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Women in Healthcare: Barriers and Enablers from a Developing Country Perspective

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ABSTRACT

Background: As the under-representation of women in management positions continues to persist globally, little is known about the experiences of women in the healthcare sector in the context of the developing Middle Eastern nations. In an attempt to address this knowledge gap, the current study explores some of the barriers that hinder and the enablers that foster women's career advancement in the healthcare sector. To meet its objectives, the current study uses a relational approach that integrates the macro socio-cultural, meso-organisational, and micro-individual levels of analysis.

Methods: Guided by institutional theory as a theoretical framework and social constructionism as a philosophical stance, the current study adopts a qualitative research methodology. It capitalizes on in-depth, semi-structured, face-to-face interviews with women managers in different occupational fields, across the managerial hierarchy in the healthcare sector in Lebanon. Snowballing and purposeful sampling procedures were used, and the interviews were analysed using thematic analysis, focusing on identifying new, emerging themes.

Results: The results of the study confirm the salience of discriminatory cultural values, gendered social roles and expectations in Middle Eastern societies, and illustrate their role as barriers hindering women's career advancement. The results also portray the spillover effect of societal expectations and cultural gender stereotypes into the organisational realm, resulting in widely experienced attitudinal and structural organisational barriers. This study also illustrates how the enablers that facilitate and promote women's career progression unfold amidst the interplay between the macro and meso factors, lending credence to the role of women's agency at the individual micro level. Amongst the toll of barriers, Middle Eastern women navigate the patriarchy of their cultures and the discrimination inherent in their organisations by using their agency and persistence as they construct and negotiate their careers in management.

Conclusion: This study provides new knowledge on the status of Middle Eastern women in the healthcare sector, a sub-category of female employees that to date, is under-researched. It primarily highlights the role of agency in building women's careers. It also stresses the notion that the complexity of women's careers in the healthcare sector can be best understood using a relational approach that highlights the intersectionality between gender, agency, socio-cultural realities and organisational boundaries.

Background

The under-representation of women in management positions in the healthcare sector persists as a global norm. Despite comprising 78% of the workforce in the healthcare sector in the USA (1) and more than 90% of the general nursing workforce in the UK (2), women are under-represented in management positions in the healthcare system, including healthcare organisations, hospitals, and medical education institutions (3-5). In addition, women healthcare executives earn significantly less than their male counterparts for doing comparable work, even after adjusting for differences in human capital, as reported by the American College of Healthcare Executives (6).

It is in this context that the current study seeks to explore the barriers and the enablers that women in the healthcare sector in developing countries face, particularly in the context of a Middle Eastern country, Lebanon. By undertaking this endeavour, the current study is contributing to knowledge in several ways. First, it is a step towards improving our understanding of the problems that working women in the economically developing non-Western nations face, as the plethora of seminal research remains predominantly

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clustered in the economically developed Western countries. Second, by focusing on the healthcare sector in particular, this study is exploring the specific experiences of women in a sector that we know very little about; a sector that has troubling statistics on the lack of gender diversity in management positions and a gender pay-gap (3) despite traditionally being perceived as "feminine" or female-friendly. Third, by adopting Syed and Özbilgin's relational approach that integrates the macro, meso and micro factors to understand the careers of women, the current study is actively responding to the scholarly calls for acknowledging the complexity of women's careers in management (7). It is also departing from the single level conceptualisations and explanations of women's employment experience towards the multi-level, relational approaches that integrate the societal, organisational and individual factors (8-11).

With that in mind, the current study focuses on addressing the following questions: What are the main barriers that women managers in the healthcare sector in Lebanon face? What are the enablers that facilitate the progress of women to and through the various managerial positions in the healthcare sector in Lebanon? To achieve its objectives, the current study draws on qualitative data from ten women managers in the healthcare sector. After reviewing relevant literature pertaining to the status of women in management, the research methodology is discussed. This is followed by an overview and a discussion of the findings. Finally, the study's implications and relevant recommendations are outlined.

Factors impacting the career of women in management

The under-representation of women in management has attracted considerable attention in the management literature as scholars attempt to understand the factors accounting for and explaining this status. Presented below is an overview of the three single-level approaches that currently dominate the generic management literature, which are often used as an explanation of women's minimal presence in management. This review is not intended to be comprehensive, but rather representative of the main explanations for this under-privileged status in management.

The first approach considers that the ascent of women to managerial positions in the healthcare sector is often hindered by macro *socio-cultural factors* (4,5,12). This approach is supported by the social role theory (13), which argues that societies are traditional by nature and thus produce and reinforce gender differences in values and interest between males and females (14,15). The impact of socio-cultural factors is further aggravated in Lebanon and in Middle Eastern societies (16-19) that are reluctant to move away from traditions. The socio-cultural values and expectations in Middle Eastern contexts are compounded by virtue of the interplay between the patriarchal nature of these society, masculine characteristics and Islam (20-22). In other words, gender configurations in Middle Eastern countries are highly impacted by the interplay between the patriarchy in these societies that give the male figure in the family the responsibility of providing for and protecting the family on one hand, and the masculine aspect that draws sharp distinctions in gender roles between men and women on the other hand (17,18,23,24).They are also influenced by the teachings of Islam that grant men pre-eminence and authority over women in terms of financial responsibility, inheritance, marriage, and divorce and prioritise the role of a woman to that of "mother" (20,21). Consequently, this tightly intertwined socio-cultural fabric is repeatedly reported to be a major barrier constraining the career advancement of women in Lebanon (16,22).

The second approach considers that the career advancement of women in management is hindered by the structural and attitudinal barriers that are engrained at the *organisational meso-level* (25-28). Studies looking at organisations in Lebanon confirm the multitude of structural and attitudinal organisational barriers that women face in their managerial career progression (22,29). For example, female physicians and nurses in Lebanon confirmed gender discrimination at their workplaces, the absence of family-friendly policies that assist working mothers in achieving a minimum level of work/life balance (30,31), and inadequate organisational support in terms of policies that protect them from discrimination at work (32). Moreover, female nurses highlighted the lack of support from supervisors, lack of training and developmental opportunities (33), and discrimination in recruitment and promotion. Male candidates in Lebanon are given preference and priority in landing management positions and are promoted at a much faster pace when compared to female counterparts (30). Female nurses also complained about nepotism (33) or what is commonly known as "wasta"; a problem that is not only widely spread within organisational contexts across the Arab region (34,35), but also empirically proven to have a significant impact on the career advancement of women in Lebanon and the Middle Eastern region (29,36).

The third approach explains the minimal presence of women in managerial positions at the *micro-individual level*. It assumes that women are under-represented in management because they lack the personality traits (26,27) and the human capital (25,37,38) needed to assume decision-making roles. According to the micro perspective, women lack the educational background, years of experience (39), and personality traits–such as aggression and risk taking (40)– that are conducive to landing management positions. Moreover, women lack the desire to hold a managerial position, given that they are more committed to their families, childcare and domestic responsibilities than to their careers, in comparison to their male colleagues (41). Women in the healthcare sector are more likely to suffer from the work-life balance challenge (3,4), given the prevalence of shift work for nurses (30) and the on-call nature of many jobs in healthcare (12). However, recent studies in Lebanon and the Middle East question the validity of the micro-individual argument. For example, the impressive increase in the educational attainment levels of Arab females during the past two decades (42) challenges the assumption that Middle Eastern women are under-represented in management because of their inadequate human capital. To further explain, an investigation concerning the impact of gender factors on the careers of women managers in Lebanon, (43) revealed that the majority of women in the study sample were well educated (most of their interviewees had at least a university degree),

had several years of work and management experience, and achieved their managerial positions because of their desire to be managers.

Drawing on the approaches explained above, together with the complexity and multi-dimensionality of women's careers (8), the current study departs from adopting a single level approach to exploring the reasons underlying women's under-representation in management. In an attempt to integrate the macro, meso, and micro levels of analysis and explanation (7,9-11), the current study adopts the multi-level relational framework in (7), originally devised in the context of diversity management, to the Lebanese healthcare sector. In parallel with the relational framework, this study is guided by the institutional theory that focuses on the deep aspects of social structure (44). According to institutional theory, institutions are social structures composed of cultural-cognitive, normative, and regulative elements (44,45) that use norms and rules as authoritative guidelines for social behaviour. In other words, for organisations to survive and to continue to provide stability and meaning to social life, they must conform with the rules and systems prevailing in their environment through the normative pillars that focus on appropriateness and the regulative pillars that focus on instrumentality and rule abiding (44,45). In relation to the status of women in management, (46) argues that the normative pillar is strongly demonstrated in the way career choices of men and women are determined by what is culturally acceptable to each gender.

Healthcare sector in Lebanon

Lebanon is an Arab, Middle Eastern country that experienced 17 years of civil war between 1975 and 1992. The consequences of the civil war, ranging from the displacement of more than 650,000 of the four million citizens to the total destruction of the country's agricultural and industrial infrastructure and sectarianism (47,48), have been detrimental to the country as it struggles with a national net outstanding public debt of US 45.62 billion as of March, 2011 (49). During the civil war, the ability of the Lebanese Ministry of Public Health (MOPH) to attend to the health-related local needs significantly deteriorated, thus creating a shortage in the supply of healthcare providers and an opportunity for the private health sector to grow and flourish (50-52). Hence, Lebanon witnessed a rapid increase in the private high-tech health sector through an increase in the number of private and non-governmental agencies (50) that, for example, provide 90% of the country's hospital capacity (52,53).

In light of the boom, the healthcare sector remains unregulated and chaotic in the absence of a clear governmental strategy for its development (51). As it currently stands, the health sector in Lebanon is weak and largely uncontrolled as a result of the ample challenges it is facing. In other words, it is challenged by the huge local national debt that shifted the focus of the MOPH to the rationalization of increasing health-related expenses (49), the constant political turmoil and civil unrest (50,53), and sectarianism where different religious sects have clinics and hospitals that are staffed with and cater to their specific group (54). Religious affiliation and sectarianism, given that Lebanon plays host to both Islam and Christianity and seventeen officially recognized sects, is the criterion for political representation, power sharing and the distribution of institutional power.

Lebanon's prevailing turbulent and unstable economic, political, and administrative situation (50) has significantly impacted the direction, focus, and findings of research in the health care sector. In other words, as a result of the toll of problems in the Lebanese healthcare sector, the majority of currently available studies are primarily grounded in finding ways to improve the quality of healthcare services (51,55). Those who are interested in the experiences of employees in the healthcare sector continue to highlight the high level of employee dissatisfaction with salaries and working conditions (33). They also stress the high intent of the health sector's employees to leave their employers and migrate to other countries with better pay scales and working conditions (56). Hence, few studies have considered the status of women in the healthcare industry in Lebanon, the root of their dissatisfaction, and their overall experiences; thus further research in this area is needed.

Women in the healthcare sector in Lebanon

The healthcare sector in Lebanon has traditionally been known as a "feminine" sector, with women at its heart. According to the MOPH (52), the number of women in the healthcare workforce is increasing; women currently comprise 79% of the public workforce in the healthcare system, with the private sector providing 80.5% of the total employment. The increased participation of women in the workforce in general, including the healthcare sector, has been motivated by their increased educational attainment and the shortage of educated people as a result of the migration of young, educated Lebanese males to neighbouring countries (22). It has also been motivated by the traditional socio-cultural attitudes in Lebanon that channel the educational pursuits of females towards fields that are traditionally perceived as more compatible with women's nature and their primary role as homemakers and mothers, such as teaching, nursing, healthcare, and social and administrative work (57). These gender stereotypes and cultural values also channel the choice of speciality among female physicians. To further explain, as a result of the sharp distinctions between what men and women should do in Lebanon, recent studies suggest that social expectations drive female physicians to specialize in general medicine, gynecology, internal medicine, pediatrics, and obstetrics, rather than surgery or orthopedics, as these latter specialties are more physically demanding, more likely to interfere with their reproductive and child-rearing roles, and are culturally perceived as unfavourable for women (55,57).

Methods

The research undertaken takes a social construction as the philosophical approach and highlights the importance of the cultural context in framing our thinking about women's careers and the obstacles they face. Unlike the more positivist approaches that obscure the links between individuals and their social worlds, social constructionism elucidates these links, facilitates a greater understanding

of the relationship between individual agency and social context, and encourages researchers to challenge dominant prescriptions of behaviour (58). As a philosophical approach, social constructionism perceives the social world as constructed by individuals through their social practices (58) and accepts the notion that investigation in the social world cannot be the pursuit of the objective truth (59). In the context of this study, social constructionism acknowledges that the careers of women are constituted by the actors themselves through their interaction with the social order and the economic realities of their local context and are not a structure that women inhabit temporarily. However, it is important to acknowledge that this study adopts a "weaker" version of social constructionism, as it does not, for example, explore the manner through which Lebanese women managers construct discrimination. Unlike social constructionism used in discourse analysis, the current study adopts social constructionism as a manner to explore the realities of women's careers and the barriers they face as an iterative and on-going process that sometimes involves the reproduction of existing structures and at other times, their transformation (58).

In line with this philosophical foundation, and to attend to the multi-faceted and complex nature of women's careers in the Middle East, the current study takes a qualitative, interview-based research approach. A mixed sampling methodology was used through incorporating the snowballing and the purposeful approaches. The snowballing approach was used to overcome the difficulties in accessing data in the Middle East, as recommended by previous qualitative studies in Lebanon (see for example 16,43). The purposeful approach was adopted as it allowed for the selection and in-depth study of information-rich interviewees (60).

Semi-structured, face-to-face, in-depth interviews were conducted with ten Lebanese women managers indifferent managerial positions across various occupations in the healthcare sector. The interviewees worked in private organisations, given that these private entities are the major providers of employment in the healthcare sector. As illustrated in Table 1, the interviewees were from different age groups, and were mostly married with at least one child. The women managers had the educational background needed to work in their field, along with several years of experience. Moreover, the interviewees' religious denominations were equally split between the biggest two religions in the country, Christianity and Islam.

An interview guide to serve the purpose of steering the discussion was prepared in advance, addressing the macro, meso, and micro factors as outlined in the literature. The interviews were conducted in English in locations chosen by the interviewees, including coffee shops and the women's offices and homes. The interviews ranged between 90 to 180 minutes and were tape recorded with the permission of the interviewees. At the beginning of every interview, the interviewee was assured of anonymity and encouraged to describe her personal experiences. The interview methodology generated a wealth of information concerning the experiences and perceptions of the interviewees and allowed for deeper reflection on the meanings and significance of their experiences.

The interviews were analysed using thematic analysis, focusing mainly on the fundamental significance through determining the coherence of the information collected and the extent to which it deepened our understanding of the phenomena under investigation (60). An analysis guide with a list of themes or codes was initially created according to the themes mostly stressed in pertinent literature. However, the guide was frequently adjusted during the analysis phase as new themes emerged (61). The transcribed interviews were analysed through a methodical comparative process to locate conceptual manifestations and identify common, recurring themes of significance to this study.

Table 1. Demographic information of the research participants

Woman Manager	Occupational Area/ Position	Education	Years of Experience	Age	Marital Status
1	Nursing/ Floor Supervisor	Bachelor of Nursing	19	45	Married + 2 children
2	Laboratories/ Manager	Master of Chemistry	7	32	Single
3	Nursing/ Supervisor	Doctor of Nursing	26	53	Married + 2 children
4	Hospital/ Head of Emergency Room	M.D./General Medicine	20	52	Married + 2 children
5	Hospital/ Head of Gynecology Department	M.D./ Gynecology	23	55	Married + 3 children
6	Hospital/ Supervisor of Pediatrics Department	M.D./ Pediatrics	10	41	Single
7	Nursing/ Head nurse	Bachelor of Nursing	5	30	Single
8	Hospital/ Head of Physical Therapy Department	Doctor of Physical therapy	8	43	Married +1 child
9	Laboratory/ Manager	Masters of Chemistry	18	47	Married + 3 children
10	Hospital/ Head of department	M.D./ Psychiatry	17	50	Married +1 child

Results and Discussion

In general, the barriers reported by women managers in the present study illustrate the interplay of macro and meso-level factors. The interviewees perceived the patriarchal, socio-cultural environment as an obstacle that creates gender stereotypes and behavioural expectations that hamper their advancement. They also stressed the attitudinal and structural organisational barriers that they faced through discriminatory attitudes towards women and biased practices and policies. Interestingly, the interviewees perceived their individual characteristics, human capital and agency as facilitators that enabled them to navigate their careers through the socio-cultural and organisational barriers. The findings are outlined in detail in the following section.

Macro, socio-cultural factors as barriers

The women managers in the healthcare sector in Lebanon highlighted the impact of the macro, socio-cultural values and expectations on shaping women's lives and careers. Although the majority of the interviewees noted the change that Lebanese society is undergoing towards a more egalitarian perspective, particularly in terms of perceptions of women, they nonetheless stressed the salience of the patriarchal ideology that grants men superiority over women by virtue of their gender. The interviewees complained about the patriarchal norms of their society that question their suitability, as women, for decision making and management positions. The patriarchy and the resulting ideologies created a normative barrier for the progression of the interviewees and resulted in feelings of uneasiness and pressure. As two of the interviewees articulated:

*"I am always questioned by my society on whether I am suitable to manage people and to make decisions, given that women are not decisive and are emotional." (*Physician, 52 years old*)*

"People always question me on whether I am a good manager because I am a woman. There is a common misconception that women are not able to be decisive because they are emotional and sensitive." (Nurse, 53 years old)

These observations suggest, in line with previous studies in the Middle Eastern region (17-19,23) and Lebanon (16,22,43), that socio-cultural values in Lebanon are traditional and reinforce gender differences in roles and expectations. The findings also suggest that social expectations and discriminatory gender stereotypes define women's suitability for managerial roles within the Lebanese healthcare sector, thus lending credence to findings reported by previous studies (4,5,12,14,15).

Moreover, according to our interviewees, masculine attitudes that confine women's responsibilities to domestic chores and childcare responsibilities are also highly ingrained. This seems to be the case despite the economic difficulties that the country is witnessing. Women in this study specifically complained about the normative pressures stemming from the traditional masculine attitudes in their society, where women are expected to primarily, and often solely, attend to their families' responsibilities. Women in this study identified that society expected them not to work, despite their high educational attainment levels, unless the males in their families could not provide for them. As stated by one of the interviewees:

"Women in this society are always questioned about the reasons underlying their employment. Unless there is a financial need, men are expected to work and make money and support their women and children, while women are expected to remain at home attending to their families." (Nurse, 45 years old)

It was interesting, however, to note that the majority of the interviewees, particularly those married with children, identified with the traditional cultural values, though in an indirect manner. In other words, most of the interviewees did not consider having a career and attending to family responsibilities to be mutually exclusive. On the contrary, they maintained full responsibility for their families in accordance with social expectations, while simultaneously attending to their careers.

"I think women should focus on their development and career growth while attending to their responsibilities towards their children, husbands, and family." (Laboratory manager, 47 years old)

So while rejecting the social confinement of women solely to domestic chores and family responsibilities, the interviewees concurred with the social values regarding the centrality of family in women's life. Hence, the Lebanese women in this study did not rebel against the social expectations, despite feeling overburdened by them. Instead, they constructed their careers through these social expectations and gender stereotypes. Regarding this issue, one of the managers said:

"As a woman, I accept the notion that women should care for their families and homes, but reject the idea that it is the primary and only role for women." (Nurse, 30 years old)

It was also interesting to note that the degree/extent of identification with cultural constraints differed across the two main religious affiliations. To further explain, some of the Muslim women managers interviewed stated that the socio-cultural values in their society (i.e., Muslim society) are heightened by the priority that Islam attributes to motherhood and the advantages that Islam grants men in terms of inheritance and divorce. As a result, this group of interviewees drew a distinction between Lebanon's Muslim and Christian societies, as they described Muslim society as more conservative and traditional. When asked about the reasons underlying their descriptions, the majority of the interviewees explained the situation in terms of the misinterpretation of Islam and the fact that Islamic texts have been predominantly interpreted by men. Similarly, some of the Christian interviewees, while emphasizing the patriarchy of Lebanese society as a whole, also described Christian society as relatively more liberal towards women's role in comparison to Muslim society, placing fewer constraints on their involvement in paid work and outside the confines of their homes. Here are some excerpts on this subject:

"In addition to the traditional culture, another societal issue for the Muslim women is Islam and the fact that men are described in the Qur'an as superior to women. This puts women in a weaker position." (Nurse, 30 years old)

"Although the Lebanese society is masculine in nature, I feel that the cultural constraints are more intense in the Muslim communities in comparison to our Christian communities." (Physician, 50 years old)

This study is the first to report differences in the illustration of Middle Eastern women to their societies based on their religious affiliation. This valuable finding concurs with (62) who revealed that Christian students in Lebanon hold more egalitarian attitudes towards working women

than their Muslim counterparts. It also lends credence to the findings of (16) who noted that Muslim managers in their study were more likely to highlight the limited freedom and equality that females have when compared to their male counterparts in Muslim communities, in comparison to their Christian female counterparts. Moreover, while these findings lend credence to previous studies regarding the interplay between patriarchy and Islamic teachings (17,19-21), they also highlight the need for further investigations that explore the reasons underlying these differences. In line with other studies with similar results (22), this study cannot draw general inferences from these findings and turns away from the simplistic explanations that align Islam with conservatism and tradition, and Christianity with liberality and modernization. The findings of the current study in this domain therefore seek a place in the larger debate regarding the fact that the slow cultural change (21) in Middle Eastern societies has allowed some pre-Islamic customs to reappear and gain acceptance in several Muslim societies (63), including Lebanese society (62). Therefore, while the real problem for women is patriarchy, the current study argues that Islam has been exploited by patriarchal societal structures to legitimize discrimination against women and the traditional and conservative interpretations of Islam and Islamic teachings.

Meso, organisational factors as barriers

The majority of the interviewees described the culture of their organisations as discriminatory, promoting gender stereotypes and prejudiced attitudes. Hence, the findings did not depart from those reported in previous studies, particularly those in the healthcare sector (4,5) and in Lebanon (22,29). The interplay between the socio-cultural and organisational level factors was evident in the discussions, given that interviewees described the cultures of their employing organisations as a reflection of Lebanese society at large. In other words, they explained the unfriendly organisational cultures and the antagonism they faced within the organisations by the spillover effect of larger societal normative barriers into the organisational frontiers. For example, several women described their experience with hostile attitudes questioning their commitment to work. They also highlighted how women were considered as being unsuitable for management and decision-making positions by virtue of their gender. As articulated by two managers:

"I had to prove myself and my suitability for the managerial position that I have. I had to fight to overcome the common misconception that women are not committed to their career or work because of their commitment to their families." (Laboratory manager, 47 years old)

"Working women in Lebanon suffer from being perceived as unsuitable for paid employment. For example, when I was promoted to my current position, one of my colleagues expressed his dissatisfaction and asked me to go home and do what a woman should do, i.e., stay home and look after her responsibilities towards her husband and children." (Nurse, 45 years old)

Stereotypical attitudes and judgements about effective management styles were also reported as barriers by the women interviewees. The women managers repeatedly complained about the salience of the "think male, think manager" stereotype in the questioning of their suitability for management and decision making positions. Typical comments were:

"I have been told that several colleagues of mine do not want me as the head of the department on the grounds that management is a man's job." (Physician, 41 years old)

Turning our attention now to the organisational practices, the interviewees perceived the organisational practices as favouring men and providing them and their careers with more support. The structural barriers identified included discriminatory recruitment and promotions practices favouring men for managerial positions, especially middle and senior positions. They also reported how women received fewer training and development opportunities when compared to their male counterparts and unfair performance evaluation, fuelled by gender stereotypes regarding the inadequacy of women for management positions. The interviewees in this study complained about having to work harder than their male counterparts, and for longer hours, in order to be noticed by senior management and to be promoted. These findings support those reported by other studies in the healthcare sector in Lebanon (30,33). As three interviewees reported:

"If the top management does not see women as suitable to be managers, then we will never be given any training or development to be managers." (Nurse, 30 years old)

"The organisations in Lebanon prefer male managers and therefore promote males more than females". (Physician, 55 years old)

"Male physicians get promoted after three years. However, women have to work harder, for more years, and achieve great results to be promoted. I feel that women have to prove themselves everyday while men don't." (Nurse, 45 years old)

Some women managers emphasized the biased organisational practices by stressing the gender pay gap. According to the women managers in this study, whose statements concur with those of other women in the healthcare sector (4-6) and in Lebanon (30,32), women managers, with equal qualifications and years of experience, are paid less than their male colleagues for doing the same job. This pay gap was often attributed to the discriminatory organisational practices and the salience of the notion that men are financially responsible for their families, and hence should be paid more to attend to their responsibilities. As one interviewee put it:

"I am paid less than my male colleagues for doing the same job… when I asked the top management for an explanation; they said that men are financially responsible for their families, while I am, as a woman, the financial responsibility of my husband." (Nurse, 53 years old)

The interviewees' career advancement was also hindered by lack of organisational support and absence of mentors and role models, as the majority of senior management positions are occupied by men who prefer to mentor other males. These findings depart from those reported by (29) where the Lebanese women managers surveyed did not perceive having a mentor as a necessity for their career progress. This divergence could be explained by the nature of the healthcare industry where mentoring is essential and plays an important role in advancing the career advancement of women (4).

"Having a mentor is very important in the healthcare sector. However, since the majority of senior managers are males, females end up with no mentors, while males can pick and choose their mentors." (Physician, 55 years old)

The women managers in this study were similar to their counterparts across various countries and economic sectors, including healthcare (3-5,28), as they were excluded from formal and informal networks at work. As one interviewee stated:

"I was always excluded from the networking activities at work. It was always about the men." (Laboratory, 32 years old)

Married women with children in particular stressed the absence of organisational support in terms of on-site day care facilities or longer maternal leaves to support them in managing their dual roles and responsibilities. These statements suggest the absence of family-friendly policies in the Lebanese healthcare sector, and confirm the lack of adequate support to protect women from discrimination and to facilitate their management of domestic responsibilities (31-33). According to one of these women:

"The Lebanese organisations do not support their women employees. They do not try to help the female employees who have children by having on-site day care facilities or providing them with additional benefits such as child care support." (Nurse, 45 years old)

Finally, further reflecting on the impact of macro-level factors on the practices of the healthcare organisations at the meso-level, the interviewees complained about the impact of nepotism and wasta. According to the interviewees, in addition to being pro-men, the organisational practices were significantly skewed towards the candidates who had more wasta. In other words, qualifications and competencies were often overshadowed by the availability of wasta. Similarly, the women managers overtly complained about the role that sectarianism plays in the healthcare sector in Lebanon. They spoke about organisational practices, particularly recruitment and promotion, being skewed towards the candidates with the right sect (i.e., the same sect as that of the ownership/top management of the hospital or laboratory). Interestingly, the interviewees blamed the spread of corruption in the healthcare sector through wasta and sectarianism on the weak role of the MOPH, policy makers, and the absence of governmental control. Hence, although the impact of nepotism and sectarianism has been referred to in other studies in Lebanon and the healthcare sector (33,48), the findings of this study are unique as they offer empirical evidence of their salience in the private healthcare sector; a finding that is very troubling for a sector that is historically expected to be highly ethical given the nobility of its raison d'etre.

Micro-individual factors as enablers

Turning our attention now to the micro-individual factors, in contrast to what has previously been reported (37,41), the majority of the interviewees perceived their human capital, personality characteristics, agency, persistence, and desire for advancement as enablers that facilitated their career advancement. Several women perceived their educational qualifications, years of international experience, and commitment to continuous education as among the main facilitators for their career advancement. Some of the women managers interviewed also focused on their personality characteristics such as self-confidence, persistence, determination, and hard work as fostering their advancement their progression to managerial roles. According to two of the women managers interviewed:

"My biggest enabler was myself. I did what I had to do and invested in my education and experience." (Nurse, 53 years old)

"I am a very patient person and I work well under stress. These traits, in addition to being a hard worker, really helped me in getting to my supervisory position." (Laboratory, 47 years old)

In reference to their education, and as expected, the majority of the interviewees emphasized the impact of socio-cultural values and expectations on their choice of education. The women managers were encouraged by their families to study nursing or medicine because these educational pursuits are socially expected for and accepted by females. Similarly, the physicians in this study chose their speciality because it was traditionally perceived in Lebanon as being feminine, which has been suggested by previous studies on the Lebanese healthcare system (55, 57). As expressed by one of the physicians:

"Since I was in high school, my mother used to encourage me to be a pediatrician. After finishing general medicine, I wanted to specialize in cardiology and I had grades that would have allowed me to do it. But my parents were so adamant that cardiology is a man's job and that pediatrics in a woman's job and that as a woman I would do a better job with children." (41 years old)

In addition, the majority of the interviewees stressed their strong aspiration for management roles and ambition as enablers to advance and a means to survive and overcome normative socio-cultural and organisational barriers. According to many of the interviewees, equipping themselves with qualifications and developing competent human capital, along with self-confidence, agency to navigate through the cultural and organisational barriers, and strong determination were the keys to succeed. One of the interviewees said:

"I was determined not to let society or anything de-motivate me. I wanted to be the head of my floor and was determined to get there, and I did." (Nurse, 30 years old)

Moreover, the married interviewees reported receiving help with childcare and domestic responsibilities from their extended families. They stressed the instrumentality of this help as a major enabler of their career progress. Similarly, all the married interviewees reported having live-in help that attended to the domestic chores of cleaning the house, doing laundry, and even cooking. This help allowed the working mothers in this study to focus on childcare rather than domestic chores. None of the married interviewees referred to receiving instrumental help with childcare or domestic chores from their husbands, and only two interviewees (a physician and a nurse) referred to receiving emotional support from their husbands and considered it as a facilitator. Some of the excerpts:

"I would not have been able to survive all the societal pressure and the problems at work if my mother was not looking after my children." (Physician, 43 years old)

"My husband has always been my rock. He motivates me to do what I think is right and not to care for what others say." (Nurse, 53 years old)

Unlike their counterparts in Western countries (3-5), the interviewees did not perceive their family responsibilities as a constraint hindering their managerial career progress or suffer from the work-life balance challenge. The divergence from the commonly expressed notions of marriage, having children, and family responsibilities can be explained in terms of the availability of multiple sources of help. In other words, concurring with previous studies in the Lebanese healthcare sector (31), despite the absence of any instrumental help from their husbands, all the married women interviewed received help with childcare and domestic chores. The external help received allowed the interviewees to successfully meet their family responsibilities and achieve some balance between their work and family responsibilities. This finding brings to light an argument and a counter-argument. One can argue that in the absence of instrumental external help, family-friendly policies, and child-care organisational support for working women, women in Lebanon would be similar to their counterparts in the Western countries. In other words, without the availability of help, Lebanese women would also find it difficult to manage their careers and family responsibilities. Therefore, one can argue that if the women did not have this help, they would have been less likely to identify with the cultural values that allocate to them the responsibilities for childcare and domestic tasks. The availability of external instrumental help could, therefore, be one of the reasons underlying the identification of some of the interviewees with traditional cultural values and maintaining full responsibility for their families. In a counter-argument, one can argue that without the external instrumental help, the Lebanese women would have been more likely to identify with their roles as mothers and wives and less likely to identify with their roles as career women. In other words, if external help was not available, and given the perseverance of patriarchal culture and the persistence of gender stereotypes, the Lebanese women might have been more likely to focus on their traditional roles and less likely to focus on their modern roles as career women.

Conclusion

To the author's best knowledge, this is the first study in the Middle East to focus on the experience of women managers in the healthcare sector. It explored the overall status of women managers in an industry that is overpopulated with women employees, under-populated with women managers, and poorly researched, particularly in the context of developing Middle Eastern countries. In particular, this exploratory study has focused on the barriers and enablers that Lebanese women managers experience in the healthcare sector, and generated several noteworthy findings. This study suggests that although women constitute the majority of the workforce in the healthcare sector, they are not fairly represented in management. Their careers in management are often hindered by macro-social and meso-organisational obstacles and barriers.

The current study is an illustration of how women's experiences and career barriers and enablers are tightly embedded within macro-, meso-, and micro-level factors in Lebanon. For example, although previous studies identified several socio-cultural factors as barriers facing women managers, the stronger salience of the normative barriers, fuelled by patriarchal, masculine values is more strongly accentuated in this Middle Eastern context. Therefore, the findings clearly demonstrate the difficulty of isolating or separating women's experiences and barriers from the prevailing socio-cultural expectations. Similarly, the attitudinal and structural barriers that women faced at the meso-level were almost inseparable from the macro socio-cultural factors and the overall employment conditions for women in the healthcare sector. In reality, the organisational barriers were often explained by the interviewees themselves as being a reflection of larger socio-cultural values and expectations that question women's suitability for and commitment to employment and management positions. Finally, the interplay between the macro and meso barriers and their impact on women at the micro-individual level was also clear, though in an indirect form. In other words, although they are hindered by barriers at the socio-cultural and organisational levels, the women managers in this study did not yield. Encouraged and motivated by their agency, the Lebanese women managers challenged these barriers through hard work and perseverance. Hence, they perceived investment in their human capital, personality traits, and desire and aspirations for management as the main enablers of their career advancement. They individually negotiated and constructed their careers around the macro national and meso-organisational barriers through commitment and determination, as well as the availability of instrumental help with childcare and domestic chores for those who were married with children.

Implications and recommendations

In recent decades, healthcare organisations in the Middle East have been overwhelmed by the struggle to retain top talent, however the findings of this study point to their failure to capitalize on the talent of their women managers. By shedding light on the overall status of women managers in the healthcare sector and illustrating the interplay between the macro and meso factors and the role of women's agency as a survival and success strategy, the findings of the current study have noteworthy implications for academics, managers, and policy makers in the healthcare field. For example, more research that interviews employers/decision-makers in the healthcare sector in Lebanon is needed. This type of research would allow us to better understand, and in more detail, the operation of 'meso-level barriers', the way employers view the role of women in healthcare, and their explanations of the discrimination/discriminatory practices that women experience in this sector.

Today's organisations need to draw on the capacity of their talent regardless of gender. For example, private healthcare providers need to attend to the problems that the industry faces, particularly the migration of qualified employees— as a result of poor salaries and working conditions— in search of better careers. Moreover, to survive today's challenging environment, healthcare organisations in Lebanon need now, more than ever, to change their salient norms and enacting policies. They need to make use of women's

talent through the active discarding of traditional gender stereotypes that impose sanctions on women's capabilities and potential by virtue of gender and tradition. Therefore, organisations must recruit and promote talented employees regardless of gender, and give women equal access to training and development opportunities, while providing them with mentors. Organisations also need to revisit their pay scales in order to close the current pay gap and introduce family-friendly policies, in an attempt to promote a culture that condemns gender discrimination. If the determination and agency that the women managers in this study displayed is a demonstration of commitment to succeed amid multi-layered obstacles, one can extrapolate about the quality of performance that women would deliver in the presence of organisational support and non-discriminatory policies and cultures.

The eradication of gender discrimination from the healthcare system cannot be achieved without the commitment and instrumental efforts of local governments and authorities to address the problem of inequality in the workplace. Notwithstanding the difficult situation of the Lebanese healthcare sector in general and its lack of resources, healthcare policy makers should not only further investigate the ubiquity of gendered policies in the healthcare sector and their consequences, but also develop strategies and action plans to reduce, if not eliminate, discrimination. For example, policy makers might consider something similar to the affirmative action taken in the USA that involves proactive employment policies and practices aimed at preventing discrimination against women and increasing their representation in decision-making positions in order to correct past exclusionary practices. In addition, given the sensitive nature of the healthcare industry, local authorities should have a stronger influence and should impose greater levels of control over the operations and practices of private providers. For example, policy makers can supervise organisational practices to ensure that, regardless of gender, performance outcomes and expectations are clearly outlined, and that gender-neutral criteria for promotion are established. Policy makers can also impose a quota that will guarantee the fair representation of women in management positions in the healthcare sector, given that they comprise the majority of the sector's workforce. Gradually, and as the number of women in senior managerial positions increases, the number of women mentors will also increase, and this will definitely help ameliorate the current shortage of female mentors. As a result of this increase in the pool of female mentors, junior females will benefit from the mentorship experience and will gain organisational visibility and access to information and informal networks. Last but not least, the empirical evidence provided by this study regarding the widespread nature of wasta and sectarianism in the healthcare sector highlights the epidemic corruption in Lebanon and the urgent need for serious governmental intervention and corrective action.

In conclusion, it should be noted that unless specific interventions are undertaken soon at the macro, socio-cultural, and governmental, as well as meso-organisational levels, the Lebanese healthcare sector will continue to fail to retain talent, the under-representation of women in managerial positions will continue, and the healthcare sector will continue to suffer the consequences of poor talent management.

Limitations and venues for further research

While this study attended to several important issues ranging from socio-cultural and organisational barriers, to individual enablers, the results should be interpreted while recognizing the limitations of the qualitative nature of the study. Though the sample size is adequate for an exploratory study, the ability to generalize the findings is limited by the degree to which the population at large resembles the sample studied. More research is needed to further investigate some of the issues raised in this study. For example, how salient is the gender pay gap among managers in the healthcare system in the Middle East and what is the role of the MOPH in narrowing this gap? How is wasta and sectarianism impacting the performance of healthcare organisations and what is the role of special interest groups and anti-corruption public committees amidst these facets of corruption? Answering these questions is imperative to improving the status of women in the healthcare sector,and further investigation is thus merited.

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Ethical issues

This study was approved by the Ethics Board of the University of New Brunsiwck, Saint John.

Competing interests

There is no competing interests in this study.

Author's contribution

HAT is the single author of the manuscript.

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