
KENYA STAKEHOLDER ANALYSIS REPORT



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ACRONYMS

APHRC:	African Population and Health Research Center
DEI:	Diversity, Equity, and Inclusion
ICRW:	International Center for Research on Women
INGO:	International Non-Governmental Organizations
KEMRI:	Kenya Medical Research Institute
KEWOPA:	Kenya Women Parliamentary Association
KIIs:	Key Informant Interviews
LMICs:	Low- and Middle-Income Countries
NGO:	Non-Governmental Organizations
RQ:	Research Question
STEM:	Science, Technology, Engineering, and Math
TICAH:	Trust for Indigenous Culture and Health
WGH:	Women in Global Health
WHO:	World Health Organization
WPL:	Women Political Leaders

EXECUTIVE SUMMARY

This report summarizes the findings of a study conducted in Kenya by the International Center for Research on Women (ICRW) in collaboration with WomenLift Health. The study is part of a multicountry effort to document the context, situation, prospects, and challenges of women's leadership in global/public health. Data for the report were gathered through desk reviews of organizations led by women in Kenya, as well as key informant qualitative interviews with women in leadership roles in a variety of influential public health organizations, institutions, and networks, including local and international non-governmental organizations (INGO), universities, private businesses, professional networks, and national health ministries and agencies.

The findings are summarized around three themes: (1) barriers and opportunities related to women's leadership in public/global health; (2) current efforts that foster women's leadership, diversity, and inclusion within organizations; and (3) various ways organizations and the WomenLift Health program can work together.

The most significant barriers to women's leadership identified by the study participants were persistent male-privileging leadership norms, marginalization of minority women, disempowering and non-supportive work environments, stigmatization of women in leadership roles, weak mentorship practices, and a lack of intentionality in supporting women's public/global health leadership. Data also suggest that some Kenyan public health decision-makers prefer to work with foreign health experts, limiting local professionals' leadership experience and skills development.

The institutionalization of work environments and organizational cultures that promote diversity and inclusivity, the creation of strong leadership mentorship and support programs that aid women's career advancement, expansion of on-the-job professional training opportunities, and targeted investments in women's and girls' education—particularly in post-secondary education—were among the recommended strategies to address existing barriers to women's health leadership in Kenya. There was also the reported need to cultivate men as workplace allies for the gender equality in leadership movement.

Efforts to advance women's health leadership in Kenya require a robust strategy for engaging with Kenyan organizations; building on existing national policies and initiatives; collaborating with influential Kenyan organizations as well as strategic political, professional, and other groups; and intentionally creating and targeting the pipeline of future health leaders.

INTRODUCTION

WomenLift Health, through support from the Bill & Melinda Gates Foundation, aims to accelerate the involvement of women in global health leadership by investing in and elevating talented mid-career women to become global health leaders. WomenLift Health believes that it is essential to contribute to transformative institutional and societal change by raising awareness about the value of women's leadership and catalyzing change through a portfolio of scaled interventions.

WomenLift Health implements a portfolio of interventions that reinforce transformative change and that ripple out to reach an increasing number of women and men. One core intervention is the Leadership Journey, which is designed to give talented women leaders the tools, confidence, networks, and understanding of barriers—along with peer, mentor, and coach support—to successfully use their voice, expertise, and leadership skills for health impact.

To inform the expansion of the Leadership Journey, WomenLift Health has partnered with ICRW to undertake a Stakeholder Analysis within East Africa to ensure the inclusion of local voices into its program design. Anchored in the principle of human dignity, ICRW advances gender equity, inclusion, and shared prosperity. ICRW's work uncovers the intersections of vulnerability and inequity that diminish opportunity for women and girls and documents proven solutions to these challenges. ICRW is committed to understanding how gender plays out in multiple areas of social life and interacts with key aspects of a person's identity to shape discrimination, privilege, and access to opportunities.

The findings and recommendations outlined below will be used by WomenLift Health to build a network of partners, identify best practices, and inform key priorities for the upcoming and future cohorts of the Leadership Journey

BACKGROUND

A thriving health sector is the foundation of sustainable economies. To ensure that the sector provides benefits to all, its leaders must understand how care delivery is changing, what reforms and innovations are required, and how to promote access to high-quality, gender-equitable care.¹ Although accounting for an estimated 70 percent of the global health care workforce, women are underrepresented in health leadership positions.² This inequality was recently emphasized by the World Health Organization (WHO), which stated that “women provide global health and men lead it.”^{3,4} Latest data from the World Economic Forum suggest that just 35 percent of the leadership roles in the global health care industry are held by women. In 2019, only 25 percent and 20 percent of global health organizations had gender parity in their senior management and governance boards, respectively.³ In 2020, only 44 women were serving as Ministers of Health worldwide and Women Ministers of Children, Youth, and Families were much less in number.⁵

It is critical to strengthen women's representation in global health leadership. Women dominate the health care consumer market.⁶ Having more health leaders who understand care-seekers' needs, experiences, and perspectives can increase innovation and business opportunities. This is especially important in the emerging global health landscape, where digital technology, such as apps and other e-tools designed and developed primarily by men, is increasingly driving health services delivery and access.⁷ Gender-diverse health leadership teams are also more innovative, more creative in problem-solving, avoid groupthink, and are more responsive to diverse customer needs. When women hold health leadership positions, they prioritize the needs of marginalized groups such as women, children, slum dwellers, and persons with disabilities, and allocate more resources to research on women's health issues, family welfare, gender equality issues, education, and nutrition.⁸

Women's public health leadership in Kenya: current situation, challenges, and opportunities

Progress in women's health leadership in Africa has been far too slow.⁹ The region experiences one of the world's most glaring shortages of women in health leadership roles.^{9,10} While there are more women in health care across

Africa, primarily in nursing and/or midwifery, very few are in positions of leadership—an indication of a women-dominated sector almost entirely controlled by men. Kenya offers an interesting context for exploring women's participation in public health leadership positions. Despite its larger female population and a 2010 Constitution that requires “not more than two-thirds of elective public bodies to be of the same gender,” Kenya's sociopolitical and economic leadership landscape remains male dominated. The country, for example, falls behind most East African countries in terms of female representation in top political leadership positions. Women hold only 7 of the 47 governorships, 23 percent of National Assembly seats, and 31 percent of Senate seats in Kenya. In contrast, women make up 61.25 percent of Rwanda's parliament, 34 percent of Uganda's parliament, 37.4 percent of Tanzania's parliament, 38 percent of Burundi's parliament, and 32.36 percent of South Sudan's parliament.¹¹

According to a recent report by Women in Global Health (WGH), women hold 42 percent of mid-level and 40 percent of top-level leadership positions in Kenya's health sector.¹² However, given that women comprise roughly 70 percent of the country's health workforce, these seemingly impressive figures should be interpreted with caution, as they conceal deep gender disparities in health leadership in the country. Muraya et al.¹³ contend that gendered barriers have a significant impact on Kenyan health workers' career trajectories and health leadership experience. They report that men and women are thought to have distinct leadership styles, and that women's leadership styles are perceived to be reactive and emotive, or overly domineering, whereas men's approaches are perceived to be calmer and more sober. These stereotypes reportedly influence appointments into health leadership positions in the country.

The above-mentioned WGH study further showed that factors operating at multiple levels—individual, household, organizational, and societal—fetter women's participation in health leadership roles. Kenyan women health leaders interviewed in the study reported that patriarchal attitudes, particularly those of their spouses, and the structure of the health sector inhibited them from advancing in their careers. Women were prevented from applying for or accepting leadership roles by family obligations and expectations, particularly if they do not receive support or encouragement from their immediate family. The Kenyan health sector was also perceived to be organized around policies and rules designed and administered by men. The “motherhood penalty”—various forms of discrimination faced by working mothers and mothers seeking employment—also hampered women's advancement to health leadership positions in Kenya. The penalty also applied to women without children because it was anticipated that they would eventually have children in the future. Overall, the “motherhood penalty” resulted in women being paid less; having stronger expectations to distinguish themselves; having lower perceived professional ability, exposure, and dedication; and having a lower likelihood of being recruited, rehired, and promoted.¹²

Gender-equitable leadership in the health sector is especially important in low- and middle-income countries (LMICs), like Kenya, where health systems face complex challenges such as fragility, resource constraints, and high disease burdens. Batson et al.² point out that women's leadership in health is more than just an issue of equity; it is the missing link that can help countries address some of the health issues they face more effectively. Research suggests that increased female leadership in Kenya's health sector is critical to addressing some of the country's most pressing health issues, such as high maternal and child mortality and a high burden of infectious disease, a lack of accountability in the use of health care resources, neonatal diseases, malaria, tuberculosis, and HIV.^{14,15}

Recent data indicate that Kenya is making progress in addressing issues such as high fertility, low contraceptive prevalence, mortality under five years of age, low vaccination uptake, and limited access to skilled antenatal care. Stronger and more sustained women's participation in health leadership in Kenya can consolidate and expand these gains. Kenya, like many other African countries, has a fairly strong pipeline of women in health leadership: junior doctors, nurses, pharmacists, medical technicians, dentists, etc. Leveraging the leadership potential, talents, wealth of experience, and skills of this upcoming generation of health professionals is key tackling the country's current and future health challenges. However, without a concerted effort to identify and eliminate the many obstacles that stand in the way of women's health leadership in Kenya, the opportunities for change, presented by gender-equitable health leadership, will continue to elude the country. The current research focuses, inter alia, on the barriers, prospects, and efforts to promote women's health leadership in Kenya, as well as the opportunities for collaboration and partnerships in such efforts.

STUDY DESIGN

WomenLift Health, through ICRW, conducted the Stakeholder Analysis for Kenya, Rwanda, and Uganda. The objectives of the Stakeholder Analysis were to:

- Conduct a desk review and analysis of existing data on women's representation in the Kenya, Rwanda, and Uganda public health sectors.
- Identify and establish relationships with the individuals and organizations that are influential in the public/global health space in Kenya, Rwanda, and Uganda.
- Draw upon their collective experiences to identify barriers and opportunities around women's leadership in public/global health to address in the program design.
- Understand current efforts to foster women's leadership, diversity, and inclusion within organizations.
- Understand various ways organizations and the WomenLift Health program may work together.

In the current study, we focused primarily on the last three research questions (RQs), namely:



RQ1: What are the barriers and opportunities around women's leadership in public/global health to address in the program design?



RQ2: What are current efforts that foster women's leadership, diversity, and inclusion within organizations?



RQ3: What are the various ways organizations and the WomenLift Health program may work together?

METHODOLOGY

Landscape Analysis

To identify influential health organizations in Kenya for the study, the study team compiled a comprehensive list of organizations by the eight identified sectors: INGO, local NGOs, university, networks, multilateral, private sector, philanthropy, and government. The team used personal networks, as well as a review of pertinent literature and an Internet search of health-focused organizations and institutions, technical working committees, and civil society groups. Additional contacts of relevant organizations, governmental institutions, and professional associations were sought through careful searches of relevant government websites and consultations with a few well-known women health professionals. From a longer list, the study team, along with WomenLift Health, worked to prioritize based on balance across the sectors, level of influence, and diversity in stakeholder participation. From the prioritized list, qualifying leaders from the identified organizations or institutions were contacted to inform them of the work of WomenLift Health and the study, and to ask for their participation. If they were not able to participate, the study team asked for an alternative contact within the organization. For organizations who declined, the team replaced them with the next organization on the prioritized list in the same sector to meet the overall sample target. A total of 17 organizations participated in the interviews.

ANALYSIS

Key Informant Interviews (KIIs)

Participants in the study were mostly women in executive or senior public/global health leadership roles in Kenya-based organizations identified through mapping activities. However, men were also included in the process. KIIs with the participants sought information on barriers and opportunities related to women’s leadership in public health, current efforts to foster women’s leadership, diversity and inclusion within organizations, and various ways organizations and the WomenLift Health program can work together.

Interviews were typically one hour long, audio recorded, and transcribed. ATLAS ti was used to thematically code transcribed interviews. Data analysis focused

on examining narratives and responses related to the themes of current organizational investments in women’s leadership, how these investments affect the work environment of women leaders, and opportunities for strengthening WomenLift Health gender equality in public health leadership efforts. In the analysis, direct quotes are used to illustrate topical issues.

Participants	
Sector	Interviews Conducted
INGOs	5
NGOs	4
Government/Public	2
University	2
Private	1
Philanthropy	1
Networks	2
Totals	17

LIMITATIONS

While this study provides valuable early insights into the barriers and opportunities around women’s leadership in the public health sector, there are some limitations to consider. First, the study relies on interviews with a few leaders in predefined, influential, health-focused organizations in Kenya, which may limit the generalizability of the findings. It is not unlikely that the perspectives and experiences of these leaders will differ from those of leaders in less influential organizations. Second, some of Kenya’s most influential female public health leaders were unable to participate in the study. These senior health leaders’ perspectives could potentially deepen understanding of the issues addressed in the research. Third, the study only focused on senior health leaders. Although research exists on the insights and perspectives of the upcoming generation of Kenya’s female health leaders on these issues, that evidence has not been integrated in this report to give more nuance to the findings.

Overall, while this study provides valuable insights into the barriers and opportunities around women’s leadership in public/global health in Kenya, the above limitations should be considered when interpreting the findings.

FINDINGS



RQ1: What are the barriers and opportunities around women's leadership in public/global health to address in the program design?

The interviews yielded a wealth of information on the obstacles to women's leadership in public health in Kenya. While interviewees generally agreed that Kenyan women have attained or are in key leadership positions in public health, they also acknowledged that women's health leadership faces hurdles. Taken together, the identified key barriers included **male-privileging leadership norms, the marginalization of minority Kenyan women, disempowering and non-supportive work environments, lack of intentional strategies for supporting women's public/global leadership, lack of role models, and a weak pipeline of highly educated women.**

Regarding male-privileging leadership norms, the study participants agreed that, while women's leadership was gradually gaining momentum in Kenya, it was neither respected nor prioritized. Narratives suggested that the dominant cultural ideas and attitudes in Kenya construct leadership as a male domain, and male leadership as the norm. These notions were reported to deter women from being in positions of leadership, dissuade them from applying for leadership positions, and/or prevent them from having confidence in their ability to lead.

In her research published in 2016, Anaya¹⁶ argued that politics and leadership in Kenya have historically been shaped by paternalism and patronage, constituted in terms of the concept of *Bwana Kubwa* (or the Big Male Boss), and generally presented as “dirty games” engaged in by the strongest and most roguish of men. In the current study, we elicited narratives that emphasized how local beliefs about leadership in Kenya have reinforced transactional or exchange-based models of leadership and supported appointment and nomination practices in which qualities such as strength, fearlessness, risk-taking, secrecy, courage, independence, hardiness, being aggressive, emotional indifference, toughness, and assertiveness are regarded as desirable and endorsed by boards, managements, and persons in power.¹⁶ Many respondents stated that because women are not generally regarded as embodying these attributes, they are easily overlooked for critical leadership posts. To one respondent, “Kenyan society has created a narrative about women being vice or secretary to men. On many boards, if the chair is a man, the highest-ranking woman will be the vice and/or secretary, and the treasurer will be a man. Women have, sort of, grown up within that standard, that their curated positions are vice chairs or secretaries...” (Woman, INGO).

The continuing masculinization of political leadership in Kenya was identified as a disincentive to women seeking positions of leadership. Respondents linked it to the abuse and humiliation of, and violence against, women seeking or in leadership roles, stating that Kenyan women seeking leadership roles frequently do so at the risk of their marriages, reputations, dignity, and vocations. Campaigns of slander are easily launched against politically ambitious women, sometimes focusing on their personal lives, sexuality, and relationships. Respondents agreed that it was not uncommon for nude or other compromising images of female leaders/aspiring female leaders to be circulated to silence them. One respondent explained how Kenya's hostile leadership culture discourages female leadership by mentioning how she recently had to prevent another woman from competing for a position as a member of parliament:

I told her it was a dirty game. I know her, and she works well in the medical field. But by the time she realizes her dream, she will be destroyed. I gave her the example of one prominent mama...but who is now in obscurity because she was used and dumped by male politicians (Woman, public sector).

According to another respondent:

There is a lot of, I would say, politics as well, in positions of leadership. I mean, as a woman, you can get very far and if you're lucky, you can get to the topmost. But there's a lot of politics around certain positions, especially where the position will have a lot of power and resources and needs endorsement by a board or, you know, nomination by the powers that be. There is always politics around that, and they will say that is not a position for a woman. You need a man there (Woman, health network).

Respondents noted that male-privileging leadership norms also stifle women's health leadership in Kenya by encouraging women to see themselves as inferior to their male counterparts and to prioritize marriage, household, family, and gender roles over professional growth and advancement, all of which hinder women's advancement and future leadership prospects. For example, respondents noted that when spouses move for work-related reasons, wives are obligated to relocate with them, sacrificing their own career objectives. Marriage also typically leads to pregnancy, which further impedes women's career advancement. Women professionals miss out on training, practice, and other opportunities as they deal with these demands and pressures, causing them to lag behind their male counterparts in terms of skills, experience, and networks. Indifferent male headship and authority at home was also reportedly making it harder for women to balance their multiple commitments and tasks. One respondent explained:

Jobs in leadership may also require being away from families in most cases. In most of Africa, including Kenya, men do not want to take up responsibilities that are supposed to be women's responsibilities to allow the women to get out. One of the heavy tasks for married women really, is that you have a family to take care of and you have children. But if you chose to take on a task that takes you out of the home, this man feels like you have abandoned your duties. If you're going to take a position of leadership, one of the things you really must do is count the cost. If you have a family, especially a young family, it may hold you back from going for that position, until your children are at such an age where, you know, you can be free to go out (Woman, professional network).

It was also observed that:

I will start with travel. A lot of time it's been associated with culture and the responsibilities of a woman. When you have a senior role, and you need to travel a lot, then you think of who is taking care of your children, you are neglecting your responsibility of being a mother and taking care of your family. So, because of this you find women shying away from leadership positions (Woman, public health sector).

And yet another vivid viewpoint:

I have a colleague when she goes out, the husband would not eat food from the maid. So, she must go to the kitchen, make, and bring food no matter how late she gets home. So, the expectation is quite a lot especially with men who don't really appreciate women or support women in these managerial jobs (Woman, academia).

Interview data further suggested that, owing largely to patriarchal norms, women in Kenya who aspire to leadership positions must seek or obtain the permission or approval of their husbands or other powerful men of authority. Reportedly, men sometimes deny wives or such women this approval, forcing them to forego leadership opportunities. Also, married women may steer clear of leadership roles to avoid conflict with their husbands

or to evade social stigma. A prevalent perception in Kenya, according to the respondents, is that women are nominated for or advance to high leadership positions by having sex with men. They observed that this belief deters women from seeking leadership positions and undermines the women's confidence once they hold the positions. Commenting on the potential effect of men's marital authority on women's aspirations for leadership, one respondent noted:

Especially when you are a married woman, you don't want to appear to be competing with or growing above your spouse. You will be seen as a feminist or given the label of someone who does not listen to her husband or is not able to stay in marriage. This is also a barrier that has contributed to women not rising to take leadership positions (Woman, academia).

In terms of perceptions of sexual impropriety among female leaders, we learned that:

Another thing is that most women leaders have been stigmatized, which tends to make women shy away from taking leadership roles. When a woman gets into a senior-level position, she is all the time associated with having slept her way up. Women are not appreciated as people who have gone to school or achieved anything by themselves. It is always believed that someone necessarily holds their hand or that someone you have slept with gave you the position (Woman, health professional network).

The **work environment** in many Kenyan organizations and institutions was another commonly reported impediment to female leadership. Workplaces were said to affect women's leadership in a variety of ways. For instance, it was mentioned that women of specific ethnicities, religious groups, and regions of the country are regularly overlooked for leadership positions, even when they are very qualified. As one interviewee noted: "I come from a marginalized community. Many positions are designated for members of the majority groups. So, even if no qualified women from the dominant ethnic groups are available for such posts, they prefer to fill them with men. The neglect of women from underprivileged or vulnerable areas is part of the problem" (Woman, NGO).

Several respondents also noted that some public health-focused workplaces in the country were still conservative, hierarchical, or controlled by men and women with traditional leadership attitudes, who were opposed to new ideas, or who were resistant to workplace gender equality. Pregnant women were reported to be regularly overlooked for promotion and refused leadership responsibilities in some public health institutions. There were also reports of women professionals being harshly ridiculed, stigmatized, and subjected to violence and harassment for speaking out about unacceptable working practices in some organizations. One respondent suggested that it was not uncommon in Kenya for women to be singled out for punishment in some workplaces merely because they advocate for gender equality. She notes, "They look at you all the time like, *wewe ndio unatetea wanawake* (you are the one talking about women's rights). They regard you as a bad employee. It's almost as though you're going against society. Nobody will ever consider you for leadership positions in that type of environment" (Woman leader, private sector). Elaborating further on how the hierarchical nature of the health sector classifies professions based on their importance and stifles women's leadership potential, an interviewee also noted:

And, somehow it has ended up that those which are perceived as least important are the ones which are dominated by women. And those which are perceived as very important are dominated by men. And so even within a small microenvironment, if it's a reward, or if it's a hospital, or whether it's a health center, there's already some hierarchy, which is embedded in the way professions within health are perceived. And so, it's very hard if you're in a profession, which is perceived as less than to emerge and take up a leadership role. You know, whether it is in the health facility, whether it's in ministry, so there's that if you look at nursing as a profession, nursing is

seen as less than medicine. By the time you come out of nursing, the training itself, the environment, where you train already shows you that you are like only third tier, or second tier, you're not the leader (Woman, NGO).

Some Kenyan public health organizations' policies, operations, and work schedules were also recognized as hurdles to women in leadership positions because they were not gender conscious and supportive of work–life balance for women. Few organizations reportedly take women's family care responsibilities seriously, protect them effectively from sexual harassment and sexism, provide childcare assistance to working women who travel, ensure the safety of women who must work at risky times, or consider women's security needs in unfamiliar settings. Noting that most public health workplaces ignore issues of work–life balance among women professionals, one interviewee noted:

Just out of my own experience in working in this field and in some organizations, I think the balance the work–life is the trickiest bit that organizations ignore. Organizations don't support women well. In fact, they often add to your crisis as a professional. The organization can say if you want promotion, then you need to have your master's degree or you need to take up that job position in Nairobi, but you live out of Nairobi and your families stay in Kisumu. Or you have kids, and you cannot even manage a masters' program right away. So, women may not advance in that trajectory as quickly as men...These organizational demands don't give a woman the space to self-actualize; we don't advance quickly because organizations don't even help you to balance your life, they are always adding pressure on you (Woman, INGO).

Another respondent noted:

The other one I think is clear is that for women compared to men, many company policies are unfair to women or do not protect them...Also, some leadership positions are very demanding in terms of the workload, the demands, the travels, and even just the location. Whereas men can simply make the decision to take a bag and go and take up a position in some parts of Kenya or outside, it's not easy, it's very difficult for women. Women must put so many things in order at home before taking up travel. Women lose out of many opportunities because workplace activities and processes do not suit them (Woman, public sector).

Although it did not emerge as a prevalent narrative topic in the study, a few respondents indicated a belief among Kenyan public officials and decision-makers those local professionals, particularly women, lacked the abilities needed to lead significant public institutions. Participants who reported this belief described it as a key barrier to women's public health leadership in Kenya, stating that government officials frequently choose to work with foreign expertise, limiting the opportunities for Kenyan women health professionals to hold leadership positions. One respondent described the situation in terms of the “colonial workplace mentality”:

This happens a lot in the public sector from my experience as a young woman leader when I worked in a technical advisory role in government. I think there is a lot of the colonial mindset in the public health sector space. What this means is that young leaders and especially young African women who are technical advisors to government are looked down on. I think they always expect an elderly white male. And that already in itself is a barrier because from how they receive you, you can already tell they are doubting your capacity. They already have some misconceptions about you...The barriers are there (Woman, INGO).

There were also mentions of the **lack of intentionality on the part of several organizations to develop women's leadership skills** in public and global health. According to several respondents, many health organizations and institutions in Kenya lack deliberate and well-thought-out plans for developing women leaders. Several current female health leaders were also viewed as less-than-exemplary mentors who have neglected to guide the next generation of leaders. The lack of intentionality in existing mentorship programs reportedly undermines the clarity of the goal and purpose of leadership development efforts, resulting in the loss of key talents, as well as the inability to measure the success of initiatives, account for failures, and correct course. As one interviewee noted:

The challenge I have given to women is to be very intentional to mentor and hold the hands of younger ones and raise other women. Everybody in these public health leadership positions should have a mentorship mentality and that's leadership. That's a paradigm shift that's really needed in our public health institutions and sector. They need to show the way by being intentional mentors. There is just a lack of intentional mentorship. This for me is the biggest undoing that we have in the public health sector and perhaps maybe across board. We should think about the ecosystem and become very intentional about mentorship (Woman, philanthropy).

She further observed:

And this I speak in terms of being young and encountering older women. Instead of holding your hand, they sort of see you as a threat and create those barriers that you really must work hard to overcome. So, I think there is also the need for a paradigm shift among women themselves in the public health care space. We really need to hold other young women up to the top. If we don't change our mindset as women, if we don't empower our very own, we will keep this vicious cycle going. It's very hard to really change social construct I believe.

Speaking about her personal experience, the same respondent added:

I have faced this...I have had to deal with insecure female leaders above me, that did not appreciate that the strength that I have is meant to make them look good and meant to make them and the work better, that I was part of a team. I can't go to this person to say look, this is what I'm facing, how do I deal with it? Instead, I find someone that is ready to bash me and to put me in my place. And so that's my personal experience.

Even where women's leadership development and mentorship initiatives exist, some respondents noted that lacked rigor and often failed to provide women with some of the critical skills and knowledge needed to succeed in leadership in highly politicized contexts. One participant noted:

I think that there are women that are ready (for leadership roles). But the training and mentorship they often get do not prepare them for those positions up there. You know the training that helps you know how to manage the politics of the day; I think that is something that has not happened well (Woman, academia).

The lack of **an adequate pipeline of future female leaders** was another highlighted barrier to women's health leadership in Kenya. The weak pipeline of future female leaders was blamed on several factors, including gender disparities in educational access, women's substantial caregiving responsibilities, marriage, and poverty. Respondents highlighted that these circumstances deny many Kenyan girls and women access to education, resulting in a shortage of highly educated women

in science, medicine, and management. These factors also deny women of high-level skills and experiences that would otherwise ready them for top leadership roles in the health sector. In the apt words of an interviewee:

Women face the challenges of getting equal access to education. I mean, traditionally, we've had an issue where, you know, if you look at the levels of education, you'll find that women are lagging behind in secondary and post-secondary education. Some girls, you know, fall prey to early pregnancies and then begin their families early. Many others do not go beyond secondary school. Others do not make it into science courses, so they don't get the kind of education they would need, you know, to get some positions (Woman, NGO).

The lack of sufficient female role models in health care was also identified as a barrier to female leadership in the sector. According to interview data, Kenya lacks adequate numbers of relatable women in health leadership roles, which deprives girls and aspiring female leaders of the opportunity to learn about the breadth and variety of roles available in the health sector, limiting their awareness of the possibilities for inspiring and rewarding careers in the sector. One commenter demonstrated the ramifications of this circumstance by noting:

I think one of the barriers...is the lack of good numbers of female role models in health leadership positions to make women and girls see the opportunities out there. And so, you know, sometimes you play by the ear, there is no one to hold your hand or you know, to tell you that you can be this or that, or this is how it is out there, this is how you deal with this, you know. You can grow up thinking women leaders in health are rare. Personally, for me, growing up, I had no strong role models to look up to (Woman, professional network).

Interviewees identified many strategies for addressing the challenges regarding women's leadership in public/global health. Among the suggested strategies were **workplace policies and procedures that foster and promote diversity and inclusivity, strong leadership mentorship and support programs, improving women's access to education and training opportunities, and showcasing, celebrating, and recognizing women leaders in Kenya and training and support to men on gender equity.**

Policies and procedures that foster work environments that promote diversity and inclusivity were considered key for advancing women's leadership. To be effective, respondents suggested that these policies should address workplace gender-based harassment as well as opaque and gender-unfair pay, hiring, promotion, travel, on-the-job training, retention practices, and work schedules. It was also suggested that public health workplaces in Kenya also need to embrace a culture of empowerment to provide opportunities for women to build their self-confidence, speak out without fear of victimization, and gain visibility for their work and achievements. A respondent who stressed the significance of having more women in organizational leadership positions made the following point:

For a workplace to support women, in my view, it doesn't just have to focus on staff output. Organizations need policies that directly support women to address the challenges they face on different levels. Women leaders can help organization to deal with these things because they themselves may have experienced them. Organizations need to change the way they employ, appoint, promote, pay, and evaluate female staff members. Organizational HR policies need to be gender sensitive overall (Woman, NGO).

Strong leadership mentoring and support programs that help women advance in their jobs were other identified strategies for boosting women's leadership. While acknowledging the increasing availability of such support and training programs to advance women's leadership, some respondents noted that there were still very few women-targeted leadership mentoring programs in Kenya. Nonetheless, such programs were generally acknowledged to be crucial in assisting mid-career female professionals in understanding leadership models and practices, as well as

developing their own management and leadership abilities and philosophy. Generally, participants recommended that institutions and organizations offer ongoing training, development, career counseling, and advancement opportunities for women as part of mentorship support programs. The view of one respondent was:

Remember, change is a very difficult thing to bring to any organization. And especially if the leadership is dominated by men, it will need a radical shift in action and mindset; it will need to be proactive to quickly identify those girls and women who are either within organizations or out there, who can take up leadership roles and actively ring fence certain opportunities for training and special support for them (Male, academia).

Further, respondents mentioned that supporting **women's access to education and training opportunities** will help to enhance the pipeline of future and existing female leaders and increase their engagement in leadership roles. It was acknowledged that access to quality education and training for women and girls in Kenya had long been a challenge. Despite remarkable progress toward gender equality in Kenyan primary education, respondents said that considerable gender discrepancies persist at higher educational levels. For example, it was observed that fewer girls pursue post-secondary education, which is frequently required for positions of leadership. Targeted investments to assist women's and girls' education and training, particularly in post-secondary education and leadership development, were regarded as crucial by interviewees to achieving gender parity in public health leadership. Respondents also highlighted the importance of actionable policies and workable programs that promote equal education, gender equity in training, and the elimination of gender biases, particularly in science, technology, engineering, and math (STEM) fields.

Respondents also generally agreed on the need for ways to constantly **showcase, value, celebrate, and recognize women leaders in Kenya** in order create role models for young women and girls. They also recommended more targeted approaches to **identifying and working with female role models in various fields and sectors to inspire and mentor young women** to pursue positions of leadership. Another common recommendation involved training **and support to men on the importance of gender equity in leadership positions and on equitable, non-sexist workplace policies**. Respondents acknowledged that men can be important mentors to women, as well as allies in the workplace gender equality movement, if they are given quality training and information that inspires trust and respect for their female coworkers. Driving home the point on male allyship in promoting workplace gender equality, a participant noted:

If men were to be allies for women to be leaders, I think it's about giving men the correct information they need on the issue of gender equality and allowing them to take the challenge up and begin to change things where they are. Many of us were mentored by men. They can do more if they are given the resources and skills to become gender equality advocates and activists (Woman, NGO).



RQ2: What are current efforts that foster women's leadership, diversity, and inclusion within organizations?

Judging by the interview data, the organizations included in the study were implementing various initiatives to promote gender diversity and inclusion in leadership roles. Recognizing the importance of **gender-sensitive workplace policies and environments that go beyond tokenism**, some of the organizations reported that they started to publicize their job openings with clear messaging encouraging women to apply. Others reported bespoke workplace initiatives to inspire more women to take up leadership roles. There were also organizations that instituted workplace policies or structures that help working mothers, like lactation rooms and longer maternity leave. Several of the organizations were implementing diversity, equity, and inclusion (DEI) initiatives and job sharing,

telecommuting, and flexible/hybrid work hours strategies to help women balance work and family responsibilities. One respondent observed:

Currently, we are running a series of courses on DEI for senior management, so that we can unpack the ways in which we can entrench more diversity, more inclusivity within our staff and our programs. And one of the things that we've decided to do is to embed more of other movements within our work, for example, the disability movement, and people from the gender non-conforming movement within our programs, because you know, we are reproductive rights organization (Woman, INGO).

Training programs for women emerged as a growing area of intervention in some of the organizations. Interview data suggested that some organizations have established short courses to assist women to develop and hone their leadership skills. These short courses reportedly covered a variety of topics, including communication and management skills, crisis management, mental health, and mentorship. In one organization, a **Women at Work Group** was established to improve women leadership within the organization, discuss issues that affect women the organization, and support female staff. The organization also invites women leaders, coaches, and guest speakers to give talks on various issues that affect women, including leadership challenges, financial literacy, investment, and stress management. There were also organizations that designed and implemented policies to support women to obtain additional professional and educational training. Respondents stated that, historically, men were the majority of those who benefited from leadership development opportunities in Kenya. Identified current efforts to address women's limited access to training courses include the Bill and Melinda Gates Foundation-funded senior management training program at Strathmore University, which has a deliberate focus on fair gender representation in leadership courses. A respondent familiar with the program observed:

So, it follows that we acknowledged that technical ability in terms of training health care professionals is not really an issue. The main issue is the lack of sufficient number of leaders who can run health care organizations well. So, that is where our training comes in terms of building health care management and leadership, and we specifically target women, to address the limited number of women in top health care management positions (Male, academia).

Some participating organizations were also implementing **gender workshops and training sessions** to educate employees on gender issues in the workplace and the implications of these issues. These workshops were aimed to raise awareness and understanding of how gender-based discrimination and bias manifest in the workplace and can be addressed. Men were noted as an increasingly popular target of these workshops to enrich their understanding of issues of workplace gender inequality; improve their mentorship, support, and advocacy for women's leadership; and enhance their capacity to challenge and disrupt gender stereotypes and biases that may limit women's opportunities for advancement.

Another increasingly popular intervention to promote women's leadership in Kenya cited by the respondents was **targeted mentorship and sponsorship programs for women**. Some of these programs reportedly pair emerging women professionals with senior leaders in organizational leadership who can advise and guide on career issues and connect them with the right networks and opportunities to advance, navigate the complex landscape of organizations, and develop the skills and networks required to succeed in leadership positions. These mentorship programs were said to take both formal and informal forms between senior and upcoming leaders and to create a strong pipeline of future female leaders equipped with the skills and confidence to overcome some of the barriers to women's leadership. One participant noted that her organization has a mentorship program that linked female professionals into formal mentors from around the world. Another responder described how, in addition to more established mentorship processes in her workplace, she has begun to allocate tough duties to her female coworkers to enhance their abilities and confidence in leadership roles. She explains this as part of her informal efforts to

prepare them for responsibilities outside their comfort zones. She says: “So now I can tell someone, you go write this abstract and go and present. I know it is such a heavy lift for her. She may not feel like she is ready yet. So, I do it to build that confidence in people and make them feel that even if they make a mistake, it’s going to be okay. There is a bit of a learning curve there” (Woman, INGO).

Other relevant, current initiatives reported by the participating organizations included rotational leadership arrangements that allow younger female staff to occasionally preside over key meetings and giving younger women the opportunity to attend conferences or organize critical events. Some organizations also designed and implemented events to celebrate women’s achievements and contributions to their organization, convened forums to shine light on the value of workplace diversity and inclusion, and conducted outreaches to communities, villages, and schools to challenge the cultural norms and stereotypes on women’s leadership. As noted by a respondent:

Some people from universities and other organizations go to villages and talk to those students in those communities to tell them what is happening and encourage them. Also, there are programs put in place for mentorship by several organizations where people like us and the others are invited to talk to students. At my institution, we do quite a bit. We invite professional leaders, for example engineers and doctors, to come and talk to our students so that they can know there is nothing hard in this world once you put your mind to it. You can do anything. I have learned that some students don’t have exposure to information on the possibilities out there” (Woman, academia).



RQ3: What are the various ways organizations and the WomenLift Health program may work together?

Several participating organizations expressed a willingness to collaborate with WomenLift Health to both broaden the frontiers of women in health leadership and to assist their employees, particularly women, in strengthening their leadership skills and capacity. Some of the identified areas for potential collaboration with WomenLift Health were:

Support in policy review and organizational capacity strengthening: Some organizations, including a university, reported having developed gender and diversity policies and programs, but experiencing challenges in implementing and evaluating them. These organizations stated that there was room to work with WomenLift Health to review and strengthen these policies and improve their implementation.

In-service training: The majority of respondents noted that their organization requires in-house leadership training and monitoring of women’s progress and that WomenLift Health could work with Kenya-based universities and organizations to develop women leadership training and coaching opportunities for these organizations. WomenLift Health could also facilitate cross-learning activities for women leaders to share their experiences and strategies for overcoming common challenges. Such activities could be implemented through online communities, media and networking events, and peer-to-peer mentoring or media campaigns. Many of the organizations also reported that it would be beneficial to collaborate with WomenLift Health to identify gaps in existing women’s leadership and competency strengthening initiatives and to cocreate interventions to address these gaps.

Establishment of women leadership support systems: Some organizations also stated that there is a need for the formation of support systems and groups for female health professionals where women can share their experiences, be motivated, and encourage one another. They see a potential opportunity to collaborate with WomenLift Health on establishing these groups in Kenya.

Technical assistance and funding support: WomenLift Health was also considered a potential source of technical assistance and funding for local organizations working on women’s health leadership issues. Respondents also

mentioned that WomenLift Health could support national efforts to highlight the accomplishments of women leaders and to shift cultural norms and perceptions about women's leadership.

Research collaboration: Some organizations do research on issues of gender, women, and development and welcomed an opportunity to work with WomenLift Health to identify new research questions related to women's leadership issues and to collaborate in answering them.

Partnership with influential organizations: The Population Health Council, Amref Health Africa, Kenya Medical Research Institute (KEMRI), ICRW, African Population and Health Research Center (APHRC), Trust for Indigenous Culture and Health (TICAH), Center for Reproductive Rights, LVCT Health, and universities were among the identified influential organizations in Kenya that WomenLift Health should collaborate with to advance women's health leadership. The Council of Governors, county assemblies, professional bodies, and CEOs in Kenya were also identified as strategic entry points for WomenLift Health's future work on women's health leadership in Kenya.

RECOMMENDATIONS

Based on the findings of this study, we recommend that WomenLift Health:

- 1. Support the development of a robust strategy and framework for supporting women's health leadership in Kenya:** According to the study's findings, many participating organizations lacked actionable, structured, strategic frameworks for actualizing women's leadership. WomenLift Health can assist organizations in Kenya with establishing a strong, evidence-based and multipronged framework for advancing women's health leadership.
- 2. Build on existing organizational policies and initiatives:** Notwithstanding enduring gender disparities in Kenya's health leadership landscape, many of the participating organizations were implementing activities to advance women health leadership. However, these organizations are at different levels in their efforts. WomenLift Health will gain a lot of traction in its work by learning more deeply about these initiatives and developing bespoke interventions to directly support the ongoing efforts of these organizations.
- 3. Target the social norms that suffocate female leadership:** Respondents to the study emphasized the impact of sociocultural norms in impeding women's leadership. Women's and girls' limited educational achievement and delayed progression in the workplace, women's lack of confidence in their competence as leaders, and unfavorable public impressions of women's leadership were, among others, all linked to social norms. Women's leadership advancement efforts in Kenya should focus attempts to address these harmful social norms through advocacy, capacity building, awareness creation, and other interventions.
- 4. Work with influential, Kenya-based organizations to strengthen local capacity to advance women's health leadership:** Data from the study suggest that some organizations are already working to advance women's health leadership in Kenya. These organizations were implementing training and mentorship programs, research on women's leadership, advocacy initiatives, and gender equality workplace actions. WomenLift Health must collaborate with these organizations to scale their work.
- 5. Target the pipeline of future health leaders:** Kenya has a strong pool of future female health leaders, including junior doctors, nurses, pharmacists, medical technicians, and dentists. WomenLift Health has a significant opportunity to advance women's health leadership in the country by implementing interventions focused on enlarging, supporting, and sustaining the pipeline of future leaders.
- 6. Build alliances with key strategic groups:** Several organizations are critical to strengthening women's health leadership in Kenya. WomenLift Health would be better positioned to deliver impact by collaborating with these organizations. Among them are political institutions such as the Kenya Women Parliamentary Association (KEWOPA) and The Council of Governors, as well as professional bodies and pressure groups such as the Kenya Medical Women's Association, the Kenya Pharmaceutical Association, and organizations of women CEOs in Kenya. There are also several universities and implementing organizations that would make good allies and collaborators.

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