INVESTING IN THE POWER OF NURSE LEADERSHIP

WHAT WILL IT TAKE?

KENYA SPOTLIGHT BRIEF

ACKNOWLEDGMENTS

This brief was produced by IntraHealth International with funding and support from Johnson & Johnson. It is part of a partnership between IntraHealth, the Nursing Now campaign, and Johnson & Johnson to address gender-related barriers in nursing to fully unlock the power of nurse leadership for better health and socioeconomic outcomes.

The purpose of this brief is to spotlight the views of Kenyan nurses as they relate to the leadership and gender-related issues raised in the 2019 report *Investing in the Power of Nurse Leadership: What Will It Take?* The brief highlights responses from 29 Kenyan nurses, nursing students, and nurse policy leaders, specifically focusing on their personal experiences relating to issues raised in the report—including the perception of the nursing profession, gender differences in advancement, juggling paid and unpaid work, nurses' decision-making authority, and mentorship.

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INTRODUCTION

In June 2019, IntraHealth International, Nursing Now, and Johnson & Johnson released *Investing in the Power of Nurse Leadership: What Will It Take?*, which analyzes the results of a global survey and key informant interviews to uncover gender-related and other barriers to nurse leadership—and policies and programs meant to mitigate these barriers. Comprised of 2,537 responses from 117 countries, the data represent a broad and diverse perspective on nurse leadership.

The report substantiates other research findings that there is a constellation of barriers at work in nursing leadership that marginalize and exclude female nurses especially from decision-making roles and career progression. Gender discrimination, bias, and stereotyping perpetuate the gender pay gap, inhibit opportunities for nurses to develop skills, and result in unequal treatment in the health workforce between women and men.

The report found that because women comprise an overwhelming majority of nursing professionals—up to

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90% in some countries—nursing is broadly perceived as a feminized profession, subjecting nurses of both sexes to biases and discrimination. The consequences of this constellation of barriers manifests between individual nurses within the profession, for nursing as a cadre within the broader health workforce, and for health as a sector in the economy.[1]

In February 2020, IntraHealth staff interviewed 29 nurses, nursing students, and nurse policy leaders in Kenya. They were selected to represent various levels of the health system, e.g., urban, periurban, and remote hardship settings and the team interviewed nurses working in public, private, and faith-based health facilities. Their views on these issues do not necessarily reflect those of nurses more broadly in Kenya or globally. However, several key themes emerged from the interviews with these nurses, nursing students, and nurse leaders.

BACKGROUND ON NURSING IN KENYA

In 2010, reforms to the Constitution of Kenya devolved health services to the counties, resulting in a restructuring of the health workforce and how health workers are managed in the country. Between 55-70% of public sector workers employed by the county are in the health sector. Since devolution, some research has found counties have struggled with health workforce management, with many counties lacking the requisite capacity.

Currently, the director of nursing services is based at the national Ministry of Health headquarters and is responsible for the leadership and governance of nursing services in Kenya. In most counties, nursing services are led by the county nursing coordinator and a subcounty public health nursing officer. According to Juma et al. (2014), involvement of nurses in policy and decision-making in Kenya has been modest, owing to structural barriers such as health systems hierarchies, interprofessional hierarchies, and intraprofessional hierarchies. However, devolution of health services presents opportunities for nurses' increased participation in decision-making and leadership.[2]

Nursing services are governed by three professional organizations—the Nursing Council of Kenya (NCK) as the regulator, the National Nurses Association of Kenya (NNAK) as the self-governance professional body, and the Kenya National Union of Nurses (KNUN) as the trade union representing nurses nationwide. The NCK has the mandate to regulate training, registration, and enrollment; licensing; and the standards of nursing practice and conduct of nurses and nursing commodities for institutions in Kenya.[3]

Nurses in Kenya provide the majority of direct health services to patients at all levels of the health system, and they form the single largest group of frontline health workers in the country.[2] Kenya has 11.7 nurses per 10,000 population,[4] compared with 8.7 per 10,000 for the African region and 36.9 per 10,000 globally as of 2018.[5] The World Health Organization projects a shortage of 80,000 to 90,000 nurses in Kenya for the year 2030. Women constitute about 76% of the nursing workforce in Kenya.[4]

Nurses are inequitably distributed in the country. About 67.9% of nurses at public health facilities in Kenya are deployed in hospitals, which account for 8.4% of all public health facilities in the country. Only 17.7% of nurses are deployed in dispensaries, which constitute 72% of all public health facilities.[6]

KEY THEMES

IMPORTANCE OF ROLE MODELS IN CAREER DEVELOPMENT

Kenyan nurses interviewed for this brief said having successful role models was key in recruiting and retaining nurses. Many were inspired by nurses who provided care to them or their family members, and five of them were inspired by nurses who were very close to them, such as parents, siblings, or neighbors.

One male nurse originally wanted to become a doctor (a majority male profession in the health workforce), but after seeing the way that the nurses who treated his own mother were directly involved in her day-to-day care, he decided that he had to become a nurse even though it was considered a job meant for women. One nurse policy leader said she fell ill when she was young, and the professionalism of the nurses who oversaw her care made her want to provide that service for others.

> *I wanted to be a doctor because I thought all people in the medical field are doctors, only to realize that in this medical field, people have different roles. And that's why I decided, "No, I'm not going to be a doctor, because I've been told that these ladies who assisted my mom were nurses." That's why I decided to be a nurse.* ***—periurban health facility in-charge***

Through their affiliation with other nurses growing up, many nurses saw a path to secure, formal employment through nursing. One nurse recalled that her older sister set a motivational example by contributing to the family's finances with her steady job as a nurse, even funding her and her other siblings' education.

Nurses' demonstrated professionalism was a key factor in the role model effect, according to several nurses. Many nurses said they grew up admiring the "clean, white uniforms" of the nurses in their communities and the organizational skills they demonstrated in commanding the daily care of patients across the ward.

Several nurses were also encouraged to continue with nursing once they had begun their schooling by more senior students and nurses who served as mentors. This was especially important in instilling a positive attitude at the beginning of a career when confidence is at its lowest.

> *This senior student was so good with them [patients], and from that you kind of get to see someone who likes and loves their job, helping others. This actually inspired me. I still remember, she later passed on. But she actually held my hand as a young student nurse, doing my first practical clinical work, and she kept on mentoring me.* ***—periurban community health management team member***

GAP BETWEEN NURSES' PERCEIVED AND ACTUAL EXPERTISE

Interviews indicated many nurses experienced dismissive attitudes from doctors and clinical officers and felt like they were seen as doctors' assistants. Those in smaller health centers said that it is often easier to lead activities when the doctors are not there. Some nurses working in larger referral hospitals or at the nursing officer level or above said they expected that a doctor would fill managerial and leadership positions before a nurse with years of experience at that facility.

> *As a nurse, most people don't understand that nurses can be leaders. You understand? Majority may just understand that leaders are doctors, clinical officers, and such. … They tell you, "You are this. You are a nurse. You're not supposed to lead us. Go there and conduct the deliveries." So, you understand the level of discrimination?* ***—periurban nurse-in-charge***

Many nurses indicated a societal disconnect between the amount and level of work that nurses do and the perception of nurses' skill level. In Kenya, many nurses oversee an entire dispensary or health center and are responsible for providing reports, including on clinic capacity, patient response and status, staffing, and facility budgets.

The knowledge level, managerial expertise, and organizational skills required of a nurse-in-charge is often not reflected in their pay, which does not correspond to the high number of hours they are required to work, some nurses said. Although nurses spend the most time with patients of anyone at the facility, several said that their decision-making power did not correspond to their level of experience.

> *I think many people have not understood nursing because they think that nurses are doctors' assistants. And they don't know how much training a nurse undergoes. They don't know the skills that a nurse has. And they only think that a doctor is the most important person in a health facility, where it's vice versa. Without a nurse, a health facility cannot run. So, in Kenya, I think even when you compare even the remuneration, nurses are underpaid … [the] nurse is always with a patient.* ***—urban nurse-in-charge***

Several nurses also noted there is often tension between doctors and nurses about which cadre can perform a certain task. According to several nurses, they are often limited to certain procedures and services, as per the nursing scope of practice, even though they are able to deliver services outside of that limitation.

The onus often falls on nurses-in-charge to find ways to diplomatically break down walls and institute harmony in their facilities. One nurse said she worked for months when she became an in-charge to change the task-sharing policies regarding injections at her facility.

> *Everybody is like guarding their territory. It's like guarding their territory, don't encroach, you're a sister nurse, you be there. Everybody's guarding their territory.* ***—remote referral nurse-in-charge***

MENTORSHIP AND KNOWLEDGE-SHARING ISSUES AMONG WOMEN

Some of the nurses said fellow women they worked with were more difficult to work with than men because they felt animosity from the other women. One nurse said she noticed this animosity between her and female doctors in her facility, noting that they expected her to 'roll with the punches' as they had to.

> *Because when we are at work at least, sometimes you might even tell a female doctor, "I have such and such an issue." They tell you, even me, "I'm a woman, and I'm going through the same issue, so don't tell me." So, you understand? … You prefer working with the male colleagues.* ***—periurban nurse-in-charge***

The difficulties that some nurses said they faced early in their career made them less willing to take the initiative to pass on their skills and knowledge to younger nurses who were just starting out. Some older nurses said they often felt that younger female nurses were demanding too much and had not had to face the same set of challenges as older female nurses.

> *They didn't pass their skills, nurture their colleagues, mentor their colleagues. … As you know, the problem is if we don't mentor these other nurses, the young nurses may borrow or adapt that behavior.* ***—urban nurse policy leader***

EFFECTS OF FAMILY AND HOUSEHOLD DUTIES ON CAREER DEVELOPMENT FOR FEMALE NURSES

Kenyans are entitled to three months of maternity leave and two weeks of paternity leave.[7] However, with little access to breast pumps, three months of maternity leave means that many women struggle to complete six months of recommended exclusive breastfeeding once they go back to work. Some in-charge nurses were able to rearrange schedules to allow women who had recently had a baby to go home and breastfeed.

> *My colleague … has a young child who's below 6, so what she does, she reports in the morning, at around 10:00, we allow her to go for breastfeeding for a whole hour. … She does get the same pay. We support one another, because tomorrow it will be me, I'll need her support, and the other day it will be you and you'll need our support.* ***—urban nurse-in-charge***

Some nurses said that they had to advocate for policies to allow for breastfeeding.

> *You could stay a whole day without going home to breastfeed. Also, remember, if you're working in an infectious hospital, you cannot leave in between to go and breastfeed and come back. Definitely, you'll transmit the infections to your household, so it was difficult for me. But we were managing. What we want … is to have at least some change so that the mothers coming after us can enjoy what we'll have invested.* ***— urban nurse policy leader***

Some nurses said they worry about losing their jobs if they continue to have problems balancing their home and work responsibilities past the three-month maternity leave period. One nursing student said she worried that when she has children, she won't be able to exclusively breastfeed for six months or that there will be periods of time when no one is available to care for a needy infant once she needs to return to work.

To help care for their children when they are at work, many nurses turn to family members if they are nearby or domestic workers if no family members are available. Oftentimes, younger siblings will stay at an older sibling's house to help with childcare and running the household, but some aren't so lucky. One nurse described the challenges she faced as the youngest sibling in her family coordinating the same quality of childcare she provided for her older siblings.

> *I'm the last born. My sisters are elder than me. My brothers are elder than me. There's no family person [that] would come and stay at my home. So I just had to look for a house help.* ***—urban nurse in-charge***

"House helps" are domestic aides in Kenya, usually women.[8] Nearly all the nurses we spoke to had hired house help to care for their children, cook, and clean while they or their spouses are at work. Nine nurses we spoke to work far from their families and rely on house helps to keep their homes running, especially those that have sought work in remote locations to earn added incentives such as hardship pay and paid travel home.

Several nurses said that as their responsibility and level of oversight increases, they have been required to travel away from home more frequently to visit different regions and cities under their purview.

> *What comes in as a challenge is, at this level of leadership, you are required in Nairobi more often. I was in Nairobi last week on Thursday, Friday. Today I'm in Nairobi and on Thursday I'm in Nairobi. So maybe that absence, you must keep traveling and when you are away from home, you are not with your family.* ***— periurban nurse policy leader***

UNEQUAL DISTRIBUTION OF NURSES

Fifteen nurses mentioned understaffing and lack of resources as barriers to moving up the career ladder. When clinics and outposts are short-staffed, nurses become overburdened and quickly burn out, leaving little energy or time for pursuing the necessary qualifications to move to the next level.

> *You know deficiency makes nurses over work. Over work leads to a lot of tension. It creates burnout you see. And it kills aspirations of people.* ***—periurban community health management team member***

Some nurses said they feel guilty for not being able to give what they feel would be enough attention to their patients. One nurse oversees 40 staff for a catchment area of 29,000 people. In more remote areas, the nurse-to-population ratio can be worse, with only one or two nurses for an entire catchment area that requires visits to the outlying houses.

Two nurses who work in remote outposts said that every time they want to take time off work to pursue additional certifications, they are leaving the facility with the volunteer assistant, who cannot perform all the tasks that the nurses can. This makes them feel guilty for leaving their community in the lurch, so they are forgoing these ambitions for now, they said.

> *So sometimes you find you are only one nurse in the ward, attending … 46 patients.* ***—remote nurse***

Some nursing students said that the facilities they do their rotations in have one or two nurses on the floor for an entire ward. They said they are frustrated that these nurses are expected to do all the routine services like redressing wounds in addition to attending to medication schedules, intake, paperwork, and any emergencies that come up in the facility.

Some nurses are hired on short-term contracts, and when a new contract starts, there is a three-month waiting period to start getting paid again. Low financial resources means that facilities often can't plan to have enough funding for more than six months at a time, making it

difficult for nurses without personal financial resources to continue in the profession, according to some nurses and nurse leaders.

Several nurses said they do not have control over their budgets, which limits their ability to get the resources they deem most important, like technological tools or isolated spaces for tuberculosis patients. Sometimes, nurses said they do not have all the items necessary to deliver a needed health service—such as having blood available but not enough intravenous (IV) devices needed to deliver transfusions.

> *We are not able to make budgetary decisions. For example, I would wish to have a computer here running. … I keep writing a hard copy yet we are in the IT era. I'm supposed to have a teleconference with my colleagues … [the] network is not a big issue with other countries but to us it's still a big challenge.* ***— urban nurse policy leader***

> *We don't have a budget that is allocated to this nursing office so that we can budget for our own things. … We don't have a budget allowance to really advocate for nursing activities. Like during the conferences, when you want to give our associations resources to attend, it's very rare to be supported.* ***— remote nurse-in-charge***

DIFFICULTY ACCESSING EDUCATION FOR ADVANCEMENT

The Kenyan scheme of service for nurses sets out strict qualifications for advancement to the next level.[9] Additional schooling is required for advancement through each of the basic levels. Beyond the basic levels and at the officer level and above, additional specific certifications and courses are required. Funding for additional levels of schooling and certifications are not provided by the government.

Some nurses told us that because decisions about advancement now lie at the county level, the county's capacity for management means that nurses can stagnate in one grade for years. For example, one nurse said he had to wait 12 years to move from nursing officer to the next grade.

> *You'll find somebody recently employed was promoted based on "who do you know," and so many other things. Unlike before when the national government used to promote everybody, after three years you definitely move to the next job group, after three years you move. For the national government it was systematic but now for the county government it is based on "who do you know?"* ***—remote nurse-in-charge***

One nurse policy leader said that nurses remain at lower levels and aren't able to be recruited for jobs they would be well-suited for because of their grade level.

> *I need to mentor somebody. I need to bring in somebody at a certain position, but most of those who are here have lower job groups, although they are highly experienced. They know they can work effectively, but because of the scheme of service which locked most nurses out of promotional basis, they cannot take the lead.* ***—urban nurse policy leader***

Nurses we spoke with working in more remote communities are prevented from taking on these further qualifications even if they have the funds due to their location and inability to take significant time off with

no backup. This indicates a need for e-learning and decentralization of education and training. One nurse told us she is saving up all her time off, forgoing seeing her family for months at a time, in order to have enough time off to take a course that could further her advancement.

The five nursing students we spoke to all needed external support in order to raise enough funds to pay their school fees. Some said they relied on their community to fundraise and on loan programs like the Afiya Elimu Fund (supported by IntraHealth International), and they anticipate they will need to rely on these sources for their entire career if they are to advance.[10]

GENDER BIAS, DISCRIMINATION, AND STEREOTYPING

Several nurses said female and male nurses are often treated differently by colleagues, leadership, and their communities. For example, one nursing policy leader told us—later clarifying it was his impression of societal views of the issue—that women are naturally "submissive" and not as many women as men are assertive, which he said has led to the perpetuation of the idea that "nurses cannot do anything." Some female nurses told us views like these could lead women to be blamed for poor outcomes.

> *You know, when you are a female and you are a leader and you are leading even men, the males, they will not appreciate you as a leader, because they believe that they are the ones who are supposed to lead. … According to the African culture, they see male as the leader, not female. So even in the workplace, they are not comfortable for the female to be their leaders. They only want for [men] to be higher.* ***—remote nurse policy leader***

Several female nurses reported being told that they should be the ones to feed and clean the patients, rather than the male nurses, because it was just more appropriate. The female nurses we spoke to also described the disconnect between themselves and the male nurses regarding nurses' position and duties. Some female nurses said male nurses thought they were 'above' certain tasks.

> *Something that I observed with the male nurses is they didn't accept nursing as nursing. They would prefer to be treated more like doctors.* ***—periurban community health management team member***

Male nurses said they were also impacted by the perception of nursing as a caretaking position due to its association with femininity.

> *Being a female-dominated field, first of all you have that sort of discouragement even from friends whereby even when you're choosing your career or whatever you're going to do in the future and you happen just to choose nursing as a male, you're just seen as a coward somehow.* ***—nursing student***

One nurse said he was more respected than female nurses and trusted to deal with deliveries when doctors were absent since they were fellow men and got more face time with the doctors there. When the doctors saw the male nurses at the facility all the time, they were seen as closer to peers, leaving the female nurses with little opportunity for advancement, he said.

> *According to African culture, our ladies, sometimes they have to come with their homes to the hospital. You are in the hospital but also thinking about your home. … So, what we used to do is that let's say we are working three nurses and the workload has gone down. I and my colleague … would ask the ladies, "You ladies go home. Let us do the work." And we could be left the two of us. And we manage very well. And you see because of that [the doctors] used to say… in Kiswahili, 'when these men are around here we are fine.'* ***—periurban community health management team member***

Some nurses said wider social and cultural change must happen to eliminate the gender gap in nurse leadership and for nursing to be taken seriously as a profession.

> *Women are women. Their stronghold is in the kitchen. That is what is known, so nothing is dominated by women. But people don't know that society is actually dominated by women, so we have an upper hand. We can drive the economy of a nation because we are service providers. Not only in our home settings, but even in hospitals or wherever at your workplace. That is a very big gap that the nation and other people should know. Women are very important, but we are underlooked, and that has been our culture.* ***—urban nurse policy leader***

NURSES' RECOMMENDATIONS

Many of the issues that were most salient in Kenya were similar to the findings and recommendations in the *Investing in the Power of Nurse Leadership* report.[1] IntraHealth asked each of the Kenyan nurses, nursing students, and nurse policy leaders interviewed for this brief what they would recommend to improve the standing of nursing services and combat gender-related

barriers to nurse leadership. Here are three of their recommendations:

1. REFORM THE ADMINISTRATION OF NURSING SERVICES AT THE COUNTY AND NATIONAL LEVELS

Nurses expressed pros and cons of the devolution of health policy-making in Kenya to the county level. Nurses broadly said that management of human resources for health (HRH), and specifically for nurses, has suffered as a result of the policy change. A significant increase in technical assistance from the national level to counties and HRH managers to reform counties' budgets and employment management systems would help eliminate the lag in promotion schemes, alleviate some concerns about level apportioning, and clarify the need to appropriate budgets to nurses' professional development, according to interviewees.

2. MEANINGFULLY INVOLVE NURSES IN POLICY-MAKING DECISIONS

Interviewees said that ensuring nurses have a stake in policy-making (such as affirmative recruitment and promotion objectives proportionate to their share of the health workforce) would go a long way to increase morale and improve patient outcomes. Workplaces should ensure that managerial positions include flexibility, set core working hours, and have an expectation of continuing some clinical work to open opportunities for women to pursue managerial tracks while balancing family responsibilities.

3. STRENGTHEN FORMAL MENTORSHIP PROGRAMS

Most of the nurses said they were inspired to go into nursing by another nurse they admired. It is imperative that nurses who have demonstrated competency, leadership, and drive to improve their job and their patients' lives are able to reach young nurses. Large numbers of strong nurse role models hold the potential to drive up recruitment and retention and will decrease dissatisfaction among new nurses, they said. Institutions should regularly identify nurses for nomination to the Global Nursing Leadership Institute or other national nurse leadership training opportunities and ensure that their staff are able to participate without adverse impact on their job.

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