GENDER STEREOTYPES AND INEQUITIES IN HEALTH CARE LEADERSHIP

PERCEPTIONS AND EXPERIENCES OF SENIOR MANAGERS IN NIGERIA

RESYST RESILIENT & RESPONSIVE HEALTH SYSTEMS

RESEARCH BRIEF | Governance research theme MARCH 2018

Women make up more than 70% of the global health workforce; however, in many countries they are overrepresented in informal, low-status and low-paid 'care' roles and are under-represented in professional categories and in leadership positions. Gender disparity in health care leadership negatively impacts gender equity in the health workforce. If decision-making spaces are dominated by men, the policies and practices that support health and wellbeing of women may be less prioritised[1]. Similarly, the persistent wage gap will continue and the levels of confidence and career progression among women will be affected.

To understand why women are so poorly represented in higher, decision-making categories of the health system, it is important to investigate the role of gender norms, roles and relations in career progression and leadership. Researchers from the Health Policy Research Group have explored this issue by carrying out detailed interviews with both male and female senior healthcare managers in Nigeria, to find out their perceptions and experiences of leadership in relation to gender and other factors.

This brief brings together the key findings from the research. It concludes by sharing an agenda for action to build gender equity in global health leadership, adapted from Dhatt et al (2017)[2].

KEY FINDINGS

Influence of gender on perceptions of leadership

Gender beliefs and stereotypes influenced how men and women were perceived to be as leaders. Women, who were described by men as 'emotional' and 'lacking in focus' were not considered strong leaders or expected to perform as well as men. Male managers, on the other hand, were viewed by women as needing to be in control and unwilling to take orders. In terms of leadership practice, women were considered to be better team players, more tolerant and likely to ask for help in managing difficult situations, whereas male leaders were seen to be more prepared to take direct action.

Despite these views, health care managers did not believe that their gender influenced their own leadership behaviour, or decisions with regards to staff promotion or employment.

"It is the performance that matters, not being female or male". (Female, Nurse)

Marital status and age were also identified as factors that influence how leaders are perceived, with married people considered to be more stable and older people more capable of leadership.

Professional hierarchies and tensions between cadres

Doctors were considered to be best positioned to take on management or leadership roles compared to other health professionals because of the nature of their training, which teaches them to identify and solve problems. Nurse training, on the other hand, was considered to be relatively narrow, focusing on practical aspects of the job rather than management skills. For many, these perceptions endured even when length of years of work experience was taken into consideration.

"If there is a nurse with 20 years of experience, the doctor with 10 years will do better if he applies his mind to it" (Male, Doctor)

Perhaps unsurprisingly, the research revealed tensions between different professions within the health system. Those in professions viewed as higher up the professional hierarchy resented being instructed by managers from lower professions. These tensions pose challenges to health care managers to handle strains between multi-disciplinary staff, and for those who are not doctors, to command respect from their team.

Role of professional, social and political networks

Senior health care managers benefited from developing strong relationships with like-minded professional colleagues in the workplace. Peer support helped to make the daily practice of leadership more enjoyable to managers.

Whilst gender was not considered to be a key factor in determining managers' progression to leadership roles, social and political networks were. For instance, the ability of healthcare managers to build and nurture networks with influential senior colleagues was found to be "rewarding" with regards to career progression and appointment to leadership positions.

CONCLUSION

Nigeria has introduced legislation to support gender equity and promote diversity in leadership through the 2006 National Gender Policy. Despite these efforts, the research suggests that gender biases prevail with regards to perceptions of leadership: stereotypical female attributes, such as emotiveness, are seen to be incongruent with strong leadership, and female managers are less accepted as leaders than men – including by women.

Health systems reflect the wider society in which they operate and across most contexts social structures support and benefit men over women. Despite the health workforce being predominantly women, the unequal distribution of power to men enables the structures that privilege men to reproduce, meaning that women find it harder to progress in their careers and hold leadership positions.

Gender is not the only factor that affects perceptions and experiences of leadership. In Nigeria, it intersects with other factors including age, marital status, and perhaps most importantly professional hierarchies, where there is an assumption that medical doctors are better suited to management roles. These findings are similar to those in other contexts: in Kenya, gendered professional hierarchies are also found to play a role in the appointment of health leaders[2].

A recent publication on the role of gender equity and women's leadership in health system strengthening, co-written by RESYST researchers, sets out an agenda for action to build gender equity in global health leadership. The agenda and corresponding policy implications are relevant to the Nigerian context and should be considered by health policymakers and healthcare organisations.

Box: Agenda for action to build gender equity in global health leadership Adapted from Dhatt et al (2017)

1. Leadership that is gender responsive and institutionalised

- All people working in the health sector should be required to go through a gender-responsive training as part of a core competencies training

2. Development of enabling environments for women's leadership

- Increase thought leadership events related to women's role in global health
- Support leadership development, including management training and soft skills
- Build capacity, including formal training in technical skills, research and mentorship
- Increase flexibility for men and women to accommodate personal, domestic and family obligations
- Cultivate mentorship early in training, with greater investment in mentorship in the mid-career level when women are at greater risk for leaving the talent pipeline.
- Develop networks and create space for women to connect with women in the global health community – locally, nationally and internationally
- Improve policy and practice in terms of the health and safety risks women face

3. Research and data disaggregated and reflexive in terms of sex and gender

- Further research and analysis on the impact of women's leadership
- Further research and analysis of the mid-career drain of women leaders in global health

ABOUT THE BRIEF

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References and related resources

1. J Downs et al. Increasing women in leadership in global health. *Acad Med.* 2014 Aug; 89(8): 1103–1107.
2. R Dhatt et al. The role of women's leadership and gender equity in leadership and health system strengthening. *Global Health, Epidemiology and Genomics* (2017), 2, e8.

- RESYST webpage on gender and leadership resyst.lshtm.ac.uk/gender-and-leadership - information and resources from the research conducted in Nigeria, Kenya and South Africa.
- Women in Global Health www.womeningh.org – an independent movement working with partners at all levels to achieve gender equity within global health leadership in order to achieve overall equity in global health.
- RinGs (Research in Gender and Ethics) resyst.lshtm.ac.uk/rings – initiative that aims to galvanise gender and ethics analysis in health systems research.

This brief has been produced by RESYST and funded by UKAid from the UK Department for International Development. However the views expressed do not necessarily reflect the UK government's official policies.

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