting the individual's self-esteem.

3. Regional Health Bureau in collaboration with South media and communication staff should use social and electronic media platforms to encourage women health professionals' aspiration to leadership positions. Useful information such as leadership potential of women health professionals and invitation to participate in structured and organized gender related activities. Vehicles such as community radio programs, and television slots may be utilized to disseminate

information to the communities, health system, and entire health professionals concerning gender role stereotypes and dichotomous thinking.

4. Political leaders should demonstrate effective participation of women health professionals in the processes of leadership, management, and governance structures that can be made accountable to women; beyond simply counting the number to increase women's representation in healthcare leadership positions.

5. Regional Health Bureau should adopt and invest in gender diversity training as a strategic tool to shape the existing health facilities diversity structure. This approach will help alter the leadership teams or health professionals composition required to interrupt old habits and routines that discriminate women in health service facilities. It is envisaged that such training and professional programs will reinforce national health policy and inspire appropriate behaviour towards health professionals from diverse culture.

6. Senior management teams of health service facilities should establish and support women health professionals' network that are critical to ensuring the voice and agency of women. These network is at the forefront of identifying problems, exploring an innovative solutions and demand for accountability from all stakeholders both from public and private.

7. District health office management team members should engage gender expert in a senior level positions for gender integration in different department in each and every health service facilities as a gender champion. This responsible staff must not only be selected, but the organization must also show that their champion is active by producing a record of the actions the champion has taken to promote gender balance in the health service facilities. Gender equity agenda requires cultivating their ability and intent to actively improve organizational practice and support the implementation of gender equity initiatives. Health professionals and gender balance champions in particular, are a great resource for the mobilization of gender balance initiatives and can provide valid ideas for their implementation and improvement. They can promote their health service facilities gender agenda by monitoring progress and adapting national objectives into their specific organizational context.

8. Health care leaders in health service facilities should create a culture of women empowerment to address the problems of gender disparity in healthcare leadership positions. This can be achieved by infusing an atmosphere that welcomes and empowers women health professionals with diverse skills to work in teams. Gender diversity initiatives in health service facilities should help to defend against resistance to change and afford them a sense of ownership.

9. Human resource for health management in health service facilities should play an important role in gender equity needs to be included and described in health professionals' skill required for jobs. This will enable health service facilities to hire competent health professionals from the increasingly limited pool of talent. Therefore; human resource managers rapidly determine health professionals' ability to handle the potential challenges of a diverse health workforce during the interview process. Furthermore, this step will allow managers to select the most aspiring health professionals from the pool of candidates who value and understand the importance of health workplace diversity and ultimately help lead healthcare sector.

10. Plan and program director in health service facilities should analyze strategic planning of an organization through a gender lens to address latent differences that may negatively impact men or women's advancement into leadership positions. Using gender lens in everyday operations and strategic planning ensures a gender-sensitive approach and development of policies, programs and services that meet the distinct leadership aspiration of women and men health professionals.

11. Despite the fact that traditional norms generally view men as better decision-makers who are more able to handle stress, making them better equipped to deal with the requirements of leadership. This can systematically exclude women from networking, mentorship and promotion opportunities. Therefore; senior-level gender expert should monitor and evaluate health facilities senior leadership positions by using gender disaggregated data collection and analysis to track the numbers of male and female health professionals in leadership positions.

The relevance and appropraitness of developed guidelines is evaluated by piloting the empowerment of female health professionals by Regional Health Bureau of Southern Ethiopia and conducting periodic gender audit.

6.3 CONCLUSION

The elements which guide the development of the conceptual framework and the guideline described in this chapter were indicators of the factors that contributed to the lack of advancement of women to the healthcare leadership positions which include but not limited to the influence of gender role stereotypes found to manifest in the form of low self-esteem, lack of confidence and lack of support from family members at home and work place, and significant others, lack of opportunity for further education, downgrading women's own potentials, lack of department or division responsible for gender issue, lack of knowledge to monitor & evaluate gender equity, and shortage of staff responsible for gender issue, and political will of the government. The conceptual framework and developed guidelines are expected to yield accelerated progress in the advancement of women health professionals to leadership positions because they have been predicated on the following: evidence-based data, use of a community-based approach and there is a link among research, policy and practice. The conduct of research informs evidence-based policy analysis, reviews and the translation of policy into practice proffer solutions and intervention to challenges of gender disparity. The transfer of policy and concept into practice is accomplished through the role played by inter-sectoral (multi-stakeholder) activities in achieving the objective of the development of a guidelines to reduce gender disparity in healthcare leadership positions cannot be downplayed. This is because stakeholders like communities, family members, and parents outside the health system have responsibilities of enhancing gender diversity.

The developed guidelines are expected to achieve gender equity given the necessary and required political will of the government to accelerate the entire process of workplace gender diversity, giving direction and guidance to all stakeholders for action.

CHAPTER 7

CONCLUSION, RECOMMENDATIONS AND THE CONTRIBUTION OF THE STUDY TO KNOWLEDGE

7.1 INTRODUCTION

Gender disparity in healthcare leadership positions and lack of inclusion of women's perspectives in decision-making process results in low organizational performance, and innovation and creativity in problem solving is also low. Women health professionals are not perceived as lacking effective leadership skills but prescriptive gender stereotypes impede women's advancement to leadership positions because they entail different social norms on how women and men can lead (Carbajal 2018:10), which is based on gender stereotype rather than leadership skills. Gender diversity is a means towards which health service organizations create conducive work environment to treat men and women fairly to address gender disparity. It is therefore imperative that gender diversity in healthcare leadership positions should be maintained and enhance the development of guideline. Addressing gender disparity in leadership positions can uplift women's professional potential and enhance their advancement to leadership positions (Silver 2018:2).

The purpose of this study was to better understand gender disparity in healthcare leadership, with the ultimate aim of developing guidelines for reducing gender disparities in healthcare leadership in study setting. In order to meet this purpose the researcher attempted to answer the following questions:

- What factors have contributed to the lack of advancement of women to the healthcare sector leadership position in study setting of Southern Ethiopia?
- What are the experiences and views of gender disparity in healthcare sector leadership positions in study setting of Southern Ethiopia?

2

Chapters 5 presented discussions of major findings, and this chapter's focus was to present summary of study findings, recommendations, limitations, contributions, and conclusions of the study.

7.2 RESEARCH DESIGN AND METHOD

In this study the researcher conducted descriptive research which is defined by Polit & Beck (2014:160) and the researcher observed, described, and documented various aspects of gender disparity in healthcare sector leadership positions.

Mixed methods research using the convergent parallel research design, described by Creswell (2014:44) as a method of inquiry involving philosophical assumptions that guide the direction of the collection, analysis and integration of quantitative and qualitative data sets in a single study or series of studies used to address pertinent research questions of the study.

7.3 SUMMARY OF RESEARCH FINDINGS

7.3.1 Sample Characteristics

For the quantitative strand of the study, the age range of the participants was 37 with a minimum of 20 and a maximum of 57 years. The mean age of the participants was 28.29 years and the standard deviation was 5.64. Forty-six percent (n=192) of the participants were males and 53% (n=220) of the participants were females. Forty-eight percent (n=199) of the participants were single, 51% (n=212) of the participants were married. According to the Ethiopian Demographic and Health Survey (EDHS 2016:11), one-fourth of women (26%) and two-fifth of men (42%) have never married. Forty-nine percent (n=203) of the participants have diploma; 48% (n=199) of the participants have bachelor degree, and only 3% (n=12) of the participants have master's degree level of education.

Ninety-eight percent (n=386) of the participants were full-time employee while only 1.8% (n=7) participants were part-time employee. Fifty-seven (n=229) percent of the participants earned below 5, 000 Ethiopian birr (<29 USD) per month, 43% (n=173) earned more than 5, 000 Ethiopian birr (> 29 USD) per month. According to the National Bank of Ethiopia on 15 April 2019, the exchange rate was 1 USD to 29 Ethiopian birr. The mean work experience of the participants is 6.21 years; the median and standard deviation are 5 years and 4.56 years respectively. The minimum work experience of the participants is one year and the maximum is 35 years. Ninety-six percent (n=398) of the participants have more than 25 years' work experience, but only one percent (n=4) of the participants have been served for more than 25 years in health service facility. Sixty-seven percent (n=264) of the participants do not have any position in a health service facility.

Seventy-seven percent (n=308) of the participants did not have leadership influence in their health service facilities. Three percent (n=12) of the participants were hospital board members; 10.3% (n=41) percent of the participants were health centre board members and 9.4% (n=39) percent of the participants were senior management team members. Eighty-eight percent (n=363) of the participants did not receive any formal leadership training while they are working in their respective health service facilities, but only 11.7% (n=48) percent of the participants have been received formal leadership training.

7.3.2 Health Service Facilities

The health care delivery model is restructured in primary hospital and health centres under Primary Health Care Unit (PHCU) with the objectives and targets of 'envisioning Ethiopia's path towards universal health coverage through strengthening primary health care which enable Ethiopia to achieve the best health outcomes that would be expected to become a lower middle income country by 2025 (FMOH 2015:16). According to the Health Planning and Statistic Department of the Southern Regional Health Bureau (2018), the health care system of Sidama district comprises a total of one

hundred twenty one health centres, fifteen primary hospitals, and two general hospitals and all are distributed disproportionately across the districts. In this study data was collected from 29.7% (n=41) of the total number of health service facilities found across seven districts of Sidama. Facilities were either health centre, primary hospitals or general hospitals. In Southern Ethiopia, primary health care and outpatient department services are primarily offered in health centres and hospitals to ensure universal health coverage at the community level.

7.3.3 Staffing

The majority of the primary health care unit facilities were seen to be staffed by registered nurse (52%; n=126), midwives (10.2%; n=42), public health officer (15.5%; n=64), and other professional qualification (21.8%; n=90). Out of the total number the participants, 45.6% (n=188) percent were working in health centre, 35.2% (n=145) participants in primary hospital, but only 19.2% (n=79) participants were working in general hospital.

7.4 RECOMMENDATIONS

Improvement in gender equity in health service facilities leadership positions will require guidelines targeting gender stereotyping by communities, health system and policy. There should be more gender sensitive formal leadership training in Universities. Since gender stereotype impede the achievement of gender equity and the advancement of women health professionals in to higher leadership positions, there is a need to educate the entire health professionals and the community into a new system where gender equity is the norm.

Health system is one of the principal agents and its main role is contributing to the expansion of the number of women leaders in health service facilities (Javadi et al 2016:229-240). Health system

should therefore motivate both men and women to pursue a career path in healthcare sector leadership and to break through perceived gender-related barriers. Javadi et al (2016:229-240) noted that "targeting further education for women to attend formal leadership training in schools of medicine, nursing, public health, and other health-related fields, especially in settings where access to education is low" Such formal leadership training program should include mentorship components that connect young women health managers to an established health sector leaders and help broaden their networks. These formal leadership training programs should be given to health science students quite early before graduation. Both men and women health professional trainees in nursing and medicine would realize that they are equal and as they graduate and assigned to leadership positions with no sex group that would feel superior or inferior to each other.

Muraya et al (2019:249–256) suggest the importance of flexible family-friendly policies and arrangements in health systems to increase the opportunities for uptake of women's leadership positions whilst still managing domestic responsibilities, as well as support with the challenges of balancing family and work-life that were particularly pertinent for women health professionals.

In addition, prospective women health managers should be supported as they get appointed into leadership positions. Support must be given to all health professionals who look for health sector leadership positions as their next career opportunities. Senior management team at regional, district health offices and health service facilities level should be aware that their support and encouragement may be the spark which moves a potential health manager to apply for leadership positions. The health system, health professionals, and the communities must also ensure that all potential women health leaders are adequately supported and have access to professional development opportunities along their career path. In short, if support from co-workers, senior management team, health systems and community members is an integral part of health professional's progression towards the goal of health sector leadership positions, then all aspirations must have access to such encouragement.

Muraya et al (2019:249-256) states that "offering gender-sensitive flexible leadership training through formal University graduate programs, may increase women health professional's chance for achieving their desired leadership positions that allow trainees to undertake training over a prolonged period of time, and with modules scheduled to fit into existing real world and personal life

responsibilities. Indeed women health professionals look and expect opportunity for University leadership training programs. Therefore; the following recommendations for increasing the number of women health professionals' advancement into healthcare leadership positions should be considered. These apply to regional health bureau of Southern Ethiopia, zonal health department, district health offices, nursing and health Science College as well as Universities graduating health science students'.

- Design and include gender equity goals and objectives into strategic planning so as to develop a detailed plan that helps health service facilities to achieve gender integration and to improve gender equity within health service organizational processes, programs and activities.

- Develop guidelines in health service facilities that affirms commitment to address gender disparity in leadership positions.

- Implement proactive strategies and demonstrate strong political will to institutionalize gender equity and promote women into senior health management positions.

- Incorporate gender related activities in job descriptions and performance based evaluation criteria.

- Monitoring and evaluation of the impact of gender inequality in organizational performance in both systematic and participatory manner, and should include as many health professionals as possible. Voices of the assessment and analysis of gender roles and responsibilities should represent all levels and types of positions within health service facilities. Results from each of the steps will increase and build organizational understanding, ownership, and readiness to act on a shared agency-wide gender equity initiative.

- Establish department or division responsible to monitor, assess, and analyse gender roles and responsibilities and to ensure follow-up, gender focal person or gender task force should be assigned in health service facilities.

- Planning periodic management meetings to the entire health workforce, and gender focal person should facilitate open and frank discussion of broader gender diversity issues by men and women in health service facilities.

- Design and offer graduate programs that reflects the need for women health managers, subjects that deals with gender-related programs, and provide special training programs on career planning and opportunities for women health science students' to participate in leadership seminars and in-service leadership training activities. In other words, women health professionals should be provided formal leadership training which will decrease male resentment over women's growing decision-making independence.

- Increase recruitment of women health professionals into management programs. To complement this intention, the affirmative action policies in place should be monitored more seriously, both in the leadership positions and in the activities that prepare women health professionals for leadership roles.

- Mentorship system within the healthcare sector management preparatory program should be established and strengthened. Mentoring can increase women health professionals' confidence and help them stay focused on their career goals.

- There is a need to create networking between women health managers and women health professionals form their own professionals association. In other words, women health professionals need to be allies to each other and develop their own professional network for relationship.

- Women health professionals should be prepared for healthcare leadership positions by providing them with the following job enrichment experiences designed to accelerate their leadership skills and competences:

  o Their inclusion into decision-making activities.

- Their designation as acting healthcare sector leaders.
- Pairing women with men health leaders.
- Providing them activities and duties that involving urgent problems in health service facilities.

7.5 FUTURE RESEARCH

The following research areas are recommended:

- Research on women's biblical interpretations to determine whether they might be influencing their leadership aspirations regardless of level of roles that could result in a more effective and efficient leadership program not only in Southern region but in Ethiopia.
- Research focusing on how much has faith influenced women's aspirations to leadership positions in health system.
- Research focusing on women's unperceived discrimination in healthcare leadership.

7.6 CONTRIBUTIONS OF THE STUDY

The study showed sever under-representation of women in healthcare sector leadership positions in a study setting. The study findings offer opportunity for reducing gender disparity that exists in health care systems management to a minimum. Such knowledge would assist in the planning of the health care systems and this would lead to a notable change in women's representation in healthcare sector leadership positions. The study will benefit; Federal Ministry of Health (FMOH), Regional Health Bureau of Southern Ethiopia, zonal health department, district health offices, and health service facilities to create conducive work environment and supportive policies that will systematically break down barriers to women's aspiration into healthcare leadership positions as well as to conduct gender audit to determine how responsive the intervention is to promoting gender equity. Gender equity guidelines developed in this study can be used to ensure that gender disparities in healthcare sector

leadership positions are reduced to a minimum. Women will hopefully aspire for leadership positions in healthcare and exert themselves as equal competitors with their male counterparts.

7.7 LIMITATIONS OF THE STUDY

Limitations to this study include relatively small sample size in the qualitative strand (n=21), which makes it difficult to draw definitive conclusions and transfer the study findings to other setting in Ethiopian context.

The use of purposive sampling procedure in qualitative approach limit the study and results in selection bias because of lower representation of women health professionals in the relevant roles resulted in significantly fewer women health manager than men being recruited. The researcher was also known to some of the participants and they might have provided responses that they thought will please the researcher.

7.8 CONCLUSION

In order to promote women's leadership positions in the healthcare sector, an understanding of the obstacles faced by women health professionals in Southern Ethiopia, and how they overcame them, is valuable. A number of factors negatively impacting their success and advancement into healthcare sector leadership positions. Support from partners, family members, health systems, co-workers, and the community is crucial, illustrating the importance of achieving gender equity at home as well as at the workplace. Finally, leadership competences and skills as well as professional qualifications are necessary to become healthcare sector leader. The career path of today's women health leaders was forged not only by their own history but also by the social and political context. Therefore; to accelerate progress in advancing women into leadership positions within the health service facilities, the collaboration of a wide range of key stakeholders at various levels including Federal Ministry of Health, Regional health bureau of Southern Ethiopia, district health offices, health service facilities,

co-workers, and the community is required. This is a long- term process that begins with increased access to formal leadership training programs for women health professionals. Gender mainstreaming within health workforce policy to emphasize on combating gender bias at the workplace, promoting role models women health managers and mentoring, providing supportive for woman health leaders, and generating commitment for quotas for women candidates. Strong political will is also required to advance gender equity in the health service facilities. This is an ambitious goal. The benefits, however; are far-reaching.

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ANNEXURES

ANNEXURE A

ETHICAL CLEARANCE
CERTIFICATE

UNISA

university
of southafrica

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

11 October 2017

Dear Getachew Lenko Yiman

Decision: Ethics Approval

Getachew Lenko Yiman

_____

Disparity in healthcare leadership in Southern Ethiopia

Qualification: DPCHS04

_____

HSHDC/722/2017

Getachew Lenko Yiman
Student 6198-349-7

Supervisor: Dr TP Makua
Qualification: D Litt et Phil
Joint Supervisor:

Name:

Proposal:
Gender

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 11 October 2017 to 11 October 2022.

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Executive Dean
College of Human Sciences
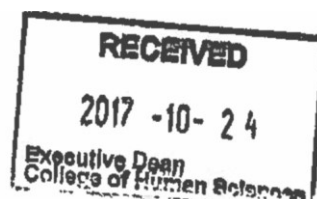
The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 6 September 2017.

The proposed research may now commence with the proviso that:

1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study,

4) [Stipulate any reporting requirements if applicable].

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on al/ forms of communication [e.g. Webmai/, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON

maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC
CHAIRPERSON

molekmm@unisa.ac.za

Prof A Philipps   **DEAN COLLEGE OF HUMAN SCIENCES**

Approval template template 2014

ANNEXURE B

**DATA
COLLECTION
PERMISSION
LETTER
FROM UNISA**

UNISA | university of south africa

Department of Health Studies
Tel: +27 124296754
Fax: +27 124296688
Email: makuatp@unisa.ac.za
Address: TvW 7-182

TO WHOM IT MAY CONCERN

RE: GETACHEW LENKO YIMAM, STUDENT NUMBER: 61983497

The abovementioned student is registered in accordance with the requirements for the

degree of **Doctor of Literature and Philosophy** at the University of South Africa.

To meet the requirements for the above qualification, **GETACHEW LENKO YIMAM**

student number: **61983497**, is to collect data in the government health facilities for the

study entitled: **gender disparity in healthcare leadership in southern Ethiopia.**

It would be appreciated if the student could be given permission to meet the study
requirements for the completion of this project.
Data collection will be within the period specified and agreed upon between the student
and the data collection site managers.

Yours sincerely

Prof Thuledi Makua
Department of Health Studies

PERMISSION REQUESTED TO REGIONAL HEALTH BUREAU TO CONDUCT

ANNEXURE C   **THE STUDY**

Department of Public Health

Dilla University

Dilla, Ethiopia

Southern Region Health Bureau

Hawassa, Ethiopia

5 May 2017

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH

I, Getachew Lenko, student number 61983497 is a Doctoral student registered in the department of health studies at the University of South Africa (UNISA) seek permission to collect data in health sectors and health facilities managed by Regional Health Bureau. The title of the study is **''Gender Disparity in Healthcare Leadership in Southern Ethiopia''**

Attached is supporting letter from my supervisor at UNISA, Ethical Clearance Certificate from UNISA, and protocol for the study.

I am looking forward to your response

Yours faithfully

....   2

Getachew Lenko

PERMISSION REQUESTED TO HEALTH RESEARCH AND TECHNOLGY
ANNEXURE D **TRANSFER OFFICE**

Dilla University

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Research & Dissemination Dir/Office

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ሀዋሳ

ጉዳዩ:- ትብብር ስለመጠየቅ ይሆናል

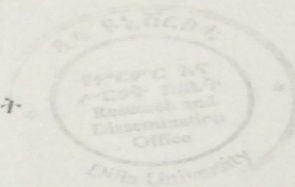በUNISA የPhD ተማሪ የሆኑት የዩኒቨርሲቲያችን መምህር ጌታቸው ሌንቆ ይማም በደቡብ ክልል ጤና ቢሮ ሥር በሚገኙት የጤና ተቋማት "Gender Disparity in Healthcare Leadership" በሚል ርዕስ ምርምር ያደረጉ ስለሆነ ጥናቱ ትኩረት የሚያደርገውም በሆነ ጤና መምሪያዎች፣በወረዳ ጤና ጽ/ቤቶች፣በሆስፒታሎችና ጤና አጠባበቅ ጣቢያዎች እንደመሆኑ መጠን ይህ ጥናት ከግብ እንዲደርስ የጤና ተቋማት አስፈላጊውን መረጃ በመስጠት እንድትተባበሩን የትብብር ደብዳቤ እንዲያፍላቸው ስንል በአክብሮት እንጠይቃለን፡፡

ግልባጭ፣

➤ ለምርምርና ስርፀት ዳይሬክተሬት ጽ/ቤት

➤ ለመምህር ጌታቸው ሌንቆ ይማም

ጸ/ዩ፣

ከሰላምታ ጋር

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South Nations Nationalities and People's Regional
State Health Bureau

ቁጥር _በ.37·186/23368_
Ref. No
ቀን _16/09/ 2011_
Date

ለ ጌዲኦ ዞን ጤና መምሪያ :- _ዲላ_

ለ ሲዳማ ዞን ጤና መምሪያ :- _ሐዋሳ_

ጉዳዩ :- ለጥናት ስለሚደረግ ትብብር ይሆናል

ከላይ በርእሱ ለመጥቀስ እንደተሞከረው በUNISA የ PhD ተማሪ የሆኑት መምህር
ጌታቸው ሌንቆ ይማም በደቡብ ክልል ጤና ቢሮ ሥር በሚገኙት የጤና ተቋማት "Gender
Disparty in Healthcare Leadership" በሚል ርዕስ ጥናታቸውን እያደረጉ ስለሆነ የጥናት ይዘት
ለአካባቢው አስፈላጊ ስለሆነ በእናተ በኩል አስፈላጊውን ትብብር እንድታደርጉላቸው
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እንድም እናት በወሊ.ድ ምክንያት መሞት የለባትም!

እመቢ.ት መስጋን
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ደጋፊ የሥራ ሂደት ባለቤት
Health research and technolgy
transfer support process owner

ግልባጭ:-
ለጤና ምርምርና ቴክኖሎጅ ሽግግር ስራ ሂደት
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Fax ✆

20-57-92
20-59-55
20-54-09
12-44-85

E-mail

snnpdhl@telecom.net.et
snnpdpd@telecom.net.et
snnprhiv@telecom.net.et

Code 251-0462

t.t

Sidaamu Zoone gashshootira Fayyimmate Biddishsha
በሲዳማ ዞን አስተዳደር የጤና መምሪያ

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Daalle Woradi Fa/Aga/B/Mine **Hirgaalame**
A/W/ Woradi Fa/Aga/B/Mine **Wondo**
Hulate Woradi Fa/Aga/B/Mine **H/Salaame**
W/G/Woradi Fa/Aga/B/Mine **Cuukko**
Ha/G/ Woradi Fa/Aga/B/Mine **Doore**
Daarrate Woradi Fa/Aga/B/Mine **Qawaado**
Ala/Cuu/Woradi Fa/Aga/B/Mine **A/Cuukko**
Borrichu Woradi Fa/Aga/B/Mine **Yirba**
Shabbadiini Woradi Fa/Aga/B/Mine **Lakko**
Lakkote Qu/ Fa/Aga/B/Mine **Lakko**
Ala/W/Qu/ Fa/Aga/B/Mine **Wondo**
Hirga//Qu/ Fa/Aga/B/Mine **Hirgaalame**
Ala/Cu/Qu/Fa/Aga/B/Mine **A/Cuukko**
Wo/Ga/Qu/ Fa/Aga/B/Mine **Cuukko**
Hirgaalamete Xaphoomu Hospittaalera **Hirgaalame**

Hajo:- **Xiinxallote Irko la'anno.**

Aleenni eote aana qummi assinoonninte UNISA yinanni rosu uurrinshara PhD roso ha'runsanni noohu kalaa Geetaacho Leenqo Yimaamihu Wodiidi Qoqqowi hundaanni noo fayyimmate uurrinshubba giddo "Gender Disparty in Health care Leadership" yinanni xiinxallote uminni xiinxallo ha'risanni noohura hasiissanno irko assinannisi gede yite W/D/D/Q/M/Fa/ Biiro **T/K የወ.37-186/23368 barra 16/04/2011** borreessitino borronni xawissinonkehura ki'ne widoonni hasiissanno irko assitinansara egensiinseemmo.

Mitte Amano ilate korkaatinni reya dinose!

Affino

➤ Fayyimmate Biddishshi sooreessira
➤ Fa/La/M/M/Ga Loosu harinshora
Hawaasa

Abilillu Yohannis Oge
Fa/L/Mi/Ga/Lo/Ha'rinsho
Qineessancho

Bilbila
ስልክ
046-220 6337
046-2200268
046-2212945
046-2212946

ፋክስ- 0462204723
ፖስታ- 51

በደቡብ ብ/ብ/ሕ/ክለ/መንግሥት
የሀዋሳ ከተማ አስተዳደር ጤና መምሪያ
S/N/N/P/R/S
Hawassa City Administration
DateHealth Department

ቁጥር _አክክክm4/2156/70_
Ref.No _17 / 04 2011_
ቀን _____

ለአዳሬ አጠቃላይ ሆስፒታል
ለሚሊኒየም ጤ/አ/ጣቢያ
ለአላሙራ ጤ/አ/ጣቢያ
ለአዳሬ ጤ/አ/ጣቢያ
ለጥልቴ ጤ/አ/ጣቢያ
ሀዋሳ!

ጉዳዩ:- የድጋፍ ደብዳቤ ስለመስት ይሆናል::

እቶ ጌታቸው ሊንቆ ይማም በደቡብ አፍሪካ ዩኒቨርስቲ የፒ.ኤች.ዲ. ተማሪ ሲሆኑ የመመረቂያ ጹ-ሀ-ፉ-ቸውን
"Gender Disparity in Healthcare Leadership in Southern Ethiopia" በሚል ርዕስ ጥናት ለመስራት
በዝግጅት ላይ ይገኛሉ:: ስለሆነም በእናንተ በኩል ለጥናታቸው አስፈላጊዉ❀ መረጃ እና እገዛ እንዲደረግላቸዉ
እናሳስባለን::

አንድም እናት መሽዓ́́ክል(በሚ.ቻል የወለ.ድ ችግር ምክንያት መሞት የለባት!!

ግልባጭ!

❖ ለመምሪያችን ሃላፊ/ጽ/ቤት

❖ ለልማት እቅድና ኢኮኖሚ አስተዳደር የሥራ ሂደት

❖ እቶ ጌታቸው ሊንቆ ይማም

ሀዋሳ

☎ 0462214761/ 0462214123/   🖷 0462204721   ✉ 2   ሀዋሳ ኢትዮጵያ

INFORMED CONSENT FORM

ANNEXURE H

Informed consent form

QUALITATIVE STRAND

My name is Getachew Lenko, and I thank you for agreeing to participate in this study. The purpose of this study is to develop gender-based theory that would motivate females to take-up healthcare leadership. I have requested you to participate in this study because I believe that you can provide valuable information on this matter. I therefore urge you to answer the following questions to the best of your knowledge.

This study is important because it will assist us to get a better understanding of gender disparity in healthcare leadership in South Ethiopia. The expected benefits include increasing women's concern and awareness of the critical role gender plays in health system, informing health ministries and institutions to create a supportive environment and supportive policies that will systematically break down barriers to women moving up into healthcare leadership position as well as to conduct a gender audit to determine how responsive the intervention is to promoting gender equity.

However, you may experience some discomfort during the interview. If that happens, please let me know and if needs be, that we discontinue with the interview.

The interview will be recorded using audio-recorder and this is to ensure that the researcher captures what you say accurately. Because your name is not captured, what you say will not be linked to you. All the information will be kept in a locked cupboard and will only be used for research purpose.

This study and its procedures have been approved by the Research and Ethics Committee of the University of South Africa and health research and technology transfer work process of the Regional Health Bureau in Hawassa.

If you agree to participate, you will be required to participate in interview which will take approximately 1 hour to 30 minutes.

If you have any questions about the study or about participating in the study, please feel free to ask me now. If you have questions after completing the questionnaire, you can call me at +251912021475.

I understand that my participation is voluntary and that I may refuse to participate or withdraw my consent and stop taking part at any time without penalty. I understand the risks/benefits associated with this study and I was given an opportunity to ask questions. I therefore freely consent to take part in this research project.

Signature of participant _____   Date_____

_____
It is my opinion that the participant understands the nature of the study, as well as related risks and benefits.

Signature of Investigator_____   Date _____

CONFIDENTIALITY AGREEMENT FORM

ANNEXURE I

Confidentiality Agreement Form

I .... having agreed to participate in the study entitled **"Gender disparity in healthcare leadership in Southern Ethiopia"** hereby pledge not to divulge any information related to this study including other participants who took part in this study. I will apply the ethical principles of confidentiality on all information that I might know.

DATE ....   SIGNATURE..

DATE...............................   RESEARCHER'S SIGNATURE...............

STRUCTURED QUESTONNAIRE FOR QUANTITATIVE STUDY

ANNEXURE J

Quantitative data collection tool on **''Gender Disparity in Healthcare Leadership in South Ethiopia''**

Purpose: To develop guidelines for reducing gender disparities in healthcare leadership in healthcare sectors.

Code Number: _____

Introduction: <u>Please circle your appropriate choice</u>

Part one: <u>Socio-Demographic Characteristics of the Study Participants</u>

1. Age in a year? _____
2. Gender.   Male   [1]   Female   [2]
3. Your marital status

   Single   [1]   Divorced   [3]

   Married   [2]   Widowed   [4]

4. Your level of education

   Diploma   [1]

   Bsc degree   [2]

   Masters' degree   [3]

5. Your professional qualification

   Nursing   [1]   Pharmacy professional   [4]

   Midwifery   [2]   Medical laboratory professional   [5]

   Public Health   [3]   General Medical Practitioner   [6]

   Other, please specify_____[7]

6. Health sector organization you are currently working in.

    Health Centre   [1]

    Primary Hospital   [2]

    General Hospital   [3]

7. Employment status

    Full-time   [1]   Part-time   [2]

8. Your monthly personal income in ETB _____

9. Your work experience in year's _____

10. Your position in your health service facility

    Chief Executive Officer /CEO   [1]

    Medical Director   [2]

    Emergency Department Head   [3]

    Out Patient Department Head   [4]

    Surgical Department Head   [5]

    Internal Medicine Department Head [6]

    Paediatrics Department Head   [7]

    Obstetrics & Gynaecology Dep't Head [8]

    Maternal & Child Health Dep't Head [9]

    Other, please specify_____ [10]

11. Your role in your health service facility

    Hospital board member   [1]   Senior management team   [3]

    Health centre board member   [2]   I do not have any role   [4]

12. Have you ever received any formal leadership training?

    Yes   [1]   No   [2]

Introduction: Please circle your appropriate choice

Part two:- <u>Questions related to gender integration framework dimensions</u>

1. Has there been an increase in the representation of women in healthcare leadership positions in the past few years?

      1. Yes   2. Not at all

2. Are gender equity goals and objectives included in strategic planning for organizational activities?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

3. Is there a need assessment, and analysis of gender roles and responsibilities in the health service organization?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

4. Does your health service facility have a written guideline that affirms commitment to gender equity?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

5. Are there proactive strategies implemented to promote women into senior health management positions?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

6. Are gender issues taken seriously and discussed openly by men and women in your health service facility?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

7. Men in your health service facility tend to dominate during staff meeting.

[1] Strongly disagree

[2] Disagree

[3] No opinion

[4] Agree

[5] Strongly agree

8. Do men and women in your health service facility differ in their views of gender issues?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

9. My health service facility is currently doing much more to institutionalize gender equity.

[1] Strongly disagree

[2] Disagree

[3] No opinion

[4] Agree

[5] Strongly agree

10. Do staffs in your health service facility think that gender equity fits into the organizational vision?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

11. Is gender awareness included in all job descriptions?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

12. Is gender awareness included in Performance Based Evaluation criteria?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

13. Is the impact of gender inequality in organizational performance monitored and evaluated?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

14. Is gender disaggregated data of your health service facility collected and analyzed for healthcare leadership position?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

15. Is there a department or division responsible for gender issue in your health service facility?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

16. Is there assigned responsible staff in your health service facility for gender integration in different departments?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

17. Is there a staff training program on gender planning and analysis?

[1] Not at all

[2] To a limited extent

[3] To a moderate extent

[4] To a great extent

[5] To the fullest extent

[6] Do not know

18. Gender diversity has positive impact on health facilities' performance & long-term improvement.

[1] Strongly disagree

[2] Disagree

[3] No opinion

[4] Agree

[5] Strongly agree

Part three: <u>Please tell me your view on gender related questions</u>

1. In your health facility, what are the characteristics of an ideal worker?

_____

_____

_____

2. Please describe any challenges you have experienced regarding gender inequality in your health service facility.

_____

_____

_____

3. What do you think your health facility should do to take action on gender integration?

_____

_____

_____

SEMI-STRUCTIRED INTERVIEW GUIDE FOR QUALITATIVE STUDY

ANNEXURE K

QUALITATIVE DATA COLLECTION TOOL ON ''GENDER DISPARITY IN HEALTHCARE LEADERSHIP IN SOUTH ETHIOPIA''

Introduction: <u>Please circle your appropriate choice</u>

Code Number: _____

PART ONE: <u>SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS.</u>

1. Your age in a year _____

2. Gender. Male [1]   Female.   [2]

3. Your marital status.

   Single   [1]   Divorced   [3]

   Married   [2]   .   Widowed   [4]

4. Your level of education

   Diploma   [1]

   Bsc degree   [2]

   Masters' degree   [3]

5. Your professional qualification

   Nursing   [1]

   Midwifery   [2]

   Public Health Officer   [3]

   Pharmacy   [4]

   Medical Laboratory Technologist   [5]

   Other, please specify_____   [6]

6. Health sector organization you are currently working in.

   Zonal Health Department   [1]

   District Health Office   [2]

   Town Health Office   [3]

7. Your monthly personal income in ETB _____

8. Your work experience in year _____

9. Your position in your health service facility

   Zonal Health Department Head   [1]

   District Health Office Head   [2]

   Disease Prevention & Health Promotion coordinator [3]

Medical Service Core Process   [4]

Public Health Emergency Core Process   [5]

Multi-sectoral & HIV Prevention & Control Core Process   [6]

Maternal & Child Health & Nutrition Coordinator   [7]

Health Development Plan Support Process   [8]

Gender Support Process   [9]

Other, please specify_____ [10]

10. Your role in your health service facility

Hospital board member   [1]

Health center board member   [2]

Senior management member   [3]

I do not have any role   [4]

11. Have you ever received any formal leadership training?

Yes   [1]   No   [2]

THE FOLLOWING QUESTIONS ARE ABOUT YOUR EXPERIENCES AND VIEWS REGARDING GENDER DISPARITY IN HEALTHCARE LEADERSHIP.

<div align="center">

PART TWO: <u>GRAND TOUR QUESTION.</u>

</div>

What are your experiences and views regarding gender disparity in healthcare leadership in South Ethiopia? (Probe)

<div align="center">

FOLLOW UP QUESTIONS

</div>

1. Please describe any challenges you have experienced regarding gender inequality in your health service facility

2. Are gender equity goals and objectives included in strategic planning for organizational activities?

3. Is there a need assessment, and analysis of gender roles and responsibilities in the health service organization?

4. Does your health service facility have a written guideline that affirms commitment to gender equity? (Probe)

5. Are there proactive strategies implemented to promote women into senior health management positions?

6. Do men and women in your health service facility differ in their views of gender issues? (Probe)

7. My health service facility is currently doing much more to institutionalize gender equity.

8. Is the impact of gender inequality in organizational performance monitored and evaluated? (Probe)

9. Is there a department or division responsible for gender issue in your health service facility? (Probe)

10. Did gender diversity have positive impact on health facilities' performance & long-term improvement? (Probe)

11. Do you have any suggestions for improvement of the gender equity?

Thank you very much!