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Gender and Age Diversity Management as Drivers of Organisational Effectiveness in Public Health Institutions: Evidence from Ondo State, Nigeria

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ABSTRACT: This paper examines two dimensions of workforce diversity management gender diversity management and age diversity management and their relationship with organisational effectiveness in selected public health institutions in Ondo State, Nigeria. The paper is anchored on Social Identity Theory and the Resource-Based View, which jointly explain how workforce differences can either fragment or strengthen institutional performance depending on how they are managed. A descriptive cross-sectional survey design was adopted across Federal Medical Centre, Owo; Federal University of Technology Akure Teaching Hospital, Akure; and University of Medical Sciences Teaching Hospital, Ondo. Using an illustrative accessible population of 245 employees, a sample of 152 was derived through the Taro Yamane (1967) formula at a five per cent margin of error. A structured instrument measuring gender diversity management, age diversity management and organisational effectiveness was analysed, for methodological demonstration, using a reproducible, transparently disclosed synthetic dataset of 152 cases, generating frequency, percentage, mean and standard deviation statistics. Gender diversity management recorded a favourable grand mean (M = 3.604, SD = 0.639), driven by fair access to leadership, non-retaliatory complaint handling and development opportunity, while fair work assignment and scheduling remained comparatively uncertain. Age diversity management was similarly favourable (M = 3.545, SD = 0.688), anchored in intergenerational respect and competence-based career progression, though recruitment fairness and protection from age stereotyping attracted more moderate ratings. Organisational effectiveness was rated favourably overall (M = 3.570, SD = 0.559), with responsiveness to stakeholders and organisational learning outperforming consistent goal attainment. The results suggest that gender and age diversity management are perceived as relevant contributors to organisational effectiveness in Nigerian public hospitals, but that fairness must be visible in routine, day-to-day practice scheduling, assignment and recruitment and not only in formal policy statements. Because the dataset is synthetic, the paper draws no causal or field-validated conclusions; it is offered as a conceptual and methodological template requiring authentic field replication.

KEYWORDS: gender diversity management; age diversity management; organisational effectiveness; public hospitals; Nigeria; Social Identity Theory; Resource-Based View

INTRODUCTION

Health services are delivered through people whose training, judgement, communication and coordinated action shape the safety and dignity of care. Hospitals depend not only on infrastructure, medicines and technology, but on the capacity of a heterogeneous workforce to work across demographic and professional boundaries. The global health workforce comprised an estimated 65.1 million workers in 2020, yet its distribution remained sharply unequal, with a 6.5-fold density difference between high- and low-income countries and a projected shortage of about 10 million workers by 2030 (Boniol et al., 2022). These shortages coexist with internal workforce differences in gender, age, ethnicity, profession and tenure. Diversity is therefore an ordinary condition of modern healthcare, while inclusion – the fair and deliberate management of that diversity – remains a managerial accomplishment rather than an automatic outcome of representation.

Gender is a central global concern because women provide a large share of health and care work while remaining underrepresented in senior decision-making. Occupational sorting can concentrate women in nursing, midwifery and lower-paid care roles and men in technical or executive positions, with consequences for pay, scheduling, exposure to harassment and access to sponsored training. Evidence across organisational settings indicates that gender balance can improve information variety and

legitimacy, but that positive outcomes are more likely where fair recruitment, equal work standards, transparent progression and safe reporting systems accompany numerical representation (Clark et al., 2021; Ferrary & Déo, 2022; Gaio et al., 2024; Obeng et al., 2025b).

Age diversity has become similarly salient as health systems rely simultaneously on experienced professionals and on younger employees familiar with new technologies and contemporary training. Age difference can support intergenerational learning: senior staff contribute tacit clinical knowledge and contextual judgement, while younger staff may bring current technical competence and fresh approaches. It can also generate stereotypes that older employees resist change or that younger employees lack commitment or authority. A longitudinal intellectual-capital perspective indicates that age-diverse human capital creates value when organisations establish knowledge-sharing routines and minimise age discrimination (Li et al., 2020). In hospitals, shift allocation, continuing education, digital transition and succession planning are practical points at which age inclusion is either strengthened or undermined.

Organisational effectiveness provides a suitable outcome for integrating these two diversity dimensions. It refers to an institution's capacity to achieve service goals, coordinate units, use resources responsibly, maintain workforce capability, learn from problems and adapt to changing health needs (Turi et al., 2022; van Knippenberg et al., 2020). Gender and age diversity management may support effectiveness when employees across gender and age groups can contribute relevant knowledge to coordinated clinical and administrative work, but unmanaged differences may instead produce fault lines, distrust and communication delays (Stahl & Maznevski, 2021).

From an African and Nigerian perspective, the management of gender and age difference occurs alongside severe workforce shortages, migration and resource constraints. Nigeria's health-system profile indicates that the supply of doctors, nurses and midwives remains below the level needed to meet demand (African Health Observatory Platform, 2024), while a nationwide survey of 913 physicians found that 43.9% intended to emigrate, with poor remuneration and inadequate facilities cited as major reasons (Onah et al., 2022). Diversity management cannot substitute for adequate staffing or compensation, but inequitable treatment by gender or age may aggravate dissatisfaction and exit, whereas a fair and inclusive climate can help protect commitment while structural reform proceeds (Lawal et al., 2022).

Ondo State offers a useful subnational setting for this inquiry. Its health sector spans federal, state and local-government institutions, and its medium-term health strategy identifies human resources as an interdependent priority alongside stewardship, service delivery, infrastructure and financing (Ondo State Government, 2021). Federal Medical Centre, Owo, is a federal tertiary referral and training facility (Federal Medical Centre, Owo, 2023); the University of Medical Sciences Teaching Hospital, Ondo, is a state teaching institution (University of Medical Sciences Teaching Hospital, 2026); and the former UNIMED Teaching Hospital Akure complex was transferred to the federal government in 2025 to become the Federal University of Technology Akure Teaching Hospital (Adepegba, 2025), a transition in which staff integration, role clarification and perceived fairness across gender and age groups are especially salient. This paper narrows its focus to two of the diversity-management practices most consistently identified in this literature – gender and age and examines how employees in these three institutions perceive them in relation to organisational effectiveness.

Statement of the Problem

Nigeria's public health sector faces a combination of workforce shortage, uneven distribution, migration, burnout and constrained infrastructure. National and subnational reforms seek to strengthen service readiness and human resources, yet staffing decisions frequently occur in institutions where gender and age intersect with professional hierarchy and organisational tenure. Where these differences are managed through opaque scheduling, unequal development access, stereotyping or exclusion from leadership, the sector risks losing part of the value of the limited human capital it already possesses (African Health Observatory Platform, 2024; Chukwu & Essue, 2024).

The practical problem is not gender or age diversity itself, since public hospitals necessarily employ people across the full range of both. The problem is that numerical representation can coexist with unequal voice, gendered occupational sorting, age-based stereotyping, restricted promotion pathways and weak or inconsistently applied grievance channels. In high-risk clinical settings these conditions can reduce information sharing, commitment and willingness to raise concerns. Existing Nigerian evidence on job satisfaction, burnout and migration demonstrates serious workforce strain (Akinwale & George, 2020; Nwosu et al., 2021; Onah et al., 2022), but it does not by itself show whether employees perceive gender and age diversity management as favourable, nor how these perceptions relate to organisational effectiveness in Ondo State's public hospitals.

A contextual gap is evident because the most directly related Nigerian public-health study was conducted among 133 employees in the Lagos State Ministry of Health and examined only gender and ethnic diversity in relation to job satisfaction and commitment,

using a smaller and older sample that predates major post-pandemic workforce disruption (Ibidunni et al., 2019). Sectoral studies from banking, food production and public agencies elsewhere in Nigeria report relationships between diversity dimensions and performance (Jekelle, 2021; Obamiro et al., 2020), but clinical work carries distinctive safety, hierarchy and interdependence requirements that limit direct transfer. A methodological gap also exists: many studies measure workforce demographic composition rather than employees' perceptions of how gender and age differences are actually managed, and few report full item-level response distributions alongside summary means. This paper is intended to help close these gaps for the two variables of gender and age diversity management, using the three selected Ondo State institutions as the empirical setting.

Objectives of the Study

The general objective of the paper is to examine gender and age diversity management practices in relation to organisational effectiveness in selected public health institutions in Ondo State, Nigeria. Specifically, the paper seeks to:

i. assess employees' perceptions of gender diversity management in relation to organisational effectiveness (Objective One); and
ii. examine employees' perceptions of age diversity management in relation to organisational effectiveness (Objective Two).

Research Questions

i. How do employees perceive gender diversity management in relation to organisational effectiveness?
ii. How do employees perceive age diversity management in relation to organisational effectiveness?

2. LITERATURE REVIEW

Conceptual Review

Workforce Diversity and Diversity Management

Diversity is the distribution of differences among members of an organisational system, spanning readily observable attributes such as age and gender and less-visible attributes such as education and tenure (Stahl & Maznevski, 2021; Yadav & Lenka, 2020a). Contemporary scholarship treats diversity as relational rather than a simple count: a characteristic becomes organisationally salient when it influences interaction, opportunity or interpretation, so that gender may be numerically balanced while leadership remains concentrated, or age may signify expertise in one department and presumed technological limitation in another (Ayoko & Fujimoto, 2023).

Diversity management is the planned organisational approach to recognising, safeguarding and using employee differences. It spans recruitment, deployment, scheduling, appraisal, promotion, learning, grievance handling and leadership, and is best understood as an integrated human-resource and organisational-culture agenda rather than a stand-alone training event (Seliverstova, 2021; Yadav & Lenka, 2020b). Practices become credible when they are specific and accountable: published eligibility and scoring criteria, disaggregated recruitment and promotion data, non-retaliatory speak-up channels and transparent role assignment (Mor Barak, 2022; White et al., 2021).

Gender Diversity Management

Gender diversity management concerns the presence and participation of people of different genders across roles and levels, and addresses recruitment, occupational segregation, pay, safety, work allocation, caregiving accommodation, career development and leadership access. In health systems, women constitute a substantial share of frontline care yet may be underrepresented in executive or specialist leadership; numerical feminisation of a profession does not by itself eliminate gendered status or reward (Adam & Alfawaz, 2025).

The performance literature on gender diversity is mixed because level and context matter: studies of corporate boards cannot be assumed to represent frontline hospital teams. Ferrary and Déo (2022) found that balanced female representation at middle-management and staff levels, rather than at board level alone, was associated with firm performance, redirecting attention toward the wider workforce pipeline. European evidence links gender diversity to aspects of job quality, though institutional conditions shape the association (Clark et al., 2021), while systematic reviews caution that tokenism, hostile climate and occupational segregation can suppress the potential benefits of representation (Gaio et al., 2024).

For Nigerian public hospitals, relevant gender-management practices include transparent job and promotion criteria, equal training access, prevention of harassment, fair scheduling and work-assignment practices, and avoidance of gendered assumptions about technical competence or leadership capacity. Equality does not require identical treatment where legitimate accommodation is needed; it requires that differences are handled without devaluing competence or imposing unjust career penalties.

Age Diversity Management

Age diversity management concerns the coexistence of employees from different age and career cohorts and the organisational practices that prevent age bias while supporting fair opportunity and reciprocal intergenerational learning. Its organisational meaning overlaps with, but is not identical to, tenure, since a relatively older recruit may have short institutional tenure while a younger employee may already possess specialised digital competence (Li et al., 2020).

Age-diverse teams can combine institutional memory with contemporary knowledge, but stereotypes may produce patronising supervision, exclusion from training, or assumptions that younger employees should remain silent. Research suggests that age diversity is better leveraged where knowledge-sharing systems, a supportive climate and age-inclusive human-resource practices are present (Li et al., 2020). In healthcare specifically, age management carries patient-safety dimensions: physically demanding duties and night shifts require evidence-based occupational arrangements rather than stereotypes, training must remain available across career stages as clinical standards change, and succession planning should preserve expertise without blocking younger talent.

Organisational Effectiveness

Organisational effectiveness is the extent to which an institution achieves valued goals while maintaining adaptability, internal functioning and legitimacy; it is broader than short-term efficiency, since a hospital may reduce cost while weakening access or quality, or increase activity while exhausting its workforce (Turi et al., 2022; van Knippenberg et al., 2020). In healthcare, effectiveness is experienced through reliable service processes, collaboration, adaptability, staff morale, public legitimacy and continuous improvement. Inclusive leadership and fair workforce management may improve effectiveness by enabling information flow, commitment and adaptive behaviour (Darweesh & Al-Abrrow, 2026).

THEORETICAL FRAMEWORK

Two theoretical perspectives support the analysis: Social Identity Theory, which explains the risk pathway through which unmanaged gender and age difference may produce categorisation and reduced cooperation, and the Resource-Based View, which explains the value pathway through which heterogeneous human capital becomes a service capability when organised through inclusive routines.

Social Identity Theory

Social Identity Theory, originating in the work of Tajfel and Turner (1979), proposes that individuals derive part of their self-concept from group membership and seek a positively valued identity through the processes of social categorisation, identification and comparison. In organisations, salient characteristics such as gender and age can become bases for grouping: employees may trust similarly situated colleagues, share information selectively, or interpret ambiguous scheduling and promotion decisions through a history of group relations. Applied to the present paper, gender and age may trigger categorisation where employees perceive bias in recruitment, assignment or advancement; fair recruitment, development and voice reduce the likelihood that these identities become fault lines, so that organisational effectiveness should improve where staff experience valued membership regardless of gender or age (Tajfel & Turner, 1979).

Resource-Based View

The Resource-Based View holds that sustained organisational advantage can arise from resources that are valuable, rare, difficult to imitate and effectively organised (Barney, 1991). A gender- and age-diverse workforce offers heterogeneous human and social capital differing clinical experience, career-stage knowledge and interpersonal networks – that can expand problem-solving capacity. Diversity itself is not automatically valuable: unmanaged differences may increase conflict and turnover. The strategic resource is the combination of heterogeneous talent with inclusive routines fair recruitment, equitable scheduling, reciprocal mentoring – that enable knowledge sharing and coordinated action (Li et al., 2020; Stahl & Maznevski, 2021; van Knippenberg et al., 2020).

The two theories are integrated because neither conflict nor value can be presumed in the Nigerian public-hospital context. Strong professional identities coexist with severe resource constraints; hospitals need to reduce gender- and age-based exclusion while organising the distinct knowledge that different genders and age cohorts bring to patient care. Social Identity Theory explains why unmanaged gender and age difference can create fault lines; the Resource-Based View explains why, once organised through fair systems, that same difference becomes a service capability.

EMPIRICAL REVIEW

International and Cross-Sector Evidence

Li et al. (2021) examined workforce diversity management and job performance among 400 telecommunication employees in China; structural equation modelling showed a positive relationship, partly mediated by person–job match and commitment. Abaker et al. (2023) surveyed 250 employees in two United Arab Emirates organisations regarding perceptions of age, gender and nationality diversity management; respondents associated managed diversity with improved performance. Khan and Javaid (2023) studied 350 textile employees in Pakistan using PLS-SEM and found that gender, age, religion and education characteristics helped explain a direct diversity-management–performance relationship. Ferrary and Déo (2022) used firm-level evidence to show that balanced female representation at middle-management and staff levels, rather than boards alone, was associated with greater profitability. These studies support the plausibility of gender- and age-management effects but arise from non-health, often corporate, settings that do not capture patient safety or interprofessional dependence.

Healthcare-Specific Evidence

Obeng et al. (2025b) used PLS-SEM on 392 respondents in Ghana's public healthcare sector and found that workforce diversity management and gender diversity were positively related to employee performance, with gender diversity moderating the main association – the closest recent African healthcare evidence to the present paper's focus. A related Ghanaian study found that organisational stress mediated part of the gender-diversity–performance relationship, indicating that representation without supportive working conditions may not realise its potential (Obeng et al., 2025a). Adam and Alfawaz (2025) similarly reported that gender diversity enhanced organisational performance through employee engagement and commitment. Darweesh and Al-Abrrow (2026) surveyed 320 employees in three Basra public hospitals and found that work engagement mediated several effects of inclusive human-resource practices on performance and learning, underlining that demographic management operates through employees' relational experience rather than composition alone.

On age specifically, healthcare evidence remains sparser than for gender, though the broader intellectual-capital literature indicates that age-diverse human capital yields value where organisations establish knowledge-sharing routines and minimise age discrimination (Li et al., 2020). Inclusive-leadership studies among nurses in China, South Korea and Egypt consistently show that fair, non-discriminatory leadership behaviour – which necessarily spans age and gender – predicts voice, reduced distress, and lower turnover intention (El-Ashry et al., 2025; Lee & Dahinten, 2021; Zeng et al., 2023), supporting the broader proposition that fair treatment across demographic lines protects institutional functioning even where age is not separately isolated as a variable.

African and Nigerian Evidence

Amsi et al. (2022) examined affective engagement, gender diversity and employee performance in Tanzania's textile industry and found supportive relationships, while Chepkemoi et al. (2022) reported a positive association between gender diversity and employee performance in the County Government of Bomet, Kenya. Jekelle (2021) drew 137 usable responses from an Abuja government agency and found that gender, age and educational-background diversity jointly explained 62.9% of employee-performance variation using multiple regression – Nigerian public-sector evidence directly supporting both of the present paper's predictors, though outside a health setting. Obamiro et al. (2020) found that gender diversity correlated with job satisfaction among Nigerian bank employees.

Within Nigerian healthcare specifically, Ibidunni et al. (2019) administered questionnaires to 133 public healthcare employees in Lagos State and found that gender (and ethnic) diversity related to job satisfaction, which in turn related to organisational commitment – a foundational but geographically and temporally limited study that did not examine age diversity or organisational effectiveness directly. Akinwale and George (2020) found that salary, advancement, promotion and managerial support predicted nurse job satisfaction in Lagos tertiary hospitals, without explicitly measuring diversity management. Onah et al. (2022) found that 43.9% of a national sample of Nigerian physicians intended to emigrate, underlining the retention stakes attached to how fairly the workforce, across gender and age, perceives its treatment.

Literature Gap and Conceptual Framework

The reviewed literature shows that gender and age diversity management can relate to performance, engagement, retention and organisational outcomes across multiple sectors and a small but growing number of African healthcare settings. It does not, however, provide a consolidated, item-level description of how employees in Ondo State's public tertiary hospitals perceive these two practices in relation to organisational effectiveness. The most closely related Nigerian public-health study (Ibidunni et al., 2019) is geographically restricted to Lagos, uses an older and smaller sample, and does not examine age diversity or a multidimensional organisational-effectiveness construct. Sectoral Nigerian evidence on gender and age diversity (Jekelle, 2021;

Obamiro et al., 2020) is not drawn from healthcare, where interdependence, hierarchy and patient-safety obligations differ from banking, food production or general public administration.

This paper addresses that gap by conceptualising gender diversity management and age diversity management as two independent constructs pointing toward a single dependent variable, organisational effectiveness, measured through goal attainment, coordination, resource use, quality, adaptability, workforce capability, responsiveness and organisational learning. The framework is deliberately parsimonious: it does not claim that gender and age diversity management are the only determinants of organisational effectiveness, since staffing, financing, infrastructure and leadership remain important boundary conditions, but it isolates two practices that the literature identifies as both theoretically distinct and empirically under-examined together in Nigerian public hospitals.

3. METHODOLOGY

Research Design

The paper adopts a positivist orientation and a descriptive cross-sectional survey design, consistent with structured instruments in which the same response options are presented to all participants (Creswell & Creswell, 2023; Saunders et al., 2019). The design is descriptive rather than causal: it identifies the distribution and average direction of employee perceptions of gender and age diversity management and organisational effectiveness without claiming that either independent variable statistically causes the dependent variable.

Study Area and Population

The paper covers three public tertiary-health institutions in Ondo State, Nigeria: Federal Medical Centre, Owo; Federal University of Technology Akure Teaching Hospital, Akure; and University of Medical Sciences Teaching Hospital, Ondo. These institutions employ clinical, allied-health, administrative and support cadres and serve diverse communities across federal and state ownership structures (Adepegba, 2025; Federal Medical Centre, Owo, 2023; University of Medical Sciences Teaching Hospital, 2026). For methodological demonstration, an illustrative accessible population of 245 employees is specified across the three institutions: 113 at FMC Owo (46.1%), 71 at FUTA Teaching Hospital Akure (29.0%) and 61 at UNIMED Teaching Hospital Ondo (24.9%). These figures are illustrative rather than official staff strengths; an actual field study must replace them with authorised, dated human-resource records.

Sample Size and Sampling Technique

The Taro Yamane (1967) finite-population formula, $n = N / [1 + N(e^2)]$, was applied with N = 245 and a margin of error e = .05, yielding n = 245 / 1.6125 = 151.94, rounded to 152 respondents. A total of 170 questionnaires was allocated to allow for non-response, proportionately distributed as 78 at FMC Owo, 49 at FUTA Teaching Hospital Akure and 43 at UNIMED Teaching Hospital Ondo. The study specifies multistage sampling: the three institutions are purposively selected at the organisational level for fitting the public tertiary-health scope, while eligible employees within each institution would be stratified by cadre and drawn through simple random sampling from authorised staff lists.

Research Instrument

The instrument for this paper draws Section A (institution, gender, age group, qualification, cadre and service duration, with a "prefer not to say" option for sensitive items) and the gender diversity management (GD1–GD8), age diversity management (AD1–AD8) and organisational effectiveness (OE1–OE8) sub-scales of a 40-item questionnaire originally developed to cover four diversity-management dimensions. Each of the 24 statements relevant to this paper is rated on a five-point Likert scale (Strongly Agree = 5, Agree = 4, Undecided = 3, Disagree = 2, Strongly Disagree = 1), with higher values indicating a more favourable perception and no item reverse-scored. An item mean is calculated from all usable responses, and a construct grand mean is the average of its eight item means.

Validity and Reliability

Face and content validity require that the questionnaire be reviewed by specialists in human-resource management, organisational behaviour and health management to assess ambiguity, duplication and alignment with the constructs' operational definitions, with a content-validity index computed from expert ratings (DeVellis & Thorpe, 2021). Cronbach's alpha assesses internal consistency, with .70 or above generally acceptable for research use (Nunnally & Bernstein, 1994). In the synthetic dataset used for methodological demonstration, alpha was .924 for gender diversity management and .940 for age diversity management, both comfortably above the .70 guideline; these values demonstrate the calculation and reporting format but cannot substitute for field reliability testing.

Method of Data Analysis

Consistent with the descriptive design, data were analysed using frequency, percentage, mean and standard deviation, calculated as Percentage = (f / N) × 100, Mean = Σfx / N, and sample standard deviation SD = √[Σf(x − x̄)² / (N − 1)], where f is category frequency, N is 152 usable cases and x is the response weight from 1 to 5. Mean scores were interpreted using the decision bands: 4.21–5.00 = strongly agree/very high; 3.41–4.20 = agree/high; 2.61–3.40 = undecided/moderate; 1.81–2.60 = disagree/low; and 1.00–1.80 = strongly disagree/very low. No inferential test of statistical significance was applied; the propositions that gender and age diversity management are perceived as important contributors to organisational effectiveness were assessed descriptively rather than through hypothesis testing.

For transparency, the analysis in Section 4 uses a reproducible synthetic dataset of 152 cases constructed to demonstrate the reporting format for this two-variable model. The dataset was not obtained from employees and does not represent field observations; it illustrates how a completed results section should be organised and must be replaced with authentic primary data before the paper is treated as an empirical account of the three institutions.

4. RESULTS AND DISCUSSION

Response Rate and Demographic Profile

Of the 170 questionnaires in the synthetic distribution account, 158 (92.9%) were returned and 152 (89.4% of distributed, 96.2% of returned) were usable, distributed as 70 from FMC Owo, 44 from FUTA Teaching Hospital Akure and 38 from UNIMED Teaching Hospital Ondo. The sample comprised 87 female (57.2%), 63 male (41.4%) and two undisclosed (1.3%) records. By age group, 30 respondents (19.7%) were 18–29 years, 57 (37.5%) were 30–39 years, 41 (27.0%) were 40–49 years and 24 (15.8%) were 50 years or above, giving reasonable coverage of early, middle and later career stages. Nursing/midwifery was the largest cadre (32.9%), followed by administration/support (21.7%), allied health/laboratory (19.7%), medical/dental (17.8%) and pharmacy (7.9%).

Gender Diversity Management

Table 1: Gender diversity management – frequency, percentage, mean and standard deviation (n = 152)

Code	Statement	SA %	A %	U %	D %	SD %	Mean	SD	Decision
GD1	Recruitment and selection decisions are fair irrespective of gender.	6.6	46.1	36.8	10.5	0.0	3.487	0.772	Agree
GD2	Work assignments and schedules are allocated fairly irrespective of gender.	6.6	38.2	43.4	11.8	0.0	3.395	0.782	Undecided
GD3	Performance appraisal uses the same job-related standards for all genders.	9.2	44.1	36.2	10.5	0.0	3.520	0.805	Agree
GD4	Promotion decisions are based on competence rather than gender.	12.5	38.2	40.1	9.2	0.0	3.539	0.829	Agree
GD5	Training and development opportunities are accessible to employees of all genders.	15.1	42.8	38.2	3.9	0.0	3.691	0.774	Agree
GD6	The institution protects employees from gender-based harassment or disrespect.	13.8	47.4	32.2	6.6	0.0	3.684	0.793	Agree
GD7	Gender-related complaints are handled consistently and without retaliation.	12.5	55.9	25.0	6.6	0.0	3.743	0.759	Agree
GD8	Employees of all genders have fair access to leadership and responsibility.	17.1	48.7	28.3	5.9	0.0	3.770	0.801	Agree
GD	Grand mean – Gender diversity management	—	—	—	—	—	3.604	0.639	Agree

Source: Author's analysis of the synthetic demonstration dataset.

The grand mean for gender diversity management was 3.604 (SD = 0.639), indicating agreement. GD8, fair access to leadership and responsibility, recorded the highest item mean (M = 3.770, SD = 0.801); 65.8% of respondents agreed or strongly agreed, 28.3% were undecided and 5.9% disagreed. GD7, consistent and non-retaliatory handling of gender-related complaints, followed closely (M = 3.743), with 68.4% agreement. Training access (GD5) and protection from gender-based harassment (GD6) also received favourable means above 3.68.

GD2, fair work assignment and scheduling irrespective of gender, was the only item in the moderate interval (M = 3.395, SD = 0.782), with 44.7% agreement, 43.4% undecided and 11.8% disagreement. This distribution identifies day-to-day assignment and scheduling as less consistently perceived as fair than formal development and leadership opportunity.

Answer to Research Question One: gender diversity management was generally perceived favourably by employees across the three institutions. Considered alongside the favourable organisational-effectiveness mean reported in Section 4.4, the pattern is consistent with the proposition that equitable gender practices are perceived as relevant to organisational effectiveness, though this is a descriptive association and not an estimated causal effect.

This finding aligns with evidence that gender diversity supports performance when representation is accompanied by fair opportunity and inclusion rather than treated as a numerical target (Ferrary & Déo, 2022; Obeng et al., 2025b). It is also consistent with Adam and Alfawaz (2025), who found that gender diversity strengthened organisational performance through employee engagement and commitment channels rather than through composition alone. The comparatively weaker rating for scheduling and work assignment supports Social Identity Theory's caution that formal opportunity structures can coexist with everyday practices – rosters, shift allocation, task distribution – that still carry gendered assumptions, and echoes the Resource-Based View's emphasis that heterogeneous talent becomes a genuine capability only when routine, not only ceremonial, systems are organised fairly (Barney, 1991; Tajfel & Turner, 1979).

Age Diversity Management

Table 2: Age diversity management – frequency, percentage, mean and standard deviation (n = 152)

Code	Statement	SA %	A %	U %	D %	SD %	Mean	SD	Decision
AD1	Recruitment and selection are fair to qualified applicants across age groups.	8.6	33.6	46.1	11.8	0.0	3.388	0.806	Undecided
AD2	Employees are protected from stereotypes or disrespect based on age.	9.2	35.5	42.8	11.2	1.3	3.401	0.856	Undecided
AD3	Training opportunities are available across age and career stages.	11.8	34.2	44.7	9.2	0.0	3.487	0.822	Agree
AD4	Duties are allocated according to ability and job requirements rather than age assumptions.	9.9	39.5	38.2	12.5	0.0	3.467	0.837	Agree
AD5	Older and younger employees exchange experience, current knowledge and new ideas.	13.2	37.5	42.1	7.2	0.0	3.566	0.811	Agree
AD6	Employees across age groups receive support to use new technology and procedures.	16.4	35.5	41.4	6.6	0.0	3.618	0.837	Agree
AD7	Career progression is based on competence rather than age.	15.8	42.8	37.5	3.9	0.0	3.704	0.779	Agree
AD8	The contributions of employees across age groups are respected.	15.8	48.7	28.3	7.2	0.0	3.730	0.814	Agree
AD	Grand mean – Age diversity management	—	—	—	—	—	3.545	0.688	Agree

Source: Author's analysis of the synthetic demonstration dataset.

Age diversity management recorded a grand mean of 3.545 (SD = 0.688), indicating agreement. AD8, respect for the contributions of employees across age groups, had the highest item mean (M = 3.730, SD = 0.814), with 64.5% agreement. AD7, fair career progression irrespective of age, followed (M = 3.704), and support for adapting to new technology (AD6, M = 3.618) and reciprocal mentoring (AD5, M = 3.566) were also favourable, suggesting a generally positive orientation toward intergenerational learning.

AD1, fair recruitment and selection across age groups, was moderate (M = 3.388, SD = 0.806), with 42.1% agreement and 46.1% undecided. AD2, protection from age-based stereotyping, was similarly moderate (M = 3.401), with 42.8% undecided. These two items indicate greater employee certainty about respect and progression once in post than about entry-stage fairness and protection from stereotyping.

Answer to Research Question Two: age diversity management was perceived favourably overall. Together with the favourable organisational-effectiveness mean, the descriptive pattern suggests that intergenerational respect, competence-based progression and technology support are viewed by employees as contributing to institutional functioning, while entry-stage fairness and stereotype reduction remain the more uncertain elements of age management.

This pattern is consistent with the intellectual-capital argument that age diversity creates value where institutions support knowledge exchange and minimise age discrimination (Li et al., 2020). Public hospitals depend simultaneously on experienced clinical judgement and current technical knowledge, so reciprocal learning – rather than fixed generational assumptions about who mentors whom – is the more appropriate managerial model. The comparatively lower confidence in recruitment fairness mirrors the gender-management finding on scheduling: formal, later-career processes such as progression and respect are rated more favourably than earlier, entry-point processes such as recruitment, again suggesting that Social Identity Theory's categorisation risk is concentrated at points of entry and allocation rather than at points of recognition.

Organisational Effectiveness

Table 3: Organisational effectiveness – frequency, percentage, mean and standard deviation (n = 152)

Code	Statement	SA %	A %	U %	D %	SD %	Mean	SD	Decision
OE1	The institution consistently achieves important service and operational goals.	5.9	32.2	56.6	5.3	0.0	3.388	0.681	Undecided
OE2	Departments coordinate their work effectively.	7.2	36.2	48.7	7.9	0.0	3.428	0.742	Agree
OE3	The institution uses staff, time and material resources responsibly.	7.9	40.8	43.4	7.9	0.0	3.487	0.755	Agree
OE4	Services are delivered in accordance with expected quality standards.	7.9	47.4	38.2	6.6	0.0	3.566	0.734	Agree
OE5	The institution adapts effectively to policy, workforce and service changes.	11.2	40.8	42.8	5.3	0.0	3.579	0.759	Agree
OE6	The institution maintains a capable and motivated workforce.	8.6	53.9	32.9	4.6	0.0	3.664	0.700	Agree
OE7	The institution responds effectively to patient and stakeholder needs.	14.5	47.4	34.2	3.9	0.0	3.724	0.756	Agree
OE8	The institution learns from problems and improves its work processes.	9.9	53.9	34.9	1.3	0.0	3.724	0.653	Agree
OE	Grand mean – Organisational effectiveness	—	—	—	—	—	3.570	0.559	Agree

Source: Author's analysis of the synthetic demonstration dataset.

Organisational effectiveness recorded a grand mean of 3.570 (SD = 0.559), indicating agreement. OE7 (responsiveness to patient and stakeholder needs) and OE8 (learning from problems) each recorded the highest item mean (M = 3.724), with 61.8% and 63.8% agreement respectively. OE1, consistent achievement of service and operational goals, was the weakest item (M = 3.388, SD = 0.681), with 56.6% of respondents undecided – the largest undecided share in the outcome construct suggesting that responsiveness and learning are rated more positively by employees than consistent goal attainment.

Comparative Summary

Table 4: Comparative summary of gender diversity management, age diversity management and organisational effectiveness

Construct	Items	Cronbach's α	Grand mean	SD	Decision
Gender diversity management (GD)	8	0.924	3.604	0.639	Agree
Age diversity management (AD)	8	0.940	3.545	0.688	Agree
Organisational effectiveness (OE)	8	0.904	3.570	0.559	Agree

Source: Author's analysis of the synthetic demonstration dataset.

Gender diversity management recorded the higher of the two independent-variable means (3.604 against 3.545 for age), though both fell within the same favourable “agree” band and both trailed organisational effectiveness only marginally. Standard

deviations below 0.70 at construct level indicate moderate clustering around the mean, with age diversity management showing marginally more dispersed responses (SD = 0.688) than gender diversity management (SD = 0.639), consistent with the larger undecided groups observed on the age-recruitment and age-stereotyping items.

DISCUSSION OF FINDINGS

Taken together, the results indicate that employees across the three institutions perceive both gender and age diversity management favourably, and that these perceptions co-occur with a favourable perception of organisational effectiveness. This descriptive co-occurrence is consistent with international and African healthcare evidence linking gender diversity management to employee performance and engagement (Adam & Alfawaz, 2025; Ferrary & Déo, 2022; Obeng et al., 2025b) and with the broader intellectual-capital literature on the value of well-managed age diversity (Li et al., 2020).

A consistent pattern emerges across both independent variables: items concerned with recognition, progression and respect once an employee is already established in post (GD7, GD8, AD7, AD8) receive the most favourable ratings, while items concerned with entry-point or allocative fairness gendered work assignment and scheduling (GD2), and age-related recruitment and stereotyping (AD1, AD2) receive the least favourable, moderate ratings. Read through Social Identity Theory, this suggests that categorisation risk in these institutions is concentrated at the points where gender and age become visible criteria for allocating scarce opportunities – who is scheduled for which shift, who is recruited, who is presumed capable – rather than at the point of formally recognising established staff. Read through the Resource-Based View, it suggests that the institutions have made more progress converting gender- and age-diverse talent into recognised capability than into a fully transparent allocation system from the point of entry.

The organisational-effectiveness pattern reinforces this reading. OE1 (consistent goal attainment) was the weakest-rated effectiveness item, with the majority of respondents undecided, while responsiveness and learning (OE7, OE8) were the strongest. This mirrors the diversity-management pattern in which downstream, relational indicators outperform structural, allocation-linked indicators, and is consistent with Turi et al. (2022), who found that diversity's contribution to organisational performance is conditional on leadership and organisational climate rather than automatic. It also lends support to the paper's decision to combine Social Identity Theory and the Resource-Based View: neither theory alone would explain why the same institutions can be simultaneously favourable on relational fairness and only moderately favourable on allocative and goal-attainment fairness.

5. CONCLUSION AND RECOMMENDATIONS

Conclusion

This paper examined gender diversity management and age diversity management in relation to organisational effectiveness in three public health institutions in Ondo State, Nigeria, using Social Identity Theory and the Resource-Based View as a joint theoretical lens. The descriptive results indicate that both gender and age diversity management are perceived favourably overall, alongside a favourable perception of organisational effectiveness, but that fairness is less consistently perceived at points of entry and allocation – recruitment, scheduling and work assignment – than at points of recognition and progression once employees are established.

The central conclusion is that gender and age diversity management in these institutions should be judged through everyday, allocative systems rather than through representation or formal policy statements alone. Leadership access, complaint handling and career progression appear comparatively strong; scheduling, work assignment, recruitment fairness and protection from age stereotyping are the areas most in need of visible, consistently applied criteria. No causal conclusion is drawn: frequency, percentage, mean and standard deviation cannot establish statistically significant effects, and because the dataset used for this demonstration is synthetic, authentic field evidence is required before any institutional or policy claim is made about the three named hospitals.

Recommendations

Publish transparent, gender- and age-neutral eligibility and scoring criteria for recruitment, work allocation, training, acting appointments and promotion, with documented reasons for selection and an impartial review route.

Audit duty rosters, shift allocation, high-risk assignments and access to desirable rotations by gender and age group periodically, investigating unexplained patterns while recognising that fairness requires job-related reasons and proportionate workload rather than identical assignments.

Strengthen non-retaliatory, confidential channels for gender-related complaints, with defined acknowledgement, investigation, feedback and appeal timelines, and an alternative channel where the immediate supervisor is implicated.

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