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COLLEGE OF EDUCATION & EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
DEPARTMENT OF EXTRA- MURAL STUDIES

PROJECT REPORT

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POST GRADUATE DIPLOMA IN PROJECT PLANNING AND
MANAGEMENT

PROJECT TITLE:

**"GENDER DISPARITY IN THE MEDICAL ENVIRONMENT
(A CASE STUDY OF MOMBASA HOSPITAL)"**

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REGISTRATION NO.: L42/P/9310/2005

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THE REQUIREMENT OF AN AWARD OF POST GRADUATE
DIPLOMA IN PROJECT PLANNING AND MANAGENT OF THE
UNIVERSITY OF NAIROBI

DECLARATION

This project is my original work and has not been presented to any other university or examinable board.

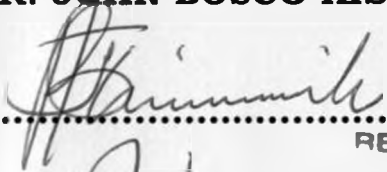
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DEDICATION

I dedicate this project to my beloved husband, George Morara Nyabicha, my daughter Valarie Kwamboka Nyabicha and son Benson Nyabicha for the love, patience and support they gave me throughout my entire course. May The Almighty God richly bless you.

ACKNOWLEDGEMENT

I sincerely acknowledge the contribution and co-operation the Mombasa for allowing me to conduct my research.

I also thank our resident lecturer John Bosco Kisimbii who assisted me through my project.

I thank my supervisor Dr. Moses Otieno for guiding me to finish the project.

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Nothing could have been done without you all. Thank you.

GOD BLESS YOU

EXECUTIVE SUMMARY

The phenomena of gender disparity in all places where human beings interact dates back to inequalities exhibited by our forefathers who curtailed the progression of girl child and explicitly supported the boys education giving rise to class distinction that has been carried forward to date. The segregation itemized some work as men's while others women's. This culture has remained with us in society that deterred progression of women even as the world is changing and women are taking the rightful place in the society as equal to men, they have realized they have a lot of ground to cover due to many years of historical discrimination.

The modern society gauges that the gap has been minimized but still suspect an externality exist that is still keeping gender apart. If it is not just imagination then the study seeks to establish what exactly it is. With support of data from various hospitals, not depending on assumption, the study sought to see if there is gender disparity and on what basis it thrives.

Since doctors and nurses are the centre of gender disparity confusion, the study focuses on the hospital environments and zeros in one hospital as a study case for accurate information. The Mombasa hospital was picked as the best case due its rich historical background and stability in progression that has in it a well cared for doctors that do not move from one hospital to the other and good records on doctors work giving representative conclusion that gender disparity still exist. The methodology used in conducting the survey was mainly by distributing the questionnaires to randomly selected hospitals distributed countrywide. These gave use to the unbiased data used in the compilation of the study. The survey therefore confirmed from the staff that the imbalance is exclusively historical not in bad faith. The rationale of the study was to justify that the gender disparity was not a premeditate action to demonize any sex.

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CHAPTER ONE:

INTRODUCTION

1.1 BACKGROUND INFORMATION

The generative assumption surrounding decision making environment in profession point of view are pre-arranged by the values held by the stakeholders. Such attitudes dictate the formation of rational basics that characterize the methods of approaching the factor that affect the inputs to the fabrics that subtend the society's freedom of association and choice. There is empirical conviction that, in medical fraternity, the training gained by practitioners has no known ethical boundary on how the learning process permeates across the imaginary membranes that exist between the perceived Proweds that gender barrier exhibit. The universal belief categorizes that whatever male and female counter part is capable of bagging from learning carve in the same atmosphere is equal ,safe for only the hidden qualities beyond what nature dictates which no human being prides to have authoritative knowledge of on deciding where one belongs. Upon this premises the

assumption made is that gender inequality goes as far as the involved individual's perceived values that rest its foundation on his imaginary thinking province which to some extent should be analyzed from its genesis. The fair approach, excluding blame game, is to trace explicitly and authoritatively the sustainers of this paradigm, if possible to contribute effectively to professional undertaking that would pierce holes on the fabrics that hold it together. It is on this humble approach, the researcher draws inspiration in seeking to determine the underlying reason as to why gender disparity exist in sacred medical environment. There are few male and more female nurses, and more male and few female doctors. These can't happen by accident as it characteristics attempt to exhibit.

1.1.1 Meaning of Gender

Gender refers to the roles and responsibilities of women and men that are created in the families, societies and culture. Patrick E. Connor (1980) said that gender concept includes the expectation held about the characteristics, aptitude and behavior and masculinity. From his writing on organization

theory and design, Patrick emphasized that these roles and expectations are learned. They can change overtime and vary within and between cultures. Clive Reading (2003) cited that the gender concept is vital because it facilitates gender analysis revealing how women's subordination is socially constructed. As such, the subordination and inferiority assumption can be changed or ended since it is not biologically pre-determined nor is it a fixed favour. By observation based on rationality, sex is the biological difference between men and women. John M. Ivancerich (1997) cited that gender equality must therefore mean fairness of treatment for women and men according to their respective needs which include equal treatment or treatment considered equivalent in terms of rights, benefits, obligations and opportunities. Patrick E. Connor (1980) cited that to ensure fairness, measures must often be put in place to compensate where appropriate, for the historical and social disadvantages that prevented women and men from operating on a level playing field. Gender can be equality or inequality, gender equality means that women and men have equal condition for

realizing their human rights and for contributing to, and benefiting economic, social, cultural and political development.

Gender equality is therefore the equal valuing by society of the similarities and the differences of men and women, and the role they play. Philip B. Crosby (1997) cited that gender equality is based on men and women being full partners in their home, their community and their society. Gender equality starts with equal valuing of girls and boys. He said the inequality reflect the opposite similarities.

Patrick E. Connor (1980) on his emphasis in valuing the gender and incorporating it in organization design, used gender lens, a tool which enables one to view the participation, needs and realities of women alongside the participation, needs and realities of men. A gender lens can be a checklist, a survey, a problem solving drama or can take on many other forms. Likewise we need two healthy eyes to see clearly and fully, we need to see the distinctive realities of men and women, boys and girls to get the full picture needed for sustainable development. In organization design, gender mainstreaming is an approach used to integrate women's and

men's needs and experiences into the design, implementation, monitoring and evaluation of policies and programmes in all political, economical, religious and social spheres, so that women and men benefit equally and inequality is not perpetuated. Organizations like medical strongly align their ideologies on ethnics; have gender responsive culture where everyone responds positively to the organizational requirement that they actively demonstrate their commitment to advance gender equality in their daily work and in their interaction with the others. The imaginary membrane purportedly exist, is a perception of the society or community that is responsible in perpetuating discrimination.

1.1.2 Profile of the Institution

The study focuses on a privately owed hospital whose historical origin stemmed from 1891, Mombasa Hospital as it is currently known, is rich in history. Its first record of a hospital (and a surgeon) in Mombasa is found in early seventeenth century manuscript, now in the British library.

This described Mombasa in 1634, during the Portuguese occupation. There was a lull of over 250 years before Mombasa physically benefited from a hospital once again. Authoritatively, the history of Mombasa hospital began in 1981, when imperial British East Africa Company granted a charter with donation to build a protestant church and a hospital. Its original name was English Hospital, a staunchly protestant organization but some what on a surprising note gave the running to the Holy Ghost Father of the Roman Catholic church.

In 1895 Dr. W. H. McDonald was appointed by British East Africa Company as the head of the hospital and the government took over the hospital from the company. In 1897, mother Auxanne Mangee, Sister James Hearty and Benilda Houston arrived from France via Zanzibar; they were accompanied by Monsignor Alleger, Vicar Apostolic of Zanzibar who escorted them to Sir Arthur Hardinge who took them to Mombasa hospital.

In 1901, the three Roman Catholic sisters handed over the hospital to lay sisters from England on November 1st. The hospital had no provision for maternity patients and 1912 the first step were taken to meet the need. A site was eventually chosen overlooking the newly established Mombasa Golf Course. The nursing home had three rooms which served as an overflow from the main Hospital. The Mombasa Electric Light and Power Company were founded in 1901 and in the following year, the hospital obtained electric power, with the cables being suspended from palm trees. In 1921, the name changed to European hospital. It had 12 beds and four nurses. In 1925, operating theatre was built with N.P Jewell as the doctor in charge. The charges were Kshs 35 per day for a private ward and Kshs 24 per day for other wards. There was high demand that the hospital never catered enough for the community. The government decided to make available a pound for pound aid scheme for capital development and it was this scheme which enabled the first major extension of the hospital to be undertaken. A Uganda Railway contractor Mr. Samuel Cohen who made money during the railway

construction left a will of £17,000 which by this time had accumulated interest to a total of £26,000 and an additional £24,000 was secured by sale of the nursing home. With a marching of £50,000 granted by the government, Mrs. Dorothy Hughes, a well known Nairobi Architect, was invited to Mombasa on 19th January 1948 and the hospital construction began. By 1950 it was completed and was opened on May 20th of the same year by Sir Charles Mortimer, commissioner of lands and the first matron Miss Jane Warden O.B.E was appointed. She served for 15th years.

The next development phase was the construction of maternity ward in 1960, initially known as Bibby wing. This was a result of contribution through a British shipping family through Mrs. Katherine Bibby. In 1962, with her permission, the hospital was renamed Katharine Bibby hospital. By 12th December 1963 racial discrimination had been overcome, although in some quarters the name Katherine Bibby hospital name still reminded them of a racial segregation leading to renaming the hospital back to The Mombasa Hospital.

Throughout the period from 1947-1985, Kenneth Adcock was closely associated with the hospital. He was the founder member of Mombasa Hospital Association and its chairman from 1947-1961. When he moved to Nairobi Mr. I. L. Roberts former managing director and vice-chairman of Bamburi Cement limited, took over on November 12th 1985. His reign ended in October 31st 1995. During his leadership, modern equipment were bought and the staff moral was boosted, there were surplus that helped finance the major development, Mr. G.C.D Groom, managing director of Bamburi Cement limited succeeded Mr. Roberts as the chairman of the Association until 31st December 1999. From the conceived plan of 1987, it was decided to increase the number of beds, provide better laboratory, out patients Administrative and theatre facilities. These saw major changes that included children's ward, 10 roomed private wings and with support from Mamujee family, private rooms increased to 22 and this project wing was named Mamujee wing. It was completed in 1990 and officially opened by then Minister for Health Mwai

Kibaki E.G.H MP on March 1st 1991. Hon. Mwai Kibaki is currently the president of the Republic of Kenya.

The second phase comprising of consulting rooms, ten additional private rooms new laboratory and outpatient/casualty were completed in October 15th 1994 with the late Joshua Augustine Minister for Health opening the extension on June 16 1995.

Phase III of the hospital commenced on November 1995 and completed in April in 1999. It consisted of the two modern operating theatre, four bed intensive care and three bed high dependency units equipped with state of the art equipment, maintenance workshop, laundry, duty staff flats, board and conference room, pharmacy and drugs store, Rafiki centre and a mortuary. In the third phase, renovation of the old hospital building, major refurbishment of main and mess kitchen including installation of new equipment, Doctors flats and entrance to the reception area were done; this was completed in December 2006. Further notable improvement thereafter embraced the hospital advisory committee, with the help of some consultant obstetrician Gynecologist and Pediatrician.

This historical background is representative enough to support any study associated with gender disparity as its staff level is commensurate with the staff level of any other in the country. Further reason for using the Mombasa hospital in this study is the complexity associated with movement of doctors. Doctors operating at the Aga Khan, Pandya, Coast General, Jocham, Mewa, Voi, and Malindi are the same ones that shuttle between the hospitals. Where records are not well kept, double counting would render the study being biased and results may be unrepresentative that have no spatial temporal reference in other words it is universally upheld.

1.2 THE STATEMENT OF THE PROBLEM

Gender disparity has persisted in medical profession inspite justification in Kenya society that male and female doctors perform equal tasks in relation to their medical qualification out of the total 6100 doctors in the country; the women doctors are imbalanced on the ratio of employment equality in the hospitals Mogoia Mosota (7/07/2008). Amref Medical researcher (2000) pegged the total number of nurses in Kenya

at 20,000, majority of who are female a confirmation of yet another gender disparity in medical profession.

1.3 THE PURPOSE OF THE STUDY

The underlying purpose of the study is to understand the number conflict and its genesis leading to the remedial action to bring the numbers of female doctors and male doctors at par or to a reasonable ratio. The study will also undertake to do the same on the ratios associated with the nurses. The urgency of the study is premeditated by the declining number of female doctors as observed on duty rosters of various hospitals across the country. Also during post 2007 presidential election clashes in Kenya, the number of women doctors attending to displaced families were fewer than the male counterparts, a phenomena that raised question as there were female patients needing assistance they could not freely narrate to male doctors delaying response to medical attention to female Internal Displaced Person's (IDP's).

1.4 THE OBJECTIVES OF THE STUDY.

1.4.1 The Broad Objective

The study aims at examining the medical practitioner for their assumption and models regarding doctors and nurses recruitment and their success in achieving progression that are supportive of gender equality and integration in the work areas in general.

1.4.2 The Specific Objectives

The objective and aims of the study include examination of medical practitioners for its assumption and models regarding doctors and nurse's recruitment and its success in achieving the training progression that are supportive of gender equality and their integration in the work area and the staff in general.

The study is also charged with making recommendation on the strategy policy to be adopted by medical fraternity to ensure that gender disparity issues are built in appropriately for future medical practitioners change. The expected outcome from the paper is to fully address the ratio imbalances, draw backs and also progress to cover benefits of equality in

numbers and future plans to the achievement of effective implementation and to establish progress already made by medical practitioners toward changing for the better.

The assumption being made is that female and male ratio inequality in the medical environment weighs negatively on the performance of the hospitals.

1. To find out the underlying reasons for gender inequality,
2. To find the rate of implementation of gender equality in medical profession,
3. To find out the level preparedness the hospital has implementation of affirmative action.

1.5 RESEARCH HYPOTHESIS

The study's hypothesis is "there is no significant gender consideration by the hospital when hiring doctors and nurses.

1.6 THEORETICAL BACKGROUND

The medical profession, specifically under those areas that took quite sometime to prepare in training were reserved for

the male students. Female students within the African context or other societies at large were mainly on the supportive of those areas, this forms the basis of quick study completion leading to a number of female students opting to study nursing, a profession that would keep them as assistant to the doctors. Also at home, the background of the support of girl child education was geared to easy subjects that would quickly graduate them and prepare them for marriage and start rearing a family. These opting to stay long in pursuit of education were categorized as defiant. A girl child was also so subjected to belief in Christian society that they were helpers to a man as a family head. In this view, going further for high academic achievement would place her in unacceptable status viewed as trying to assume the role of a man as the head of the family. Head of the family came along with high income more than everybody else in the family and with a medical doctorate degree would automatically raise her to that position. So the point of departure for peaceful life in the family and at the in-laws was to opt for a nursing profession. A combination of quick way out to employment and the

avoidance of complexity at family level led to decision for female's high number in some profession and less in some.

1.7 SIGNIFICANCE OF THE STUDY

The outcome of the study will explain to the board of directors and the society at large the reasons why there are few female doctors than male. Also, there will be clarity why there are few male nurses in the hospitals. The study will be of benefit to the hospital when planning for the future staffing and when acquiring resources that may be gender sensitive in the work area. The government would also benefit by knowing the establishment that are enforcing affirmative actions and reasons why they are doing so.

1.8 THE SCOPE AND LIMITATION OF THE STUDY

1.8.1 The Scope of the study

The study mainly concentrated on the recruitment of the human resource in medical profession mainly doctors and nurses and the results of the study will reflect specifically that outcome.

1.8.2 The Limitations of the Study

The six months duration of the study is too short to master any changes by way of new graduates entering the medical job market. The amount of money assigned to this study was also limited confirming the study of the hospital in Mombasa town. The information given may not have exhausted the desired details as majority of the hospital visited treated the information divulged as guarded. Some were suspicious that what is found came through the clerical staff from human resource department who might not have had authoritative control on the level of desired information.

1.9 ASSUMPTIONS OF THE STUDY

The assumption being made is that inability to increase the number of female medical practitioners mainly at doctors level would weigh negatively on the general performance of the hospital. Also in this modern world with globalization activities such impression on gender disparity send wrong signals to the developed nations' local organizations they interacts with in the international level.

1.10 JUSTIFICATION

John M. Ivancevich (1997) argued that low number of female in some jobs appointment violates the requirement of affirmative action which dictates that minorities should be considered in job allocation to bring their ratio to acceptable competitive level in a society. This argument has attracted worldwide attention that several organizations have adopted the scenario of calling themselves equal opportunity employer. Jeff Madura (2007) believes that employment of the less fortunate group and women in the organization up to a number that minimizes the gap between them and the leading majority is an act of social responsibility so long as they are not under any obligation to do so. He further emphasized that it is not reactionary but social responsiveness where the public is allowed to participate on matters that affect them in this case inequality in employment.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The literature on gender disparity in social environment is as old as mankind and can be traced biblically to the time of Adam and Eve. The Bible gave an account of the happenings in gender of Aden when gender issue featured prominently when the dominant sex preferred the blame to be loaded on the weaker sex. The number games we deal with now on gender are worth exploring into detail.

2.2 THEORETICAL LITERATURE

The concept of gender and its application of thinking and development practice have become epical issues and contemporary concern regarding social change. Yet a clear conceptual notion of gender is still lacking that means it is still defined in the concept embodying traditional dimensions which include social, physical, cultural or biological components.

2.2.1 Historical Dimension

Richard O. Connor (1980) viewed gender as structural component of society, mainly because the difference of social structure, expression and behavioral norms are used to divide the members of society often on the basis of net sex differences into dynamic social categories with constructed expectations. It around historical thinking of social categories that gender distinction revolves and thus continuously changing and being dignified. Historical dimension based on characteristics of animals who do share mankind's wisdom display gender in equality on sex. Almanac (2006) clearly showed a lioness hunting a deer and after killing one left the male lions to eat and the balance of the meat is eaten by the lioness in a group.

2.2.2 Causes of Disparity.

The behavioral characteristics of animal some how explains that gender differences is beyond attributes that can be controlled voluntarily by man. Human being however basing

the consideration on humanitarian ground, believes, the gender difference can be based on the other factors not

biological and line be drawn to divide its impact on the live hood of individual in a society. The human being therefore attributes the cause of gender disparity on relation and part in the interactions which demonstrate social categories of men and women. In this view gender relation and its origin become a form of social organization; they don't simply refer to interaction between women and men in terms of biological relations. In modern civilization where education has taken main stage, the approach on gender disparity shifts considerably from physical to mental where the physical causes are being abandoned due use of machines. Such paradigm shift moved women closer to men as anything a man can do based on his biological strength, a woman can do using the machine.

2.2.3 Historical Belief

Stefan D. Bleomfied (1980) cited in ancient history that there were many important facts related to eco-system of women at home and in the society. The evidence showed that either society tendered to follow matrilineal or patrician system in the society, the mother was the head of the family and children followed in the descending order with respect to the women who had given birth to them. The property and inheritance destroyed the foundation of the patricidal and matrilineal ecosystem and led to divisive people in social classes where gender becomes a major issue.

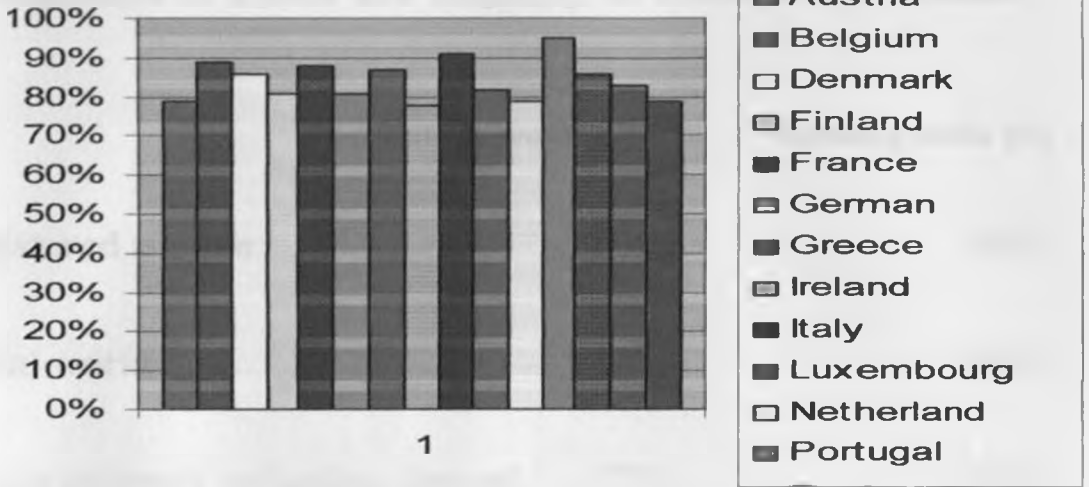
2.3 EMPIRICAL LITERATURE

Empirical literature traced the struggle by women for their rights dating back to 1848 when the first women's rights convention was held in Seneca Falls New York. Women right journal (1848) stated that a declaration of sentiment which outlines grievances of women rights movement was signed by 68 women and 32 men. In the same country, in the state of Massachusetts in a town known as Worcester, the first women

National conventional right was held, attended by 1000 participation way back in 1850, followed by another National convention which took place yearly except for 1857 through 1860. In old democracies like United States show that struggling for gender equality predated way back to 16th century. The first ever women magazine, to be published to address women issues, was done in 1971 several years later. The magazine, however, became the major forum for feminist voices and turned a co-founder and editor Gloria Steinem's into icon of the modern feminist movement. The wage gap between women taking home less than what men earned. Such inequality perception spread to the schools where the parent preferred instead to send boys to school while keeping girls home to help the mothers on errands which was considered worth whole. Working women earnings were in themselves a discouragement in a spending a long period of time in college pursuing a degree in medicine and ends up earning less than a male counterparts with the same qualification. The numerical gender equality and emolument

imbalance were also being pursued in Europe as itemized in the data below Wage gap, selected European countries.

Country	Women's wages as Percentage of men
Austria	79%
Belgium	89%
Denmark	86%
Finland	81%
France	88%
Germany	81%
Greece	87%
Ireland	78%
Italy	91%
Luxembourg	82%
Netherlands	79%
Portugal	95%
Spain	86%
Sweden	83%
United Kingdom	78%



Note: Figures are unadjusted, and reflects the average gross hourly earning of all paid employees aged 16-64 who worked 15+ hours per week in 1999

Source: *The social situation in the European Union: 2003*

Also as referred to earlier, most women were employed in special areas accepted to the men and the country as whole.

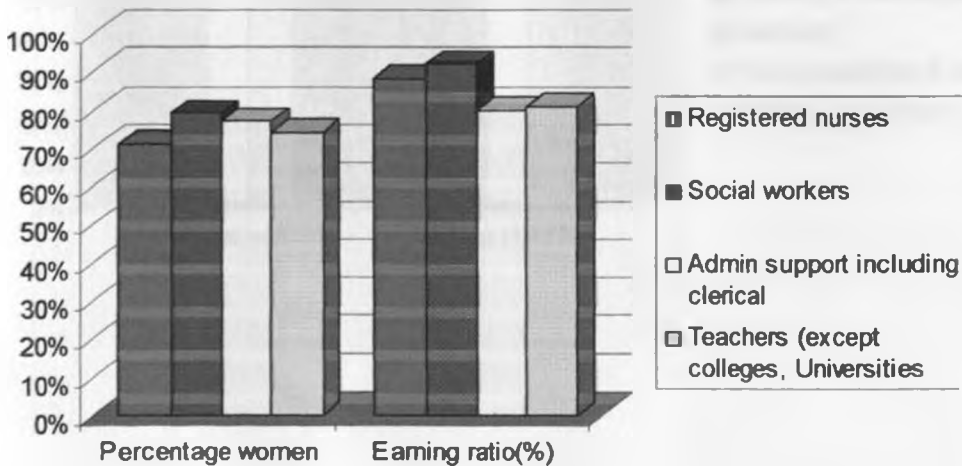
These are itemized as below in these European countries.

Gender wage gap by selected occupation, 200

Occupation in which the majority of workers are women

	Percentage women	Earning ratio (%)
Registered nurses	91%	88%
Social workers	71%	92%
Admin support including clerical	77%	80%
Teachers (except colleges Universities)	74%	81%

Gender wage gap by selected occupation, 2005

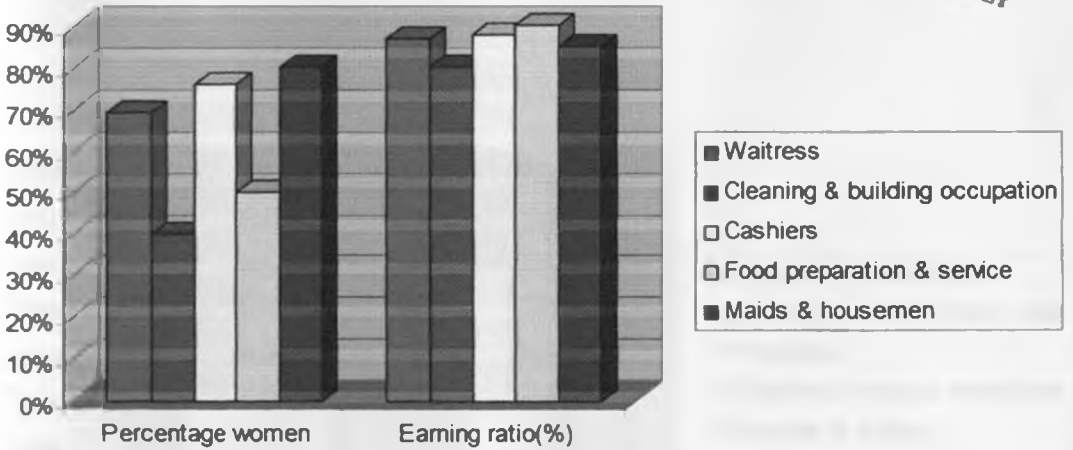


Occupation with estimated earning below & \$20,000

Waitress	69%	87%
Cleaning & building occupation	40%	80%
Cashiers	76%	88%
Food preparation & service	50%	90%
Maids & housemen	80%	85%

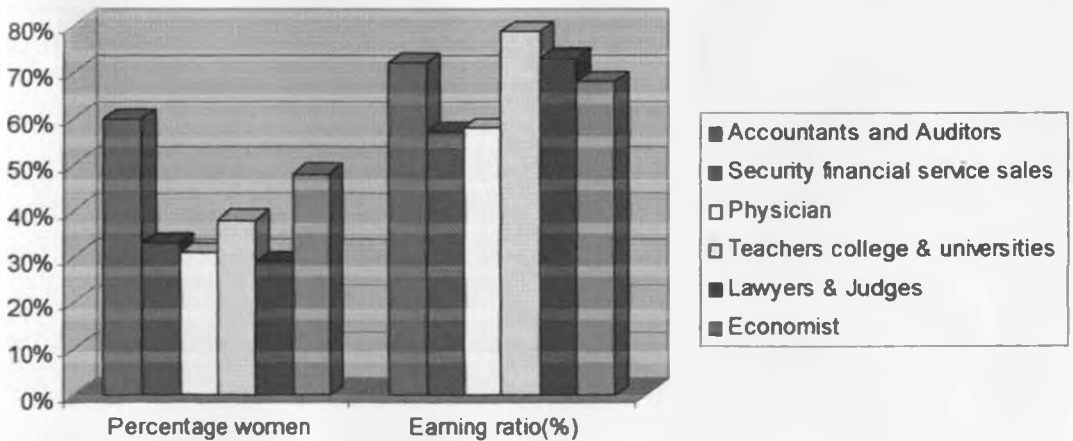
Occupation with estimated earning below & \$20,000

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Occupation with estimated earning over \$34,000

Accountants and Auditors	60%	72%
Security financial service sales	33%	57%
Physician	31%	58%
Teachers college & universities	38%	79%
Lawyers & Judges	29%	73%
Economist	48%	68%



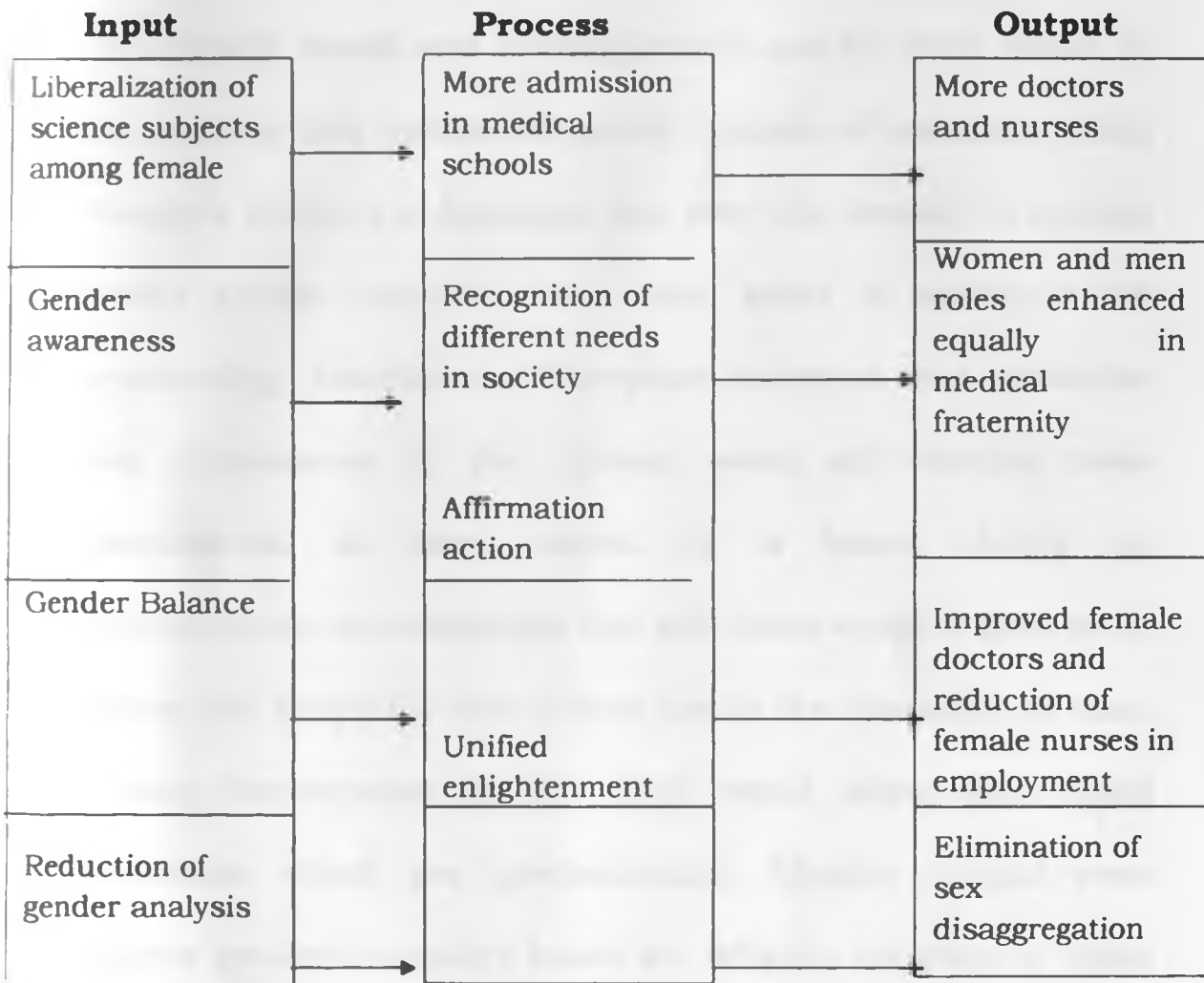
Source: National committee on pay equity (2005)

In European countries registered nurses are 91% with earning ratio of 88% while physician, the female are 31% with earning ratio of 58%. Gender disparity exists throughout the world specifically in the mentioned professions.

2.4 THE CONCEPTUAL FRAMEWORK

The following conceptual framework highlights dependent and independent valuable under investigation in the study. It is proposed that independent variables be manipulated to bring about the expected results.

Fig 2.1 : Conceptual framework



2.5 SUMMARY OF THE LITERATURE REVIEW

The gender in historical perspective covered in the contents of theoretical literature historical review and extending to the causes of gender disparity is a clear indication that gender

forms a force in life that worth exploring. The causes of gender disparity are arguable with many studies say it is biologically based and nothing much can be done about it. Supporting this notion is purely actions of animals which displays male as a dominant sex over the female. In human ranks gender inequality is a man made in society worth eradicating. America and European countries that symbolize old democracies in the current world still exhibit these imbalances. At some extent, it is based clearly on humanitarian consideration but still when worse it goes on to shove the inequality that comes live in the character of man. Young democracies in the third world along side Asian countries which are predominantly Muslim uphold even higher gender inequality based on religion, societies in these areas use undocumented pressure to clamp down the people disobeying the separation. In view of this, women choose some careers that are considered feminine and even disappear from being seen in public. Past studies on small business enterprises investment in Pakistan revealed that there are specific businesses women can do. Some case

applies to African countries, those jobs that take women away to spend nights in locations other than their homes are considered a taboo or women working with men in construction sites are not acceptable to their families leading to discomfort at home.

CHAPTER THREE

METHODOLOGY AND REASERCH DESIGN

3.0 INTRODUCTION

The study was carried out at The Mombasa hospital. An appropriate sample design was prepared which showed the structure within which the study was conducted whose aim was to yield efficient study thus maximum information. The evidence relevant to the study was availed at less cost, time and minimal effort. Mombasa hospital was chosen due to its gender diversity.

3.1 DATA TYPES AND SOURCES

The data is primary, collected from the Mombasa hospitals where an appropriate sample design was prepared to show the structure within which the study was carried whose aim was to yield efficient thus maximum information on gender. The evidence relevant to the gender imbalance was availed at less cost, time and minimal effort expenditure.

3.2 TARGET POPULATION / SAMPLE SIZE

The size of the population was 90 respondents covering all level of medical staff at Mombasa Hospital and sample size was 60 selected by putting in mind the time factor and resources for collecting, analyzing and interpreting data and much so to avoid complexity.

3.3 RESEARCH DESIGN

The study is of descriptive nature that is it requires the analysis and diagnosis of the hospital and its characteristics to determine the frequency within which gender disparity occurs and its association with other medical activities.

3.4 SAMPLING TECHNIQUES

Sampling techniques was used because it enabled the researcher to use minimal time as much as possible to lower costs, speed up interviews, to ensure availability of the study respondent and also to obtain the accurate information required. A stratified random sampling technique was used

because high accuracy was obtained and all elements of chances were covered and the staffs were in a better position to give the required information. The sampling frame was the hospital personnel list of all the staff excluding the casual workers and the validity was counter checked against the attendant log book signed by the staff coming in and going out both at lunch and evening time.

3.5 DATA COLLECTION TECHNIQUES/INSTRUMENTS

Primary and secondary data were used. The primary data was obtained through questionnaires because it saves time, convenient to send during free time. The questions being straight forward enabled the respondent to easily understand and they could give their honest view. The secondary data originated from historical background that has transgressed through uncoordinated changes whose validity to support the study considered is a suspect.

They were only used due to their availability and less cost but served no good purpose as an attachment due to their outdated condition and nature.

3.6 DATA PRESENTATION AND ANALYZING TECHNIQUES

The analytical technique used for processing and analyzing data included SWOT analysis histogram and hypothesis testing.

3.6.1 SWOT Analysis

Through the interview and questionnaires, the strengths and weakness were identified. They were internal to the medical organization and had ability to control while the opportunities and threats over which they had no control. These features that make Mombasa hospital competitive and stable, ranges from experience due to its long-term establishment being in a class of its own in discharging its medical duties, competitiveness due to its financial muscle by attracting prominent board members from prominent organizations like Bamburi Cement limited and Kenya Ports Authority (KPA), highly trained staff with the required more personalized services to the customers and an avenue for growth and development for the staff. The short fall of Mombasa hospital are inability to conduct gender audit creating imbalances in

the staff categorization, inability to expand and maintain its network and being less sensitive to the larger Mombasa. The opportunity that can be taken advantage of are the private firms backing gender equality among the doctors and nurses, increased capacity due to development of new expansion to provide for more medical services to diversify in many areas enabling it to complete effectively. The threats posed on Mombasa hospital are the long term name association with western social segregation and perception of high cost outfit. More conservative out look that keeps away even the high class locals who can form adaptive clientele. Above all these driven from this fear many small and medium size hospitals get windfall profit at the expense of this lack of understanding.

Table 1: Mombasa Hospital staff response

Class	frequency		Midpoint		
	(F)	(X)	FX	X ²	FX ²
0 - 1	7	0.5	3.5	0.25	1.75
1 - 2	9	1.5	13.5	2.25	20.25
2 - 3	6	2.5	15.0	6.25	37.5
3 - 4	14	3.5	49.0	12.25	171.5
4 - 5	8	4.5	36.0	20.25	162.0
5 - 6	6	5.5	33.0	30.25	181.5
6 - 9	4	7.5	30.0	56.25	225.0
9 - 12	6	10.5	63.0	110.25	661.5
	Σ 60	Σ 36	243	Σ 238	1461.0

Source study data (2007)

$$\text{Mean} = \frac{\sum fx}{\sum f}$$

$$= \frac{243}{60}$$

$$= 4.05$$

$$\text{Standard deviation} = \sqrt{\frac{\sum fx^2}{n} - \left(\frac{\sum f \times^2}{n}\right)^2}$$

$$= \sqrt{\frac{1461}{60} - \frac{59049}{3600}}$$

$$= \sqrt{24.34 - 16.4}$$

$$= \sqrt{7.95}$$

$$= 2.82$$

Population mean = mean + z x standard error

Assuming 95% level of confidence

$$\text{Value of Z critical} = \frac{0.05}{2}$$

$$= 0.025$$

$$= 1.96$$

Standard error = standard deviation / square root of n

$$= \frac{2.82}{\sqrt{60}}$$

$$= 2.82 / 7.75$$

$$= 0.36$$

$$\text{Population Mean} = 4.05 + 1.96 \times 0.35$$

$$= 4.74$$

$$\text{Or } 4.05 - 1.96 \times 0.35$$

$$= -3.36$$

$Z = \text{population mean} - \text{mean} / \text{standard error}$

$$4.74 - 4.05 / 0.35$$

$$= 1.97$$

$$-3.36 - 4.05 / 0.35$$

$$= -1.97$$

As the value of Z is more than critical value we reject the hypothesis that there is no significant gender consideration by the hospitals when hiring doctors and nurses and accept the alternative hypothesis that gender consideration features in decision when hospitals hire nurses and doctors.

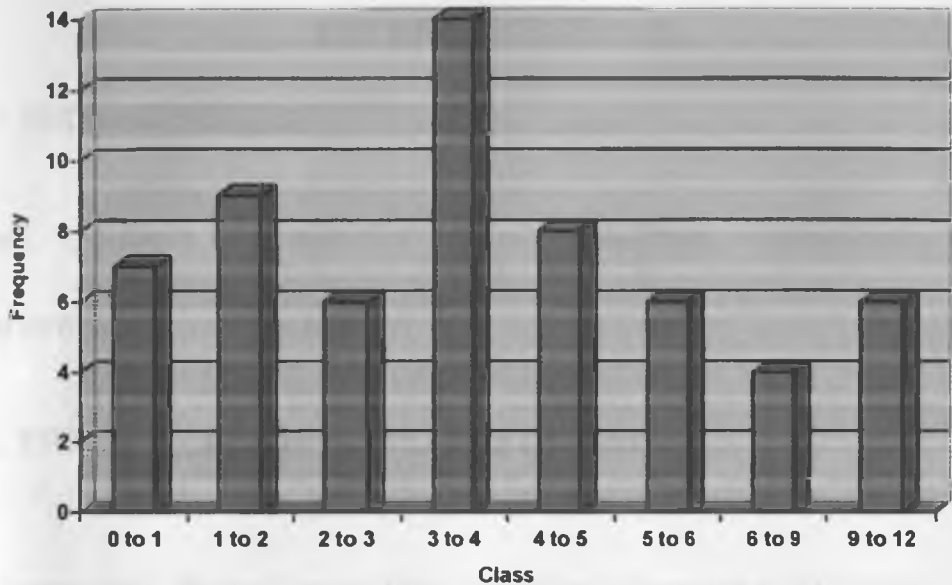
3.6.3 Histogram

The histogram shows the respondent responses to the question in the questionnaire.

Table 2: Mombasa Hospital response to the questionnaire

CLASS	FREQUENCY
0-1	7
1-2	9
2-3	6
3-4	14
4-5	8
5-6	6
6-9	4
9-12	6

Source study data (2007)



Source Study Data 2007

The histogram shows that although the rate in which gender disparity is being reduced, the male domination number in hiring of the doctors is still high and the female domination number in hiring the nurses also remain higher and dominant in human resource planning throughout the year.

CHAPTER FOUR

PRESENTATION OF FINDINGS, ANALYSIS & INTERPRETATION

4.0 INTRODUCTION

This chapter presents the findings, analysis and interpretation of the study.

4.1 PRESENTATION OF THE FINDINGS

The research found out that gender disparity in work place specifically in medical profession between doctors and nurses is real and exist in large number of hospital both locally and internationally. It also came clear from the study that struggle to achieve gender equality started way back in 1848 in united states and later in European countries where democracy has been practiced for decades. The most astonishing thing is that gender disparity and wage gap associated with men and women in work places are more a consequence of man made social imbalances than of performance effect. This is a confirmation that gender inequality eradication can be made

operative and its efficacious perception curtailed by meaningful programmes advocating gender balance especially on the professional grounds.

4.2 ANALYSIS AND INTERPRETATION

The hypothesis put forth in the study intending to answer the concern of gender imbalance in hospital under study shown in the analysis below rejected the position that there significant consideration by the hospital when hiring doctors and nurses. Similar inference can also be drawn that male nurses trained in recognized medical institution perform their duties as well as female nurses and therefore there is no justification of having more female nurses in the hospital than male nurses.

4.3 HYPOTHESIS TESTING AND INTERPRETATION

The study null hypothesis is that, there is no significant difference in performance between the hospital which are gender sensitive when hiring the doctors and nurses and those which are not the study seeks to establish by getting information from the staff.

4.4 SUMMARY OF FINDING

The study found out that there is still gender biasness against women in old democracies like United States and several European countries along side the third world countries. Even at the level of boys and girls, some responsibilities which either sex can perform comfortably are designated for boys and not girls resulting into gender discrimination from the early stages perpetuating gender imbalances in societies decades later when numbers are badly needed in professionally controlled environment like, medical. The study also found out that the wage gap between women and their male counterpart kept on widening even in Europe and America where affirmative action is highly practiced.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1 CONCLUSIONS

There is a need to have gender awareness in the society but when professionalism is under considerations, gender framework should be used as a guide for approaching methodologies and policies of an organization. This postulate argument that gender balance is necessary in medical environment at doctors or nurses level. Gender discrimination, a difference in treatment of people based entirely on their being a male or female contributes to uncalled-for structural inequality in society. The study clearly support gender audit as management and planning tool as it evaluates gender responsiveness in the organization culture and how well that organization is integrating gender perspective into its work. For example female gynecologist has unique qualities a male counterpart may not naturally posses and hence she can be more responsive to the needs of a woman in labor.

5.2 RECOMMENDATION

Through manifestation of gender awareness professionals should recognize that women and men perform different roles in society and therefore have different needs. In this view gender division of labour can be achieved among men and women to what is considered suitable or appropriate. Women gynecologist may make better workers in labour and maternity the area of responsibility than men as they naturally understand themselves over and above the skills gained from medical training and experience. Affirmative action should be accelerated to remove unnecessary values held by some individual in the society to perpetuate discrimination against women and other minorities.

5.3 AREA OF FURTHER RESEARCH

It beats logic that some individual in society still uphold gender inequality in the profession environment. Since this number is sizable and normally biased against women, there is a need to conduct a further research to unearth the basic reason why they still uphold this position.

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APPENDIX I

QUESTIONNAIRE

The researcher designs a questionnaire to seek answer on questions related to existence of gender disparity and what may be its genesis.

FOR USE IN THE LIBRARY ONLY

Name -----(optional)

Designation-----

1. Length of duration in employment at the hospital

2. In your opinion to join Mombasa hospital which was

influential

Employee's diversity

Gender Equality

Family environment

3. In your opinion what in doing on issues that affect the hospital operation?

Yes

No

something states...

4. How many female doctors are employed by the hospital and how many male doctors are employed by the hospital?
5. How many female nurses and how many male nurses are employed by Mombasa hospital?
6. Has there been any complaint on gender disparity in scheduling employees both in doctors and nurses category?
7. In the human resource planning has there been complainant on gender biases

Yes

No

Either way state why?

8. What issues on gender have featured prominent to you ever since you joined the hospital?
9. Which of the following factors influenced your decision to join Mombasa hospital?

Gender equity

Working with only males

Working with only female

10. In your opinion and written in your own words compare male and female doctors/ nurses with other hospitals in Mombasa?
11. Do you have any knowledge or suspicious that female and male doctors working in night shift end up being lovers?
12. What of doctors and nurses?
13. Could this be the fear that leads to few female doctors working in the night shift and many of the day shift?
14. Is this medical environment free from such thought?
15. When did you hear about it last. You are free to leave your name out and comment constructively?
16. In our society, could such reasoning have something to do with administration hiring more male doctors than female doctors?
17. Depending on how you answered number 6 question do you have any reason to change and give a new answer. If so comment?

.....
.....

18. Recall all if you believe in God, are all the answers you have given true and reflect the true picture of the situation on the ground?

THANK YOU VERY MUCH FOR YOUR TIME AND MAY GOD BLESS YOU

APPENDIX II

TIME SCHEDULE

ACTIVITY	Duration in weeks
Choosing the area	3 weeks
Background information and literature review	2 weeks
Methodology and budget	3 weeks
Data collection	3 weeks
Data analysis	3 weeks
Revising and submitting	2 weeks
Numbers of weeks taken	16 weeks

APPENDIX III

MONEY BUDGET

FINANCIAL BUDGET	AMOUNT
1) Internet	1,000.00
2) Transport	2,500.00
3) Library services	1,000.00
4) Typing and binding	4,000.00
5) Stationery	1,000.00
6) Photocopy	1,500.00
7) Printing	2,000.00
Total	13,000.00