Health Leadership and Management Development in Malawi: Towards a Theory for Health Systems Strengthening

Thomasena O'Byrne
2022

Supervised by: Dr Frédérique Vallières

This dissertation is submitted to the University of Dublin in fulfilment of the
requirements for the award of the Doctorate in Philosophy,
School of Psychology

Declaration

I, Thomasena O'Byrne, declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

I agree to deposit this thesis in the University's open access institutional repository or allow the Library to do so on my behalf, subject to Irish Copyright Legislation and Trinity College Library conditions of use and acknowledgement. I consent to the examiner retaining a copy of the thesis beyond the examining period, should they so wish (EU GDPR May 2018).

Thomasena O'Byrne
31st December, 2021

Dedication

"There's a crack, a crack in everything
That's how the light gets in"
Leonard Cohen

This thesis is dedicated to Papa, Mum, Caitlin, and Sarah.
My past, present and ongoing light.

Acknowledgements

Executive Summary

Background: Despite health leadership and management development featuring highly on the global agenda, there remains a dearth of literature demonstrating its effectiveness within low and middle-income countries (LMICs), and particularly in sub-Saharan Africa (SSA). Indeed, much of the empirical research and international funding for developing health leadership and management has taken place in high income settings, often failing to account for organisational and cultural context as well as stark disparities in available resources. Accordingly, key thinkers have called not only for more evidence-based research on approaches to developing leadership and management within SSA, but for efforts to engage more with context, so as to understand how to best strengthen health systems with such approaches. Moreover, central to international policies, frameworks and interventions, is the emphasis on placing people at the centre of health systems. This relates not only to people as consumers of healthcare but to the providers as well, reminding us that the health system is a 'human system'. Here too, however, there is a sparsity of literature around the role that people play in strengthening health systems across different contexts. Launched by Malawi's Ministry of Health and Population (MoHP) in 2019, the Leadership and Management Task Team for Health Managers was initiated to address 'weak' leadership across the health sector as well as to harmonise efforts and build capacity across the health workforce to address broader system challenges, meet global health goals, and improve health system performance.

Objectives: The aim of this thesis is to develop a theoretical model for how health leadership and management can be understood and further developed for health systems strengthening in Malawi. To address this research question, the following four research objectives are put forward: 1) To offer an in-depth description of current leadership and management for health systems strengthening efforts in the context of Malawi; 2) To describe how key stakeholders conceptualise and understand health leadership and management in this context; 3) To identify why health leadership and management approaches are being used to strengthen health systems within this context; 4) To explore how the development of health leadership and management approaches are being implemented in practice in Malawi.

Methodology: The research objectives were addressed using a qualitative case study approach, underpinned by a constructivist epistemology, and drawing on the concepts and tools of soft systems thinking and grounded theory approaches. Research objective 1 was addressed by **Phase 1**, which consisted of an exploratory stage consisting of a broad desk review and preliminary field work. Results from Phase 1 were then brought forward in **Phase 2**, which consisted of conducting and analysing 37 semi structured, in-depth interviews with a diverse range of stakeholders. Stakeholders included individuals from non-profit organisations, development partners and external funders, academics and researchers, and those working for the MoHP across all levels of the health system. Interviews were supplemented by documentary review and non-participant observation, all of which contributed towards mapping the research to generate an in depth understanding of the context and its key stakeholders, in fulfilment of objectives 2 and 3. This was then visualised through context diagramming and map-making, resulting in advancing our understanding of the Malawian health system. Findings were regularly fed back to stakeholders, which together with further analyses conducted in **Phase 3**, resulted in the identification of how health leadership and management approaches are being implemented in practice Malawi, in fulfilment of objective 4.

Key Findings: Together, findings from the three phases are synthesised to propose a theory for how health leadership and management, as an approach to health system strengthening, can be understood and further developed within the context of Malawi. Findings highlight challenges and strengths to previous and current efforts to HSS and evidence a need for a

greater understanding for how health leadership and management is being developed in this context. Insights were gathered from the values that people attached to perceived effective leadership and management (e.g. teamwork, relationships, safe spaces, mutual respect, decision-space), whilst also revealing common negative traits and characteristics participants ascribed to ineffective leadership and management (e.g., lack of training, unsupportive, poor accountability, hierarchical). There was an element of individualistic framing of leadership in this context; in the sense that it was noted as important to focus on one's own leadership style first, before turning to others, but ideals of effective leadership and management principally emerged in the eyes of the participants and others, as being more relational in nature, and aligned with the principles and styles of a collective or distributed leadership approach.

Findings suggested that perceived political interference and bureaucratic inertia was stalling the decentralisation process, with an evidenced reluctance from central level to devolve power and enable autonomy further down the health system structure. A common expected outcome of developing health leadership and management at district level in Malawi was that any efforts to develop health leadership and management would 'trickle down' to primary level, leading to improved workforce performance, better service delivery, rises on the demand side of healthcare with increased patient satisfaction, and a happier and well-motivated health workforce. There was limited evidence to suggest that evaluation of efforts, often short-term, provided strong linkages between the development of health leadership and management and HSS more broadly. With much of the focus being directed at district level and district health management teams (DHMTs), it was evidenced that these already overburdened teams faced unrealistic expectations as health leaders and managers. Findings thus highlighted a stark contrast between what stakeholders assumed to be happening and the lived experiences of those intended to benefit from leadership and management interventions.

A tangible lack of attention was directed towards HRH at primary health care level, with findings highlighting the negative impact of an unsupportive working environment and organisational culture on health leaders and managers at lower tiers of the health system, as well as on other HRH, and patients. Need was identified for efforts to extend to developing health leadership and management at all levels of the health system, leveraging existing, yet often ignored strengths and resilience at primary health care level. Thus, the development of health leadership and management in Malawi should be inclusive, system-wide, collective, integrated, more supportive and attentive to the needs of the healthcare worker, as well as being open to learning and mindset change.

Conclusions: This thesis provides evidence for the everyday resilience of the seemingly often neglected primary health care system and overlooked frontline HCW in Malawi, calling for leadership and management capacity to also be developed at this level, as well as at other levels of the health system. For leadership and management development to contribute to HSS, it must be aligned to the principles of systems thinking and applied faithfully system wide to enable people to better cope with their contexts. Moreover, this research contributes to calls for commitments to reorientating health systems towards PHC to go beyond rhetoric to action, highlighting investment in people-centred health systems to mean investment in human resources for health (HRH) as well as patients and the wider community.

Table of Contents

List of Tables and Figures

Acronyms and Abbreviations

Abbreviation	Full Name
AEHO	Assistant Environmental Health Officers
AFIDEP	African Institute for Development Policy
AHPSR	Alliance for Health Policy & Systems Research
AU	African Union
CAS	Complex Adaptive Systems
CCM	Community Case Management
CDC	Centres for Disease Control
CGH	Centre for Global Health
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
CHSS	Community Health Services Section
CHW	Community Health Worker
COM	College of Medicine
CRT	Critical Systems Thinking
DC	District Commissioner
DDHSS	District Director of Health and Social Services
DEHO	District Environmental Health Officer
DHMT	District Health Management Team
DHO	District Health Officer
DHRMD	Directorate of Human Resources Management and Development
DHSSi	District Health Systems Strengthening Initiative
DIAHLS	District Innovation and Action Learning for Health Systems Development
DIP	District Implementation Plans
DoH	Department of Health
DPPD	Directorate of Planning and Policy Development
EHP	Essential Health Package
EIDM	Evidence-informed decision making
ETAT	Emergency Triage Assessment Treatment
EVIDENT	National Evidence Informed Decision Making Network for Health Policy and Practice in Malawi
EVIPNet	Evidence-informed Policy Network
GDPR	General Data Protection Regulation
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GP	General Practitioner
HCIGs	of Health Centre Improvement Grants
HCMCs	Health Centre Management Committees
HCW	Healthcare Worker
HEPU	Health Economics and Policy Unit (HEPU)
HICs	High Income countries
HPSR	Health Policy and Systems Research
HRH	Human Resources for Health
HRIS	Human Resource Information System

HRM	Human Resource Management
HSA	Health Surveillance Assistant
HSS	Health Systems Strengthening
HSSP II	Health Sector Strategic Plan II
IFMIS	Integrated Financial Management System
IMF	International Monetary Fund
ISS	Integrated Supportive Supervision
KCN	Kamuzu College of Nursing
KUHeS	Kamuzu University of Health Sciences
LDPs	Leadership Development Programmes
LGA	Local Government Act
LMICs	Low and Middle-income countries
LOI	Letter of Intent
LSTM	Liverpool School of Tropical Medicine
MAC	Malaria Alert Centre
MDGs	Millennium Development Goals
MHSP-TA	Malawi Health Sector Programme -Technical Assistance
MIM	Malawi Institute of Management
MLGRD	Ministry of Local Government and Rural Development
MoHP	Ministry of Health and Population
MLW	Malawi-Liverpool-Wellcome Trust
MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
MSI	Management strengthening intervention
NCDs	Non-communicable diseases
NCHS	National Community Health Strategy
NGO	Non-Governmental Organisation
NHSRC	National Health Sciences Research Committee
NQPS	National Quality Management Policy and Strategy
PHIM	Public Health Institute of Malawi
PIH	Partners in Health
QMD	Quality Management Directorate
RMNCH	Reproductive, maternal, newborn and child health
ONSE	Organised Network of Services for Everyone's Health Activity
OPC	Office of the President and Cabinet
PAR	Participatory Action Research
PEA	Political Economy Analysis
PHC	Primary Health Care
PI	Principal Investigator
P2S	PERFORM2Scale
QECH	Queen Elizabeth Central Hospital
QMD	Quality Management Directorate
QoC	Quality of Care
REACH Trust	Research for Equity and Community Health Trust
RESYST	Resilient and Responsive Health Systems
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SDI	Staff Development Institute
SHSAs	Senior HSAs
SSA	Sub-Saharan Africa
SLAs	Service-level-agreements

SSM	Soft Systems Methodology
SWAp	Sector-wide approach
TCD	Trinity College Dublin
ToC	Theory of Change
ToT	Training of the Trainers
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UNIMA	University of Malawi
USAID	United States Agency for International Development
VHCs	Village Health Committees
WHO	World Health Organisation
WHO AFRO	WHO Regional Office for Africa

Chapter 1: Introduction

1.1 Chapter Introduction

This thesis is about systems thinking, health systems strengthening, and approaches to developing health leadership and management in sub-Saharan African (SSA) settings, and more specifically, Malawi. Informed by a qualitative case study methodology, drawing on the concepts and tools of soft systems thinking and grounded theory, the purpose of this work is to advance our understanding and theory on developing leadership and management capacity within the Malawian health system. Underpinned by a constructivist epistemology, this thesis evidences the complex interactions and patterns of relationships within the health system through exploring the perspectives and interpretations that emerge from an array of stakeholders, as well as insights gained from being embedded in the Malawian context. Launched by the Malawi's Ministry of Health and Population (MoHP) in 2019 the Leadership and Management Task Team for Health Managers was initiated to address 'weak' leadership across the health sector as well as to harmonise efforts and build capacity across the health workforce to address broader system challenges, meet global health goals, and improve health system performance.

1.2 Overview of the Study Background

1.2.1 Universal Health Coverage

The Sustainable Development Goals (SDGs), the recent 40th anniversary of the Alma-Ata Declaration – which identified Primary Health Care (PHC) as the official health policy of 'Health for All' across the globe – and more recently, the devastating effects of the COVID-19 pandemic, have all served to reinforce the call to strengthen primary health care systems towards Universal Health Coverage (UHC) by continuing to invest in health (George et al., 2019; Ghebreyesus et al., 2018; WHO, 2020). Strengthening health systems, however, involves significant efforts to improve health system performance (Kutzin & Sparkes, 2016), as a prerequisite to reaching UHC and the SDGs (UHC2030, 2018; WHO, 2017). Should strengthening health systems not take precedence on the global health agenda, UHC is likely to "remain an empty promise" (Meessen et al., 2014, p. 78; Watkins et al., 2018).

1.2.2 Global Spotlight on Health Systems

Health systems are commonly described as "all organisations, people and actions whose primary intent is to promote, restore or retain health" (WHO, 2007, p. 2). Prior to 2019, the need for strong and resilient health systems was often cited in reference to disease outbreaks, such as the West Africa Ebola virus or Zika virus (Gulland, 2016; Kieny et al., 2017; Kruk et al., 2015). Embedded in these narratives was a sense of "them" and not "us", in terms of which countries such outbreaks impacted on most, and which health systems did, or did not, weather the challenge. The advent of COVID-19, however, served as a sobering wake-up call to virtually all countries and populations around the world (English et al., 2020; Gilson et al., 2020). Suddenly "them" and "us" became "we", with all eyes on the global health system, and with all hope and reliance on the health workforce working at their full capacity (Nagesh & Chakraborty, 2020). This thesis is not about the resilience of health systems during a global pandemic, however, but rather it is about the people at the centre who give life to health systems pandemic or no pandemic: the Human Resources for Health (HRH).

1.2.3 No Health System without a Health Workforce

HRH, also referred to as the health workforce, comprises "all people engaged in actions whose primary intent is to enhance health" (WHO, 2006, p. 1). Considered the backbone of any health system, when working effectively, the health workforce remains fundamental to achieving UHC (Watkins et al., 2018). With the 2018 Astana Declaration calling for renewed political commitment to developing integrated people-centred health services and to strengthen PHC as the foundation of strong health systems, the baton is firmly in the hands of a supported and effective health workforce to meet population needs (Kraef & Kallestrup, 2019; WHO; 2018). It is well evidenced that in the absence of a well-performing workforce, the scaling up of health interventions and services, especially in low-and middle-income countries (LMICs) is likely to be severely hindered, if not unachievable (Mshelia et al., 2013; WHO, 2016). Such a critical barrier to progress contributes to the ongoing crisis in HRH, which continuously faces challenges in recruiting, financing, managing, motivating, training and retaining a health workforce regardless of commitments and declarations (Afriyie et al., 2019; Willcox et al., 2015) .

1.2.4 Human Resources for Health 'in crisis'?

More recently, there has been much discussion about how much progress has been made in addressing the HRH crisis, with calls from Mandeville et al. (2016) to "move out of this crisis mode" (p. 220) and start working on long-term solutions. Correspondingly, a core vision of the *Global Strategy on Human Resources for Health 2030* is to "accelerate progress towards UHC and the UN SDGs by ensuring equitable access to health workers within strengthened systems "(p.8). At the Fourth Global Forum of Human Resources for Health in Dublin, 2017, projections indicated an additional 40 million health worker jobs would be created by 2030 (WHO, 2016). However, this figure represents jobs created in predominantly upper-middle and high-income countries. Anticipated for the same period is a needs-based shortfall of 18 million health workers, with gaps predominantly in LMICs, where the highest burden of morbidity and mortality remains (WHO, 2017). This highlights the continued burden of health workforce shortages falling heaviest on LMICs, a widening of the HRH workforce inequity gap, and offers no signs of an alleviated HRH crisis. When closing the Global Forum of HRH, progress on the crisis in HRH was cited in relation to Seamus Heaney's "The Cure at Troy", claiming with hope and optimism that "a further shore is reachable from here". Situating this within the current context of the aforementioned figures, one might be forgiven for thinking that there is still huge ground to cover (Fieno et al., 2016).

1.2.5 Where the Crisis Hits Hardest

Despite efforts to implement HRH plans, scale-up interventions, and train health workers, SSA falls far behind other World Health Organization (WHO) regions when it comes to HRH progress (Afriyie et al., 2019; Agyepong et al., 2017; Frenk, 2010). At one point, SSA housed 37 out of the world's 57 HRH crisis countries on the continent (Fieno et al., 2016). The figures for health worker shortages further illustrate the extent of the HRH crisis in SSA. For example, 80% of the SSA population are without a physician and 60% are without a nurse or midwife (Asamani et al., 2019). Despite the highest burden of disease, the continent only has access to 1% of the world's health professionals (WHO, 2006), perpetuating a self-reinforcing cycle. Furthermore, the misdistribution of health workers in SSA, whereby health workers are predominantly found in urban areas, contributed to the estimated "77% of the rural population with no access to health care services in 2015"

(Scheil-Adlung, 2015). Willcox and colleagues (2015) as well as Scheffler et al., (2009) have commented on the projected "stagnation" within HRH, indicating that many African countries will be unable to employ, produce, and retain the health workers needed to achieve UHC. Accordingly, the Lancet Commission's report on the future of health in SSA (2017) highlights the development of the health workforce as one of the critical areas to building health systems, commensurate with Africa's health needs and the challenges of the 21st century. As expressed by Agyepong et al., (2017), "the opportunities ahead cannot be unlocked with more of the same approaches and by keeping to the current pace" (p.2803).

1.2.7 "Without leaders, even the best designed systems will fail"

Leadership and management are often treated as theoretically different but may practically be considered one and the same when it comes to relevant competencies needed for strengthening complex adaptive health systems (CAS) in LMICs, as contexts where health managers are given a very broad scope of responsibility and that are often overburdened (Daire et al., 2014; Gosling & Mintzberg, 2003). Specifically, strong leadership and management capacity in any health system is considered key to a health system's effectiveness and resilience (Daire et al., 2014; De Savigny & Adam, 2009; Gilson et al., 2017). Despite a plethora of policy documents, pledges, strategies and reports that call for and are committed to strengthening leadership and management for effective health workforce governance and stewardship however, weaknesses especially persist in LMICs, impacting on the performance of the system and on population health outcomes (Anand & Bärnighausen, 2004; Brinkerhoff & Bossert, 2014; Dieleman & Hilhorst, 2011; Johnson et al., 2021; Lim & Lin, 2021; RESYST/DIAHLS learning site team, 2020; Speybroeck et al., (2006); WHO, 2020).

General approaches to developing leadership and management tend to concentrate on formal training, on-the-job-training, and in more recent years, the use of participatory approaches such as action learning (Cleary et al., 2018; Martineau et al., 2018; Nzinga et al., 2021; Tetui et al., 2017; RESYST/DIAHLS, 2020). In SSA, strengthening leadership and management is largely focused at district level, with some attention to specific cadres of health workers at primary and community level, but rarely focusing on the system as a whole (Bonenberger et al., 2014; S. Bradley et al., 2013; Kwamie et al., 2015; Mshelia et

al., 2013; RESYST/DIAHLS, 2020; Tetui et al., 2017). A focus on district level managers is largely based on the premise that workforce performance improvement is best achieved by intervening at management levels close to frontline health workers (Fetene et al., 2016; Martineau et al., 2018), with managers perceived to have a greater "decision space" (Bossert, 1998) for implementing strategies. However, and while interventions and approaches for strengthening leadership and management are increasingly common, with district strengthening specifically increasing in popularity, there remains limited evidence to suggest that health systems in LMICs are transformed in the long-term (Daire et al., 2014; Johnson et al., 2021).

Moreover, some have called for leadership and management interventions to go beyond everyday managerial skills by including a focus on the 'software' of health systems, encompassing other types of managerial strategies, organisational capacities, and in recognition of the importance of understanding complex relationships and interactions at all levels of the system (Agyepong et al., 2018; Bulthuis et al., 2021; S. Cleary et al., 2018; Gilson et al., 2017; Heerdegen et al., 2020; Kok et al., 2017a; Nzinga et al., 2021; RESYST/DIAHLS, 2020). Here, and whereas the hardware of a system refers to the more defined building blocks of a health system (e.g. infrastructure, finances, human resources, commodities), the software of a system therefore refers to both tangible (e.g. knowledge, skills) and intangible (e.g. values, relationships, norms, power) components (Elloker et al., 2012; Gilson et al., 2017). Despite interest in the field, funding the development of leadership and management in LMICs remains fairly elusive, which may, in part, be due to the limited evidence-base, including rigour of evaluation, demonstrating the impact of leadership and management on performance of the overall system(Gilson & Agyepong, 2018; Johnson et al., 2021).

1.3 Focus of the Study

1.3.1 Background to the Research Question

A management strengthening intervention (MSI) for district health managers to improve health workforce performance was tested in three African countries (Ghana, Tanzania and Uganda) during the PERFORM project between 2011 and 2015. Management teams worked together to solve workforce performance problems, within existing resource constraints, aimed at improving health leadership and management as well as improving

health service delivery. To have a wider impact, and thus contribute to UHC, the MSI is being scaled up as part of the PERFORM2Scale (P2S) project (funded by European Union Horizon 2020 Research and Innovation programme). The overall aim of the P2S project is to develop and evaluate a sustainable approach to scaling-up the district-level management strengthening intervention (developed under the PERFORM project) in different and changing contexts. This involves implementation of the MSI across 27 districts in Ghana, Malawi and Uganda and is managed through a consortium of seven partners from African and European countries, including the Trinity Centre for Global Health at Trinity College, Dublin (TCD). This research partnership of seven partners was established at the start of 2017 with a focus on health systems, human resources, management and public health within the health sector of low-and-middle-income countries.

As one of the seven consortium members, TCD has been tasked with contributing expertise in capacity development, health systems strengthening and implementation research. Additionally, TCD is a paired with the Research for Equity and Community Health (REACH) Trust in Malawi. The purpose of this paired partnership is to ensure continuous support and interaction between the EU partner and African institution (DOA, 2016). As one of the world's 57 HRH crisis countries, and as the paired partner to TCD through the P2S project, Malawi provided an opportune context within which to situate my own doctoral research. Moreover, my own interest in this subject emerged from my background living and working in Malawi for over eight years, where I developed a strong interest in understanding and improving pathways to care between primary, district and tertiary levels of health care. Coming from this background, and within my existing role as a health systems researcher in Malawi, I was motivated to understand more broadly how management and leadership is being developed as part of health system strengthening efforts, and how stakeholder perspectives can be leveraged to enhance our understanding of advances in leadership and management, as a strategy employed to mitigate the dearth of HRH in this context.

1.3.1.1 Structure of the Malawian Health System

Ongoing since the 1990's, the Malawi Department of Local Government commenced a process of devolution whereby administration and political authority was transferred to district and local levels (Kutengule et al., 2014). While the process of decentralisation in Malawi is still considered to be in transition (Chikaphupha et al., 2021), the delivery of

health services has largely been decentralised and management and implementation of health service provision at district and lower levels falls under the responsibility of the Ministry of Local Government and Rural Development (MLGRD).

Health care services in Malawi are provided by both the public and private sectors. The public health services are provided for free while the private sector charges user fees. The Malawian health system is described as consisting of four levels connected through a patient referral system: community, primary, secondary, and tertiary. Health care in Malawi is mostly delivered through government facilities (63%) which are free at the point of access. The remainder of care is delivered by the Christian Health Association of Malawi (CHAM; 26%) and the rest by private and civil society providers (WHO, 2018; 11%). CHAM is the largest non-governmental healthcare provider and trainer of healthcare practitioners in Malawi. A useful visual of the different system levels, delivery system, and services offered in Malawi can be seen in Figure 1.1.
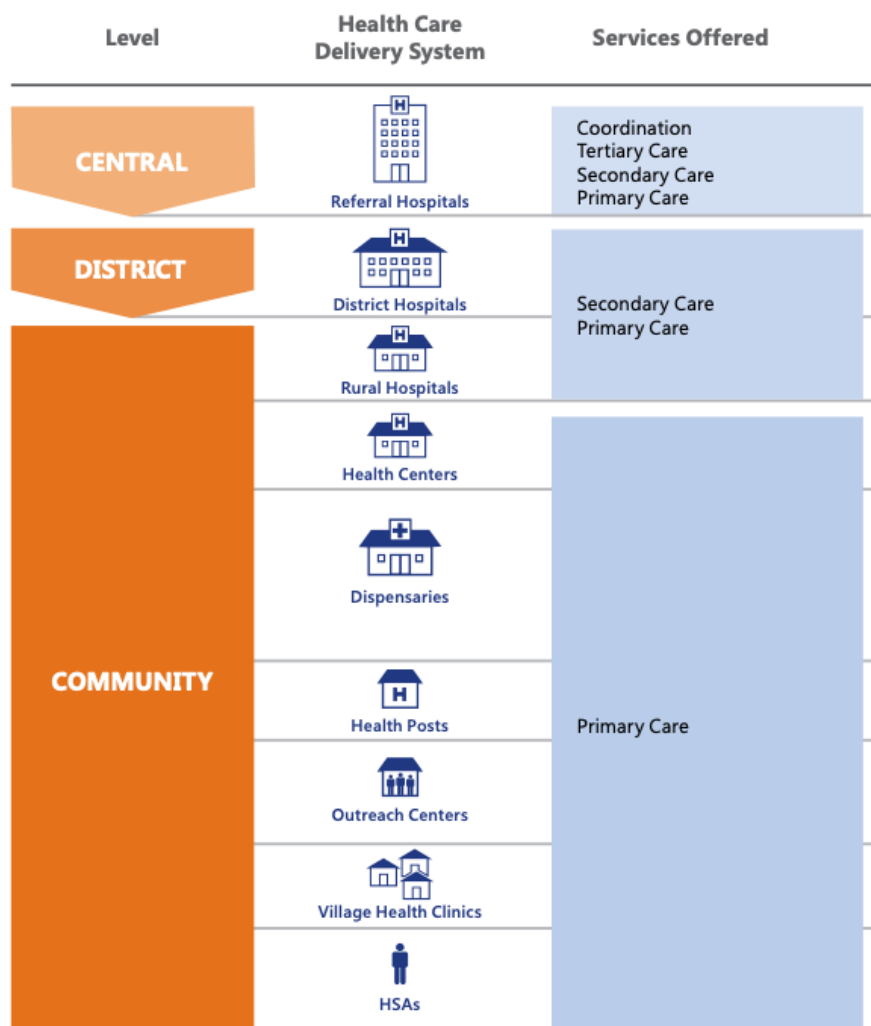
Figure 1. 1 Malawi's Health System (Source from Devlin et al., 2016)

More recently, efforts towards decentralisation have led to a recent restructuring between the different levels of the health system. The position of District Health Officer (DHO), for example, has been renamed District Director of Health and Social Services (DDHSS) and now reports directly to the District Council (DC) instead of the MoHP, receiving directives from the District Commissioner as the head of the council. As appointments of District Commissioners are made directly by the President however, they are not always considered as politically neutral, often facing pressure from national level (Chiweza, 2015; Chiweza, 2011). This is contrary to the ethos of decentralisation and autonomy. That said, the DHSS has now been empowered to recruit, promote, and transfer staff at the primary care level, which may include the potential for increased ownership and broadening of decision-making space (Mohammed, North and Ashton, 2016). Another promising signal is the MoHP's expressed desire to strengthen health leadership and management of district level managers (Government of Malawi, 2017). This desire to strengthen leadership and management is widely accepted to be in response to concerns around the strength of management at district level: despite Malawi having a decentralisation process, District level managers and management teams are still considered to have limited decision space, primarily because of power imbalances, but also due to other factors that are explored in greater detail throughout the remainder of the thesis (Bulthuis et al., 2021).

1.3.2 Statement of the Problem

As efforts and investment to strengthen health systems in LMICs, such as Malawi, continue to increase, with a view to meeting the SDGs and achieving UHC, interest in leadership and management development as part of these efforts will likely remain high (Bradley et al., 2015; Dieleman et al., 2009a; Rockers & Bärnighausen, 2013; Roman et al., 2017; RESYST/DIAHLS, 2020; Yeager & Bertrand, 2015). Despite health leadership and management development featuring highly on the global agenda, however, there is a dearth of literature demonstrating its effectiveness within LMICs, and especially within SSA (Figueroa et al., 2019; Gilson & Agyepong, 2018; Johnson et al., 2021). Indeed, much of the empirical research and international funding for developing health leadership and management has taken place in high income settings, often failing to account for cultural context as well as stark disparities in available resources (Figueroa et al., 2019; Gilson &

Agyepong, 2018). Accordingly, key thinkers have called not only for more evidence-based research on approaches to developing leadership and management within SSA, but for efforts to engage more with context, so as to understand *how* to best strengthen health systems with such approaches (Gilson & Agyepong, 2018; Kwamie, 2015; RESYST/DIAHLS, 2020). Such research is necessary to provide a richer understanding of how approaches to developing health leadership and management may work to address HRH challenges more broadly, if at all, within the context of the health system and health systems strengthening.

Moreover, given the renewed emphasis on integrated, people-centred health services, is the emphasis on placing people at the centre of health systems, or indeed, viewing the health system as a human system (Agyepong et al., 2017). When considering health leadership and management approaches, this 'people complexity' (Jackson & Sambo, 2020) is often absent from the literature, prompting calls for more soft systems thinking and soft systems approaches to explore the different stakeholder perspectives and relationships at the centre of health systems strengthening (Gilson et al., 2017; Jackson & Sambo, 2020; Kok et al., 2017b; RESYST/DIAHLS, 2020; Sheikh et al., 2014) . In specific, prioritising soft systems approaches may help to bring people complexity to the fore, making learning and progress more tangible and evidence based.

1.3.3 Purpose Statement, Research Question and Research Objectives

Considering the aforementioned gaps, the overall aim of this research was to understand and subsequently construct a theory to advance our knowledge of how current approaches to improve health leadership and management can be understood and further developed to strengthen the Malawian health system.

To address this research aim, the following four research objectives are put forward:

1) To offer an in-depth description of current leadership and management for health systems strengthening efforts in the context of Malawi, including the identification of key stakeholders involved.

2) To describe how key stakeholders conceptualise and understand health leadership and management in this context;

3) To identify why health leadership and management approaches are being used to strengthen health systems within this context;

4) To explore how the development of health leadership and management approaches are being implemented in practice in Malawi.

Taken together, these objectives will therefore contribute towards addressing the identified need to engage more with context to understand health leadership and management development as part of health system strengthening in Malawi. Moreover, objectives 1 to 4 will contribute towards the need for more evidence-based research on developing health leadership and management within SSA, with particular attention paid to understanding these concepts from the perspectives of stakeholders.

1.3.4 Significance of the Research

This research contributes towards advancing theory, policy and practice, using (soft) systems thinking for health systems strengthening in Malawi. While there are a small number of studies focused on health leadership and management practices in Malawi, these are predominantly conducted with regards to a specific, externally led, intervention, with no studies to date offering an in-depth explanation and mapping of current leadership and management development efforts across the country, including why and how these are being implemented in this context.

Specifically, this research generates insights into the type of leadership and management that people want, as well as insights into how people think that leadership and management development may enable system change, which may also contribute to future efforts and help to define which approach(es) may be best suited to the Malawian context, including who and where to target. Results are synthesised to propose a theory for how health leadership and management, as an approach to health system strengthening, can be understood and developed within the context of Malawi, with relevance for similar settings globally. Findings from this research also have important implications for policy and practice, both within Malawi, and towards a better understanding of how improving

leadership and management may or may not contribute to health system strengthening more broadly.

1.4 Structure of the Thesis

This research is organised into seven chapters that describe the body of work, the research process, findings, and their implications for theory, policy and practice.

Chapter 1 provides an overview of the study background, including an introduction to the HRH crisis in SSA as well as the current focus on developing health leadership and management as a way of tackling the HRH crisis and strengthening health systems. Against this background, the research problem, purpose, question, objectives, and a statement on the significance of the research are put forward.

Chapter 2 builds on the background presented in Chapter 1 in the form of an extensive literature review. Specifically, key literature is presented and synthesised across four subsections: (1) the conceptualisation of health systems and health systems strengthening, with an overview of the different levels of a health systems; (2) an introduction to systems thinking and its different theories, methods and tools, as well as how they can be used as an approach to strengthening health systems; (3) the contextualisation of the research to SSA; and (4) the use of health leadership and management approaches for health systems strengthening. The chapter concludes by identifying key gaps in extant knowledge, as the foundation for the thesis.

Chapter 3 describes in detail the choice or methodology and process undertaken. It describes social constructivism as the epistemological stance in this thesis and provides a rationale for choosing a qualitative case study methodology that draws on the concepts and tools of soft systems thinking and grounded theory approaches, as the methods of data collection and analysis. Trustworthiness, reflexivity, and ethical considerations for this research are also discussed.

Chapter 4 is the first of three empirical chapters. Results are presented so as to address the first objective of this research, by offering an in-depth description of the context of Malawi relevant to developing leadership and management for health systems strengthening,

including the identification of initiatives and stakeholders when it comes to leadership and management development within the Malawian health system.

Chapter 5 introduces the study participants, and reports the findings in fulfilment of objectives two and three, offering an in-depth analysis of how people conceptualise and understand effective leadership and management within the context of Malawi, and why leadership and management approaches are used as a strategy to strengthen the health system within this context.

Chapter 6 addresses the final research objective by describing how the development of health leadership and management approaches are being implemented *in practice* in Malawi, towards advancing our understanding of how leadership and management practices, or lack thereof, are manifested "on the ground".

Chapter 7 provides a synthesis of the findings from chapters four to six towards a 'theory' for how health leadership and management can be understood and further developed for health systems strengthening in Malawi. Research findings are also discussed in terms of their implications for policy, practice, and future research.

Chapter 2: Literature Review

2.1 Chapter Introduction

This chapter situates this thesis within the literature by providing important background information across four distinct, but related, sections:

Section 2.2 Conceptualising Health Systems and Health Systems Strengthening
Section 2.3 Seeing Wholes Rather than Parts: A Systems Thinking Lens
Section 2.4: Context Matters: Health Systems Strengthening in SSA
Section 2.5: Health Leadership and Management as a strategy to strengthen Health Systems

The key outcomes of this chapter include an analytical review of key concepts and relevant theory within the field of Health Policy and Systems Research (HPSR), evidencing the existing gaps in knowledge that this research will contribute towards addressing. Specifically, these outcomes are achieved through a review of the extant literature in health systems, including a review of relevant health systems theories and frameworks, with an emphasis placed on health systems strengthening, systems thinking, and the use of health leadership and management approaches for HRH as a way to improve health system performance and health system strengthening. The chapter concludes by identifying key gaps in knowledge as the foundation for the research objectives, and as a precursor to the methods chapter.

2.2 Conceptualising Health Systems

Historically, efforts towards improving health outcomes have focused primarily on "vertical" or intervention or disease-specific health programming, such as programmes developed to address HIV/AIDS, Tuberculosis and Malaria, with variable levels of success (Murray & Frenk, 2000; Sherr et al., 2013). Attention later shifted to the role of the broader health system and PHC, in recognition that vertical health interventions may be more effective and sustainable when considered as part of the broader health system (Bassett et al., 2013). Today, it is widely accepted that strengthening health systems is crucial to improving health outcomes (Adam et al., 2012; Evans et al., 2008). Specifically, efforts designed for health systems strengthening (HSS) will lead to improved health systems

performance, successful scale up of health interventions, and accelerate progress towards the health-related SDGs and advancing UHC (Kruk et al., 2018; Shakarishvili et al., 2010).

Accordingly, a growing evidence base for HSS over the last couple of decades has coincided with increased funding for HSS initiatives, both globally and nationally. Such interest has further provoked much discussion around defining and understanding health systems, a call for more HPSR, and has led to a plethora of health systems frameworks, a number of which are reviewed in Section 2.2.3 (Bennett et al., 2011; Sheikh et al., 2011). Over the years, definitions of health systems have varied, with health systems being described as "a means to an end", as a "black box" (too complicated), as a "black hole" (too costly to fix), or as a laundry list (inventory of organisations)" (Frenk, 2010, p. 1; Tumusiime et al., 2019). These latter definitions however, view health systems as problematic, resource draining, and disconnected. In contrast, one of the more evolved and widely used definitions of health systems first appeared in the WHO's *World Health Report 2000*, which described health systems as comprised of 'all organisations, people and actions whose primary intent is to promote, restore or retain health'. The initial goals attached to this definition, and later echoed by the responsibilities attached to UHC, included a focus on "'improving health and health equity in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources" (WHO, 2007, p. 2)

2.2.1 Health Systems Strengthening

Perhaps more so debated than what constitutes a "health system", is the lack of consensus on what constitutes "health systems strengthening" (Witter et al., 2019). The term HSS evolved in response to the growing field on HPSR, HSS initiatives, and as a result of the continued drive and need to understand what does and does not work, and for whom, in terms of improving health outcomes. Accordingly, the WHO (2011, glossary) defines HSS as "any array of initiatives that improves one or more functions of the health system and leads to better health through improvements in access, coverage, quality or efficiency". Adding to this definition, Chee et al (2013) further emphasise that efforts should lead to a permanent change in system's functionality, and "not just fill[ing] gaps or support[ing] the system to produce better short-term outcomes" (p. 87). Others again have added more specificity to the term. The Alliance for HPSR's third flagship report *Systems Thinking for*

Health Systems Strengthening (2009), for example, emphasises the need for a strong systems perspective to be present to ensure that interventions truly have system-level effects and therefore constitute HSS.

The literature does seem to agree, however, that HSS requires a different approach to vertical health programmes, with activities taking place at all levels, as prioritised by stakeholders (Marchal et al., 2009; UNICEF, 2016). Recently weighing in on this debate, Witter et al. (2019), echoing other leading health systems researchers (Agyepong et al., 2017; Kruk et al., 2018) have called for clearer concepts, frameworks, and methods to support future investment in HSS in LMICs. And while Witter et al. (2019) do not offer a specific definition of HSS, their evidence review of HSS contributes at least two valuable inputs to the discussion on the meaning of HSS. The first draws attention to the role of the community and the need to engage communities and build connections between them and the more formal systems. Secondly, based on existing HSS definitions, Witter et al (2019) offer inclusion criteria for what should qualify as HSS. Specifically, HSS should include (1) Scope, to cut across the health system and to focus on more than one disease, (2) Scale, to cut across more than one level of the system and to have national reach, (3) Sustainability, for addressing systemic blockages and sustaining effects over time, and (4) Effects, showing impact on outcomes, equity, responsiveness and financial risk protection. Therefore, among other things, this inclusion criteria stresses the need for health efforts to extend across the health system if they are to be considered systemic.

2.2.2 Health System Performance

Related to the concept of HSS, and in line with Witter et al.'s (2019) fourth criteria, or the need for HSS to lead to notable effects, is the concept of health system performance. Put another way, HSS has been described as 'what we do', to get what we want (e.g. UHC, health security and health resilience) (Kutzin & Sparkes, 2016, p. 2). Exploring the effectiveness of 'what we do', or what actions we take to strengthen health systems and to improve health, often attracts attention to any notable changes in performance within the system (Murray & Frenk, 2000). In this sense, strengthening health systems involves "a significant, purposeful effort to improve [overall] performance" (Hsiao, 2003, as cited in Kutzin & Sparkes, 2016, p. 2).

The WHO'S (2000) *Framework for Assessing the Performance of Health Systems* still stands as one of the most significant attempts to understand the concept of health system performance and its key determinants, including how these determinants might interact with each other. The Framework argues that performance is a relative concept that should be assessed according to "the worst and best that can be achieved for a given set of consequences" (Murray and Frenk, 2010, p78). This highlights the importance of HSS initiatives being appropriate for their context, and for outcomes to be assessed and determined accordingly. More recent discourse on health system performance has focused on specifics such as improving and measuring performance of the health workforce (Agarwal et al., 2019; Ballard & Montgomery, 2017; Dieleman et al., 2009b; Kok, Dieleman, et al., 2015) or reviews of performance of primary healthcare systems (Bitton et al., 2019; Munar et al., 2019) as well as district and hospital systems (Gile et al., 2018; Nxumalo et al., 2018). Likewise, and drawing on familiar factors associated with earlier health system performance frameworks (Arah et al., 2003; Hurst and Jee-Hughes, 2001; McPake and Mills, 2000; Murray and Frenk, 2000), UHC2030 (2018) advocates for health systems strengthening to focus on five dimensions of health system performance: equity, quality, responsiveness, efficiency and resilience. Each of these goals are discussed further below, in context of evidence of their frequent use within HPSR literature and demonstrating a general consensus within the field of global health around these desired performance goals. Consequently, health system performance is commonly assessed by the extent to which individual countries achieve each of these goals (WHO, 2000; WHO, 2007), with individual health systems placing different levels of emphasis on the goals, and with varying levels of understanding of these goals across different stakeholders.

2.2.2.1.Equity

The concept of equity as a measure of health system performance is based on fairness and social justice, with equitable access to health services without financial suffering key to UHC (Braveman et al., 2011). Unfortunately, inequitable access to health services remains a widespread reality, especially in LMICs and among more vulnerable populations. Accordingly, addressing inequities in health features as a key component of the SDGs, and specifically SDG 3 (Good health and Wellbeing). In the absence of strong information systems, practitioners and policy makers do not necessarily know who and where to target

when it comes to reducing inequitable access to care. Identifying those most in need therefore represents a first step in addressing health inequities, such that barriers to financing health can be addressed, towards improving health system performance, as well as health outcomes (UHC2030, 2018).

2.2.2.2 Quality

Recent evidence estimates that between 5.7 and 8.4 million people die annually in LMICs because of poor Quality of Care (QoC) (NASEM, 2018). Similarly, less than one quarter of people in LMICs believe that their health systems work well compared to half of people in high income countries (Kruk et al., 2018). Accordingly, some have called for high quality care to feature as both the "DNA" and "raison d'être" of all health systems (Kruk et al., 2018, p.1196). Likewise, the definition of UHC mentions quality health services as a prerequisite. Attention paid to QoC within global health is further evidenced by the numerous QoC frameworks that have emerged over the last two decades, (Kruk et al., 2018; Raven et al., 2012). In 2015, the WHO built onto existing frameworks to produce a single framework specific to maternal and newborn health, outlining the key characteristics of QoC necessary to improve desired health outcomes. These characteristics included safe, effective, timely, efficient, equitable and people-centred care(Tunçalp et al., 2015) .Although many indicators of quality have been identified, a challenge lies in measuring and monitoring inputs, outputs, and outcomes, which some consider as holding back progress on improving health (Berwick et al., 2018; Kieny et al., 2017; Kruk et al., 2018). Those involved in improving QoC and health system performance are further keen to point out that quality does not necessarily come with increased coverage, nor does responsibility for QoC lie with health care workers (Berwick et al., 2018; Kieny et al., 2017; Kruk et al., 2018). Indeed, when quality is poor, the temptation is to blame people, such as the frontline health workers, rather than to attribute blame across the system as a whole. Reports published within the last 5 years further evidence the importance of QoC and how the global community can achieve UHC and improve QoC, while also broadening access to care (Berwick et al., 2018; Kruk et al., 2017; National Academies of Sciences & Medicine, 2018; The Lancet, 2018; WHO, 2018).

2.2.2.3. Responsiveness

Responsiveness refers to the extent to which a health system meets people's expectations "for non-health enhancing dimensions of their interactions" (Darby et al., 2003). Here, 'expectations' refers not only to users but also to other health systems actors, such as policy makers or service providers. Mirzoev and Kane's (2017) framework proposes an understanding of health system responsiveness which places people's interactions and experiences with the heath system at its centre, with emphasis placed on 'trust'. Trust as a measurement of health system responsiveness can have relevance beyond the patient perspective to further include the perspective of health providers within the health system, and where trust can have both a negative and positive impact on levels of motivation, retention, performance, and delivery of quality care (Okello & Gilson, 2015). Mirzoev and Kane's framework further expands on earlier work on the importance of accountability between service providers, managers, and policy makers, as well as the implications and significance of these interactions for influencing responsiveness to patients and communities (Cleary et al., 2013; Mirzoev & Kane, 2017).

2.2.2.4.Efficiency

The WHO (2018) defines efficiency as "the extent to which available inputs generate the highest possible level of health outcomes" (p12). Although this is relatively broad, efficiency is critical for sustainability within health systems, especially in terms of cost-effective interventions. Inefficiencies and waste will simply hinder, if not cease, efforts geared towards strengthening health systems. Unfortunately, lack of accountability and transparency have at times contributed to corruption or misappropriation of resources within health systems (Yip & Hafez, 2015). Accordingly, there is a call for countries to start investing more in health, to prioritise health within their domestic budgets, and to use existing health resources more efficiently (Agyepong et al., 2017) This is easier said than done, however, and as noted in a 2015 WHO report on *Improving Health System Efficiency*, countries need to undertake reforms in order to address issues of inefficiency. Such reforms are complex, continuous and require a system-wide approach (Yip & Hafez, 2015). *The Health System Efficiency report* (2015) further provides a useful review of 10 country cases that demonstrate increased attention to efficiency as a way of improving health system

performance towards UHC. These vary from the introduction of task-shifting in Ethiopia to address increase in service demand, to the introduction of an essential drugs list to address problems around inequitable drug financing and access to medicines in South Africa (Yip & Hafez, 2015). While these studies reflect a range of different interventions, the authors note that future efforts should concentrate on designing interventions using a systemic approach, and present solid evidence of the process and implementation.

2.2.2.5 Resilience

In recent years, the concept of health system resilience has been at the forefront of HPSR, as a key characteristic necessary for strong and well-performing health systems (Barasa et al., 2018; Fridell et al., 2019; Gilson et al., 2017; Kruk et al., 2015; Tumusiime et al., 2019). The concept itself has attracted debate not just in terms of defining a resilient health system, but also in terms of how to best build resilience within health systems. In the context of the Ebola crises, for example, Kruk et al (2015) defined health system resilience as "the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learnt during the crisis, recognise if conditions require it" (p1). Adding to this interpretation, Gilson et al. (2017) and Barasa, Cloete and Gilson (2017) make a strong argument for understanding resilience as something to be considered on a daily basis, rather than in response to shocks. Accordingly, they conceptualise health system resilience as "creative adaptation and transformation" and "not simply bouncing back" (p.91). Further to this, both Gilson et al. (2017) and Barasa, Cloete and Gilson (2017) argue for more emphasis to be placed on the system's software for health system resilience, rather than just on the hardware (e.g., Funding, surveillance systems). While Section 2.3.4 offers a more detailed account and contrast of the hardware and software of systems, generally speaking, building resilience around the software a health system focuses on analysing the influence of power dynamics (internal and external) and strengthening leadership and relationships across systems that embody respect, empower others and enable learning (Barasa et al., 2017; Gilson et al., 2017).

According to the WHO, improving health system performance via each of the five dimensions, requires a focus on three interrelated health systems policy areas: (i) Service Delivery, (ii) Health Financing and (iii) Leadership and Governance. Whilst also doubling

as three of the WHO-defined six Health System Building Blocks, these areas are also said to be core functions that encompass the remaining three sub-systems and building blocks of a health system of (iv) health workforce, (v) medical products, vaccines and technologies, and (vi) health information systems (See Figure 2.1). Measuring health system performance, however, remains an important methodological challenge, which may partially explain the more common focus on trying to understand, strengthen, and improve health systems instead (Van Olmen et al., 2012).
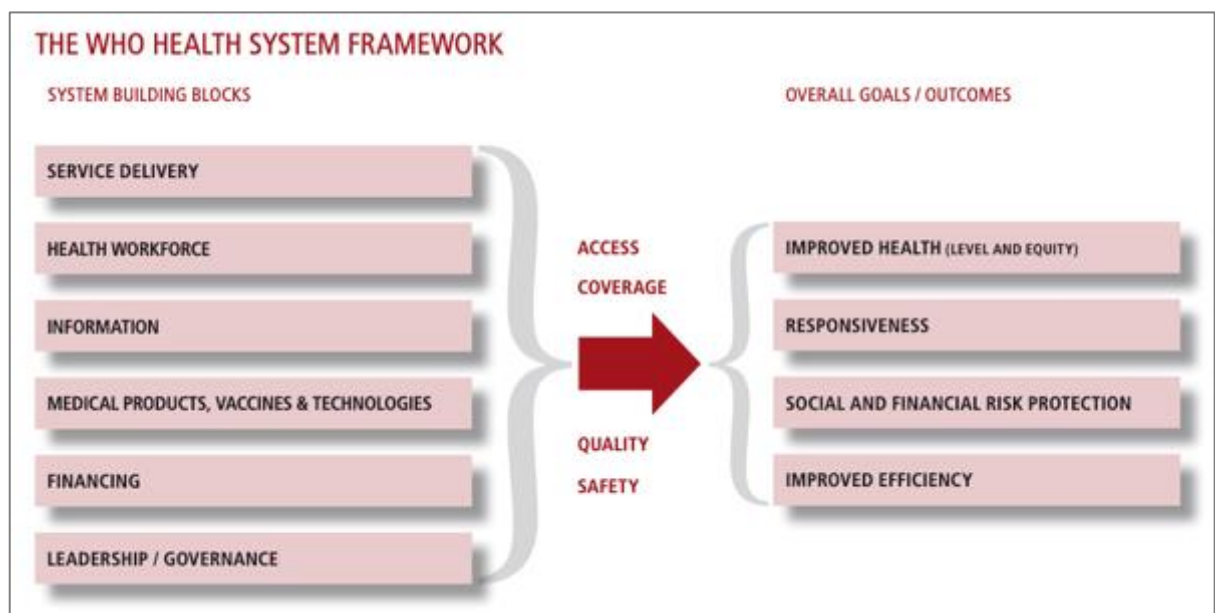
Figure 2. 1. The Six Building Blocks of a Health System (WHO, 2007)

2.2.3 Health Systems Frameworks: Bird's Eye View over the Health System

Having established that there is consensus around the need for a global focus and movement to build strong health systems as a way to improve health system performance, health systems frameworks often illustrate how people and countries prioritise interventions, strategies, and approaches to HSS towards improving their health system's performance. Such thinking is generally displayed in health system frameworks, of which there are many.

As already mentioned in Section 2.2.2 and represented in Figure 2.2, one of the most widely used conceptualisations of health systems is the WHO's Building Blocks framework (2007), which originally consisted of six independent health system blocks (Hoffman & Frenk, 2012). This framework was introduced in the landmark *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes – WHO's Framework for Action* (WHO, 2007) as a model to describe what health systems look like and as a guide towards health system strengthening. The idea behind this original WHO (2007) framework is that each of the blocks should be strong enough to achieve the overall health system's goals, defined in this model as improved health (level and equity), responsiveness, social and financial protection, and improved efficiency, through improving access, coverage, quality and safety. These concepts resonate with the earlier defined dimensions of health system performance, demonstrating the parallels between health system performance and the overall goals of a health system. The WHO subsequently updated this framework in 2009 to further include people at the centre of the framework, and to emphasise the interconnectedness between the blocks, as illustrated in Figure 2.3 (De Savigny & Adam, 2009)

Figure 2.2. The Dynamic and Interconnectedness of the Health Systems Building Blocks
(Source from De Savigny and Taghree, 2009, p.32)

Despite being one of the more commonly referred to frameworks, however, the updated Building Blocks model has been challenged, resulting in multiple adaptations or alternatives (Mounier-Jack et al., 2014). This is perhaps best exemplified by the results of a review of health systems frameworks conducted by Hoffman et al (2012), which identified 41 different frameworks. Many of these existing frameworks had the WHO framework at their root. These frameworks were subsequently classified into whole system frameworks, sub-system frameworks (focused on various parts) and supra-frameworks (focused on interactions between societal systems and the health system). In their conceptualisation of health systems, Hsiao and Saidat (2008) were more specific in their classification of frameworks as descriptive, analytical, deterministic and predictive. Drawing on Hsiao and Saidat's (2008) classifications, Shakarishveili et al. (2010), whose work has proven instrumental to initiating discussions around converged frameworks, went further, advocating for multi-purpose frameworks that would be efficient at addressing health systems challenges at institutional, operational, structural and functional level.

Amidst the flurry of reviews of health system frameworks emerging over the course of a few years, a latter review by van Olmen et al. (2012) observed that health systems frameworks are 'products of their time', attributing the focus on HSS to shifts in the political landscape as well as the changing global interests. Therefore, and while it is

expected that frameworks evolve over time to address weaknesses in others, the above evidences the complexity of conceptualising health systems, with no one framework necessarily agreeable for all uses (Hsiao & Saidat, 2008; Shakarishvili et al., 2010). The challenge with health system frameworks therefore appears to be the need to strike a balance between illustrating the inherent complexities of health systems, with the need to ensure that frameworks remain parsimonious and "user-friendly", for purposes of research, planning, and policy making. Moreover, what emerges is that varying frameworks have different or many purposes. The last decade has focused less on trying to reinvent frameworks, focussing instead on the converging and utilisation of different and existing frameworks, elaborating on the dynamics and relationships within health systems, and on improving performance through truly systemic approaches to HSS.

Taken together, common critiques for the Building Blocks framework include its apparent "one-size-fits all" framework failing to recognise the importance of being able to adapt to context (Mounier-Jack et al., 2014). In addition, the framework does not acknowledge the dynamics and interactions between the different health system components and players (Mounier-Jack et al., 2014; Van Olmen et al., 2012). It should be noted however, that the Building Blocks, regardless of their perceived simplicity, still remain at the core of many HSS efforts, given the value of its shared understanding and common language (Hoffman & Frenk, 2012; Mounier-Jack et al., 2014).

2.2.3.1 Drawing on the Strengths of Others

Whilst this thesis relies on the WHO Building Blocks framework as a basis, it also considers and draws on the strengths of other frameworks that capture critical elements not explicit within the Building Blocks. This idea of using the existing Building Blocks as a foundation is consistent with what many others have done, including De Savigny and Taghreed (2009) (Sacks et al., 2019). Much like Witter et al.'s (2019) inclusion criteria for HSS, the following describes elements or criteria from other health systems frameworks that have informed the development of this thesis, and which were included to overcome the simplification and aforementioned weaknesses of the WHO Building Blocks, allowing for greater flexibility and contextuality.

Stressing the importance of systems dynamics, De Savigny and Taghreed outline in *Systems Thinking for Health Systems Strengthening* (2009) that "conceptualising the

synergies, intended or not, of intervening in the health system depends upon a fuller understanding of the 'system', and how its component parts act, react and interact with each other in an often counter-intuitive process of connectivity and change" (p.41). Similarly, van Olmen et al. (2012) place an emphasis on the interactions between the different building blocks, including the involvement of multiple stakeholders and varied perspectives in their Health System Dynamics Framework, as an extension of the WHO model (See Figure 2.3). Here, the model recognises health systems as social systems, basing the dynamic dimension on the characteristics of CAS (Van Olmen et al., 2012). Specifically, van Olmen et al.'s (2014) framework stresses the inability of a system's interconnected parts to function independently of each other, the complexity of the relationships between the different parts of a system, and the need for the system to adapt and change over time (Atun, 2012; De Savigny and Adam, 2009; Paina and Peters, 2012).
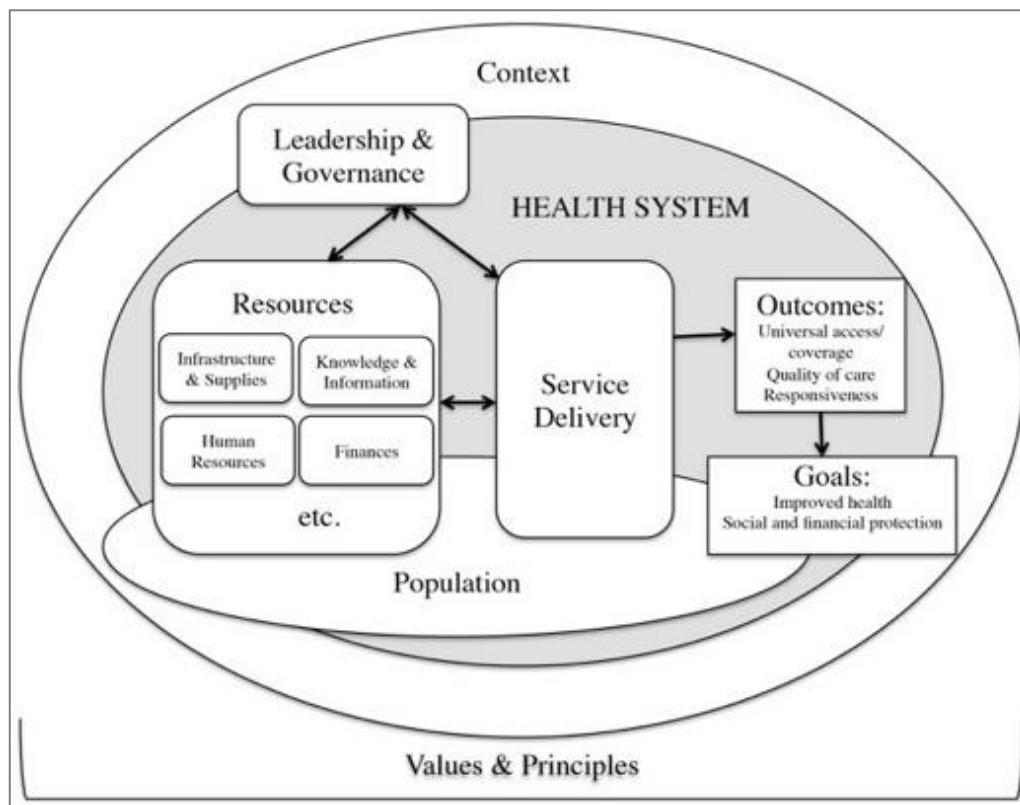
Figure 2.3 The Health Systems Dynamics Framework,
(Source adapted from van Olmen et al., 2012, p4)

Moreover, the Dynamics framework highlights outcomes and goals, values and principles, context, and population as much needed elements of a health system. Specifically, van Olmen et al (2012) argue that if consideration is to be given as to why

people identify the goals that they do, or make certain choices around HSS, it is also important to include the concept of values and principles shaping these decisions, which inevitably differs between contexts. Therefore, if anything, the addition of 'values and principles' lends a sense of realism to the model and an inevitability around the different tensions that have the potential to arise in efforts to strengthen health systems (Jackson & Sambo, 2020). According to van Olmen et al. (2012), these tensions should ideally be managed and balanced locally by the leadership and governance of a health system. Such a recommendation, however, rests within the theory and is not always evidenced in practice. Furthermore, in acknowledging the importance of values, the framework encourages the reader or user to consider the socio-political history of a system and its actors, and how these impact on the behaviour of people (Roncarolo et al., 2017; Van Olmen et al., 2012).

The idea of placing people and values at the centre of health system frameworks is further reflected by other global scholars and actors in their HSS efforts and understanding of health systems. Kruk et al (2018), for example, underpinned high quality health systems by virtue of them being for people, equitable, resilient, and efficient, echoing some of the aforementioned dimensions necessary for health system performance. Similarly, a recent systematic review identified that people and values are present across all health system components, interactions and functions (Whyle & Olivier, 2020). Specifically, values are said to be part of a health system's software alongside norms, interests, ideas and relationships, forming the foundations of HPSR as well as determining "the existing architecture of health systems and then continuing to influence proposed reforms to that structure" (Whyle and Olivier, 2020, p. 1). Whyle and Olivier (2020) further identified a sparsity of research around social values in HPSR in LMICS. This gap suggests a need to strengthen the evidence-base and to further recognise social values as an important dimension of people-centred health systems (Abimbola, 2021; WHO, 2015; Whyle and Olivier, 2021).

The recognition that people and communities, not only diseases, need to be at the centre of health systems is also endorsed and advocated for in the WHO's *Integrated People Centred Health Systems framework* (2015). This framework is rooted in the core values and principles of PHC, that being the right to health, social justice, solidarity and participation (WHO, 2015). While it is understood that the implementation of the

framework will take time, as well as sustained political commitment, its importance lies in the strategies it puts forward, which focus not only on empowering and engaging those on the demand side of health care but on the supply side as well. This marks progression from vertical, technocratic and diseased-based models towards those that are participatory, results-orientated, systems strengthening, evidence-based, ethics-based, equity-focused, sustainable, and country-led (WHO, 2015).

2.2.4 "The Invisible Level of health Systems"

Whether or not recently renewed commitments to PHC and people-centred health systems will translate from 'rhetoric to reality' is surrounded with uncertainty and concern(Pandey, 2018). Sacks et al. (2018) and others, for example, have demonstrated weak evidence for centralising the role of communities and achieving health for all unless *community roles* are explicitly integrated into health systems frameworks. In line with this, they propose an expansion of the WHO Building Blocks (see Figure 2.5) whereby community health forms an integral part of the health system which "can help policy makers improve responsiveness and efficiency, as well as increase focus on social determinants of health and institutions only indirectly linked to health" (Sacks et al., 2019, p. 3). This framework therefore simultaneously recognises the renewed interest in PHC, while also focusing specifically on health outcomes related to healthy people and communities (Sacks et al., 2019). Therefore, "the question [for health systems] is consequently not whether communities play a role, but how communities can be recognised and elevated within the system (Sacks et al., 2019, p. 5).
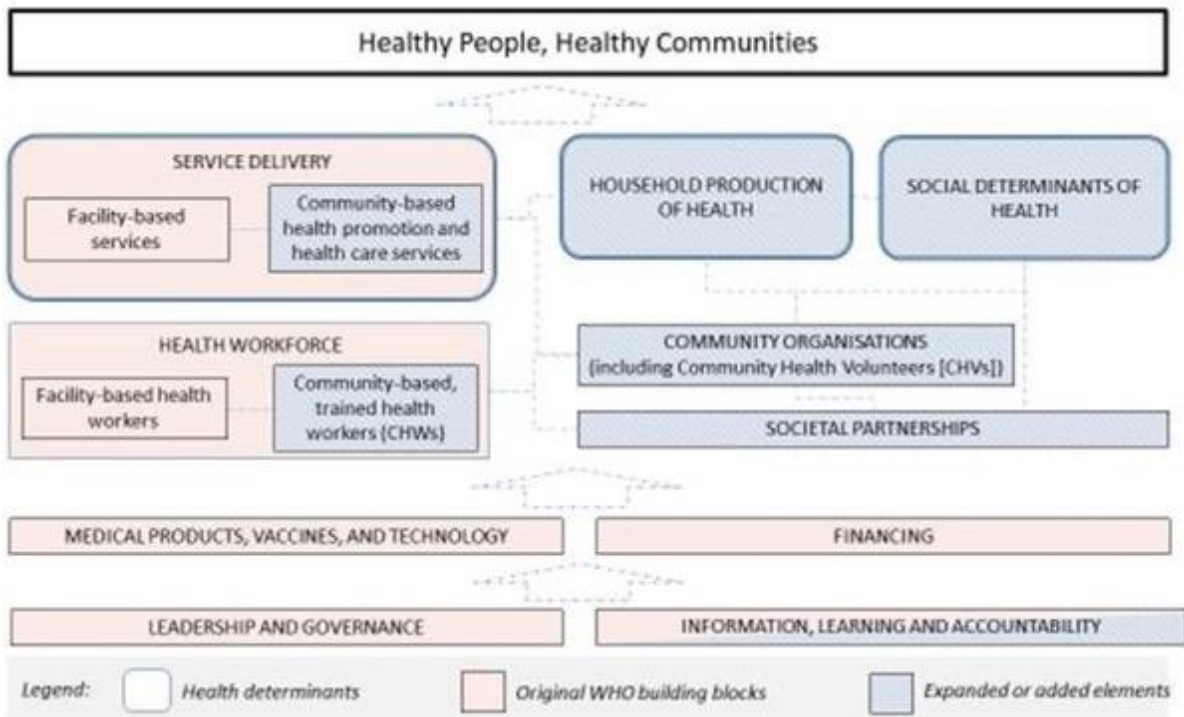
Figure 2. 4. Beyond the Building Blocks Expanded Framework, (Source from Sacks et al., 2019, p3)

Taken together, the multiple health system frameworks available seem to converge on the idea that strong health systems are necessary and critical for achieving health for all. Moreover, and in addition to the importance of different stakeholders, global players and multiple perspectives, a more recent emphasis has been placed on sustainable collaboration, leadership and partnership to move forward with achieving UHC (Jackson & Sambo, 2020; Sacks et al., 2019).

2.2.5 Global Health System Actors and Partnerships

The global health arena is becoming increasingly crowded, following a dramatic change in the actor landscape in the 21st century with the introduction of the Millennium Development Goals (MDGs) (Laaser & Brand, 2014; Szlezák et al., 2010; Van Olmen et al., 2012). Today, actors are identified as national governments, intergovernmental organisations, civil society, non-governmental organisations, public-private partnerships, professional associations, UN entities, academic institutions, multilateral development banks and philanthropic institutions and foundations (Hoffman & Cole, 2018). Consequently, the global health system is currently made up of a variety of actors, individuals and organisations, who all operate at different levels of the health system,

ranging from community to global "with a primary intent to improve health and the polylateral arrangements for governance, finance, and delivery within which these actors operate" (Hoffman & Cole, 2018, p. 4) . Moreover, Global Health Initiatives (GHIs) and foundations, such as the Bill and Melinda Gates Foundation, have been particularly influential in shaping priorities for global health, further evidencing that different actors have varying levels of power and influence in terms of HSS (Mwisongo & Nabyonga-Orem, 2016; Van Olmen et al., 2012).

In addition to an increasing number of stakeholders in the area of global health, partnership approaches have become increasingly popular in global health - usually on the grounds that they offer more sustainability, synergy, integration, and effective coordination of efforts (Shaw et al., 2015). However, partnerships are not without their challenges and can at times be more disabling than enabling (Warren et al., 2013). These challenges tend to stem from conflicting interests and priorities of the individual partners/institutions, which can lead to issues around trust, as well as issues integrating interventions. Given the combination of self-interests and donor dependency, the literature further evidences that large duplication of efforts, including parallel reporting systems and governance structures; competing agendas that do not necessarily align with a country's needs; top-down priority setting, differing accountability structures and budget cycles are common (Mwisongo & Nabyonga-Orem, 2016; Swanson et al., 2015).

Similarly, and while it is common for actors to agree on desired outcomes from HSS, they may not necessarily agree on how to achieve them (Samuels et al., 2017; Van Olmen et al., 2012). These may be attributed to the implicit and explicit values that stakeholders have (Borgonovi & Compagni, 2013; Byskov et al., 2019), whereby partners or actors with the most funds typically have the most say. This can lead to processes being driven by funding, with little capacity being developed or leveraged within countries, leading to a focus on end results rather than building country capacity. Similarly, Swanson et al. (2015) argue that stakeholders often only focus on strengthening technical capacity rather than also focusing on "soft" organisational capacities such as leadership, communication, networking, and political advocacy, as competencies considered to have broader reach in terms of improving health systems. The consequences include a lack of country ownership, alignment, harmonisation and inclusive partnership, and ultimately, to

unsustainable and burdensome initiatives (Goldberg & Bryant, 2012; Mwisongo & Nabyonga-Orem, 2016; Okech & Lelegwe, 2015).

Further to this, the debate continues as to how systemic approaches manifest in practice, compared to the usual reductionist vertical approach on health-related 'themes' or diseases (Marchal, Cavalli & Kegels, 2009; Warren et al., 2013; Swanson et al., 2015). Ideally, the responsibility for the coordination of key players should rest with governments, fostering accountability, transparency and good leadership and governance (Mwisongo & Nabyonga-Orem, 2016; Rizvi et al., 2020). In practice, however, and given the number of actors and partners currently involved in global health, this coordination amounts to a mammoth task, especially in contexts with already strained resources and a high burden of disease.

Academic institutions and research partnerships are also fundamental to HSS efforts, with a clear evidence-base for health research contributing towards the achievement of UHC (Cole et al., 2014; Gilson et al., 2021; Woodward et al., 2016) There remains substantial criticism and debate around research collaborations between North-South partnerships, however, the principle criticism being that research conducted in LMICs is often led by those in the Global North (Beran et al., 2017; Dossou et al., 2016) instead of building research capacity in the South to encourage locally-led research and locally-determined research priorities (Beran et al., 2017; Dean, Njelesani, Smith & Bates, 2015; Veken, Belaid, Delvaux & Brouwere, 2017). This requires a shift in thinking around collaboration as well as a need to address power imbalances inherent to HSS research funding primarily disbursed to partners in the Global North (Van der Veken et al., 2017). Although not universal, progress on unfair collaboration has been reflected in the emergence of networks and consortia which are deemed to encourage mutual capacity development as well as being "less hierarchal" in terms of leadership and not as "competitive" or "individualistic" as other global health or research partnerships (Franzen et al., 2017; VanderZanden et al., 2019). Recently, Gilson and colleagues (2021) offered their experiences of an approach to strengthening health systems through embedded research and a long-term collaboration between researchers and decision makers, which supported the co-production of knowledge as a way of addressing power dynamics and building trust.

2.2.6 Every Level Counts

Thus far, this chapter has compared and contrasted the literature around what constitutes a health system, health systems strengthening, and the different dynamics of health systems performance and how these are incorporated into a variety of health systems frameworks to suit different stakeholders' objectives and goals. The abundance of global actors and stakeholders involved in HSS is highlighted, drawing attention to the important elements of power and influence between them within the global, regional, and national political economy.

Successful HSS often depends on how well the different levels of a health system are understood, as well as understanding the different roles, functions and interactions between the different levels, so as to determine which level(s) interventions should ideally target. The remainder of this section therefore explores these different levels and their interactions to illustrate their relative importance in delivering the functions of a health system. Generally speaking, individual countries describe their health systems as having between three to five levels. These usually include: community, primary, secondary, tertiary and central/national levels. Often community falls under primary, secondary generally includes primary and district, and national appears less frequently in models. Tertiary tends to refer to specialised services, usually housed within third level referral hospitals.

In an *Introduction to Health Policy and Systems: A Methodology Reader* (2012), Gilson outlines the operations of a health system across macro, meso and micro levels as illustrated in Figure 2.6. Here, macro level corresponds to the wider national and international context where policies and regulations are developed, meso focuses more on the district health system including management of health services and primary health care facilities, and adaption of policies and guidelines, and finally, micro level, concentrates more on the individuals within the system, including policy elites, citizens, patients and providers, and the relationships between them, including managerial decision making and leadership across the system. What is not necessarily obvious in this model however, is the potential layer of informal providers (e.g., traditional healers, traditional birth attendants and herbalists (Sudhinaraset et al., 2013), and services below primary level, as well as the referral system which links the different levels. In many LMICs, the informal sector

provides a significant bulk of healthcare and is therefore important to acknowledge in any conceptualisation of a health system.
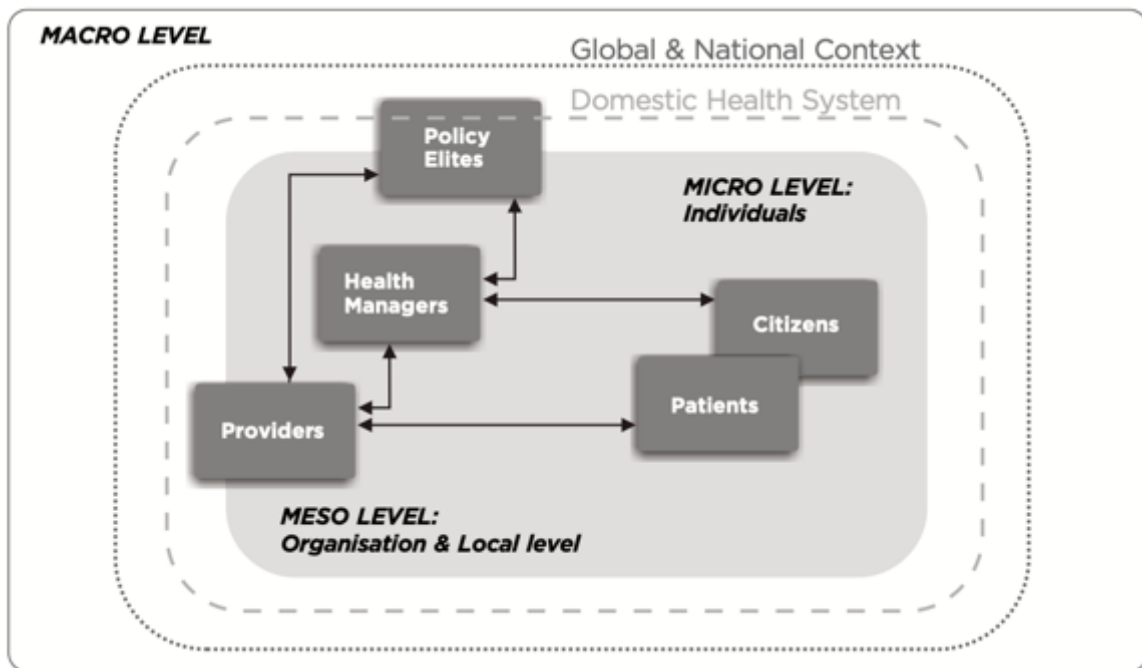
Figure 2. 5 The Different Levels of a Health System (Source from Gilson, 2012, p24)

2.2.6.1 Central/National Level

Responsibilities at this level usually include setting policy, coordinating government departments, tertiary care services, health programming, quality assurance, planning, resource allocation and financing, as well as development of national health strategic plans. Calls for LMICs to revise their priority-setting processes and budget allocation for health are common throughout the literature. Hipgrave et al. (2014), for example, emphasise the importance of tailoring priority setting to local needs and context as much as possible, while also recognising the limitations and challenges presented when faced with "weaker" health systems (Hipgrave et al., 2014). These same authors, however, report little by way of the literature to inform the reform of these processes, citing donor and political influences as important challenges. Also relevant to this, is the realisation that regardless of how highly prioritised programmes may be, problems within health systems must be rectified first (Hipgrave et al., 2014). In other words, it is unlikely that priority interventions will be successful where the system is not functioning, prompting them to encourage countries to

"tidy the house and check with the bank before commencing a renovation" (Hipgrave et al., 2014, p. 198).

Scholars writing several years after Hipgrave et al. (2014), also found a lack of healthcare priority setting within policy making, indicating a need for more accessible frameworks and knowledge sharing between researchers and policy makers (Gilson et al., 2021; Kapiriri & Razavi, 2017) as well as more systems theory approaches to understand the context as part of a wider dynamic of system interactions (De Savigny & Adam, 2009; Petricca et al., 2018). Whatever priorities are identified, must then be included in the planning process, which should be inclusive and link up with all levels of the system ensuring there is sufficient capacity to address these priorities at each level of the health system. This, however, is not always the case, with many blue-print approaches to planning failing to consider relevant stakeholders such as implementers, civil society, and frontline health workers. This can lead to approaches that do not reflect the reality on the ground, which are therefore devoid of ownership, and potentially responsible for undesired and unintended consequences (Barasa et al., 2017).

2.2.6.2 District level

District level, sometimes referred to as subnational level, is where all the decisions, planning, resources and policies agreed at national level, are expected to be implemented and managed. Expectations are generally high of the district health staff, who are responsible for ensuring targets are met, and that as a district, they are responsive to the health needs and demands of their populations. The team responsible at individual district level is generally referred to as the District Health Management Team (DHMT). For district managers to meet expectations, managers must have what Bossert (1998) referred to as adequate 'decision space', defined as the range of choices allowed by the central level that local managers have in decentralised (see 2.2.6.2.1) contexts (Bossert, 1998). These decisions are usually linked to the health systems functions, or building blocks, whereby who makes these decisions is determined by where power lies within the system (Bulthuis et al., 2021; Martineau et al., 2018; McCollum et al., 2018). For example, Alonso-Garbayo et al. (2017) argued that decision space may be influenced by a DHMT's own perceived authority and how they use that space to make decisions. Alonso-Garbayo et al. (2017) also

called for stronger evidence demonstrating whether, and if so how, transferring decision-making power from central to district translates to more autonomy for the district level managers.

2.2.6.2.1 Decentralisation

The transfer of power or authority over decision making from higher to lower levels of administration is commonly referred to as *decentralisation* (Mills, 1994). Three different types of decentralisation exist: 1) *devolution* involves transfer of power to separate local governments; 2) *deconcentration* transfers to lower levels within a ministry structure; and 3) *delegation* refers to transfer of defined managerial odd administrative functions to semi-autonomous bodies (Frumence et al., 2013; Kolehmainen-Aitken, 2004). Despite scant evidence for decentralisation however, decentralisation is often used as a strategy or reform in LMICs through focusing on decision-makers closer to service delivery (Panda et al., 2016), including DHMTs, in the hopes that this approach will strengthen health system performance, and subsequently strengthen the overall system (Bossert, 2016; Cobos Muñoz et al., 2017; Liwanag & Wyss, 2018; Roman et al., 2017).

This idea that DHMTs are close to service-delivery underpins the assumption that decentralisation results in communities being more engaged with health decision-making, and that authorities, in turn, should be more accountable and responsive to the users (Mills, 1994). Accountability is thus central to the concept of decentralisation, whereby decentralisation offers potential assurances "of checks and restraints on power and discretion, of increased oversight and scrutiny, or of closer connections between service users and providers" (Brinkerhoff, 2004). This description by Brinkerhoff (2004) covers both external (to the people/users) and bureaucratic (between different levels of the system or facilities) accountability mechanisms inherent to decentralisation reforms. In *Exploring the Functioning of Decision Space*, Roman, Cleary & McIntyre (2017) are keen to point out the benefits of such accountability mechanisms, so long as responsibility and reporting lines have been made explicit. Ultimately, it is about striking a balance however, such that a level of autonomy is maintained despite monitoring and oversight from above (Cleary et

al., 2013). Additionally, Liwang, and Wyss (2018) found that although it is important for power to be transferred, central-level decision makers still have a supportive role to play to ensure districts are performing well, suggesting that a combination of both top-down and bottom-up strategies may be most effective in improving health system performance (Abimbola et al., 2015).

While decentralisation and a realignment of power may seem attractive in theory, however, in practice decentralisation can cause tension between the different levels of the system. Decentralisation can also have unintended consequences, especially if equity is not a priority (Panda et al., 2016), relationships are not valued (Nxumalo et al., 2018) autonomy is undermined (Frumence et al., 2013; Molyneux et al., 2012) and resources and capacity are insufficient (Cobos Muñoz et al., 2017; Kigume & Maluka, 2018).

2.2.6.3 Primary Level

While both primary level and community levels generally fall under the same jurisdiction of individual districts, they are increasingly discussed and recognised as separate levels of the health system (Sacks et al., 2019). Here, these levels are discussed in terms of their functions, but are also discussed in greater detail under Sections 2.2.3.1 and 2.2.4 in relation to their importance towards integrated people-centred health care.

As previously mentioned, PHC is widely considered to be the backbone of any efficient, effective, and integrated health system (Bodenheimer, 2006; WHO, 2018) as well as the basis for UHC (Rao & Pilot, 2014; Rifkin, 2018). Frontline health care workers (HCWs) and community health workers (CHWS) are commonly responsible for providing preventative and curative services to a defined population, most commonly operating from PHC. In 2018, the WHO updated their concept of PHC in *A Vision for Primary Health Care in the 21st Century* to be understood as:

> A whole-of-society approach to health that aims equitable to maximise
> the level and distribution of health and well-being by focusing on
> people's needs and preferences as early as possible along the continuum
> from health promotion and disease prevention to treatment, rehabilitation

and palliative care, and as close as feasible to people's everyday environment. (p. 2)

Remove PHC from the WHO agenda and any health system becomes weak, unresponsive and potentially collapses. Despite starting as a philosophy, the redistribution of power and authority manifested much like that to district level, whereby a set of services were made available as the first point of contact with the health system. When effective, PHC has been evidenced to produce better health outcomes, reduce hospitalisations, improve access to care and cost effectiveness (Kringos et al., 2010; WHO, 2018). Despite a strong emphasis, evidence and clear recognition of PHC since the Declaration of Alma-Ata in 1978, "leaving no one behind" has been challenging, and not always at the forefront of practice. If anything, while some progress has been made in some countries, such as through the universal adoption of the decentralisation concept (WHO, 2018), or through good health practice initiatives such as Kangaroo Mother Care in Malawi (Bergh et al., 2014), or through Ethiopia's Health Extension Programme (Admasu, 2016) to improve equity in access to services, others lag behind for various reasons linked to internal inequalities, economic shocks, using a blue-print approach, and conflict and fragility (Agyepong et al., 2017; Pandey, 2018; Rifkin, 2018). There is also a possibility that an increased complexity of health needs, caused by aging populations and growing numbers of noncommunicable diseases (NCDs), has been a catalyst for renewed calls in the reorientation of health systems towards PHC. This too, however, requires commitment from all levels of the global health system and its political economy to align policies and finance the support needed, as well as empowering people and communities through action and not just talk (Landes et al., 2019; WHO, 2018;). In other words, if the commitment and inclusion is not there in practical terms, PHC risks remaining an empty promise (Pandey, 2018).

2.2.6.4 Community Level

Closest to the people is the level of the community. Community health level embodies a system that is made up of more than CHWs to also include civil society organisations (CSOs), other informal health providers such as those mentioned in Section 2.2.6, local communities, and health service users. As demonstrated by the Ebola epidemic, engaging communities is only as successful as the relationships that are existing between

communities and the health sector (Scott et al., 2016). At community level, focus is very much around the needs of the people and delivery of the relevant services at this level, as well as involving community members in the planning and delivery of health services.

In many countries, the CHW is central to any community health system, acting as a bridge between local health facilities and the communities they serve (Lehmann et al., 2019). The CHW role is evidenced to create trust, thus increasing the potential for improved community access to health services (Kok, Dieleman, et al., 2015). While CHWs play a vital role in supporting communities, they are often volunteers and/or poorly remunerated, overburdened, lack training and supervision, and are over-utilised by various partners, prompting the WHO (2018) to introduce guidelines on *Health Policy and System Support to Optimise CHW programmes*.

Recent years have seen an increased effort to understand more about CHW roles and interventions to target support structures for CHWs (Cometto et al., 2018; Kok et al., 2015; Olaniran et al., 2019; Zulu et al., 2014). Overall, the evidence supports that while CHWs require substantial investment, their contribution to PHC can be invaluable, especially on issues of prevention, healthy living, basic curative care and increasing health service coverage (Lehmann et al., 2019). Despite their demonstrated importance towards community health systems however, there is still resistance to integrating CHW programmes into formal health systems (Zulu et al., 2014), hence Sacks et al's (2019) efforts to increase visibility of community level within health systems frameworks. This resistance stems from fear of losing the embedment that CHWS have within their communities by overburdening them with task-shifting roles that serve to further distance them from their valuable positioning close to the people (Zulu et al., 2014). In contrast, Sacks et al. (2019) argue that the benefits of community engagement are already known and there instead needs to be a push towards learning and maximising these benefits for individuals and the health sector (Cometto et al., 2018; Lehmann et al., 2019).

2.2.6.4.1 Social Accountability

Social accountability (see 2.2.2) - as another means of engaging communities and important for accountability – is not only key to health system performance, but has also appeared as

a theme cutting across health systems actors as well as within the context of the other levels of a health system (see sections 2.2.5 and 2.2.6.1). Defined as "engaging citizens in holding public officials and service providers accountable" (Brinkerhoff & Wetterberg, 2016, p. 274) social accountability is therefore seen as a way of improving quality, performance, and responsiveness of health providers (Lodenstein et al., 2017). More recently, social accountability has also been recognised as a way to strengthen relationships between community and primary level, especially as a means to engage people to participate, strengthen communication and empower community members to claim and stand up for their rights (Sacks et al., 2019). Accordingly, in the context of this thesis, social accountability further refers to the link between community users and health services in LMICs. Some examples of social accountability initiatives include co-facility management, the establishment of health committees, community monitoring of service provision, suggestion boxes and joint problem analysis (Brinkerhoff & Wetterberg, 2016; Kruk et al., 2018).

While social accountability initiatives are assumed to improve responsiveness of health providers, Lodenstein et a. (2017) emphasise the need for Global Health practitioners to also take into account the perspectives of the health providers as well as socio-political contexts. For example, providers may not have the ability or decision-space to make changes in the system, regardless of citizens' demands. Further, it may be the case in some contexts that providers do not value the inputs or contributions from the communities and therefore commitment to improving service provision, for example, is variable (Lodenstein et al., 2017). Where social accountability initiatives are supported by donors or external partners, these should not be tokenistic, with ample time given for design, mutual learning, capacity building and evaluation for long-term evidence of change. This investment of time and money, however, is not always forthcoming (Brinkerhoff & Wetterberg, 2016; Molyneux et al., 2012).

2.3 Seeing Wholes rather than Parts: Through a Systems Thinking Lens

Health systems frameworks provide a useful starting point for understanding the core functions of health systems, as well as the different elements that characterise them. However, as with any frameworks, these are sometimes thought to be an overly simplistic

representation for what are ultimately highly complex processes. Moreover, the way health systems frameworks are perceived and understood impacts on the chosen approaches for HSS, or how approaches are implemented. Having a more nuanced understanding of health systems requires a more profound insight into how and why interactions and connections between people and processes occur the way they do within each respective context. Afterall, De Savigny and Taghreed (2009) were keen to stress that the health systems building blocks do not constitute a system; rather it is the "multiple relationships and interactions between the blocks – how one affects and influences the others, and is in turn affected by them- that convert these blocks into a system" (p. 31).

2.3.1 Health Policy and Systems Research

Key to strengthening health systems is to establish an evidence base of what works, for whom, and under what circumstances (De Savigny & Adam, 2009). Such an evidence base has been deemed critical to achieving UHC in addition to HSS in LMICs (Adam et al., 2012; Bennett et al., 2018; Peters, 2014; Witter et al., 2019). Over the course of the 21st century, and more especially the last decade, global consensus has been reached on the need to generate new evidence and new knowledge on health systems research with the intention of informing decision making around policy and practice in HPSR (Adam, 2014; Bennett et al., 2018; Jackson & Sambo, 2020; Sheikh et al., 2011). Here, the inclusion of 'P' in HPSR serves as an acknowledgment of the significant link between research and policy. This shift in thinking came together with the multiplication of global actors and GHIs, general shifts in political ideologies, increased focus on the performance of health systems, increased attention on implementation research, and the recognition of health systems as complex (Bennett et al., 2018; Van Olmen et al., 2012). Similarly, Hoffman et al. (2012), contributing to the *WHO Global Strategy on Health Systems Research,* emphasises the multidisciplinary nature of the field as being both a strength as well as a conceptual challenge. The field of HPSR thus allows for a broad array of disciplines, paradigms, and research designs, but complementing all of these in a way that can accommodate different stakeholder perspectives and crossing traditional research divides can be a considerable task that requires a strong interdisciplinary culture (Adam et al., 2012; Hoffman & Frenk, 2012; Sheikh et al., 2011). This, combined with the various contexts in

which health systems are embedded, illustrates only some of the complexities involved in HPSR.

2.3.2 Entangled in complexity

Complexity is a reoccurring term across the global health literature. The popularity of the term stems from an almost contradictory idea that "complex" is a simple way to describe that which is consisting of many different and connecting parts and is often considered difficult or challenging to understand (Stevenson, 2010). Such complex situations are often also referred to as "messy" (Hunter, 2015; Jackson and Sambo, 2019). It is therefore not surprising that health systems are also themselves described as sharing characteristics with complex adaptive systems (Adam & de Savigny, 2012; Agyepong et al., 2012; Paina & Peters, 2012). As CAS, health systems also have the capacity to adapt as well as to self-organise and learn (Agyepong et al., 2012; Kwamie et al., 2014; Barasa et al., 2017). Accordingly, health is increasingly being viewed through a complex systems lens (Adam, 2014; Peters, 2014; Wilkinson et al., 2018) reflecting a paradigm shift in how we think about health (Adam et al., 2012; Greenhalgh & Papoutsi, 2018a; Wilkinson et al., 2018). Such thinking is further reflected in the conceptualisation of health systems as resilient (see Section 2.2.2.5), as an emergent property of CAS (Barasa et al., 2017).

The last two decades have also seen a growth in complexity science and systems theory within health research (Adam, 2014; Jackson & Sambo, 2020; Mutale et al., 2016; Wilkinson et al., 2018). This too reflects a shift in thinking, towards recognising how interactions between different system components lead to the overall behaviour of the system (Checkland, 2000; Thompson et al., 2016), as well as acknowledging how an organisation's performance can be understood as well as changed (Atun & Menabde, 2008; Frenk, 2010). This shift therefore sees systems as a whole rather than a sum of its individual parts (Von Bertalanffy, 1976). Earlier discourses and reductionist perspectives on health systems took time to conceptualise and recognise health systems as *complex,* rather than just complicated and disjointed. The global health system has evolved, however, with Frenk (2014) now describing the current era in global health as one of "complex interdependence" (p. 94). While this concept emerged within the context of globalisation, it is nonetheless applicable on both a large and small scale, be it across nations, across sectors, or across

systems. It is important that this concept of health systems as inherently complex social structures remains present in one's thinking, specifically as a reminder that there is no one-size-fits-all approach to health systems strengthening. This is reflected in the multitude of frameworks that have emerged, as discussed earlier in the thesis. Further, and although heath systems are required to adapt, they are resistant to change, "if only as a consequence of the sheer number of independent players, established policies, zealously guarded interests, entrenched professional silos and divergent cultures" (Hoffman & Sossin, 2012, p. 158) which adds to their complexity (Checkland, 2000; Atun and Menabde, 2008). To truly decipher the complexity of health systems, to understand the relationships within the systems, and to possibly make it easier for policy and decision makers to makes sense of this complexity to implement and scale-up interventions, involves adopting a systems-thinking approach (Agyepong et al., 2017; Agyepong et al., 2012; Peters, 2014; Wilkinson et al., 2018).

2.3.3 Systems Thinking

Systems thinking has been described as "an enterprise aimed at seeing how things are connected to each other within some notion of the whole entity" (Peters, 2014, p. 1), or as a tool of systems analysis (Mutale et al., 2016). Broadly speaking, systems thinking approaches are situated within a large philosophical framework, and span several disciplines. And while the volume of names and backgrounds go far beyond the scope of this thesis, key systems thinkers most relevant to this thesis will be included, particularly where they pertain to *health* systems.

Within the context of health, systems or complexity thinking (Plsek & Wilson, 2001), "demands and creates a deeper understanding of the behaviour of systems…[by] decod[ing] the complexity of a health system, then appl[ying] this understanding to design and evaluate interventions that maximise health and equity" (Campbell, 2009, p2; De Savigny & Taghreed, 2009). Some scholars have argued that systems thinking is the only response to complexity and essential for HSS (De Savigny & Taghreed, 2009). Similarly, key systems thinker, Russel Ackoff (1999) considered systems thinking as perhaps the only way to challenge the inevitable and natural resistance to change connected with any social system.

Within the context of health systems as social systems, the Alliance for Health Policy and Systems Research (WHO, 2019) prioritises and promotes systems thinking as a way of focusing on real world issues, taking a broader perspective, and making the work tangible for translating into action or policy. Systems thinking permits focus to stretch across the different levels of a health system (i.e., macro, meso and micro), and in doing so, allowing for more realistic expectations of what might happen within a wider, dynamic system once an intervention has been introduced, ensuring that all contexts (e.g., social, historical and political contexts) are taken into consideration (WHO, 2019). By using the tools and approaches attached to systems thinking, interventions should be designed to at least account for the behaviour of systems and to understand and appreciate the relationships within them.

In recognition that despite investments and interventions, HSS efforts in the first decade of the 21st Century were largely inefficient, De Savigny and Taghreed (2009) set out ten steps to systems thinking in health systems, as a way for researchers and practitioners to understand more about the blockages, and towards accelerating HSS. Designed to be flexible, these steps include: (1) convene stakeholders, (2) collectively brainstorm, (3) conceptualise effects, (4) adapt and redesign, (5) determine indicators, (6) choose methods, (7) select design, (8) develop plan and timeline, (9) set a budget, and (10) source funding (De Savigny and Taghreed, 2009). Accordingly, de Savigny and Taghreed put forward systems thinking as an approach to firstly, find blockages, and secondly, to come up with solutions that translate across sub-systems through promoting a dynamic network of stakeholders, inspiring learning, and fostering more systems-wide planning, evaluation, and research (De Savigny and Taghreed, 2009).

Despite the maturation of HPSR (Bennett et al., 2018) from a disease-specific focus to a more systems-focused and pragmatic perspective, Jackson and Sambo (2019) - building on de Savigny and Taghreed's thinking - identified four key areas that remain a challenge for HSS and systems thinking. These include: (1) a lack of shared conceptual clarity around health systems as 'dynamic entities', (2) understanding which intervention(s) work best in which contexts, (3) retaining coherence in such a multidisciplinary field, and 4) lack of evidence on the success of HSS initiatives due to challenges around evaluation (Jackson & Sambo, 2020) This sense of a lack of practical guidance on how to apply systems thinking is not, however, unique to the thinking of Jackson and Sambo (Adam, 2014; Adam & de Savigny, 2012; Augustsson et al., 2019b). Indeed, the literature

evidences that debates around systems thinking theories, methodologies and tools persist, with what is lacking or what is needed, often dominating discussions as a digression, rather than a progression, of the field (Jackson & Sambo, 2020; Peters, 2014). This points to the challenges involved in marrying the multitude of complexities involved in health systems strengthening with the need for contextualisation.

2.3.4 'Hard' and 'Soft' Systems

The literature commonly distinguishes between "soft system'' thinking and "hard systems" thinking (Checkland, 1999), or more simply as the hardware and software of a system (Sheikh et al., 2011). This recalls the idea that while every health system comprises of both hardware and software, global health tends to lean towards more "hardware" approaches, whereby "they must define an objective for the system they are seeking to improve and all see their pursuit of the most efficient means of achieving that objective" (Jackson, 2019, p. 524). Here, the technical matter takes precedence over the emotional involvement of people, producing measurable data, and perceived to be more rigorous and relevant to policy-makers (Whyle & Olivier, 2020). Hard system thinking has also been said to privilege the objectives of stakeholders, who not only tend to be more powerful, but who are often looking for fast and straightforward solutions to specific problems, and as unable to accommodate multiple perceptions of reality (Jackson, 2019).

Soft systems approaches, on the other hand, recognise the real world aspect of health systems and the challenges in defining and solving problems. Peter Checkland, in his push to feature the human factor in systems thinking, is often accredited with the development of a soft systems methodology (SSM) (Checkland, 2000). Here, Checkland recognises the social and cultural dimensions of involving people in systems, together with the realisation that similar concepts attract multiple perspectives that need to be accommodated. Soft systems thinking or SSM is thus key for engaging the multiple stakeholders involved in health systems and is designed to make explicit the differing perspectives and perceptions (Checkland, 2000; Peters, 2014; Willis et al., 2014). It further provides a framework that makes explicit different stakeholder perspectives, towards the development of models that more closely represent the real world, whereby the 'real world' refers to the unfolding and interacting flux of events and ideas experienced as every-day life (Checkland, 1990)

Checkland's (2000) research paper, *Soft Systems Methodology: A Thirty Year Retrospective,* succinctly describes the difference between hard and soft systems thinking, which he believes people often mistake for being a simple straightforward, well-defined, understanding versus fuzzy and ill-defined. This further highlights the importance of distinguishing between how the word 'system' is used to differentiate between 'soft' and 'hard' thinking. This distinction lies in understanding hard systems, or a 'system' as a label for something outside of ourselves, and soft systems to be a process of inquiry into the world as a learning system (Checkland, 2000). Hard systems thinkers therefore see the world as systemic, whereas soft systems thinkers see the *process of inquiry* as systemic (Checkland, 2000). This is perhaps better understood by Checkland's illustration of the two different stances as seen in Figure 2.8.
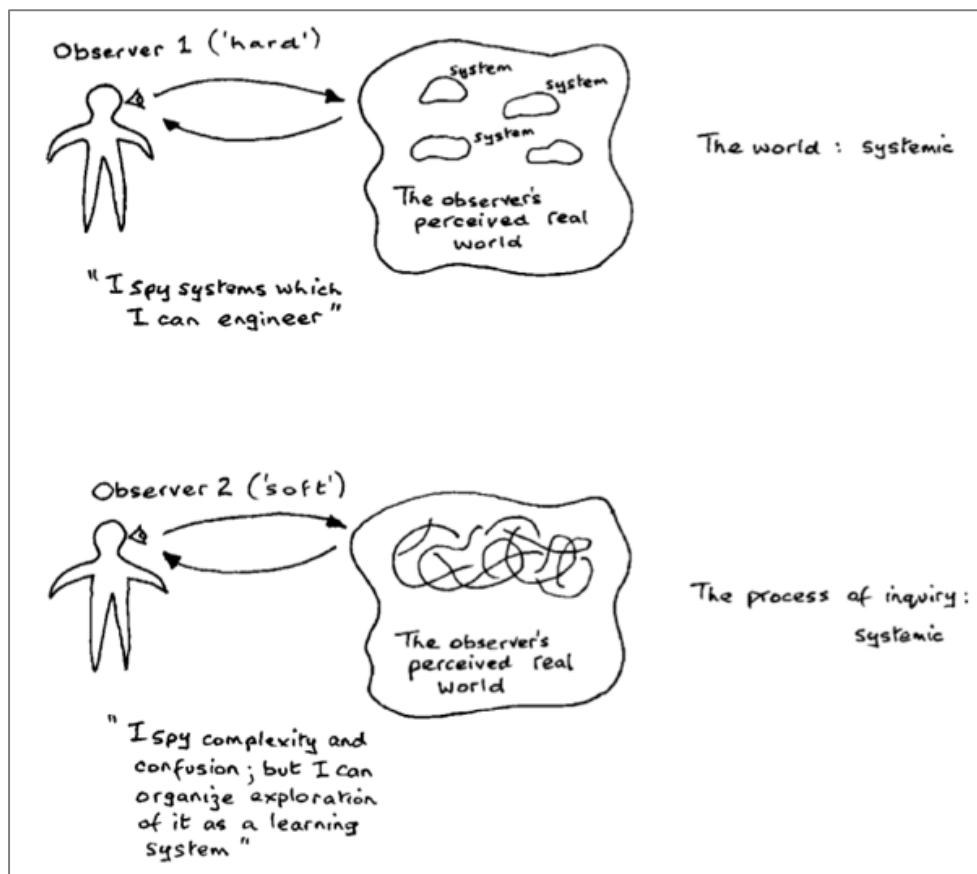
Figure 2.6 Hard and Soft System Stances (Source from Checkland, 2000)

Drawing on Checkland's thinking, and recalling the concept of "resilience" as a key dimension of health system performance, Barasa, Cloete and Gilson (2017) fervently argue that efforts to strengthen the system require that health systems be viewed as comprising

of both hardware and software. This reflects the reality that health systems need to be resilient and prepared for everyday realities, rather than reacting to challenges as they occur (see 2.2.2). In this view, systems are not always stable and need to have the capacity to transform and change in response to the existing and emerging influences and dynamics of a health system as well as respond to those people in it. To understand the complexity surrounding people within health systems, Jackson (2019) suggests adopting a soft systems approach as the most appropriate for making sense of different stakeholder perspectives, and to ensure consensus on which action(s) should be taken towards strengthening health systems. Soft systems approaches, according to Jackson (2019), are therefore an appropriate way to improve organisational performance. One of the more commonly used soft systems approaches to people complexity is Checkland's SSM.

2.3.4.1 Soft Systems Methodology (SSM)

Briefly introduced at the beginning of Section 2.3.4, SSM is Checkland's approach for "tackling problematic messy situations of all kinds" (Checkland & Poulter, 2006, p. 191). SSM thus moves away from the idea of idealised designs and goal-setting, with Checkland (2000) considering reality as problematic and full of peculiarities. Reference to SSM and attention to the software of health systems and soft systems thinking are common within the HPSR literature, especially in concluding and recommendation sections of peer-reviewed articles that call for more emphasis to be placed on this more intangible aspects of systems (Augustsson et al., 2019b; Whyle & Olivier, 2020). This is not surprising, given acknowledgements of complexity, messiness, and making sense of a whole host of perspectives stemming from a diversity of stakeholders. SSM is therefore grounded as a process designed to deal with situations that are perceived as problematic and in need of improvement (Augustsson et al., 2019b) and has been identified as an action research approach, as one that is participatory and well suited to facilitating change (Augustsson et al., 2019a; Checkland, 2000) by recognising interconnections between the different parts of the system (Greenhalgh & Papoutsi, 2018b). Specifically, SSM engages stakeholders in a learning cycle where stakeholders look at a challenging situation; develop a rich picture of the situation within the context; develop conceptual models and compare with the real world; take action based on agreed improvements; and implement these iteratively (Augustsson, et al., 2019; Checkland and Poulter, 2006). This learning cycle, first

conceived as depicted in Figure 2.7 but then later refined to that in Figure 2.8, the latter removing the dividing line dropped between the "real world" and "systems thinking about the real world".
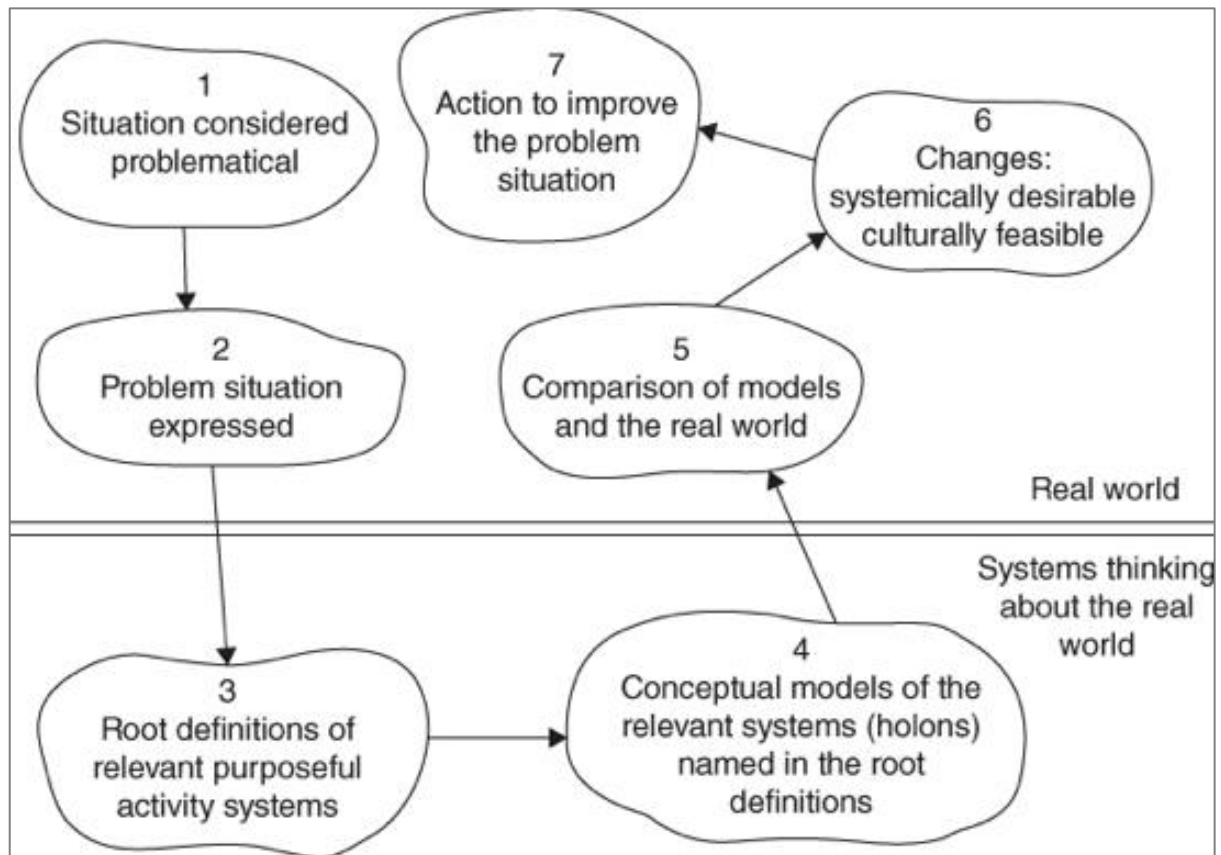
Figure 2. 7 The Learning Cycle of Soft systems Methodology (Source from Checkland, 1981)
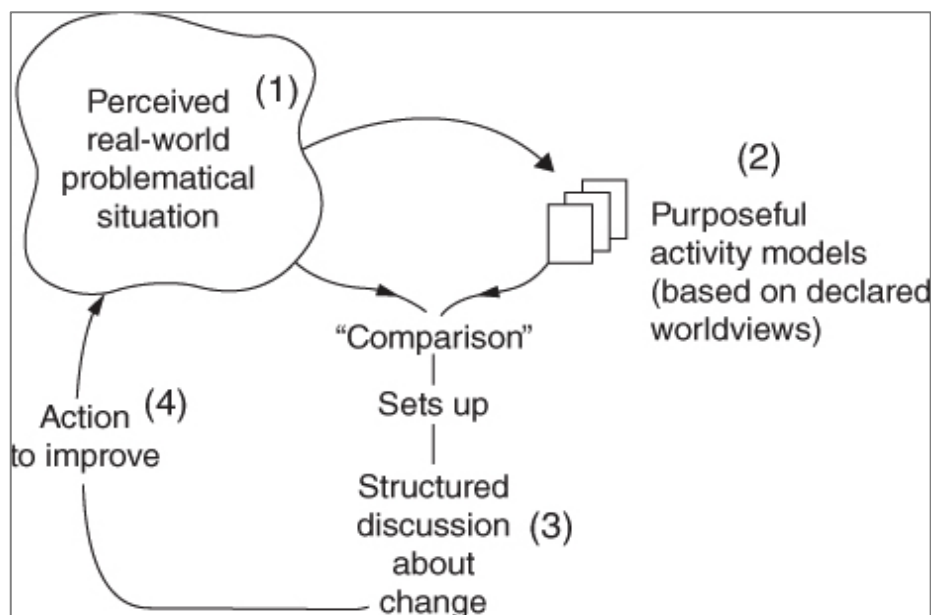
Figure 2. 8. The Iconic Representation of SSM Learning Cycle
(Source from Checkland and Poulter, 2006)

Put another way, Checkland's approach recognises that despite having shared purpose, the behaviour and values of different actors means that each actor may expect the process to play out in different ways according to their concept of change (Checkland and Poulter, 2006; Whyle and Olivier, 2020). Including iterations, engaging continual improvement, and learning, is therefore assumed, at least theoretically, to give everyone a voice and a chance to debate actions (Checkland and Poulter, 2006).

A recent scoping review of soft systems methodology in healthcare, gaps and future directions, based on research conducted over the last 50 years (Augustsson et al., 2019a) identified context and stakeholders as core to the soft systems approach, whereby more stakeholder involvement is associated with more effective outcomes (Augustsson et al., 2019a). In the review's attempts to understand more about the practical uses of SSM and soft systems thinking, however, the authors observed that SSM is not always applied in the routine way that Checkland and others propose (Augustsson et al., 2019a). This is perhaps not surprising given SSM's complexity, and the demand placed on practitioners and change agents to accommodate different tools, different stakeholders, and divergent studies. What was clear from the literature, however, is that while SSM is being used, *how* SSM is being implemented and the outcomes of its interventions are poorly documented (Augustsson et al., 2019a) particularly in LMICs. If anything, there is strong evidence for SSM being used successfully in problem structuring and/or defining and identifying the intervention, with less evidence for its implementation and outcomes (Augustsson et al., 2019a). Moreover, while stakeholders are a key component of SSM and the software of a health system, the review identified inconsistencies in stakeholder involvement. Possible reasons for these inconsistencies included a difficulty or lack of understanding of the methodology or to systems thinking more generally (Haynes et al., 2020), poor documentation of stakeholder involvement, and interventions only paying 'lip service' to stakeholder involvement. Similarly, Haynes et al (2020) observed that while policy-makers and practitioners within the Australian public health context saw the value in systems thinking, they simply did not possess the skills and played with safe with the status quo. With increasing attention being paid to systems thinking, accompanied by calls for more practical examples of it being put into practice, it is imperative for policy-makers and other stakeholders to understand and to be part of the process to ensure positive impacts on policy processes (Haynes et al., 2020)

2.3.5. Putting Systems Thinking into Practice

In addition to the need for more evidence of practical application of systems thinking within health, is the need to advance existing concepts, methods and tools for systems thinking. Several reviews in recent years have examined the field of systems thinking (Carey et al., 2015; Rusoja et al., 2018; Wilkinson et al., 2018). Common to all reviews is an attempt to synthesise thoughts around complexity in health and the application of systems thinking to public and global health, towards achieving the SDGs. In the most recent and most comprehensive of these reviews, Wilkinson et al. (2017) concur with others spanning more than a decade, such as Martin and Felix-Bartolotti (2010) and Jackson and Sambo (2020), that systems thinking is still trying to bridge theory to practice. However, they also offer rich evidence of the multitude of tools, methods and concepts available as a means to close this theory-to-practice gap. In addition to considerations as whether the reality of systems thinking lives up to the rhetoric, as well as numerous calls for action for applied systems thinking, the commonalities emerging from the reviews are Figure 2.9

Key Learning Points from the Literature on Applying Systems-Thinking Approaches in Global Health
1) Research that considers itself to be **using a systemic lens is not always applying systems methodologies** and therefore places more emphasis on the conceptual nature.
2) The majority of existing research has taken place in **high income countries**
3) Linked to point 1, **many studies are retrospective rather than prospective** with people superimposing concepts on to the data rather than framing their study within a systems approach.
4) The benefits of systems thinking for **improving decision-making by highlighting unintended consequences**. These are generally highlighted by embracing the complexities of the real-world such as power, interests and values.
5) Systems models are **not often evaluated for their usefulness or validated** in different contexts. Further, diagrams are not always displayed.
6) Systems approaches need not be the only way forward; they can also **compliment and contribute to other approaches in global health**
7) The distinction between 'hard' versus 'soft' approaches, with the recognition that the **application of soft systems thinking is likely to increase in popularity with regards to policy and knowledge transfer**
8) A shared objective is to **provide practitioners and planners with reference for implementation.**
9) The most commonly used methods and tools include **social network analysis (SNA), agent-based modelling (ABM), casual loop diagrams (CLDs), change management history, process mapping and stock and flow diagrams.**
10) Although many **methods and tools** exist, they are **underutilised**.
11) There are potential **benefits for leaders** in CAS to use systems thinking to nurture relationships, improve decision making and planning, synthesise perspectives and to create a shared vision. This may **empower all agents in a system** and **challenge reductionist thinking** as well as **encouraging ownership.**
12) Multidisciplinary approaches do not automatically equate to systems approaches.

Figure 2. 9 Synthesis of key learning points on applying systems-thinking approaches in Global Health

Ultimately, utilising systems thinking to strengthen health systems assumes that change will occur (Best & Holmes, 2010). To precipitate such change involves engaging and empowering those responsible for and affected by the change (Byrne-Davis et al., 2017). Theory-driven evaluations have become an increasingly popular way of evaluating and understanding how and why individual initiatives or programmes work (Chen & Rossi, 1983; Coryn et al., 2011). These include Realist Evaluation (RE), logical frameworks, logic models and Theories of Change (ToC). However, and given that logical frameworks and logic models tend to be more linear in their approach, ToCs and RE have emerged as increasingly popular ways to unlock and evaluate complexity in health. The latter two approaches to evaluation encourage research designs that are fitting for complex adaptive systems, allowing for "consideration of unanticipated effects, adopting more flexible designs, capitalising on patterns and regularities emerging in the observations, and adopting an iterative manner of inquiry" (Prashanth et al, 2014, p2).

2.3.6. The Road Less Travelled

> Understanding how individuals solve particular problems in field settings
> requires a strategy of moving back and forth from the world of theory to
> the world of action. Without theory one can never understand the general
> underlying mechanisms that operate in many guises in different
> situations. If not harnessed to empirical problems, theoretical work can
> spin off under its own momentum, reflecting little of the empirical world.
> (Ostrom, 1990, p. 129)

Section 2.3 of this literature review has introduced and discussed systems thinking as an overarching approach to HSS. Specifically, the extant literature argues that more informed use of theory can strengthen programmes, interventions, and initiatives, to ensure their effectiveness towards HSS and achieving UHC. The reality, however, is that complexity is a permanent fixture in HPSR, posing many challenges for decision-makers. These challenges are not disputed, but Jackson (2019) considers many of the proposed solutions as failing to recognise that "optimising the performance of one part [of the system] may have consequences elsewhere that are damaging for the whole....fundamentally they are not systemic enough" (p.35). While it is doubtful that in every circumstance, others have failed

to recognise the interconnectedness of health systems, the shift from theory to practice is still in its infancy, with a dearth of literature offering practical guidance in *how* systems thinking approaches can be applied in HPSR. Moreover, those trying to demystify the theory underlying systems thinking approaches, argue for the importance of systems thinking within efforts to strengthen health systems, emboldened by the idea that stakeholders can unknowingly still engage with theory. Accordingly, "it is not whether [stakeholders] use theory but whether they make explicit the particular theory or theories, informal and formal, they actually use" (Davidoff et al., 2015, p. 228)

2.4 Context Matters: Health Systems Strengthening in SSA

In 2020, the OECD Secretary General, Angel Gurria declared that "unless we adopt a systems approach, unless we employ systems thinking, we will fail to understand the world we are living in" (P.3). A crucial factor in understanding the world we live in, and how to improve health outcomes, is context (Pfadenhauer et al., 2017). A common thread running through Sections 2.2 and 2.3 of this review, is the critical role that context plays in health systems strengthening. There are few practical examples available from LMICs, including those in the SSA region, of the role that context plays (Pfadenhauer et al., 2017). Although the merit of systems thinking for HSS is attracting positive debate, many of its abstract concepts, theories, methods and tools require wider application so as to ensure that the literature reflects a broader range of experiences, examples, and ideas that, when taken together, validate this approach across other complex interventions and contexts. The literature presented thus far in this chapter demonstrates that HSS does not have a 'blue-print' and that approaches within each country must be evidenced-based, unique and sensitive to the social and economic context, so as to respond to the particular needs of its population. As a prelude to the introduction of Malawi as the case-study in this thesis, the following sections (Section 2.4 and Section 2.5) present the broader context of healthcare in SSA, detailing and discussing efforts to strengthen individual health systems, particularly through the development of health leadership and management capacity of the people at the core of the system – the health workforce.

2.4.1 An Overview of the State of Healthcare

Despite global improvements in health and development, mortality rates in LMICs remain much higher than in HICs (Naghavi et al., 2017). Similarly, Dieleman et al. (2017), argue that even if the knowledge and novel ideas exist to eradicate or reduce causes of mortality, it is likely that existing financial resources and the continued insufficient investment in health systems will not suffice to achieve the health-related targets of the SDGs within LMICs. This, alongside the weakness of health systems within turbulent contexts, does not bode well for achieving UHC. When considering health systems in LMICs, SSA emerges as the region with the heaviest disease burden and health system challenges (Agyepong et al., 2017). The rate of under-5 mortality in the region is the highest in the world, with 83 deaths per 1000 live births in 2015. By comparison, regions such as Central and Eastern Europe reported 17 deaths per 1000 live births in the same year (Naghavi et al., 2017). Despite greater need, the continent has less than 1% of the world's health expenditure (UN, 2017). With the sharpest increase in global population said to occur in Africa over the next 30 years, roughly tripling in size, the strain placed on the health system is unlikely to alleviate soon (UN, 2017). Although infectious diseases continue to dominate the disease burden, NCDs are increasingly posing a double burden to health systems in SSA (Gouda et al., 2019). Many African countries simply do not have the infrastructure and capacity to deal with these increasing burdens (Gouda et al., 2019), In addition, one of the biggest barriers to care is out-of-pocket expenses, whereby some of the poorest spend catastrophic amounts on health each year (Bukhman et al., 2020) with the likelihood of health payments pushing more into poverty (UN, 2015). This is a reminder of one of the key dimensions of health systems performance: Equitable access to health services without financial burden.

Given the circumstances, many countries in SSA rely on assistance from outside their governments to support in-country health systems. This includes assistance from non-government organisations, faith-based organisations, and international donors (see Section 2.2.5). As it is believed that this support will continue to be needed for the foreseeable future (Bekker et al., 2018; Bukhman et al., 2020) this dependency on external support and funding creates a situation where agendas are often driven by 'outsiders', which can skew planning and prioritising at central level, as well as attracting health care workers to the private sector (i.e., NGOs) for higher salaries, and thus further exacerbating health worker

shortages (Doherty et al., 2018; Mash et al., 2019). In such cases, and while health systems should fall under the remit of the Ministry of Health (MoH), they are often essentially managed by funders and NGOs through what Agyepong et al. (2017) describe as a "parallel health system".

2.4.2 Historical Context

Many of the existing health systems' challenges and weaknesses are said to be rooted within SSA's colonial past (Tumusiime et al., 2019). Africa, as a continent, is comprised of very different countries. With the introduction of colonialisation from predominantly European countries, tensions emerged between traditional medicine, which existed for millions of people prior to the arrival of the Europeans, and "Western medicine", as well as Christianity. Consequently, there exists a juxtaposition of 'western' medical practice and traditional African health systems, with a sometimes unresolved tension between the two11/10/2022 13:54:00(Coovadia et al., 2009). Specifically, and while the organisation of health systems took the form of European systems, the educational systems and investments for training health workers have often been criticised as being inadequate compared to that of HICs where training is a core part of capacity building (Agyepong et al., 2017). This is said to go some way in explaining the continued high staff shortages. Moreover, many SSA countries "have yet to recover from the impact of structural adjustments and other economic reports imposed by the International Monetary Fund (IMF), the World Bank, and other international agencies" (Agyepong et al., 2017, p. 2806) prevalent during the era of post-colonialism. Accelerated by the HIV/AIDS epidemic, African scholars describe an emerging culture of dependency resulting in "loss of self-confidence, self-respect, and self-determination, and the humiliation of being forced to implement solutions that Africans knew to be wrong [resulting in] an insidious and malignant psychological demoralisation of many African leaders and populations" (Omaswa & Crisp, 2014, p. 60).

Albeit not unique to the continent, it would be remiss not to acknowledge concerns around corruption and accountability in SSA. The World Bank expressed concerns in 2010 about 'how quiet corruption" was undermining the region's efforts to develop. Likewise, the impact of corruption on health systems has been said to impact on health outcomes,

leading to inequities and moving health centres away from being people-centred (Kirigia & Barry, 2008; Rispel et al., 2016). Within the health system, corruption has materialised in different ways, whether at central level, with the misallocation or disappearance of health equipment (Rispel et al., 2016), wages not being paid (Gauthier & Wane, 2009) or medicines being sold at facility level leading to drug shortages, all impacting on health outcomes and trust in the system (Huss et al., 2011).

2.4.3 New Beginnings: The Africa we Want

In a new era, voices from SSA are not only calling for changes and improvements to be initiated, but for the continent itself to take the lead in these efforts. The 2019 Africa health Strategy (2018-2030) adopted in line with the African Union (AU) Agenda 2063 and SDGs recognises the importance of strengthening and investing in research and innovation in the health delivery systems for tackling many of the challenges on the African continent. Moreover, the strategy calls for stakeholders and partners to align with Africa's agenda. Agyepong et al. (2017) confidently stated that African countries are starting to take leadership over their own agendas, with promises that "the future in Africa is bright, so long as no one is left behind" (p. 2803). In Omaswa and Crisp's 2014 book, *African Health Leaders: Making Change and Claiming the Future*, the editors also express confidence in a new generation of African health leaders, claiming:

> African leaders and leadership in health have an enormous role to play in a new Africa, where Africans recognise that the responsibility for making Africa an equal player in the global community rests primarily with Africans. (p. 71)

Similarly, in the *Lancet Commission's report on the Future of Health in sub-Saharan Africa: The Path to Longer and Healthier Lives for All Africans by 2030* (2017), contributors emphasise how African leadership for health can be brought into play at all levels, identifying opportunities for health development while also warning that these cannot be achieved if the region continues at its current pace, or "evidence-based optimism with caution"(p.2809) As expressed by Agyepong et al. (2017) however, without a sincere

shift in mindsight the current pace will be a "recipe for failure" (p. 2819). In addition, the report heavily emphasises the need for local ownership, including home-grown solutions for country-specific needs and challenges. Most of all, and in response to an evidenced lack of people- centred care, the Commission further stresses the need for a framework shift to deliver better care through people-centre health systems, focused on prevention, primary care, and public health. Table 2.1 summarises and highlights key challenges for health systems in SSA as identified by the Lancet Commission's report.

Table 2.1 Key Challenges for 21st Century Health Systems in SSA
(Source adapted from Agyepong et al., 2017)

Areas to Focus on for 21st Century Health Systems in sub-Saharan Africa
o People-centred health systems, UHC, the social determinants of health, and health outcomes
o Leadership, stewardship, civil society engagement and accountability at all levels
o Financing for health
o Commodity security
o Public Health systems
o Health workforce development
o Research and Higher Education
o Innovation in product, service delivery, and governance

Although there is some evidence of people-centred approaches to strengthening health systems in SSA, initiatives tend to be on a small scale and not necessarily always integrated into the overall system. For changes to happen, the Lancet Commission on Africa states that:

> Sub-Saharan countries need to recognise the centrality of health systems
> software (people and processes) to determine what the hardware (the
> WHO building blocks of financing, governance, information systems,
> human and other resources) is able to achieve, to transform health
> systems to benefit people's health (p. 2821)

2.4.4 Putting People at the Centre

The importance of putting people at the centre of health systems is a concept not yet fully embraced within the African region, or globally for that matter. Starting by recognising their (African governments) own importance in any effort to improve health and well-being, the recognition that people need to be at the centre of health systems echoes the

WHO's Integrated People Centred Health Systems Framework (2015) as introduced in Section 2.2.3.1. This thinking not only highlights health care for all but also the importance of leaving no one behind in the African region. Building on this and other frameworks (De Savigny & Adam, 2009; Murray & Frenk, 2000; Shakarishvili et al., 2010), the WHO Regional Office for Africa (WHO AFRO) developed their *Framework on Health Systems Strengthening for UHC and the SDGs* emphasising: (i) integrated people-centred care, with emphasis on district and community health systems and realigning the health system "building blocks" towards communities and families' health; (ii) improving data generation, analysis, and use to support PHC and UHC performance; and (iii) improved governance, management and accountability at operational (districts) and community levels linked clearly to health service coverage and quality results (WHO, 2017). As illustrated in Figure 2.10, at the centre of the WHO AFRO framework is a commitment to producing robust health systems suitable for an individual country's contexts and its priority needs. Achieving such is supported by the need for multi-stakeholder and international engagement and partnership, as evidenced by the convening of forums in Rwanda such as *Putting People First: the Road to Universal Health Coverage in Africa* as well as being highlighted by the Director-General of the WHO in discussions about building health system resilience in the context of PHC revitalisation for attainment of UHC (Ghebreyesus, 2020). Similar to the other frameworks discussed under Section 2.2, as well as the key dimensions of health systems performance, the WHO AFRO framework therefore places resilience as an important output of performance, in addition to quality of care, equity and efficiency and service demands (WHO, 2017).

A relatively newer framework, there is little evidence for how the WHO AFRO framework has been translated into action, but it nevertheless provides crucial insights into what countries, in the African region specifically, think is required to strengthen health systems for the SDGs and achieving UHC (Ibeneme et al., 2020). Specifically, and firstly, the framework acknowledges that many priorities in the region are still partner-driven, with many health systems strengthening efforts being vertical rather than linked, and duplicated rather than integrated (Ibeneme et al., 2020). Accordingly, the framework maintains that if change is to be sustained, individual countries will need more ownership over the programmes rather than parachute-in-and-out efforts. Secondly, the action framework is open for adaption to each country in the region, acting as a flexible guide rather than a one-size-fits all framework. Finally, the framework suggests a list of operational actions that

are designed to assist countries in determining and phasing in priorities when planning, implementing, and monitoring their national health strategies (WHO, 2017). The framework therefore goes beyond the 'what' to do, offering additional insight into 'how' to achieve health for all under SDG3.

The logic behind the WHO AFRO framework is therefore a focus on the HSS initiatives and actions needed to improve health systems performance to attain the required coverage of services, highlighting interventions that are considered important for populations to achieve the impact that *they* desire. Taking the health workforce as an example, a range of actions are identified in the framework to ensure that motivated, productive and fit-for purpose health workers are available, including a focus on leadership and governance, policy and regulations, and planning. Emphasis is also placed on linking investments to health service outcomes, and a set of cross-cutting system performance areas for countries to assess is provided to ensure focus is not just on one building block but on all building blocks through the promotion of systems thinking (Dooris, 2013). The WHO AFRO framework therefore goes some way towards filling the identified gaps in African health systems, including the minimal translation of robust health policies into operational strategies. It also underlines the need for another key dimension of health system performance, the need for health systems to be resilient and "capable of responding to routine as well as unexpected challenges that might arise in the future" (Kieny & Dovlo, 2015). The framework alone however, will not strengthen health systems, requiring further commitment and investment from governments as well as other stakeholders to put the framework into practice.
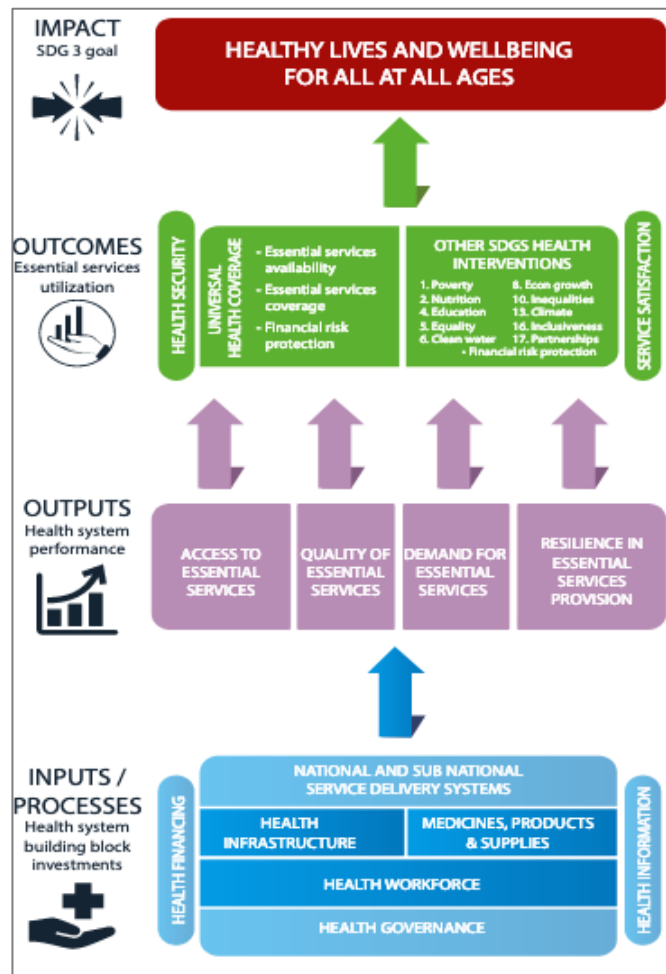
Figure 2.10 Framework of Actions for solving Africa's Complex Health Systems Challenges
(Source from WHO, 2017, p.11)

2.4.5. Human Resources for Health: The Critical Pathway to UHC

The introduction to this thesis highlighted the crucial role of HRH; it also highlighted the critical nature of the HRH crisis. One of the most worrying and urgent challenges that continues to face SSA is increasing shortages of health workers, which is only forecasted to worsen in coming years (Afriyie et al., 2019; Munga & Mæstad, 2009; WHO, 2013; WHO, 2016). The region has only 3% of the world's health care workers yet shoulders 25% of the global disease burden (Crisp, 2011). Taking cancer as an example, some countries in SSA have no clinical oncologists and radiotherapy services are only available to around 50 per cent of countries on the continent (Abdel-Wahab et al., 2013; Sharma et al., 2011). More generally, less than 30% of countries in SSA are able to meet the 2.3 health worker per 1000 population which was set by the WHO (Campbell et al., 2013; WHO, 2014). Accordingly, Africa has the lowest proportion of health management and support workers, resulting in clinical health workers having less managerial support to deal with

the heaviest health burdens. The full severity of the dearth of HRH in SSA in comparison to other regions is depicted in Figure 2.11.
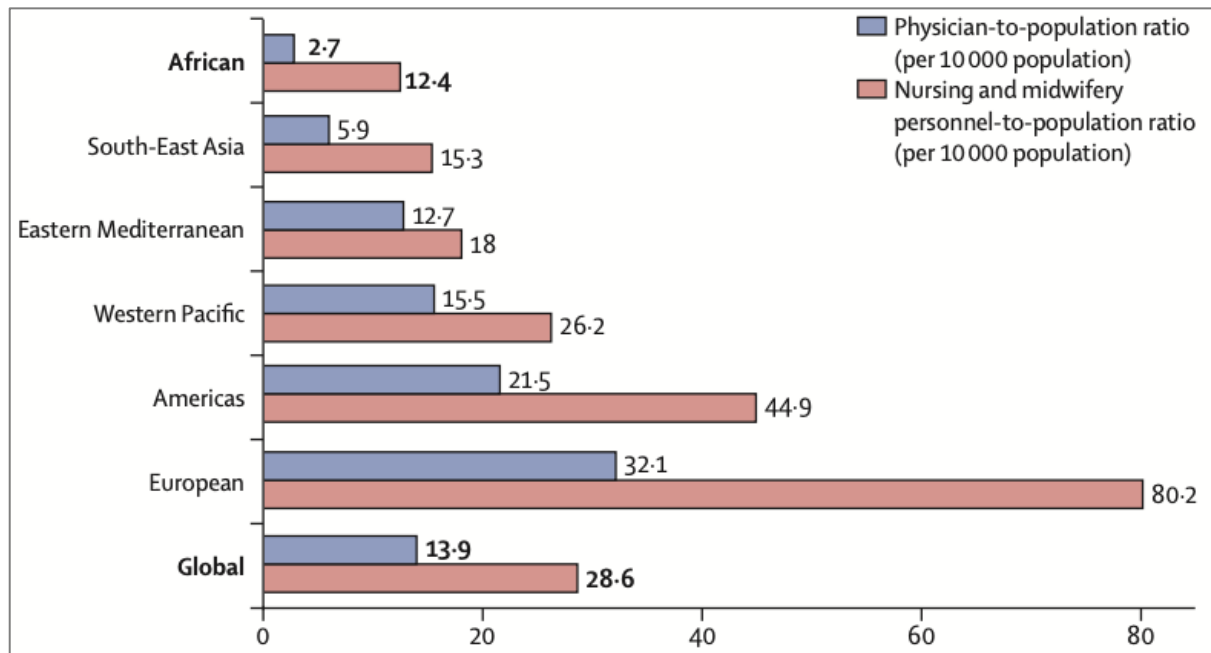
Figure 2. 11 Health Workforce to Population Ratios by WHO region (2007-2013)

Putting people at the centre of health systems strengthening efforts therefore also includes putting HRH at the heart of health system performance (WHO, 2016), whereby the other health system elements and building blocks will underperform without a well-performing and well-funded health workforce (Lassi et al., 2016). Specifically, HRH are the foundations and pillars of any efforts to improve health and well-being and without them, health system interventions will fail (George et al., 2019). Consequently, both UHC and the SDGs are dependent on the health workforce. However, and as argued by George et al. (2019) their individual and collective agency are often ignored.

The failure to recognise HRH individual and collective agency is perhaps a large contributing factor to the continued crisis in HRH (Campbell et al., 2013). Moreover, and although health workers are recognised as being critical to health systems, this is not reflected in the less than 4% of development assistance for health that is directed at human resources (Fieno et al., 2016; Micah et al., 2018). In their political economy analysis of HRH in Africa, Fieno et al., (2016) attributed this lack of investment in HRH to "powerful political and institutional incentives" pushing stakeholders at national and international

levels away from HRH to focus on other building blocks or development areas that they deem more investable. These priorities may include the prioritisation of vertical programmes (Fieno et al., 2016). According to Fieno et al. (2016) politicians and bureaucrats do not readily reap the benefits from HRH investment, as they would for a new clinic or school, for example, and for which they can be praised for during their tenure. Over-crowded with multiple stakeholders, such as different Ministries, training institutions, professional boards and associations, the WHO, GHIs and donors, the HRH sector and policy space often fails to find consensus on addressing challenges with the health workforce. Such over-crowding within the sector has also proven problematic within the context of donor driven agendas, where weaker capacity in the bureaucracy of HRH units has allowed for outside consultants and donors to maintain control and to take advantage of decision-making, without the transferring of skills (e.g., for creating HRH strategic plans) (Afriyie et al., 2019; Fieno et al., 2016).

Consequently, existing health workers are overstretched and lack recognition, particularly in lower level and more rural health facilities (Willcox et al., 2015). Moreover, many health workers, especially at primary and community levels, vary considerably in their levels of training, with some given responsibilities that extend beyond their training (Nkomazana et al., 2016; Schriver et al., 2017). There are numerous examples of the health workforce feeling unsupported and demoralised, often attributed to lack of supportive supervision and leadership (Nkomazana et al., 2016; Schriver et al., 2017; WHO, 2008). Lack of leadership and support has often led to migration of health workers from public to private sectors, rural to urban, or to different countries (Muthuri et al., 2020). Taken together, the state of HRH in the African region has been classified as "neither fit for purpose, sufficient or distributed equally" (Asamani et al., 2019), directly impacting on people and with devastating impacts on health outcomes.

2.4.6 Efforts to Address the Crisis

Numerous responses over the last decades have tried to pull SSA out of the HRH crisis. Guidelines for developing national HRH policies and strategic plans were introduced and in 2012 the WHO AFRO developed a Regional Road map for scaling up the health workforce, though the latter has mostly remained on paper than resulted in action (Liu et

al., 2017; WHO, 2013). By 2015 however, only 36% of the 47 member states had developed a HRH policy (Afriyie et al., 2019). For countries needing to make strategic plans and anticipate future needs, more attention must be paid to keeping track of the size and composition of their respective health workforce (Pozo-Martin et al., 2017). Recent appeals have come from the region for a further strategy that will replace the "current inefficient, compartmentalised and ineffective approach that breeds inequity and extracontinental resource drain" (Asamani et al., 2019, p. 1).

The majority of the literature on interventions related to HRH is linked to health systems strengthening in one way or another, and focuses on many areas such as workforce supply, distribution, education, performance, leadership, management and governance (Witter et al., 2019). While a discussion of all HRH interventions is beyond the scope of this thesis, the remainder of this section briefly discusses the evidence-base in relation to some of the more common interventions, including skills mix approaches to address staff shortages (2.4.6.1), training to increase knowledge and competencies (2.4.6.2), and mechanisms to improve health workforce performance, such as supportive supervision (2.4.6.3). In addition, the last section of this chapter will focus on the development of health leadership and management as a prominent and crucial approach to addressing the HRH crisis, towards strengthening health systems more broadly.

2.4.6.1 Skill Mix Approaches: The Community Health Worker

Initial responses to HRH shortages in SSA involved the recruitment and capacity building of CHWs as a form of lay health worker, with such programmes attracting considerable attention in terms of their long-term success and sustainability (Cometto et al., 2018; Lehmann et al., 2019). As discussed in Section 2.2.6.4, the literature focused on CHW programmes is immense, and somewhat of "a virtual explosion of scientific evidence" (Cometto et al., 2018; Lehmann et al., 2019). Drawing on the synthesised evidence contained in recent literature reviews on SSA, Lehmann et al. (2019) highlighted four key elements required for the success of CHW programmes including:

1) **Embeddedness, connectivity, and integration** into the larger healthcare system
2) **Cadre differentiation and role clarity** to maintain clear scopes of work and accountability
3) **Sound programme design based on local contextual factors and effective people management**
4) **Ongoing monitoring, learning, and adapting** based on accurate and timely local data in order to ensure optimal fit to local context, since once size does not fit all

While the reliance on lay health workers to provide health services in communities has the potential to strengthen health systems, the elements that Lehmann et al. (2019) have outlined echo many of the broader requirements characteristic of systems thinking. For example, the strong emphasis on the importance of context, the need for ongoing learning, and the purposeful focus on people and their complexity. These elements are further recognised across the extant literature on how to improve the performance of CHWs (Cometto et al., 2018; Kok et al., 2017a; Kok, Kane, et al., 2015).

Exploring case studies of CHW programmes across five SSA countries (DRC, Ghana, Senegal, Uganda and Zimbabwe), Raven et al. (2015), identified management and support of CHWs as vital, with a need to ensure that it is not just frontline health workers offering this support, but also other management actors. Further emerging from this study was the importance of not making assumptions about the needs of CHWs, as expectations are not often met, calling for more attention to context-appropriate strategies for Human Resource Management (HRM) (Raven et al., 2015). This is not unique to CHW programmes, but something evidenced across global health programmes in general (Dieleman et al., 2009; WHO, 2016). Centring on context and how context may be linked to performance of health workers recalls the need for HSS approaches to be more than just about the hardware of a health system, but also concerned with its software. Likewise, and in the context of CHWs and their position within complex adaptive systems (Kok et al., 2017b) the importance of recognising complexity involves the need to understand more about perspectives through the ideas, interests, relationships, power, values and norms of different health system actors. This resonates with the concept of people-centred health systems and its importance in understanding how and why a health system might be strengthened. Therefore, where CHWs are a critical component of health systems in LMICs, such programmes should focus on CHWs as people and accompanied by

supportive measures such as appropriate training, supervision, motivation, leadership and management (Kok et al., 2017b; Vallières et al., 2020).

2.4.6.2 Training

The elements of training, supervision, motivation, leadership and management, applies to all health workers as a "properly trained and competent workforce […] essential to any successful health care system" (Kabene et al., 2006, p. 3). Consequently, several interventions aimed at addressing shortages of HRH focus on transforming the education and training of health workers (WHO, 2009; Frenk et al., 2010; WHO, 2016). This training ranges from focusing on developing skills of new recruits to building capacity of existing health workers, with training activities attracting considerable investment and sponsorship from GHIs and donors (Finn et al., 2021; WHO, 2016).

While training institutions for HRH have increased, this varies considerably across the continent, with speciality training still inadequate (Kruk et al., 2018). Unfortunately, increased training has not necessarily corresponded to an increase in the availability of jobs following graduation, forcing many graduates to seek employment outside of their countries, further contributing to the 'brain drain' (Cancedda et al., 2015). Moreover, where a diverse range of stakeholders have invested in training health workers, the priorities are often driven by external partners and focused on specific diseases, which do not always align with local priorities (Cancedda et al., 2015). This can lead to failure to meet the needs of the health workforce in a particular context (e.g., lack of people-centred approaches) which may result in lack of interest and motivation on behalf of the health workers (George et al., 2017). While historically many of the training initiatives have focused primarily on classroom teaching, recent years has seen the advent of more innovative trainings, with a recognised focused on team work and more participatory approaches (Bradley et al., 2013; Cancedda et al., 2015). In general however, training remains an area that still needs to be accelerated, especially towards the generation of new graduates, but also to support the existing health workforce (Agyepong et al., 2017; Rowe et al., 2021).

2.4.6.3 Mechanisms to Improve Workforce Performance: Supportive Supervision

Improving supportive supervision for HRH is another common intervention to try to maximise health workforce performance in LMICs. Specifically, supportive supervision is seen as a promising approach to improve motivation and job satisfaction, strengthen skills, improve management practices as well as quality of care, and, ultimately, to improve performance of health workers as well as health systems (Bailey et al., 2016). Here, "supportive" supervision emerged as a challenge to traditional top-down authoritarian supervision (Clements et al., 2007), whereby supportive supervision, as defined by Marquez and Kean (2002), is "an approach to supervision that emphasises joint problem-solving, mentoring and two-way communication between the supervisor and those being supervised". According to various scholars, supportive supervision should comprise of (1) performance observation, (2) facilitative feedback, (3) provision of guidelines, (4) advice on opportunities for improvement, (5) social and emotional support, (6) problem solving as a team and, (7) follow-up on previous visits (Avortri et al., 2019; Bailey et al., 2016). Supportive supervision therefore places an emphasis on the people involved and the relationship between them; people-centred, human interactions being key to the software of performance. Given the aforementioned issues around the need to support and supervise lay health workers, the concept of supportive supervision is not limited to health workers, but is also required for community-level health workers through supervision being available at the level of the health facility (Purity et al., 2017).

In their 2016 systematic review of *Supportive Supervision as a Strategy to Improve Primary Healthcare Services in sub-Saharan African* however, Bailey et al. call into question the mixed evidence for the effects of supportive supervision in LMICs, suggesting that the impact of supportive supervision is dependent on various factors (Bradley et al., 2013). That said, positive outcomes from supportive supervision interventions in SSA have been noted, especially linked to better health worker performance (Glenton et al., 2013) improved documentation and skill sets (Mwedwa et al., 2017), and improved adherence to standards and guidelines. Similarly, in a mixed methods intervention study in four SSA countries (Ethiopia, Kenya, Malawi and Mozambique), supportive group supervision, when combined with individual and/or peer supervision was found to improve community health worker motivation and performance (Kok et al., 2018). On the other hand, other studies reveal little evidence of positive effects (Madede et al., 2017). In a 2011 systematic

review looking at the impact of supportive supervision on PHC, Bosch-Capblanch et al. (2011) had a little to report on the long-term impacts of supportive supervision. Similarly, and with regards to quality of care as a key dimension of health systems performance and core component of UHC, there remains little evidence to suggest that supportive supervision has resulted in improvements in quality of care (Leslie et al., 2016).

As with other HRH strengthening interventions, supportive supervision is sometimes introduced as a project or for a disease specific intervention, rather than as a systems approach (Avortri et al., 2019; Bailey et al., 2016) with implications for its embeddedness as well its sustainability. Accordingly, these supportive supervision approaches tend to be more about fulfilling donor requirements (Onuka et al., 2015), ticking boxes, and inspection and control (Bradley et al., 2013). In addition, task assistance may not always be possible when supervision is conducted more generally, rather than by individuals with expertise in particular areas, which can lead to staff frustration (Roberton et al., 2015). This calls into question the quality of the supervision itself and the importance of ensuring that those in positions of authority are themselves trained on how to conduct supportive supervision to ensure its effectiveness and avoid fault-finding approaches (Avortri et al., 2019; Karuga et al., 2019). For example, a recent study in Kenya found positive effects for supervision practices by supporting the supervisors themselves with the skills necessary to shift from fault-finding to coaching, mentorship and problem solving (Karuga et al., 2019). This included the need to focus again on the human interaction component which is built on "trust, confidentiality and empathy and emphasis on task assistance" (Avortri et al., 2019; Bailey et al., 2016; Karuga et al., 2019). This is consistent with findings from other studies which indicate trust and relationships as important determinants of performance (Aberese-Ako et al., 2014; Kok, Dieleman, et al., 2015; Kok et al., 2018).

2.4.7 Motivation, Trust and Relationships

While HRH are essential in the delivery of health services, the ongoing HRH crisis impacts on both the intrinsic and extrinsic motivation, attrition rates, and performance of health workers (Borghi et al., 2018; S. Bradley & McAuliffe, 2009; Vallières et al., 2020) serving as a reminder that the health workforce is comprised of human beings and that the health

system is a human system (Jackson, 2019). Accordingly, factors such as supportive supervision, training, leadership, management and a mix of financial and non-financial incentives impact on motivation and retention of HCWs, as well as quality of care in LMICs (Muthuri et al., 2020; Vallières et al., 2020). Motivation, in particular, is seen as a cross-cutting element across all aspects of HRH, entire health systems, and health outcomes and is well illustrated by Bhatnagar et al., (2018) in Figure 2.12.
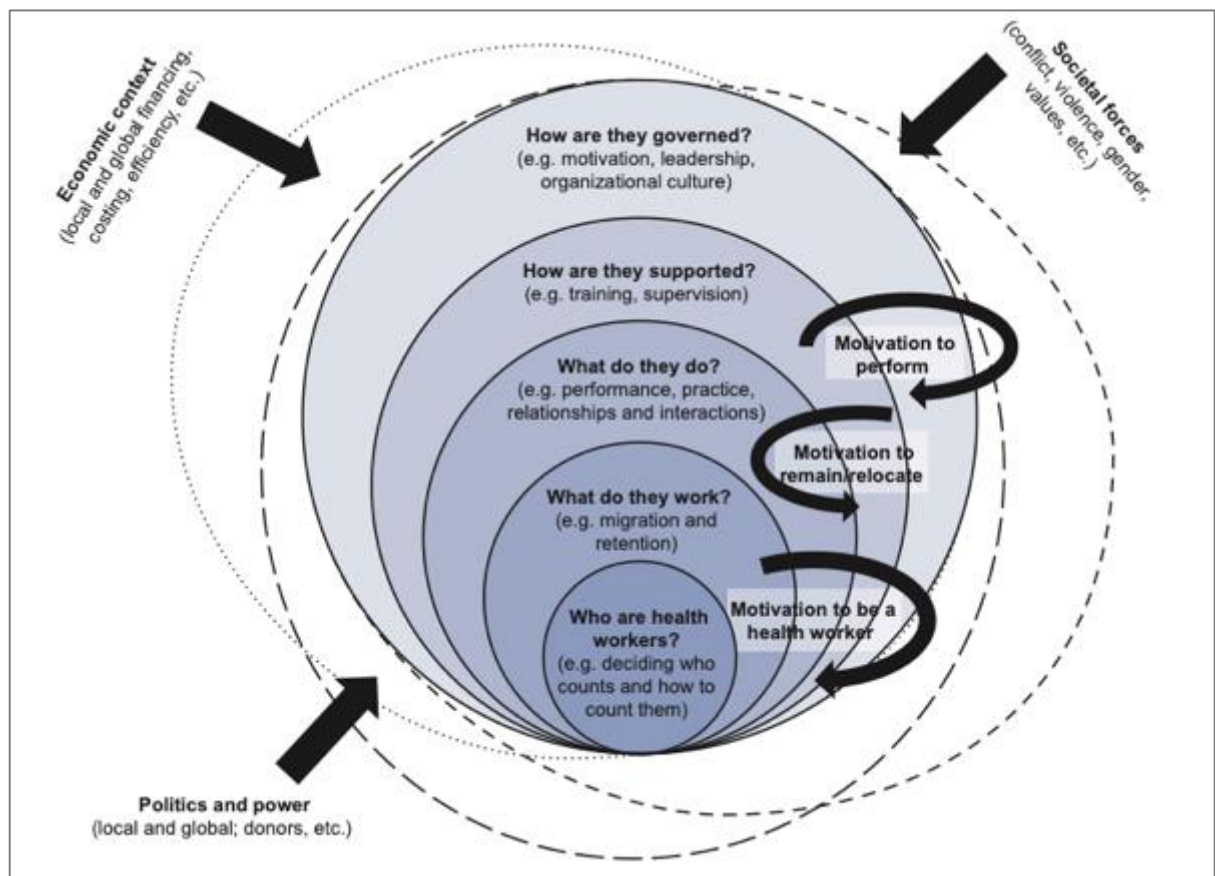
Figure 2. 12 Motivation as a theme that cut across all aspects of HRH

As a theoretical construct, motivation has attracted considerable scholarly attention (Aberese-Ako et al., 2014; Bhatnagar et al., 2018; Bonenberger et al., 2014; Borghi et al., 2018; Lohmann et al., 2016; Muthuri et al., 2020; Vallières et al., 2020). Furthermore, the importance of investing in HRH motivation was recently endorsed and encouraged at the Global Conference on PHC, 2018. Understanding what motivates HRH is therefore fertile ground for researchers, implementers and policymakers as part of any efforts to strengthen health systems.

Work motivation has been defined within organisational psychology as a "set of energetic forces that originate both within as well as beyond an individual's being, to initiate work-related behaviour and to determine its form, direction, intensity and duration" (Pinder, 2008, p. 11). This emphasises both the "conscious or unconscious stimulus" in individuals, as referred to by Borkowski when discussing organisational behaviour in health care (2020). According to Gagné and Deci (2005), people are either intrinsically motivated by interest and satisfaction to do the work, or extrinsically motivated by the external consequences of performing tasks. Policy attention however, has tended to focus on extrinsic motivating factors (Okello & Gilson, 2015), rather than intrinsic motivation which is also linked to positive health worker behaviours (Dieleman et al., 2009a).

Workplace trust relationships have been found to indirectly influence HCW intrinsic motivation, with motivational theories suggesting that HRH need to trust those that are administering the system for them to respond positively (Okello & Gilson, 2015). In their 2015 systematic review that explored the influence of trust relationships on motivation in the health sector, Okello and Gilson identified the following motivational factors as linked to trust: (1) respect, recognition, appreciation, and rewards, (2) supervision, (3) teamwork, (4) management support, (5) autonomy (6) communication, (7) feedback and openness, and (10) staff shortages and resource inadequacy.

These motivational factors present an interesting lens through which to understand and consider relationships within the health system, highlighting dimensions that may sometimes be forgotten about when considering HSS. Many of the motivational factors linked to positive trust relationships were often associated with managers and supervisors, although trust between co-workers is also considered important for work performance (Østergaard, 2015). In SSA, several examples illustrate both the positive and negative impact that trust, or lack thereof, can have on HCWs' ability to work effectively. For example, looking at the role of non-financial incentives and HRM tools in SSA, qualitative interviews with health professionals in Benin and Kenya highlight the importance of recognition, appreciation, and acknowledgement of their professionalism by supervisors and managers to strengthen HCW ethos and motivation (Mathauer & Imhoff, 2006). Similarly, Dieleman et al., (2006), identified mechanisms for recognition and being given more responsibility as an important gain for HCW motivation in Mali. It follows therefore

that distrust, disrespect, disconnect, and generally stressful relations with managers and supervisors have a detrimental impact on HCW trust relationships and levels of motivation. For example, maternal and neonatal health care providers across Burkino Faso, Ghana, and Tanzania reported feeling discouraged by favouritism and abuse of power by management in their respective facilities, leading to resentment, feeling undervalued, and demotivation (Okello & Gilson, 2015; Prytherch et al., 2013). Taken together, the evidence is clear for the importance of strong and supportive health leadership and management, as a way to bolster health workers motivation, as a key determinant of health worker performance.

2.5 Health Leadership and Management for HSS in SSA

While Section 2.4.1 highlights several shortcomings of health systems in SSA, it is worth noting that twelve SSA countries *did* meet Millennium Development Goal 4, in reducing childhood deaths (UNICEF, 2015). This reduction in mortality has largely been attributed to strong leadership and management. The four-country study (Liberia, Zambia, Zimbabwe and Kenya) conducted by Haley et al. (2019), for example, demonstrated the role of strong health leadership and governance in improving maternal, neonatal and child health. This is consistent with the idea that leadership and management is one of the WHO's most critical health system building blocks, cross-cutting and connecting all of the different blocks together, (Bradley et al., 2015; Daire et al., 2014; Figueroa et al., 2019; Reich et al., 2016; WHO, 2007).

While the field of health leadership and management development is too broad to be discussed at length within the context of this thesis, leadership and management theory forms the backdrop for the thesis aim. The following sections of this chapter thus introduce and discuss relevant key concepts, theories and empirical research related to health leadership and management. Specifically, the following section also explores the reasons why the development of leadership and management capacity of HRH is at the forefront of HSS efforts in SSA, and how people are approaching leadership and management development (Yeager & Bertrand, 2015).

2.5.1 Defining Leadership and Management

It is only in more recent years that leadership and management practices have been studied within the context of healthcare, rather than from a business perspective (Johnson et al., 2021; Mathole et al., 2018), with theoretical and practical applications transferable to the understanding and functioning of different health systems and their contexts. While it is generally agreed that there is substantial overlap between leadership and management when it comes to the functioning of organisations, the literature also acknowledges variations in definitions and differences between the two (Daire et al., 2014; Galer et al., 2005; Gosling & Mintzberg, 2003; Yukl, 2013). In healthcare, management has been defined as planning and using resources efficiently to produce intended results, and leadership as "mobilising, influencing and communicating the organisational vision to inspire, motivate and empower others to work towards achieving this vision"(Aberese-Ako et al., 2018, p. 1). As exemplified by the concept that managers in health must always be "managers that lead" (Galer et al., 2005), leadership and management are often considered together within the context of complex adaptive health systems (Kwamie, 2015). Specifically, leadership and governance are said to be intertwined, requiring a "critical mass of people with new leadership skills with micro-practices of governance [who] work to change the context from within, and new structures of governance that spread decision-making power and encourage multiple forms of accountability" (Gilson & Agyepong, 2018, p. ii). All of this existing within complex health systems and requiring system-wide collaboration (Gilson & Agyepong, 2018; Plsek & Wilson, 2001).

Connected to both the concepts of leadership and management is the organisational culture. Organisational culture is understood to be about the patterns of values, beliefs, meanings, behaviour, norms and assumptions that organisational members share, contributing to the unique environment of an organisation (Mbau & Gilson, 2018). Both health leadership and management are increasingly being recognised as important towards shaping organisational culture, and vice versa, as well as being critical to the success of organisations' performance, quality, safety and improvement (Daire & Gilson, 2014; Mannion & Davies, 2018; Mbau & Gilson, 2018; Nxumalo et al., 2018) (Nxumalo et al., 2018; Mannion and Davies, 2018; Mbau and Gilson, 2018; Gilson and Daire, 2011).

As a concept, organisational culture recognises health systems as social systems, and as a "system of values and practices that are socially constructed and shared by actors and influence their relationships, attitudes and behaviour towards changes, and can be manipulated or influenced, at least in part, through managerial strategies to enable achievement of the desired organisational goals" (Mbau & Gilson, 2018, p. 2). House et al. (2004), makes the interesting distinction between *practices* referring to how things should be done, versus *values*, referring to judgements of how things should be done. If anything, this emphasises the softer, less visible, aspects of health systems that also need to be considered and taken into consideration within the context of health systems strengthening. Organisational culture also acts as a reminder of health systems as complex, comprising of multiple interactions and relationships between people, from which leadership and management have a common purpose (Plsek & Wilson, 2001; Plsek and Greenhalgh, 2001). In the WHO's (2015) Global Strategy on Integrated People-Centred Health Services, the importance of organisational culture for strengthening leadership and management for change is recognised under Strategic Goal 5: Creating an enabling environment.

2.5.2. Different Styles of Leadership and Management

Numerous leadership styles appear in the literature, including some of the following: individualised, transformational, transactional, strategic, relational, charismatic, laissez-faire, authoritarian, participative, servant, consultative, pluralised relational, shared, distributed collectivistic and situational (Currie & Lockett, 2011; De Brún et al., 2020; Johnson, Begg, et al., 2021; Johnson, Sahr, et al., 2021; Lowe et al., 1996; Mbau & Gilson, 2018; Russell & Stone, 2002; White et al., 2016; Yukl, 2013).

Focusing on the more commonly referred styles, *transactional leadership* focuses less on the professional relationship between staff and leaders, and more on reward and punishment for good or bad work, demanding stringent adherence to the rules and regulations (Antonakis et al., 2003, 2017; Bass, 1997). Such approaches align with more traditional styles of supervision. *Transformational leadership*, on the other hand, involves establishing trust and confidence, and guides others to "feel intrinsically motivated to perceive their performance in terms of the interest of the general good, so they strive to

promote organisational goals" (Aberese-Ako et al., 2018, p. 17; Antonakis et al., 2003, 2017). Much has been written about both transactional and transformative leadership, with Alimo-Metcalfe (2018) simplifying the former to just managing, versus the latter as managing and leading. At the other end is laissez-faire leadership, which is -exactly as the name implies - a less involved style, providing little guidance or inspiration for people to do their work well (Antonakis et al., 2003, 2017; Bass, 1997).

Observing the impact of different leadership theories and styles, research has revealed how transactional forms of leadership have often led to more negative responses from the health workforce, whereas theories on transformational forms of leadership have yielded more positive outcomes in terms of engaging staff and encouraging innovation, as well as participation in shaping their environment(Aberese-Ako et al., 2018)). Evidence in SSA specifically has demonstrated that health workers are more motivated by transformative leaders rather than leaders who are transactional and/or laissez faire (Musinguzi et al., 2018). This explains why newer forms of supportive supervision are more favourable than the traditional, top-down approaches. In practice however, health leaders and managers within SSA often operate and exercise power in a more authoritarian and hierarchical ways (Aberese-Ako et al., 2018). Moodie (2016) argues that leadership and authority, however, should not be considered one and the same as "many in authority are ineffective and potentially harmful leaders, whilst many who have little or no authority can be effective and inspirational leaders" (p.2). Moodie (2016) goes on to describe an ideal being when those who are in authority, and have control over resources, also have strong leadership skills. An increasingly ideal style of leadership that incorporates this thinking is *distributed leadership*.

Distributed leadership refers to a more holistic sense of leadership and is defined as a "constellation in which individual members play distinct roles and all members worker together" (Nzinga et al., 2018). Consequently, there have been increased calls for more collectivistic, inclusive approaches to leadership in LMIC healthcare settings, such as relational or distributed leadership, that incorporate inclusivity, collectiveness and collaboration, and strengthen performance of health systems (Cleary et al., 2018; McDonald, 2014; Nzinga et al., 2018; De Brún 2019). Here, *relational leadership* focuses on the "interactions, exchanges, and influences processes among many people in an organisation" (Yukl, 2013, p. 295) and it is a way of "being and relating with others,

embedded in everyday experience and interwoven with a sense of moral responsibility" (Cunliffe & Eriksen, 2011, p. 1432). Such collectivistic approaches to leadership, whether distributed, shared, relational or collective, aptly link to the concept of health systems as social systems. To date however, these approaches seem to be more common within healthcare settings in HICs, with insufficient attention, and the exception of very few studies, given to these approaches within LMICs (Chigudu et al., 2018; S. Cleary et al., 2018; Doherty et al., 2018; Gilson et al., 2021; Nzinga et al., 2021; RESYST/DIAHLS learning site team, 2020; Sheikh et al., 2014).

2.5.3 Health Leadership and Management in LMICs

The value of leadership and management to HSS has been somewhat neglected until more recently (Bradley et al., 2015; Figueroa et al., 2019; Witter et al., 2019). This coincides with a renewed energy for people-centred health systems; that it is people who are responsible for making the important decisions that determine health system performance (Chigudu et al., 2018; S. Cleary et al., 2018; Johnson et al., 2021; Sheikh et al., 2014). Furthermore, research on developing health leadership and management is unquestionably limited in LMICS, and more so, in SSA (Bradley et al., 2015; S. Cleary et al., 2018; Curry et al., 2012; Figueroa et al., 2019; Gilson & Agyepong, 2018; Johnson et al., 2021; Kwamie, 2015). Consequently, and alongside others, the Alliance for Health Policy and Systems Research has called for more multidisciplinary research on the nature, quality and contributions of leadership and management in health systems (WHO, 2016, P.9). Likewise, the WHO has emphasised leadership and management as key factors driving progressive change in LMIC health systems (Gilson & Daire, 2011; WHO, 2007). This is best evidenced by the inclusion of 'leadership and governance' as one of the WHO building blocks.

Figure 2.13 displays the *WHO (2007) Framework for Strengthening Health Leadership and Management*. Specifically, the framework outlines four organisational factors (and their interactions) considered necessary for HSS to occur and for improved health to take place: adequate number of managers, appropriate competencies, functional support systems, and enabling working environments (WHO, 2007).
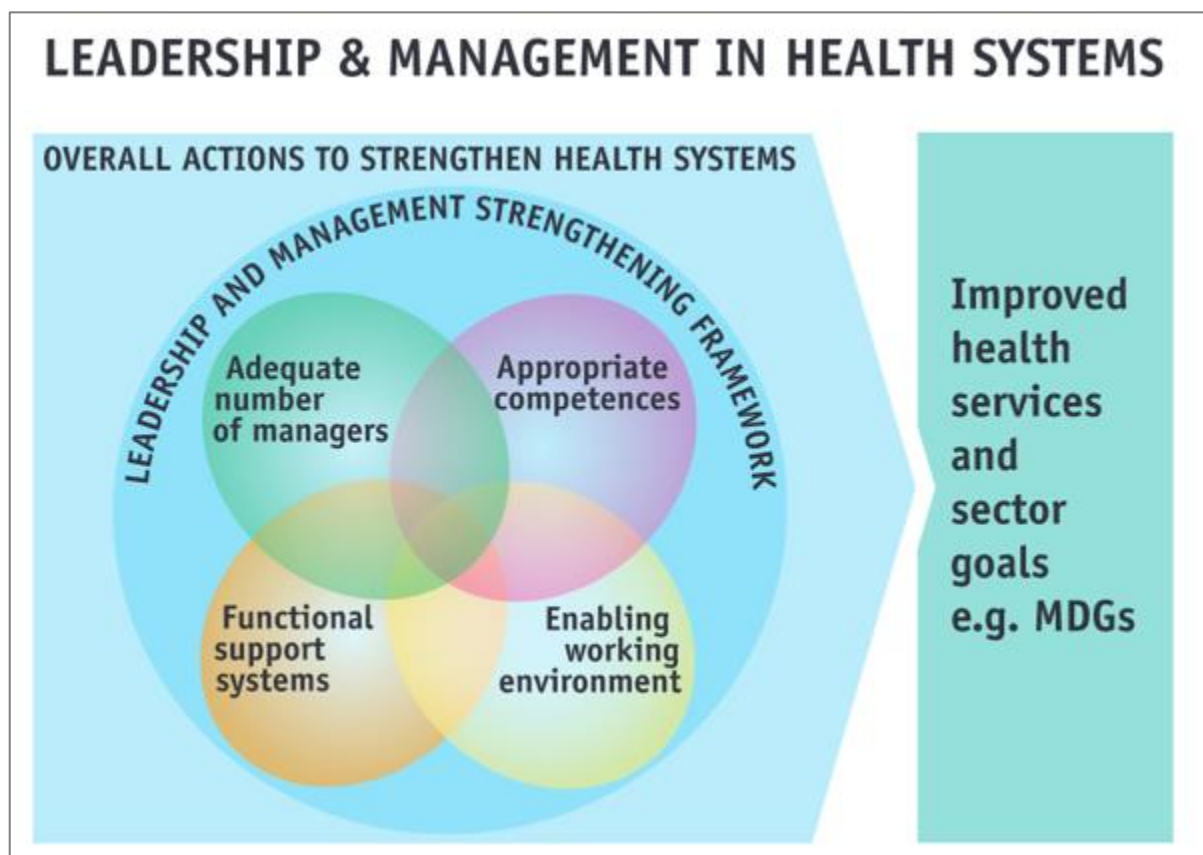
Figure 2. 13 Framework for Strengthening Leadership and Management in Health Systems

(WHO, 2007)

Since the publication of this framework, the complexity and interconnectivity of health systems has attracted more attention, with calls for efforts to go beyond individual competencies to the more "systemic goals of accountability, innovation, and learning" (Kwamie, 2015). Kwamie's (2015) highly cited commentary published in the *International Journal of Health Policy and Management*, for example, was a direct challenge to the status quo; an argument for people-centred management in LMICs to be considered through the lens of complex systems and their organisational challenges. Further to this, the AHPSR called for future policy and practice research on leadership and management to strongly consider "the role of context, the reciprocal influence actors have upon one another's interests and priorities, and the enabling environment within the health eco-system [as] important considerations in understanding, supporting and creating leadership that

addresses the needs of the population in future-thinking health systems" (WHO, 2016, p.8). Again, this recalls the need for attention to be paid to the software of health systems as well as the hardware.

2.5.4 Impact of Leadership and Management Practices on HRH

Effective leadership has been associated with numerous positive outcomes across the health system, ranging from staff retention, financial performance of the organisation, to satisfaction of both staff and patients (Chimwaza et al., 2014). All of these have implications for the quality of care provided as well as health outcomes, as reflected in a supplement in *Health Policy and Planning* on health leadership in Africa and its development across different contexts, where several key messages emerged:

1) Leadership practices, often negatively, impact on staff motivation, teamwork and quality of patient care, with certain health system contexts encouraging negative leadership practices
2) Efforts to develop leadership and management should involve system-wide reforms with attention given at individual, team, and system levels
3) Going forward, research on leadership and management development should afford more attention to the role that it plays in strengthening health systems.

(Adapted from Gilson and Agyepong, 2018)

Despite resource constraints, studies have demonstrated both positive and negative impacts of leadership and management capacity on health workers and their performance in SSA (Aberese-Ako et al., 2018; Bonenberger et al., 2014; Mathole et al., 2018; Nyikuri et al., 2015; Nzinga et al., 2018). Using maternal care in two rural districts hospitals in South Africa as an example, research findings demonstrated how the leadership styles and practices across both hospitals impacted on performance of the teams, despite similar health system challenges (Mathole et al., 2018). Specifically, the hospital that demonstrated strong and committed leadership was able to effectively mobilise teams and create conditions of good performance, whereas in the other hospital, performance was considered poor, with health workers reporting low morale, lack of commitment and being demotivated by a lack of approachable and effective leadership (Mathole et al., 2018). That said, the potential for

effective leadership may be there, but hindered by contextual factors, such as national health policies, directives, and funding, as illustrated by research conducted in Ghanaian hospitals (Aberese-Ako et al., 2018). Not only did these factors impact on the frontline workers, but also on the managers themselves who complained of feeling frustrated with having the knowledge and the 'know-how' but not always having sufficient space and power to make decisions on how and when to apply this knowledge (Aberese-Ako et al., 2018). This resulted in demotivated managers and affected health workers on the frontline.

Some argue that strategic leadership and management is even more crucial in turbulent, and resource challenged contexts within the African region, where HRH must be innovative in their attainment of health targets given scarce resources, achieving large ends with limited means (Bradley et al., 2015). Accordingly, strong leadership and management competencies have been identified as essential to health system responsiveness, the latter being a key dimension of health system performance (see 2.2.2) (Daire et al., 2014; De Savigny & Adam, 2009).

Given that the vast body of literature on leadership and management comes from HICs, it is especially relevant to understand what this means for LMICs, and, more specifically, to those individuals within their own context of SSA. Interviews conducted with health care leaders across Ghana, Liberia, Ethiopia and Rwanda, identified five key themes as important to leadership and management in these contexts: (1) having an aspirational, value-based vision for improving the future health of the country, (2) being self-aware and having the ability to identify and use complementary skills of others, (3) tending to relationships, (4) using data in decision making, and (5) sustaining a commitment to learning (Curry et al., 2012, p. 1). Around the same time, interviews conducted with key informants in formal healthcare leadership roles in The Gambia also agreed with vision setting and shared leadership, paying attention to human relations in management as other important aspects of leadership (Chigudu et al., 2018).

2.5.5 Introducing Health Leaders and Managers

Health leaders and managers are not always perceived as the same in SSA, with the literature commonly distinguishing between frontline leaders and managers. DHMTs for

example, may be considered on the frontline of operations, despite there being a big difference in their responsibilities, daily routines, and resilience, compared to frontline health workers based at primary facilities and within communities. This is a necessary point to keep in mind when trying to understand *who* is being targeted when interventions aim to develop leadership and management of those 'on the frontline'. That said, those with leadership and managerial roles or responsibilities can include any member of the workforce within a health system, clinical and non-clinical, engaged in enhancing health (WHO, 2006; Gilson, 2016).

Health leaders and managers must navigate making decisions for both the hard and soft aspects of a health system, as well as ensuring the translation of policies into action (Sheikh et al., 2011). In SSA, many health leaders and managers are also trained health professionals, with little to no experience or training in leadership or management (Johnson et al., 2021). Instead, the literature suggests that managers are often appointed based on their clinical expertise, with managerial and leadership capacity often assumed to be something that can be learned 'on the job' or through brief trainings (Johnson et al., 2021). And while clinical leadership and management have proven to be important to HSS, the empirical research is again minimal for SSA (Nzinga et al., 2018). Moreover, it is common for leaders and managers to emerge from the top and middle levels of organisations, with less attention paid to those in the lower levels who routinely deliver health care (Nzinga et al., 2018).

A recent publication entitled: "Lest we forget, primary health care in Sub-Saharan Africa is nurse led. Is this reflected in the current health systems strengthening undertakings and initiatives?" (Michel et al., 2018) raises the issue of who has the 'right' to lead, or who is perceived to be an acceptable leader within SSA health system contexts. It is a debate that comes up time and again, and in some countries within the region, especially in more rural areas, it is often considered more appropriate to have cadres who have less training to be in positions of authority simply because they are considered 'clinicians' or because of their male gender (Bradley et al., 2013). Other factors may include cronyism, nepotism, or other political, economic and social associations that outweigh one's expertise in the field (Bradley & McAuliffe, 2009). Within Michel et al.'s (2018) study, South Africa is highlighted as one country in the region where nurses are often the ones in charge of PHC facilities, but who receive less priority than General Practitioners (GPs) when it comes to

health systems strengthening activities. Drawing on qualitative interviews and employing a theory of change approach to observe policy implementation in a pilot district in South Africa, Michel et al. (2018) draws attention to the high levels of responsibility held by nurses in charge, all while combatting numerous systems challenges such as data demands, resource challenges, being overburdened with patients, human resource management and lack of supportive supervision, mentoring and problem solving (Michel et al., 2018). Although the Department of Health (DoH), in conjunction with other partners, was leading on numerous HSS initiatives such as leadership and management training, GP contracting, referral system strengthening and so on, these failed to include nurses in PHC (Michel et al., 2018). It could be argued that this is a general reflection of the neglect PHC often receives (Nyikuri et al., 2015). Informed by systems thinking and awareness of the complexities of PHC, Michel and colleagues conclude by proposing a Framework for Health Systems Strengthening in a PHC setting that is specifically nurse led, taking into account the challenges and roles of a PHC nurse (Michel et al., 2018). While this framework clearly advocates for nurse leaders, buy-in for the same is necessary across the system before such changes can occur.

With considerable attention on 2020 as 'the year of the nurse' and calls from the WHO and beyond to invest in nursing education, jobs, and leadership (WHO, 2020), there is reason to believe that more support for nurses is imminent within LMICs. Similarly, and in light of the global spotlight that is on the 'State of the World's Nursing', governments and stakeholders are called to "strengthen nurse leadership – both current and future leaders – to ensure that nurses have an influential role in health policy formulation and decision-making, and contribute to the effectiveness of health and social care systems" (Munyewende et al., 2016) WHO, 2020, p.vii).

It is impossible to ignore that nursing is a highly gendered profession with associated biases (Dhatt et al., 2017). Globally, 75% of the health workforce comprises of women (Reich et al., 2016) with approximately 90% of the nursing workforce being female. Very few leadership positions in health are held by nurses or women, however, with men more likely to hold higher positions in both hierarchy and pay grade (WHO, 2008; WHO, 2020). This certainly is not a phenomenon unique to SSA and in an exploration of the success and challenges of five female health leaders across the globe, Reich et al. (2016) concluded that there was a general need to (1) target scholarships for women to attend

formal leadership training, (2) create time and space for leaders and followers to discuss a shared vision, and (3) pair young girls with existing health leaders to serve as role models and mentors (Reich et al., 2016). Specific to SSA, Shung-King et al. (2018) also found evidence of women 'lagging behind' their male counterparts but identified a strong intersection of race with gender through the lived experiences and career pathways of black female managers, as well as doctors. Consequently, and in addition to Reich et al.'s (2016) recommendations, Shung-King et al. (2018) recommended the need to ensure that "transformative health systems policies and practices recognise and adapt, supporting the multiple social and work roles that managers, in particular, play" (p.1). Together, these recommendations are consistent with other research exploring the role of women's leadership and gender equity in leadership and HSS (Dhatt et al., 2017; Shung-King et al., 2018).

2.5.6 Competencies

Health leadership and management capacity is often determined by competencies, which in turn are determined by the organisational context, whereby the responsibilities attached to leadership and management vary across different levels of a health system (WHO, 2007). At national level, decisions more often pertain to issues of strategy, setting and monitoring policy, as well as managing the allocation of resources. At a more operational level, generally district management is responsible for ensuring the implementation of policy for the production of services that are respondent to population needs (WHO, 2009), including the management of resources as well as managing stakeholders.

There is no shortage of literature when it comes to defining the competencies that are needed for health leaders and managers in LMICs (Daire et al., 2014; Johnson et al., 2021). There does appear, however, to be a consensus around what these competencies are, with an increasing acceptance that competencies go beyond that of simply acquiring skills, with the need to also focus on cognitive, emotional and social intelligence aspects, as well as positive team dynamics among health managers at district level (Boyatzis, 2008; Daire et al., 2014; Heerdegen et al., 2020). While some cognitive skills can be acquired through formal traditional training, social and emotional intelligence is a developmental process requiring a more practice-based approach in real-life settings. Some of the more tangible key competencies identified for health management include strategic thinking and problem

solving, HRM, financial management, operations management, performance management and accountability, governance and leadership, political analysis and dialogue, and customer and community assessment and engagement (Bradley et al., 2015; Fetene et al., 2017). These elements combined are therefore considered a requirement for organisational change. Tetui et al. (2016) developed an iterative, dynamic, and complex model, illustrating the processes of building a competent health manager in LMICs, which is illustrated in Figure 2.14. A key element of this model is the supportive component required for capacity to be strengthened and sustained, as well as the involvement of a range of stakeholders (Tetui et al., 2016). The framework also highlights the more relational aspects of leadership such as the mentoring and supportive supervision.
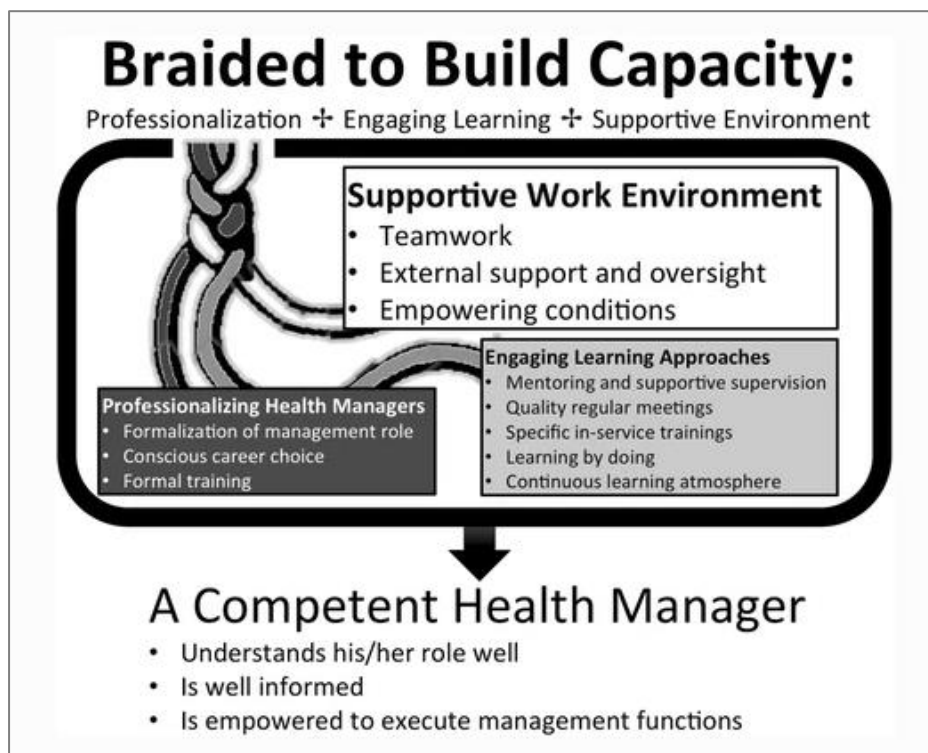
Figure 2. 14 Model for building a competent health manager in LMICS (Tetui et al., 2016)

2.5.7 Competency in Decentralised Contexts

Nowhere is change within health systems more expected, and needed, than when health system reforms are introduced. To this end, there are bodies of literature focused specifically on leadership and management within the context of health system reforms, usually revolving around major structural reforms such as decentralisation and the decision

space of managers in decentralised health contexts (Barasa et al., 2017) (see Section 2.2.6.2.1 on decentralisation; Kohlemainen-Aitkin, 2004; Bossert 1998; UNICEF, 2016; Barasa et al., 2017; Tsofa et al., 2017). Due to the fiscal and/or administrative decentralisation of healthcare (Gilson and Mills, 1995), focus on capacity strengthening often occurs at district level, with the assumption being that those on the front line can make more informed decisions and hence improve system performance (Bonenberger et al., 2014; Bossert, 2016; Heerdegen et al., 2020).

Decentralisation processes also highlight issues of power, processes, values, resources and governance, all of which impact on district and facility level leadership and management (Bulthuis et al., 2021; Heerdegen et al., 2020; Kwamie et al., 2015; Nyikuri et al., 2015; Tsofa et al., 2017).

Despite limitations on decision-space within a decentralised context, district level managers are still required to tackle problems collectively, motivate staff and encourage teamwork (Bulthuis et al., 2021) In Kwamie et al.'s (2015b) case study of district managers in Ghana, the authors draw on Boosert's decision-space theory to demonstrate the complexities of decentralisation revealing how "the rhetoric of decentralisation does not always mirror actual implementation, nor always result in empowered local actors" (Kwamie et al., 2015b, p.356). Constrained decision-space for district level managers therefore result from existing dominant processes at central level, leaving those on the ground complying with those above rather than responding to everyday health system challenges (Bulthuis et al., 2021).

In a systematic review of the decentralisation of health systems in LMICs, Muñoz and colleagues (2017) found a mix of both positive and negative effects of health system decentralisation, particularly in relation to HRH. In one respect, quantitative findings from this review found a positive effect of decentralisation on human resources, with examples of increases in average salaries in Columbia (Muñoz et al., 2017). Qualitative findings however, reflected several additional negative effects of decentralisation on the management and retention of human resources, whereby retention deteriorated, health workers experienced delays in the payment of salaries (Phommasack et al., 2005), maldistribution of health professionals was observed after decentralisation (Liu et al., 2009), and where local authorities were found to interfere in the recruitment of health workers (Munga et al., 2009). Given these negative impacts of decentralisation on human

resources, Muñoz (2017) and colleagues concluded that countries should consider interventions to mitigate these negative effects, including the need for interventions to strengthen the management competencies of DHMTs in the first place (Mschelia et al., 2013; Uduma et al., 2017; UNICEF, 2016).

In sum, weak leadership and management capacity at district level is commonly put forward as a major obstacle for responsive health service delivery, prompting calls to increase leadership and management capacity at this level (Bradley et al., 2015; Doherty et al., 2018; Heerdegen et al., 2020; Kwamie, 2015; Nzinga et al., 2018; RESYST/DIAHLS, 2020). With the enormity of work, be it clinical or public health service related, placed on those HRH at the operational level, one might assume that the decision space of managers is also broad. However, it is this lack of decision space that leaders and managers have within already inadequate support systems that continues to attract considerable scholarly attention (Bulthuis et al., 2022; WHO, 2007; WHO, 2009).

2.5.8 Approaches to Developing Leadership and Management in SSA

Given what is known about the state of health leadership and management across SSA, the following section reviews key approaches often used to develop leadership and management capacity for the purposes of strengthening health systems. Strengthening leadership and management competencies have often revolved around health training programmes, practical education, short courses, mentoring and coaching (Curry et al., 2012; Daire et al., 2014; Kwamie et al., 2015). In many cases, trainings are cadre or disease specific rather than across interdisciplinary teams (Johnson et al., 2021). Moreover, in many countries across SSA, there is a fundamental lack of institutionalised leadership training in the health system (Chigudu et al., 2018; Johnson et al., 2021). One criticism of leadership and management training programmes is thus their lack of continuous or ongoing support to newly trained leaders and managers once they return to their workplaces, which in SSA often tend to be poorly resourced and challenging (Kebede et al., 2012). Consequently, there is a general desire to move beyond programmes that focus on skills acquisition towards approaches that use action-learning and teamwork within a cyclical approach to define root causes, planning, and monitoring and evaluation, to once again identify or define further root causes (Curry et al., 2012; Heerdegen et al., 2020;

Mutale et al., 2016; RESYST/DIAHLS, 2020). Moreover, there is a drive to introduce more mentorship and support for health leaders as a more sustainable approach to such programmes (Aberese-Ako et al., 2018; Ajeani et al., 2017; Doherty et al., 2018; Kebede et al., 2012; Mutale et al., 2016; Reich et al., 2016). In recent years, several initiatives aimed at HSS through leadership and management development, have been driven by international research consortia, spanning across several SSA countries over a longer period of time (Bulthuis et al., 2021; Martineau et al., 2018; RESYST/DIAHLS, 2020). Standing out from the few examples, is the extensive research programme of work carried out by the RESYST/DIAHLS consortium who established, in partnership with health managers, three district-level learning sites in Kenya and South Africa to understand the everyday realities of health system governance, as well as to support emergent system change led by the health leaders and managers (RESYST/DIAHLS, 2020).

2.5.8.1 Leadership Development Programmes (LDPs)

Leadership Development Programmes (LDPs) have been growing in popularity, though little is currently known about their effectiveness given some of the identified challenges with evaluation rigour (Bailey et al., 2016; Johnson et al., 2021; Mansour et al., 2010; McDonald, 2014; Mutale et al., 2016; Seims et al., 2012). In a recent review of their role in SSA, Johnson et al (2021) identified a broad range of conceptual approaches to leadership development, with few demonstrating clear conceptual frameworks. That said, Johnson and colleagues identified that the majority of LDPs in SSA are concentrated across the same five countries (South Africa, Kenya, Ethiopia, Zambia and Uganda), consisted largely of interdisciplinary groups, and lasted between 6 months and two years. Of the LDPs that took place over a longer period of time, most consisted of on-the-job learning (Johnson et al., 2021) with an expressed goal of improved health service delivery or health system performance. Given the broad range of categories for learning content, however, only the following three occurred across more than half of the programmes: concepts or experiences of leadership, project management, and change management or quality improvement (Johnson et al., 2021). With regards to learning methods, all of the LDPS used lectures or workshops as part of the approach, with over fifty percent of the LDPs also incorporating real-world project and group work. An overview of the lessons learnt about the design of the LDPs is illustrated in Figure 2.15. Though the majority of LDPs were

evaluated, Johnson et al. (2020) described the evaluations as mostly of "poor quality" or "poor alignment between the methods and the stated objectives of the LDPs" (p9), making it difficult to draw out useful conclusions. In this way, Doherty (2018) was not alone in thinking that continual evaluations of leadership and management initiatives are required to ensure that learning is applicable and relevant to the practical needs of those on the ground.

Programme design
  Ensure that the programme is accredited

  Sustain the follow-up for longer
  Ensure consistent administrative support
  Coordinate effectively across countries
  Lengthen the intervention to include multiple cycles
  Provide remote follow-up after the training
  Remain flexible to external changes
  Select data for evaluations carefully

Learning content
  Adapt the curriculum to the specific context
  Ensure a balance between technical skills and critical thinking
  Include emotional intelligence, dealing with any
  buried personal trauma and stress management
  Include policy and advocacy
  Include systems thinking and reflective practice
  Provide support for research ethics applications
  Use a standard curriculum

Teaching and learning methods
  Use real-world case studies

  Include work-based learning
  Use peer learning

  Close knowledge gaps early to set a
  common baseline between participants
  Draw on participant issues in discussions
  Use reflective sessions
  Use team-based learning
  Use coaching
  Use peer facilitators to weaken existing hierarchies

Participants and selection
  Invite participants from across hierarchies
  Make the significant workload explicit
  Open the programme to wide range of health professions
  Remunerate participants
  Select students carefully

Faculty and staff
  Ensure adequate faculty numbers and availability
  Allocate floating mentors to support where
  mentors in host institutions become too busy
  Ensure that the programme director is directly engaged in teaching

Figure 2. 15 Lessons about the design of Leadership Development Programmes in SSA, (Source adapted from Johnson et al., 2021)

From Johnson's review it is evident that many LDP's have started to introduce newer ways of learning, and there is marked progress in SSA in how people are starting to think about developing leadership and management. Further to this, Johnson et al (2021) offer useful discussion and learning points from their scoping review to guide future research into this rapidly growing field:

1) There is a lack of consensus on how leadership functions in the SSA context, with a need for clearer theoretical frameworks to ensure alignment with goals.
2) As discussed in Section 2.5.1, there is a need to incorporate elements of both leadership and management in a balanced manner, to ensure topics such as self-reflection, network building, ethics and professional values, are covered alongside technical knowledge and project management (Chigudu et al., 2018)
3) In response to LDPs that relied on leadership frameworks from outside the region, it is suggested that further research is needed into "whether there are distinctive features to the leadership roles, the health system context and the wider societal cultures within SSA that need to be better understood and built around" (p.13). This would apply to individual countries as much as to the region itself.
4) Reflections emerging on the evaluation approaches included: short timing, the provision of funding, and the issue of causation. The authors felt that the timing did not allow for evidence of change(s) in behaviour or results. Timing is often linked to funding, whereby LDPS were predominantly supported by aid or research agencies, which meant that priorities of programme delivery may have taken precedence over evidence generation. Finally, Johnson et al., 2020 highlighted the difficulty in establishing any improvement to health outcomes as a result of the LDP, given the enormous complexity of health systems. The authors put forward the suggestion of strengthening their evaluations by basing it on a more explicit theory of change outlining how the LDP might make a difference to the individuals as well as to the health system.
5) Johnson et al (2020) noted that LDPs need to be institutionalised for effectiveness and sustainability. While ambitious given that many of the LDPs were funded externally, embedding LDPs within systems may begin with small steps (i.e., incorporating LDPs into existing health system structures and/or engaging health workers from across the system, as well as senior institutional leadership and other diverse stakeholders). This is consistent with findings from other studies (Chigugu et al., 2018).

Providing a more in-depth example of the application of an LDPs, Kwamie et al (2014) used realist evaluation to demonstrate how and why an LDP works, when introduced at district level in Ghana. They struggled however, to argue the case for the LDP meeting their objective of developing increased systems thinking in management and decision-making, given the complexity of the organisational context and the complexity of the intervention itself. The authors related challenges to the political economy, with high

uncertainty within the district and hierarchical authority. Consequently, while it may have been recognised that the decision-making process required nurturing relationships between actors, the district managers did not feel enabled to cope with their context (Kwamie et al., 2014). This demonstrates a need to institutionalise LDPs, as well as to integrate key stakeholders into the planning to ensure that the differing perspectives of leaders, managers and their complex situations are recognised, adopted and hopefully championed (Wilkinson et al., 2017; Agyepong et al., 2017; Chigudu et al., 2018). Moreover, there is a need to embed political economy analysis (PEA) into the design of studies like Kwamie et al. (2014) to account for the impact of the political economy on interventions and HSS (Bulthuis et al., 2021).

Increasingly, the value of PEA is emerging, with the use of a PEA lens usually meaning to dig deeper into the dynamic interactions between context (structure) and actors (agency) of the political context to make sense of the processes of change (or lack of change) within the political and economic environment of the health system, and to consequently gain a better understanding of the elements that influence what and who gets prioritised for health systems strengthening and what and who does not (Bertone & Witter, 2015). Consistent with understanding these processes is to understand more on how to manage the implications of the political economy (Walsh et al., 2020). Inevitably, findings from a PEA can illustrate how the political economy impacts or influences decision making, prioritisation, stakeholder relations and resource allocation across the whole spectrum of the health system (Walsh et al., 2020).

2.5.8.2 Putting the District first

As mentioned in the introduction, focus on understanding and developing leadership and management typically initially takes place at district level, with the assumption that its effects will trickle down to primary level (Martineau et al., 2018). Being the first point of contact for individuals seeking healthcare, leaders and managers at facility level, however, often face huge pressure on a daily basis, much of which revolves around human resource management challenges (Daire and Gilson, 2014; Gilson et al., 2017; Nyikuri et al., 2015). Unfortunately, they rarely receive leadership and management training (Nyikuri et al., 2015), leading to a call for more capacity strengthening to take place at primary health

facility level, as a way to focus not just on system hardware but also on both the tangible and intangible elements of system software, including the ongoing, daily negotiation of power, decisions and the importance of relationships between local actors (Barasa et al., 2018; Daire & Gilson, 2014; Gilson et al., 2017; Macarayan et al., 2019; Madede et al., 2017; Nyikuri et al., 2015; Nyikuri et al., 2017; RESYST/DIAHLS, 2020; Tsofa et al., 2017). Specifically, developing capacity in leadership at this level entails:

> Enabling others to face challenges and achieve results under complex conditions, is likely based on values such as respect for others, or a sense of duty, is inclusive, empowering others to be decisive and innovative in response to challenges, and entails role modelling, and the deliberate use of language to encourage new ways of seeing problems and opportunities" (Gilson et al., 2017, p11).

Few studies have focused on simultaneously understanding and/or strengthening district and facility leadership and management (Madede et al., 2017; McCollum et al., 2018; Michel et al., 2018; Purity et al., 2017; RESYST/DIAHLS, 2020). Of those that have, however, one in particular was able to demonstrate emergent change, led by managers in their systems who were given the space to engage with the software of health systems (Cleary et al., 2018; RESYST/DIAHLS, 2020): As part of the broader DIAHLS (District Innovation and Action Learning for Health Systems Development) collaboration, researchers co-created leadership development processes with managers from primary facilities and members of the sub-district management team in South Africa in an attempt to enable relational leadership (Cleary et al., 2018). Others, such as Nyikuri et al (2015) and Daire and Gilson (2014), have identified primary facility level managers as showing resiliency in the face of highly hierarchical structures, using their resiliency as an opportunity to push for and emphasise the importance of leadership and management development for managers at lower levels to apply their critical soft skills towards the crises they face on a daily basis. This is another example of the need for resiliency as a key dimension of health systems performance.

2.5.8.3 Exploring the Different Methods

Yukl's (2013) *Leadership in Organisations* argues, in reference to more relational styles of leadership, that the methods most appropriate for understanding "evolving relationships and reciprocal influence processes among multiple parties" (p. 296) are seldom used in leadership and management research (Uhl-Bien, 2006). Leadership and management were traditionally studied within a more positivist paradigm, slowly changing over the years with the recognition that leadership and management is not objective nor value-free (Sheikh et al., 2011). Accordingly, trying to establish which intervention(s) do or do not work and which can be replicated is deemed inappropriate for the development of leadership and management. That said, both quantitative and qualitative methods have contributed, in their own way, to our understanding of developing health leadership and management in complex settings (Yukl, 2013).

Aligned with more positivist approaches, quantitative methods have traditionally been used to measure leadership and management (Cummings et al., 2010; Fetene et al., 2014; Heerdegen et al., 2020). For example, Fetene et al., (2014) investigated the association between district level management capacity and health system performance in Ethiopia, as measured by public health indicators. As one of few studies to investigate the association between management capacity at the district level and how it might interact with management at the health centre, findings indicated that increased management capacity at district level was associated with strengthened management at facility level (Fetene et al., 2017). Again, this is a link that many programmes and studies usually assume will happen as a result of increasing management capacity at district level, but which few programmes actually go onto demonstrate (Kwamie et al., 2014; Martineau et al., 2018; Mutale et al., 2017). While it is not entirely clear from Fetene et al.'s (2017) study *how* the functioning of health facilities might have improved as a result of intervening at the district level, nor whether it is management capacity at district level that causes strengthened capacity at facility level, given the correlational nature of the data the authors discuss added staffing, stronger coordination, and better accountability structures as potential mechanisms.

Mixed-methods or qualitative approaches, however, are more commonly used to uncover the possible mechanisms for these observations, in support or to refute quantitative findings (Bryman, 2016), and to better understand more about the dynamics and human interactions that occur across health systems (Yukl, 2013); that being the software of the

system (Cleary et al., 2018; RESYST/DIAHLS, 2020). Qualitative studies more generally have relied on ethnographic components or semi-structured and in-depth interviews to gather a rich understanding of context and perspectives (Aberes-Ako et al., 2018; Bulthuis et al., 2020; Heerdegen et al., 2020). Others still, have drawn on reflective practices, results of which have followed in a call for newer forms of leadership that will bring about changes in PHC that correspond to relationships between the different levels of the health system (Gilson, 2014; Gilson and Agyepong, 2018). Reflecting on experiences from the RESYST/DIAHLS programme in South Africa, for example, authors argued that a leadership of 'sensemaking' is required that will enable frontline staff to exercise their collective discretionary power to strengthen PHC (Gilson et al., 2014). Sensemaking here being the "process individuals undertake as they try to understand what is going on around them, as they try to make sense of events and experiences" (Balogun, 2003, in Gilson et al., 2014). In other words, proponents of leadership as 'sensemaking' argue that changes in organisational culture will commence once health system actors start to think and work differently, requiring changes, even if subtle, in what shapes behaviour (Gilson et al., 2014; Gilson et al., 2021). This requires leadership to support PHC facility managers to take ownership of their own visions such that they will incorporate them into their every-day practices rather than feeling disengaged and disempowered (Gilson et al., 2014). If the assumption is instead that developing leadership and management should take place at higher levels of the health system, it is understandable that primary level managers may collectively feel disinterested.

2.5.8.4 Actions Speak Louder than Words

Chairs of the Advisory Group for the *WHO's Flagship Report on Leadership in Health of AHPSR (2016)*, and those at the forefront of calls for new forms of leadership, have suggested that the time is now for a new agenda for health leadership as one that is focused on collective leadership and involving leaders across all levels of a health system (Chunharas & Davies, 2016; Gilson & Agyepong, 2018). This call is consistent with the concept of systems thinking in acknowledging all of the different actors and how they engage across health systems. According to Chunharas and Davies (2016), what is needed is thus systemic interactive leadership as opposed to top-down leadership. In addition, they advocate for operational leaders to be empowered to assert themselves as leaders as well

as enabling patients, families, and community groups to participate in health leadership (Chunharas and Davies, 2016). Much of this thinking puts people at the centre of health systems, and consequently, is an ideal echoed by many scholars in SSA (Mathole et al., 2018; RESYST/DIAHLS, 2020).

Though not always explicit, some of the methods that have been applied within the leadership and management literature in SSA are indeed consistent with the characteristics of systems thinking, including participatory approaches (Gilson et al., 2014; Gilson and Agyepong, 2018; Kwamie et al.2015; Martineau et al., 2018; RESYST/DIAHLS, 2020). Accordingly, one of Checkland's (2003) conditions for serious systems thinking and action was as following:

> In order truly to engage with perceived reality, adopt a sharply defined
> action research methodology, with recoverability of the research story as
> the best available validity criterion, allowing coherent discussion of both
> the course of the thinking during the research and its results (p. 555)

Participatory leadership has more recently attracted positive feedback for its role in "encouraging teamwork and relationships, tackling problems collectively, spreading motivation and positive staff attitude" (Agyepong et al., 2018; Cleary et al., 2018; Gilson and Agyepong, 2018, pii2). Gilson and Agyepong (2018) put forward the argument that popularity for participatory leadership is growing alongside the recognition that health systems are complex and therefore require such leadership to "guide and enable the different parts of the systems to work towards common goals" (pii).

Understanding more about what components work in different programmes and how programmes can then adapt through feedback, has emerged from such action learning processes, which often include participants in the co-design and development of programmes for co-production of knowledge (Cleary et al., 2018; Lehmann and Gilson, 2015; Gilson et al., 2021 RESYST/DIAHLS, 2020). Such participatory approaches were identified as key to Checkland's SSM and have proven to be particularly popular in LMICs, as well as within the context of developing health leadership and management. Consistent with the ethos of HPSR as well as the WHO AFRO Framework on Health Systems Strengthening for UHC and the SDGs (2017), participatory approaches also place people

at the centre and as part of the research process. Action learning, as outlined, can thus be understood as taking an 'attitude of enquiry' based on the idea that experiences generate knowledge, and the process involves the application of cycles of reflection and action to solve real problems (Brockbank & McGill, 2003). Programmes of work such as RESYST/DIAHLS is a key example of a long-term collaborative action learning research approach involving partnerships between academic institutions and government health departments designed to support an emerging district health system (Lehmann and Gilson, 2015). Among other things, this programme demonstrates both the importance of engaging practitioners and researchers in co-producing knowledge, and also highlights that building trust and relationships takes time and should not be taken for granted (Lehmann & Gilson, 2015). Although trust has been introduced previously within the context of the workplace, here it extends to trust between researcher and participant involved in achieving common goals, such as improving performance of the health workforce as a way of strengthening the overall health system (Gilson et al., 2021).

Makuta and O'Hare (2015) had previously demonstrated that workforce performance is more likely to improve when using a combination of strategies. Similarly, relating the use of action research and learning back to management and leadership development at district level, a recent study of the PERFORM project involving a management strengthening intervention at the level of the DHMTs across multiple countries and districts (Ghana, Tanzania and Uganda) suggested that to improve the performance of the workforce, a set of context-specific human resource strategies should be integrated with other health system components rather than as a one-off intervention (Martineau et al., 2018). Specifically, the PERFORM project applied a participatory Action Research process (see Figure 2.21) whereby following a situational analysis and a problem identification workshop within each study district, the following actions occurred according to each step of the Action Research Cycle:

1) Plan: Development of work plans to address problem identified
2) Act: Implement workforce improvement strategies
3) Observe: Review implementation of work plans through follow-up visits and joint district meetings
4) Reflect: Reflective diaries were used to record implementation and effects, contributing to continuous learning.
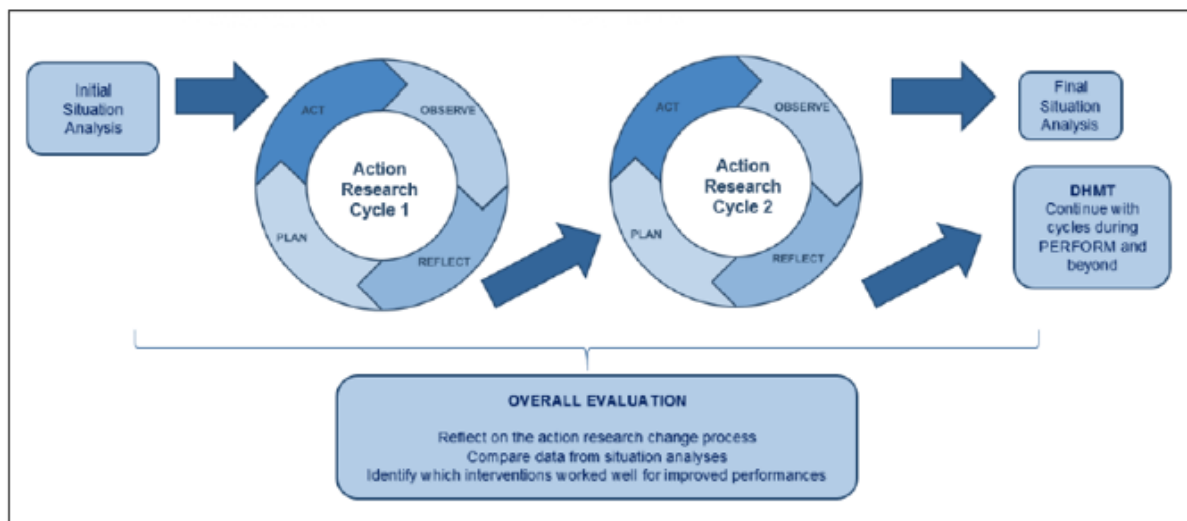
Figure 2. 16 Action Research Process used by PEFORM project (Sources Martineau et al., 2018)

Such interventions therefore align with newer approaches to developing leadership and management, whereby emphasis is placed on reflection and strengthening teamwork (Curry et al., 2012; Daire et al., 2014, Doherty, 2018; RESYST/DIAHLS, 2020; WHO, 2016). The PERFORM intervention then was tested across nine districts in each of the three countries and involved the development of management competencies, as well as encouraging DHMTs to design and integrate HRM and health systems strategies into their workplans to address identified problems. Examples of identified problems included the need to improve data management, improve supportive supervision, and reward best performing facilities in response to poor implementation of a new vaccine schedule (Martineau et al., 2018). In relation to HRH performance, the main area mentioned was improved supportive supervision, however, it is not clear how this was measured other than recorded through qualitative interviews (Martineau et al., 2018). Findings from the study indicated that DHMTs generally accepted the intervention and that management competencies as well as teamwork improved at the level of the DHMT. This is consistent with findings from other studies, which found that health leaders desire to focus on working collectively, and on improving relationships within their teams through action learning (Agyepong et al., 2018; Tetui et al., 2018; RESYST/DIAHLS, 2020). Additionally, Tetui et al., (2018), who also approached strengthening capacity at district level by using participatory action research (PAR), found that using PAR promoted feelings of engagement with the project through collaboration, which in turn increased responsibility

and enhanced chances of long-term sustainability. Such flexible approaches also enhance opportunities for the coming together and finding a shared purpose across involved parties, again resonating with systems thinking which seeks to allow for multiple stakeholders and continuous reflection and learning (Adam and de Savigny, 2012). However, the evidence suggesting whether, and if so, how these approaches impacted on the performance of the health workforce (i.e., within lower levels of the health system) as well as the overall health system is lacking.

2.6 Chapter Summary and Research Gaps

This chapter synthesises the literature on a broad range of issues relating to health systems and the role they play in meeting the SDGs and achieving UHC. In specific, this chapter offers an extensive review of health system frameworks, health systems strengthening and performance, global actors, and systems thinking, more specifically soft systems thinking, as an approach to strengthening the health system. Focusing on the SSA region, as the region facing some of the greatest human resource for health challenges, as a critical component of achieving UHC, this chapter further offers an analytical review of approaches to developing health leadership and management in SSA.

A common theme emerging from this literature is the importance of 'people' at the core of health systems, and the need to consider behavioural and relational aspects of the people who both define and shape health systems. This idea that health systems are human systems is further reflected across several international policies, frameworks, and interventions, where attention is not limited to consumers of healthcare, but also extends to healthcare providers (Agyepong et al., 2017). In practice, however, there remains a dearth of literature describing the role stakeholders play, both individually and collectively, towards strengthening health systems across different contexts. Moreover, and while there is some evidence for the transfer of systems thinking to the field of health, it is, as described in Section 2.3.3, still considered in its infancy within LMICs. Specifically, the development of health leadership and management is considered an under-researched phenomenon in LMICs and SSA, as much of the literature has been from studied from HIC perspectives (Chigudu et al., 2018; Figueroa, 2019). This gap may largely be attributed to the complex adaptive nature of health systems and the myriad of challenges and complex interactions

and relationships that occur both externally and within health systems globally. Accordingly, recent years have seen an urgent call for more attention and research to focus on the 'software' of health systems to better understand how health leadership and management development, as a key strategy towards strengthening health systems, manifests in practice (Chigudu et al., 2018; Swanson et al., 2019; Witter et al., 2019; RESYST/DIAHL, 2020). This, however, requires research to rigorously engage with context, implementers, and policy makers, to explore and explain existing relationships within health systems and how these impact on the health system, while simultaneously challenging our own assumptions as researchers.

In recent years, SSA has been more vocal about the need for initiatives to be designed, or at the very least co-produced, and led by the region. That said, considerable influence and funding provided from organisations and government located outside of the region can work to undermine local autonomy and decision-making. With effective health leadership and management development identified as a key approach to addressing both the HRH crisis and critical to strengthening health systems, there is still a dearth of literature describing how health leadership and management interventions and approaches *that also* demonstrate systems thinking through engagement with context (Gilson and Agyepong, 2018) are carried out in practice, especially within SSA. That which does emerge from SSA, often focuses on evaluations and approaches towards developing leadership and management at higher levels of the health system, with a dearth of literature focused on health leadership and management at lower levels of the health system, especially primary level. And while it is commonly thought that the District Health System is an important platform for strengthening PHC (Chopra et al., 2009), an overemphasis on building capacity in health leadership and management at district level has resulted in an almost 'fingers-crossed' expectation about how such approaches translate to long-term positive results within primary care. Consequently, there is a lack of consensus on how health leadership and management are, firstly, conceptualised locally (Chigudu et al., 2018; Daire et al., 2014; Eckert & Rweyongoza, 2010; Nyikuri et al., 2015), ultimately, generated in the context of healthcare in SSA (Johnson, 2021). It therefore remains unclear how effective existing efforts to developing health leadership in management for health systems strengthening- particularly at primary and community levels - in SSA are (Agyepong and Gilson, 2018), as a well-recognised gap within HPSR (Aberese-Ako et al., 2014; Gilson et al., 2014; Gilson et al., 2017; Nyikuri et al., 2015).

Within SSA, Malawi is a country where the health system is under significant pressure, with the country facing some of the most severe HRH shortages across the African region, and where little is known or understood about how health leadership and management is being developed as part of current efforts to strengthen the health system. As part of the PERFORM2Scale programme (see Chapter 1.3.1), Malawi was therefore identified as a case-study to explore the gaps outlined in this chapter.

Considering these gaps, the following research objectives are put forward:

1) To offer an in-depth description of current leadership and management for health systems strengthening efforts in the context of Malawi, including the identification of key stakeholders involved.

2) To describe how key stakeholders conceptualise and understand health leadership and management in this context;

3) To identify why health leadership and management approaches are being used to strengthen health systems within this context;

4) To explore how the development of health leadership and management approaches are being implemented in practice in Malawi.

Taken together, these objectives will be used to construct a theory to advance our knowledge of how current approaches to improve health leadership and management can be understood and further developed to strengthen the Malawian health system. Chapter 4 presents an in-depth description of the context of Malawi.

Chapter 3: Research Methodology and Methods

3.1 Chapter Introduction

The aim of this research was to develop a theory for how health leadership and management, as an approach to HSS, can be understood and developed further to strengthen the Malawian health system. To fulfil this aim, a qualitative case study, underpinned by a constructivist epistemology and drawing on the concepts and tools of soft systems thinking and grounded theory, was chosen. This chapter provides justification for the methodology, as well as outlining the data collection and analysis methods used. The research approach builds on learning from the literature on HPSR, as reviewed in Chapter 2, and more specifically around HRH, health leadership, and management and health systems strengthening, combined with learning from systems thinking, as a lens to manage complexity (Checkland, 1981).

3.2 Research Approach

3.2.1 Soft Systems Thinking Lens

As described in Chapter 2.3, the growing significance of systems thinking in health requires consideration for the complex adaptive nature of health systems, while also placing people and their complexity at the centre of efforts to strengthen health systems. This thesis, therefore, uses systems thinking as a lens through which to perceive a health system as a whole, while also considering the interrelatedness, interrelationships, and connectivity of its different parts as important to understanding how patterns of behaviour emerge and contribute to or hinder change (De Savigny and Adam, 2009; Adam and De Savigny, 2012; Peters, 2014). This approach thus stands in contrast to more traditional, more reductionistic methods, which focus on isolating cause and effects within HSS (Adam and De Savigny, 2012). Systems thinking thus requires a more complex understanding of health systems and a more profound insight into how and why interactions and connections between people and processes occur the way they do in their respective contexts (Adam, 2014). Accordingly, soft systems was ultimately chosen as a lens through which to engage the multiple actors involved in health systems, while making explicit the plurality of

perspectives and multiple realities through concerning itself primarily with people complexity (Jackson, 2019).

Systems thinking has already been popularised as an approach to understanding and developing leadership and management by key organisational and management thinkers such as Ackoff (1999), Senge (1990), Checkland (1981) and Jackson (2019). Additionally - and consistent with calls within HPSR for more deeply contextualised studies (see Chapter 2.3.1) and the critical value attached to stakeholder participation to strengthening research rigour and relevance (Asha et al., 2018) - Goodwin (2000) argued that leadership and management in complex organisations is best understood as a close dialectic between "person" and "context". The consideration of people and their agency at the centre of health systems therefore requires contextualised understandings (Sheikh et al., 2014). Key to achieving the four research objectives, and research objectives 2, 3, and 4 in particular, was therefore to understand how health leadership and management is being developed as part of efforts to address HRH challenges, and in turn, strengthen health systems in the context of Malawi from the perspectives of stakeholders. Such understanding also comes from exploring the web of connections and constraints of the context in which the research is situated (Charmaz, 2014), towards the fulfilment of research objective 1.

Taken together, soft systems thinking and the principles of HPSR were therefore chosen as they consider context to be critical to health systems strengthening, and no less when conducting research on approaches to developing health leadership and management within its specific organisation or setting. Moreover, Greenhalgh (2004) appropriately expressed the reasons why involving the perspectives of people involved in efforts to strengthen health systems are so paramount to success or failure:

> People are not passive recipients of innovations. Rather (and to a greater or lesser extent in different persons), they seek innovations, experiment with them, evaluate them, find (or fail to find) meaning in them, develop feelings (positive or negative) about them, challenge them, worry about them, complain about them, "work around" them, gain experience with them, modify them to fit particular tasks, and try to improve or redesign them – often through dialogue with other users (p. 598)

Accordingly, data collected throughout the research process primarily stemmed from a diversity of stakeholders and sectors directly involved with approaches to developing health leadership and management within Malawi, whereby stakeholders referred to "any individual, group, organization, institution that can affect as well as be affected by an individual's, group's, organization's, or institution's policy or policies" (Mitroff & Linstone, 1995, p. 141). In this way, and consistent with Checkland's SSM (1994) as outlined in Chapter 2.3.4.1, engaging stakeholders in a "process for acquiring knowledge about and taking action in a human situation thought of as problematic" (p. 193) was seen as the principal means through which to develop a rich picture of leadership and management for HSS within the context of Malawi, as "the real world", towards addressing the extant research gaps, as outlined in Chapter 2.3.4.1.

3.2.2 Constructivism

The principles of SSM see a process of inquiry into the world to uncover real world complexity as experienced by stakeholders (Checkland, 1994; Jackson, 2019). Therefore, a constructivist approach - as the ontological stance that reality is constructed and thus best understood through multiple perspectives and world views (Denzin et al., 2017; Vygotsky & Cole, 1978) - was deemed an appropriate theoretical paradigm to interpret the numerous realities presented in this thesis. Similarly, Birks and Mills (2015) defined "constructivism" as "a research paradigm that recognises that reality is constructed by those who experience it and thus research is a process of reconstructing that reality" (p. 177). Schwandt (1994) argued that, to some extent, we are all constructivists if we believe that the mind is active in the construction of knowledge. Putting this in the context of 'knowing' not being something that is 'passive' and a "simple imprinting of sense data on the mind" (Schwandt, 1994, p. 137), but rather that humans construct or make knowledge (e.g. through abstractions, concepts, models) to make sense of our experiences, inferring that "knowing" is something that is "active". Schwandt (2007) explains that these interpretations are not constructed in isolation but are rather based on shared practices, understandings, experiences, and language. In the case of this thesis, this implies that both participants and I co-constructed knowledge and understandings at the same time as a way to make sense of how health leadership and management is understood within the context of Malawi. This co-creation of understandings is thus characteristic of a subjectivist epistemology within a constructivist paradigm (Denzin et al., 2017). By bringing subjectivity into view, an

assumption is made that "people, including researchers, construct the realities in which they participate" with constructivists acknowledging that "their interpretation of the studied phenomenon is itself a construction" (Charmaz, 2014, p. 342). That said, co-creation of knowledge in this thesis occurred not only through the experiences of the participants and the researcher, but also through the literature and other secondary data sources.

3.2.3 Qualitative Research

Constructivism is one of several paradigms within qualitative research (Denzin & Lincoln, 2011) whereby qualitative research "consists of a set of interpretative, material practices that make the world visible" and "locates the observer in that world" (Denzin and Lincoln, 2011, p. 3). HPSR researchers have been forthright in calling for more inclusive and wide-ranging insights and perspectives to advance equity in health, that extend beyond quantitative approaches (Daniels et al., 2016; Greenhalgh et al., 2016). Qualitative methods were therefore chosen as they enable "us to transform HRH from being faceless numbers or units of health producers to the heart and soul of health systems and vital change agents in our communities and societies" (George et al, 2018). Moreover, whereas hard systems thinking tends to consist of more quantitively focused modelling methods, soft systems thinking is typically qualitative and often action based (Carey et al., 2015). In other words, qualitative research provides a voice and insights, and engages people, including decision-makers, in uncovering relationships and complex dynamics within health systems and HPSR. Qualitative methods are therefore aligned with the increasing focus on both soft system approaches and people-centred health systems. Specifically, qualitative approaches are consistent with soft systems thinking, such that they facilitate understandings about debates that lead to change (Augustsson et al., 2019; Checkland, 1981).

Furthermore, there have been calls for greater use of qualitative methods for leadership and management research (Kempster & Parry, 2011). Given that qualitative methods offer a useful approach to accommodate the differing worldviews and perspectives of stakeholders (Creswell & Poth, 2016) qualitative approaches are therefore useful when trying to understand a problem through the interpretive lens of actors and how they construct meaning and frame challenge, consistent with the objectives of this thesis. This understanding was particularly useful when feeding back the results of early findings to

key stakeholders, towards developing a common, or shared, understanding of leadership and management in the context of Malawi.

3.2.4 Qualitative Case Study

Often based on a constructivist paradigm, case study research approaches are often used as a method to study complex systems and derive learning through "thick description" (Anderson et al., 2005; Denzin & Lincoln, 2011; Yin, 2003). "Thick description" is what Geertz (1973) referred to detailed accounts of a social setting that can form the basis for the creation of general statements about a culture and its significance in people's social lives." (Gertz, 1973, in Bryman, 2016, p. 697). Given the complexity of the phenomenon of developing health leadership and management to address HRH challenges, towards strengthening health systems in LMICs, and to gain an in-depth understanding of how people are thinking about systems and the context of the health system in Malawi specifically, a qualitative case study design was deemed appropriate for the 'how' and 'why' questions and research objectives (1-4) (Yin, 2003). Specifically, qualitative case studies align with calls from within HPSR for "methodological fit to be dictated by the research question asked and its intended inference' rather than by 'ability to confirm attribution" (George et al., 2018, p. 2; Gilson et al., 2011). Additionally, case studies are widely used in HPSR given the influence of contextual factors, the complex behaviours and relationships among health systems actors, and their ability to generate information for decision making (Gilson, 2011).

Stake (1995) referred to case studies as "both the process of learning about the case and the product of our learning" (p. 237). Creswell (2018) went further and described case study research as a "qualitative approach in which the investigator explores a real-life, contemporary bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information" (p. 96). This flexibility thus permits the researcher to go beyond in-depth interviews, to also draw on sources such as observations, informal meetings and conversations, documents and reports, towards data triangulation, allowing for multiple facets of the phenomenon to be revealed and understood, as well as adding to the rigour of the research (Baxter & Jack, 2008; Crowe et al., 2011; Patton, 1990; Yin, 2003). This thesis thus used a qualitative case

study approach to understand better, through exploration, the every-day context-based factors and underlying mechanisms related to the development of health leadership and management towards HSS. Using such an approach helped to reveal gaps within the case study that, in turn, helped to develop and refine the theory, as the principal outcome of the thesis (Crowe et al., 2011).

3.2.5 Constructivist Grounded Theory

Combining a case study and grounded theory approaches within systems research has been evidenced to provide greater flexibility, producing "a rich harvest of fine-grained research data" (Laws & McLeod, 2004, p. 17) that illuminates an area of research and acknowledges the importance of a multiplicity of perspectives and truths (Strauss & Corbin, 1998). Indeed, and consistent with calls for grounded, qualitative approaches into the relational and processual issues of leadership and management within discrete contexts (Bryman, 2004; Kempster & Parry, 2011), it is not uncommon for findings that emerge from a constructivist paradigm (Creswell, 2016) to be presented in terms of the criteria of grounded theory (Charmaz, 2006; Denzin et al., 2017).

So while this thesis does not claim to be a grounded theory study – as one that would require a broader set of methods implemented throughout the research process (Birks & Mills, 2011; Charmaz, 2006; Strauss & Corbin, 1998) it does draw on some of the concepts, methodological strategies and tools of Charmaz's constructivist grounded theory in order to capture and analyse participants' perceptions and definitions of the health system and approaches to developing health leadership and management within Malawi (i.e., research objectives 1, 2, 3, and 4). In addition, the research utilises Clarke's (2005) grounded theory approach to situational analysis by representing complexity through mapmaking (i.e, research objective 1). This approach is thus consistent with Birks and Mills' (2011) reference to the 'hybrid utilisation' of grounded theory methods within other qualitative methodologies, as contributing to the rigour and "analytic import" of the research. Drawing on a variety of methods is also consistent with the literature around complex adaptive systems (Martin et al., 2016), as well as critical systems thinking (Jackson, 2019), as these

can be seen to help in a range of functional ways for generating and organising information about a system.

Constructivist grounded theory evolved from the epistemological underpinnings of Glaser and Strauss (1967) and the belief that the researcher constructs or builds towards a theory (Charmaz, 2000). Where Charmaz still relies on a systematic method of qualitative analysis, epistemologically, constructivism emphasises the subjective interrelationship between the researcher and participant (Charmaz, 2006). Moreover, Charmaz (2014) was keen for a grounded theory approach to be more nuanced and reflexive, suggesting that constructivist grounded theorists specifically pay attention to the "production, quality, and use of data, research relationships, the research situation, and the subjectivity and social locations of the researcher" (p342). In constructivist grounded theory, data or theories are thus co-constructed by the researcher and participants, while influenced by the researcher's interactions, values, privileges, perspectives, and geographical locations (Charmaz, 2008; Mills et al., 2006). This approach thus fits well with the WHO's HPSR strategy, which states "knowledge generation and knowledge translation are, therefore, not unidirectional…they are bidirectional, with the decision-makers, as well as the researchers, teaching each other and learning from one another" (WHO, 2012, p. 14). In addition, constructivist grounded theory places considerable value on the contextual setting, whereby gaining insight of the context are important dimensions of its use within research (Charmaz, 2006). This aligns with the principles of both systems thinking and case study research, with a motive of being as faithful to the context as possible, towards presenting findings that are "grounded" in the data and that have practical relevance (Charmaz, 2014; Creswell, 2016; Strauss and Corbin, 1990).

Whereas grounded theory was originally considered to be inductive, however, its methods have since evolved to incorporate both deductive and abductive methods (Charmaz, 2006). Consequently, processes commonly include theoretical sampling, coding, reflective memo-writing, theoretical saturation, concept mapping, and constant comparison (Birks and Mills, 2015; Charmaz, 2014). Furthermore, data collection and analysis happen concurrently throughout the study, which thus informs later phases of data collection (Charmaz, 2006). This "prompts researchers to make considered decisions, ask analytic questions to interrogate data, gather new data to answer these questions, and construct nascent analyses – while still in the field" (Charmaz, 2019, p88). Accordingly,

approaches to constructivist grounded theory analysis are highly iterative, such that core concepts and theory can only emerge after "multiple rounds' of data analysis (Bryant, 2017, Charmaz, 2014; Corbin and Straus, 2015). To address issues of trustworthiness and rigour throughout the research, this thesis further adopted specific systematic procedures of Charmaz's grounded theory in the analysis phases, discussed in more detail in Section 3.8.

It is worth noting, that there has been debate over Charmaz's interchangeable use of constructivism versus social constructionism (Glaser, 2002). Though the two concepts are intrinsically linked through their belief that people construct meaning through subjective interpretations (Vall Castelló, 2016) constructivism focuses on the individual and "the meaning-making activity of the individual mind" whereas social constructionism is focused on the "collective generation of meaning" (Crotty, 1998, p. 58). So, whereas Charmaz's (2014) initial motive may have been to ensure that the role of personal subjectivity was acknowledged in grounded theory, she later agreed that knowledge and understanding can derive from both personal interpretation as well as social interaction. In this sense, I agreed with and adhered to this mutual alignment of constructivism and social constructionism.

3.3 Overview of Research Process and Data Collection

This thesis sought to explore, understand, and advance knowledge on how health leadership and management is being developed as part of current health systems strengthening efforts in Malawi. To address the thesis objectives, the research was conducted across three phases using a flexible research approach, based on emergent findings. Each phase thus contributed to answering all four of the thesis objectives. An overview of the processes involved throughout the research phases is summarised in Figure 3.1.
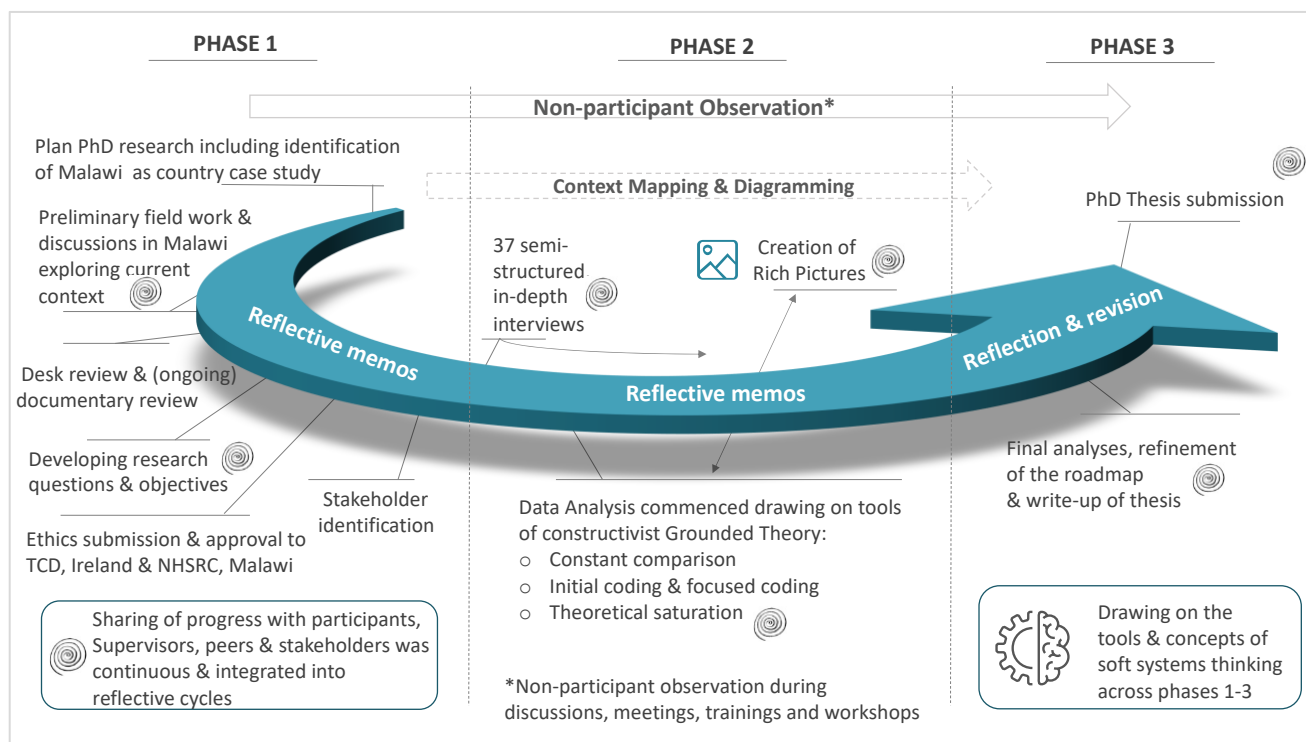
Figure 3.1. Overview of Research Process

Phase 1 was structured as a largely exploratory phase, beginning with a broad desk review and non-exhaustive literature review of complex health systems literature and health systems strengthening in Malawi as well as discussions with experts in the field of HPSR and the Malawi MoHP. This included preliminary field work in Malawi to refine research questions and objectives as part of the research protocol, as well as to map stakeholders within the context, towards research objective 1 (i.e., identification of key stakeholders in this context). Embedded as a health systems researcher in Malawi (Olivier et al., 2017; WHO, 2012), **Phase 2** included qualitative data collection across 37 semi-structured, in-depth interviews with a diverse range of stakeholders involved in HPSR, HRH, and health systems strengthening through health leadership and management. Data analysis took place alongside continued documentary review of materials gathered throughout the research process. With data collection dominating phases 1 and 2, **Phase 3** involved final analyses, refinement of the data, data synthesis and write-up of the research. Non-participant observation was integrated throughout the three phases, through my attendance across a variety of workshops, trainings and meetings, as well as presenting and discussing findings, and through the use of reflective discussions, all of which were documented through a field

diary and memos. Together, the ongoing desk review, qualitative interviews, and non-participant observation all contributed towards mapping the research to generate a thick description and in-depth understanding of the context and key stakeholders, visualised through context diagramming and mapmaking, and resulting in the development of a series of rich pictures of leadership and management within the context of the Malawian health system.

The majority of data collection took place in Malawi, apart from the initial desk review, which was conducted between Ireland and Malawi from August 2017 to August 2018. Following ethical approval from TCD, Ireland and the NHSRC, Malawi, semi structured, in-depth interviews commenced in February 2019 (pilot interviews November 2018) and were concluded in December 2019. Between May 2019 and June 2020 there was considerable unrest in Malawi in response to the 2019 disputed political elections resulting in opposition protests and widespread disruption until the election results were nullified by the Constitutional Court of Malawi in February 2020 and a re-run of the elections produced a newly elected government in June 2020. During periods of unrest, and at times violence, data collection was delayed and new dates and times for in-person interviews were arranged (Britten, 1995). There were further disruptions to workshops and interview follow ups with the COVID-19 pandemic reaching Malawi in April 2020. These delays were navigated with online communication via phone, skype or zoom and notes were recorded electronically or in written form.

3.4 Accessing the Case Study

Malawi was identified as a geographically defined, or bounded, case study and context (Luck et al., 2006). Approaching Malawi as the case study for this thesis was based on three key factors:

1) As outlined in Chapter 1.3.1, the research was situated within the P2S project, which is managed through a consortium of partners. Consortium members from the REACH Trust, Malawi being paired with consortium members at the Trinity Centre for Global Health at TCD, Ireland, provided

an opportunity for Malawi to be selected as an appropriate case study to explore approaches to leadership and management development.

2) In addition to the outlined research gaps identified in Chapter 2.6, Malawi faces significant health system, and in particular HRH challenges, with a sparsity of evidence around the development of health leadership and management approaches to strengthen the heath system. This therefore made for fertile ground to explore and generate new insights into this area of HPSR within the Malawian context.

3) My background and strong familiarity with Malawi, as well as my appreciation of the complexity of the Malawian health system, meant that the selection of Malawi as a case study was also a personal, as well as an academic endeavour.

Research that is undertaken in Malawi is required to be accommodated under a Malawi based organisation. Based on my long-standing and reciprocal relationship with the Malawi-Liverpool Wellcome (MLW) Trust Clinical Research Programme in Blantyre, Malawi, as well as the partnership between TCD, Ireland and REACH Trust through the P2S programme, the research in Malawi was housed under both institutions. Specifically, when in Blantyre I was provided desk space and situated within the Policy Unit and Public Health Theme at MLW. Likewise, desk space was also provided at REACH Trust in Lilongwe. While data collection was mostly divided between Blantyre and Lilongwe, some field trips to other districts in the southern and central regions also took place.

Critical towards embedding myself within the context of the research, and to formalise access, my primary supervisor and the Principal Investigator (PI) for the P2S project at TCD, Dr Frédérique Vallières, took on the role of gatekeeper and contacted the Project Coordinator for P2S at LSTM as well as the implementing research team in Malawi, REACH Trust, to inform them of the doctoral research taking place. An invitation was subsequently extended to be housed within REACH Trust when in Lilongwe (See Appendix 1). During a preliminary field visit to Malawi in July and August 2017, I spent time consulting informally with individuals in Malawi involved with efforts to strengthen health systems. Specifically, I met with two leading HPSR experts from MLW and School of Public Health at Kamuzu University of Health Sciences, Blantyre (KUHeS) (formerly known as the University of Malawi, College of Medicine). Great insights were provided

into health leadership and management development in Malawi, and the individuals later agreed to act in an advisory capacity. During the preliminary fieldwork, I was invited to take part in a Leadership Skills Alumni meeting with health professionals and researchers from local institutions in Blantyre including MLW Trust, Queen Elizabeth Central Hospital (QECH), the then University of Malawi's College of Medicine (COM), Kamuzu College of Nursing (KCN), and the Malaria Alert Centre (MAC). This time was crucial for learning about contextual changes in the landscape and contributed towards preparing the initial research protocol, ensuring coherence with the "interests, values, priorities, pressures and understandings of those on the ground" (Chaskin, 2008, p. 139). This time also allowed for a meeting with the Director of MLW who suggested that I submitted a Letter of Intent (LOI) for research affiliation. This LOI was later submitted to the Research Strategy Group at MLW and support for the research was granted in October 2018. The letter of approval is in Appendix 2.

Before finalising the ethics protocol, I relocated to Malawi in August 2018 and liaised with stakeholders in Malawi's MoHP National Health Sciences Research Committee (NHSRC) to determine the appropriate directorate under which to conduct the research. It was decided that the research would fall primarily under the Directorate of Human Resources as well as being supported by the Directorate of Quality Management. Thereafter access to the case study was formalised via ethical approval from TCD, Dublin and NHSRC, Malawi, as discussed in detail in Section 3.10.

3.5. Procedure for Participant Sampling and Recruitment

The sampling frame for this research included individuals involved or interested in efforts to strengthen the health system by addressing HRH and other health system challenges in Malawi through the development of health leadership and management. The research therefore relied on semi-structured, in-depth interviews with a wide range of individuals who held positions in stakeholder organisations including bilateral and multilateral organisations, private sector companies, NGOs, and academic, research and training institutions. Interviews were also conducted with stakeholders from the Malawi MoH at national, district, primary and community level, as well as government health-related entities such as medical councils. In total, (n=44) individuals were sampled using

purposeful, snowballing, and theoretical sampling procedures however, (n = 7) individuals were unavailable for interview, with (n = 5) postponing due to the political unrest and other commitments, and (n = 2) failing to respond to the invitation.

3.5.1 Participant Sampling

Constructivist grounded theory prompts the researcher to look for data where they are likely to find it (Charmaz, 2006). Thus, the recruitment process was initially guided by purposive sampling techniques (Patton, 1990), which included drawing up a list of organisations and individuals that could act as potential participants. This list was derived through a review of the few existing documents that could be sourced, and preliminary discussions with individuals familiar with HRH, health systems strengthening and approaches to developing health leadership and management in Malawi. As there was a sparsity of published literature on health leadership and management development in Malawi, I largely relied on grey literature from the MoHP as well as from external partners. A key document for identifying potential participants was Malawi's HRH Strategic Plan, 2018-2022 (2018) which had an extensive list of stakeholders. Additionally, I held discussions with individuals who had been involved in more recent HRH research in Malawi, as a way of understanding which organisations or individuals were currently active in health leadership and management development. At this stage, the inclusion criteria for participants were deliberately broad, with the first four participants sampled according to their expertise and knowledge in the aforementioned areas. These initial 4 interviews thus informed the direction of the sampling, which was thereafter influenced by theoretical sensitivity, as the point where the awareness of key ideas emerging from the data starts to increase (Hoare et al., 2012).

Specifically, Charmaz (2014) describes this as a moment in the process of researching when the researcher stops to ponder the data and to consider the different perspectives, while making comparisons and building on ideas. Here, sampling thus shifted from purposeful to theoretical sampling, which, consistent with grounded theory approaches, allows for better understanding of the characteristics and variation in categories and concepts, as well as to capture richer perceptions across different levels of the health system (Charmaz, 2014; Ritchie et al., 2013; Timonen et al., 2018). In addition, "snowball" sampling was simultaneously used where participants indicated relevant individuals or

organisations who may be interested in participating and who were thought to be able to contribute meaningfully towards addressing the research objectives (Miles & Huberman, 1994).

Recruitment of participants concluded once theoretical saturation had been reached, defined as the point where sufficient data allowing for a rich picture of the breadth of stakeholders' perspectives on health leadership and management in Malawi had been obtained (Charmaz, 2006). The final sample size (n = 37) was therefore determined by the data gathered, rather than established a priori (Corbin & Strauss, 2008).

3.5.2 Participant Recruitment

The majority of potential participants were initially contacted via email or phone, with the intent of arranging for a preliminary meeting and conversation to build rapport and allow space for an open discussion (Charmaz, 2014; Creswell & Poth, 2016; Pope & Mays, 2006). On occasion, I also went to an organisation or institution in person to try and arrange an initial meeting with potential participants. Of the (n = 8) participants identified through 'snowball' sampling, (n = 3) were first introduced to me by a previous participant via email. This initial point of contact provided an opportunity for me to introduce myself as well as to explain the nature of the research. Due to logistical challenges, initially meeting people in person was not always feasible but I ensured efforts were made to hold informal discussions prior to commencing the informed consent process. Section 3.10 provides details of the informed consent process.

3.5.3 Participant Characteristics

Of the final sample of (N = 37) participants, (n = 26) were women and (n = 11) were men. While (n = 23) of the participants were from Malawi, (n = 4) were from other countries in SSA, and the remaining (n = 10) were from Europe, Australia, and North America. Participants held various positions across the different organisations, all had knowledge of HRH challenges in Malawi, as well as awareness of efforts to develop health leadership and management as part of health systems strengthening in this context. Table 3.1 provides a breakdown of participants according to their employment at the time of interview.

Table 3. 1 Participants' Organisation Type

Organisation Type	n =
Non-profit organisations and development partners	11
Academic and Research Institutions	14
Ministry of Health and Population (National, district, primary and community level)	12
TOTAL	37

3.6. Methods of Data Collection

A breadth of data were collected across an array of sources, perspectives, and viewpoints including through: an extensive desk review and ongoing documentary review, semi-structured in-depth interviews, a combination of context mapping and diagramming for the development of rich pictures, and non-participant observation. Field notes and memos were also used and formed part of the data set.

3.6.1 Desk Review & Ongoing Documentary Review

It has been said that there has been underutilisation of documents as sources of data by qualitative researchers (Dalglish et al., 2021; Prior, 2008; Silverman, 2015). Lincoln and Guba (1985) underlined the value of documents to research referring to them as 'a rich source of information, contextually relevant and grounded in the contexts they represent' (p277). This view is further supported by scholars such as Yin (1994) and Stake (1995), who both emphasised the critical role of document reviews to ground the research in context for qualitative case studies. Furthermore, the use of documents in qualitative research acts as another source of data to be triangulated to other sources gathered during the research process, which provides a "confluence of evidence that breeds credibility" (Eisner, 1991, p110) and reduces the impact of potential biases that can exist in a single study (Bryman, 2016). As such, documents were identified as a key source of data in this thesis, and were used to provide insight into the Malawian context. The desk review and

ongoing documentary review was also used to enhance understanding of the process of developing health leadership and management specific to Malawi.

To guide the desk review and ongoing documentary analysis, a tool was developed that was broadly structured around the research question, aim and objectives, as well as the health systems context in Malawi (Appendix 3). The review was thus based on information collected through a comprehensive review of over 200 academic and grey literature sources on specific topic areas including government actions, historical factors, health system past and present, health sector reforms including decentralisation, political economy, health system actors, HRH challenges, health systems strengthening and health leadership and management. In specific, and in addition to the peer-reviewed academic literature and scholarly work presented in Chapter 2, the desk review incorporated MoHP reports, strategies, policies and minutes from Technical Working Group Meetings, local and international NGO text including United Nations (UN) documents, media and communications, literature from professional associations, training curricula, as well as guidelines and regulations for HRH, health service delivery and quality management such as the *MoHP HRH Strategic Plan 2018-2022, MoHP Guidelines for District Health Planning 2018-2022, MoHP Health Sector Strategic Plan II 2017-22, MoHP Quality Management Policy for the Health Sector (2017), Options Health Sector Efficiency Report (2015), MoHP National Community Health Strategy 2017-2022, Overseas Development Institute Fragmented Governance Malawi (2014), Malawi Health Sector Programme Progress Report Health Centre Improvement Grants (2018), Malawi Decentralisation Policy (1998), and WEMOS Country Report Malawi (2018)*. The desk review thus further served as an effective source of historical background to the political, social, cultural and economic context of Malawi.

This method of reviewing documents continued through the process of data collection, as emerging layers and dimensions of the research emerged, especially via the interviews that took place (Bowen, 2009). And whereas traditionally, grounded theorists would have warned against undertaking literature reviews prior to data collection to prevent tainting the researcher's ability to observe, constructivist grounded theory advocates for a critical appraisal of existing literature (Charmaz, 2014; Thornberg & Dunne, 2019). The extensive literature review was therefore considered an important step to capture the

multiple perspectives of the health care system in Malawi, as well as approaches to addressing its challenges through health systems strengthening.

Electronic documents were initially sourced online using key words and phrases that were extracted from the research aims and objectives as well as the literature review (Chapter 2). Such documents included policy and protocol documents, reports from websites of international organisations such as the WHO, UNICEF and CDC, and information from other global health related websites such as Health Systems Global, the Primary Health Care Performance Initiative and HRH2030. For sources specific to health systems strengthening programmes in Malawi, the majority of which are not available online, I made efforts to secure these through email requests, obtaining hard copies once based in Malawi, or from individuals willing to share to a USB drive. Such documents were not always easy to access and often involved various trips to different offices to obtain the hard copies, of which there were many. Time was also spent searching newspaper archives from the Science Communication Department within the MLW Trust, which proved especially useful for sourcing information on health systems challenges, such as HRH shortages. All documents were scanned for relevant material, offering insight into how the events were captured and framed from local, national, and global perspectives (Corbin and Strauss, 2008).

3.6.2 Interviews

Semi-structured, in-depth interviews were the primary method of data collection used to capture the perspectives of participants, towards the construction of the theory for health leadership and management in Malawi (Charmaz, 2006). Qualitative interviews were chosen as they have been used extensively in HPSR (Pope and Mays, 2006), they are widely used technique and method in constructivist approaches to research (Creswell and Poth, 2018), and more specifically, they are considered appropriate when using a soft systems thinking lens (Checkland, 1994; Jackson, 2019). Qualitative interviews are therefore particularly important to the latter, given the emphasis on engaging people and understanding more about relationships, norms, and values within systems thinking research (Ison, 2017). The interview guide used for the qualitative interviews (Appendix 4) and the interviewing process therefore remained open to exploring definitions,

processes, meanings, actions and deeper understandings from the perspectives of the participants (Charmaz, 2006). Furthermore, using qualitative interviews, as a tool for systems thinking, was considered useful for identifying key blockages and challenges within a system, with a view towards learning and actioning on leverage points, which Meadows (1999) defined as "places within a complex system where a small shift in one thing can produce big changes in everything" (p1).

All 37 interviews were conducted on a one-to-one basis in English and audio-recorded with participants consent. Each interview took place at a time and setting convenient to the participants, with all efforts being made to ensure privacy. Where privacy was not possible (i.e., sporadic interruptions, people passing by, or coming into an office), conversation would generally cease and resume thereafter. Twenty-five (n = 25) interviews that took place in-person: (n = 5) took place in a quiet area of a café or hotel, (n = 1) took place at a participant's home and the remaining (n = 19) took place within an office space. The remaining (n = 12) interviews took place over the phone or through skype. These online interviews were conducted between the MLW Trust in Blantyre, REACH Trust in Lilongwe, and a private residence in Blantyre. Where there were network issues, particularly with the internet, interviews were paused until I switched to a different network. Consistent with Birks and Mills' recommendation for conducting qualitative interviews, emphasis in the interviews was not necessarily on the amount of data captured, but rather on the meaning communicated (Birks and Mills, 2015).

The interviews typically lasted between 45-90 minutes, with the exception of two that had to be cut short, and two interviews that took over two hours. All interviews were monitored closely and transcribed verbatim within days after they were completed (Section 3.7). In keeping with the tenets of grounded theory approaches, rapid transcription allowed for prompt assessment of the data, to ensure questioning was of sufficient standard, and to reflect on the issues raised by participants during the interviews towards the development of further lines of questioning across later interviews (Charmaz, 2006).

The flexibility of the research design aided discovery of "discourses and to pursue ideas and issues immediately that emerge(d) during the interview" (Charmaz, 2014, p. 85). The initial interview guide (Appendix 4) was developed following an extensive and critical review of the academic and grey literature (as presented in Chapters 2 and 4) however, with

changes occurring to the guide as the interviews progressed. Such changes were also informed by the ongoing desk review.

Time was allocated to pre-testing and validating the interview guide by interviewing two staff members at the MLW Trust, in order to optimise quality and rigour. The aim of the interview guide was to draw out a contextually specific discussion about health systems strengthening in Malawi, towards achieving the research objectives, without being overly prescriptive or directing participants. Although there was a loose structure around the interview guide, the interviews were, for the most, in depth, with some issues being discussed in greater detail (Pope and Mays, 2006). The depth of interviews also increased with theoretical sampling. While the interviews were initially semi-structured, they did consist of open-ended questions around a participant's background, understanding of the health system in Malawi, challenges within health systems and how they are addressed, HRH programmes at different levels, health leadership and management and whatever else the participant chose to introduce to the interview (Mason, 2017). Most interviews commenced with the open-ended question, 'Can you tell me a bit about your background and how you have come to be in your current role?'. This question was designed to allow participants to prioritise what they wanted to discuss first and to therefore encourage comfort and ease with the interview (Patton, 1987; Charmaz, 2014).

Focusing on the soft systems approach to interviewing, I was keen to gain a holistic perspective of complex problems embedded within the system, as well as identify potential solutions. Thus, interviews facilitated exploration of both the implicit and explicit assumptions central to introducing approaches to developing health leadership and management in Malawi as a way of addressing HRH challenges and strengthening the health system, from the perspectives of the participants interviewed (i.e., research objectives 1, 2, 3, and 4). Additionally, using the soft systems approach to interviewing provided an opportunity to further explore the conceptualisation of health leadership and management in Malawi, as an area with limited empirical research. Furthermore, it provided an opportunity to explore how participants link health leadership and management with strengthened health systems.

In conducting the interviews, I adapted and incorporated 'Innovation History' as a tool for guiding systems thinking (Douthwaite & Ashby, 2005; Peters, 2014). Innovation

or change management history aims to generate knowledge about events that have happened, including intended and unintended outcomes, and actions taken to address emergent issues (Peters, 2014, p3). Peters (2014) advises using this method with various stakeholders to understand the performance of the system from different perspectives, with Douthwaite and Ashby (2005) attesting to the useful role innovation histories play in allowing participants to reflect on their actions, how these were linked to the actions of others, and how results may be achieved differently in the future. This proved very useful when inviting participants to think through events such as the HRH crisis in Malawi, discussed in further detail in Chapter 4, as well as reflect on past approaches to developing health leadership and management in Malawi.

At the end of each interview, participants were encouraged to ask questions about the research, as well as to give feedback on the interview itself. For example, I would ask if participants felt that further questions should be considered for future interviews. Additionally, having sought permission from participants to contact them for any clarifications, I on occasion followed up with participants on specific issues that came up in the interviews. For example, if the audio recording was unclear or if there was misunderstanding around something a participant had introduced to the conversation. Field notes were recorded during the interview process, including details on the environment, body language, tone, and mannerisms of the participants (Bryman, 2016). In line with a constructivist grounded theory approach, both reflexive and theoretical memos were generated in tandem with the analysis of interviews and informed theoretical sampling. An example of a memo is included in Section 3.8.1.

3.6.3 Non-Participant Observation

Data collected via the interviews was supported by ongoing non-participant observation, understood as the researcher being able to "record data without direct involvement with activity or people" (Creswell and Poth, 2018, p168; Bryman, 2016). According to Charmaz (2014), "revealing data resides in such observations" (p136). And while this thesis was not an ethnography, given the embedded nature of the researcher, the research "had elements of an ethnography" (Waters, 1999, p360 in Waters, 2018) due to the interactions that occurred outside of the formal interview process. Such interactions were regular given that

I often had access to people outside of their interview and without being audio-recorded (Hammersley & Atkinson, 2007). Such conversations were usually causal and informal, and individuals were usually aware of my position as a doctoral student conducting research. Additionally, I had the opportunity to take part in various workshops and trainings, including but not limited to Technical Working Group meetings at the MoH or leadership and management training at the Staff Development Institute. Non-participant observation was integrated throughout the research process with observational data recorded in memos, a field diary and self-recorded voice notes on my phone. Notes taken provided a useful reminder of activities, events, behaviours, and thoughts that were observed in the field, but not digitally recorded. For example, on a number of occasions I travelled to field sites for interviews where interventions, organisations or participants were based. This often involved an informal walk around and an opportunity to be introduced to different people in the area. On one such occasion, I was invited to spend the day at a remote site, which resulted in field notes providing useful thoughts for reflection at a later stage.

Outside of the interviews, I was often asked to share and discuss the research and ongoing findings. Such dissemination and reflective discussions took place across various meetings and workshops held on the topics of district health systems strengthening and leadership and management development. Ultimately, the insights I regularly shared with the QMD at the MoH resulted in my appointment to the MoH Leadership and Management Taskforce, where I was asked to contribute a situational analysis to the initial stages of their programme. In addition, I attended various webinars on health systems strengthening and more specifically, attended training sessions on leadership skills and the policy landscape in Malawi. There were also opportunities to share the research with peers across TCD, MLW, REACH Trust and the P2S consortium, which provided useful opportunities to reflect, learn, observe, and take field notes. Such experiences contributed to my understanding of the context as well as allowing for reflection, as discussed in Section 3.9.1.

3.6.4. Developing Rich Pictures through Mapping the Context

The importance of context to health systems strengthening, to people-centred health systems, and to the success or failure of interventions has been greatly emphasised (Bates et al., 2014; Brakema et al., 2021; Peters, 2014). Consistent with calls for more people-centred approaches, I employed a combination of diagramming, mapping, and developing of rich pictures as both a method *and* analytical tool to engage my colleagues, supervisors and stakeholders, in reflection, interpretation and further inquiry (Checkland and Poulter, 2006). Specifically, I drew on a combination of techniques such as context mapping (including stakeholder mapping) and diagramming (for eliciting and capturing the perspectives of other people). Together, these techniques contributed to understanding the processes involved, such as the 'how' of developing health leadership and management, as aligned with research objectives. Consistent with grounded theory approaches, data collection and analysis happened concurrently throughout the research process. Explanatory visualisations were thus used to describe current efforts and processes to strengthen the system in Malawi, the actors involved, as well as solicit stakeholder feedback towards a theory for health leadership and management going forward (aligned with research objectives 1-4). As the development of the rich pictures and mapping constituted both method and analysis, these are discussed as such below (Haynes et al., 2020).

3.6.4.1 Context Mapping and Diagramming

Context mapping and diagramming, as forms of systems mapping, were chosen as they are common to both systems thinking and grounded theory. They also serve as useful generative tools within Clarke's (2005) situational analysis, aligned with constructivist grounded theory. Notably, Clarke (2005) introduced situational analysis as an approach and method for grounded theory to make sense of complex adaptive systems and social worlds by representing complexity through mapmaking. According to Clarke (2005), maps are a useful way to visualise connections, patterns and relationships within complex systems across data sets. Here, however, situational analysis is more focused on rules and moving from 'messy maps' to 'more ordered maps' that fall under three categories: situational maps, social world maps and positional maps (Clarke, 2005). Therefore, and while I drew

on Clarke's (2005) thinking behind mapmaking to make sense of complex adaptive systems (and to me from the 'analytic paralysis' (p84) that can occur), situational analysis was used only as a guide for gathering, representing and making sense of the data and context throughout the research process (Davison, 2006). For example, when I faced research conundrums, such as how participants' assumptions played out, it was useful to map out the different perspectives to look for similarities or disconnects in the system .Examples of the context mapping generated as part of this process are illustrated in Figures 3.2 and 3.3.

Figure 3. 2 Mapping the different methods used for developing health leadership and management

Figure 3. 3 Mapping the expected outcomes of health leadership and management development

As part of research objective 1, stakeholder mapping was used to identify participants for interviews. I further used mapping to explore how the different actors were connected to each other, including the potential strengths of the relationships and whether they were informal or formal. This helped to determine links between stakeholders, of which there were many, while also illustrating the complexity of the relationships between them, remembering health systems comprising of people complexity (Jackson, 2019; WHO, 2015). Additionally, diagramming guided theoretical sampling in terms of identifying new potential participants (Buckley & Waring, 2013). This approach to exploring the context was also used for the literature review and ongoing documentary review. Examples of the initial stages of both mapping stakeholders and mapping the literature are displayed in Figure 3.4.

Figure 3. 4. Using diagramming and mapping to for the stakeholder analysis and desk review

While not dissimilar to mapping, diagramming allows for one to conceptualise the process and results of the research visually, towards the development and construction of a theory for health leadership and management in Malawi (Buckley & Waring, 2013). Clarke (2003) argued that diagrams can help the researcher "see" what may or may not have been noticed in written text. This also relates to the idea of "sites of silence" (Clarke, 2003) in the data, as data present but unarticulated. Within this thesis, diagramming was used as a process to visualise the development of health leadership and management as a form of health systems strengthening, culminating into the final theory (Chapter 7.3). Figure 3.5 serves as an example of diagramming used to construct the theory in its earlier stages, as a way of making it more accessible to the researcher and others (Goulding, 1999).

Figure 3. 5 Early theory construction

3.6.4.2 The Rich Pictures

One of the tools from Checkland's (2000) SSM is the concept and development of a 'rich picture' to make sense of a system and its behaviour. Here, a rich picture may take the form of the map of a system, offering an overview rather than a linear representation (Conte & Davidson, 2020). This method is thought to aid the researcher in identifying patterns and making connections, providing what Conte and Davidson (2020) referred to as an "entry point to a complex system that has many facets" (p. 2), through making the complex visible (Buckley and Waring, 2013). While the systems thinking literature more often describes the use of rich pictures for participants themselves (Checkland, 2000), there are increasing examples of them being used as an inquiry process (Conte & Davidson, 2020; Crowe et al., 2017; Monk & Howard, 1998). Crow and colleagues (2017), for example, make use of rich picture to inform quality improvement in pathways that span multiple setting. In the case of this thesis, the development of a rich pictures were used to make sense of and offer an overview of the health system in Malawi, as well as some of the emerging concepts, theories and methods, towards the development of a theory for health leadership and management. The development of the rich pictures were shared with colleagues, supervisors, and stakeholders at different points of the research process, promoting learning and facilitating discussion points around systems thinking. This sharing of progress

throughout the research process, also promoted reflection and further inquiry from stakeholders (Checkland, 2000). While there are no fixed rules for drawing rich pictures, however, with some more cartoon-like and others more formalised (Jackson, 2019). That said, Thiadens (2012), in *Growing Wings on the Way: Systems Thinking for Messy Situations*, suggests that 'rich pictures' include: not structuring the rich picture; not using too many words; not excluding relevant observations about culture, emotions and values; other points of view; a representation of the researcher; and a date and title.

The initial stages of developing the 'rich pictures' commenced by mapping the data on to A3 pages, as illustrated in Figures 3.6 and 3.7. I then worked with a local artist, who also happened to be a Clinical Officer, to transform the text into images, some of which are present throughout the thesis.

Figure 3. 6 Initial stages of unpacking the complexity within the context of Malawi

Figure 3. 7 Mapping the 'real-world' implementation of leadership and management approaches

3.7 Data Management and Confidentiality

In-depth interviews were recorded both digitally and through hand-written notes. Observations were recorded both in written form, in research diaries, as well as electronically, via the researcher's computer. Strict procedures were followed for assuring confidentiality and privacy during the data collection, management, and analysis as detailed below:

(a)   Participant Identities

For the interviews, names of participants, place of work, and specific job titles were omitted, and each participant was given a unique participant ID number for identification. This included a random code number and pseudonym. The identification key was stored separately to the main data, in a password protected document, on a password protected terminal. For the interviews conducted via Skype, participants were given the option to utilise the video feature on Skype, however, the visual component was not necessary, and voice only was recorded though Dictaphone. The only document containing the participant's name was the consent form, stored separately to the main data. Quotes from interviews during

dissemination were presented by pseudonyms. Stakeholder mapping displayed within this thesis substituted participant names with the same unique participant ID numbers.

(b)   Data collected

After each interview, audios were uploaded and transcribed and both audio files and transcripts were stored on a password guarded computer and USB devices in encrypted files. All images and drawings were kept in a zipped folder in a secure storage area within my private residence.

(c)   Hardcopy records

Hard copies of consent forms were stored in a secured filing cabinet at MLW as well as a locked cupboard at my residence during periods of COVID-19 lockdown. All hardcopies of participant details, questionnaires, and the audio recordings (transferred to a hard drive) were kept in separate storage units in a locked room at my place of residence.

Transcripts of the interviews were maintained for future reference, for a minimum time as the final thesis is being assessed and results disseminated. They are kept in a secure location with access limited to myself and my primary supervisor. Anonymised data was retained as recommended by NHSRC and TCD research best practice guidelines. After five years, the data will be destroyed following the procedures set by the Data Protection Commissioner of Ireland.

3.8 Data Analysis

All audio recordings were coded, organised, and managed using NVivo (QSR International Pty Ltd. Versions 11 and 12 Qualitative software, Melbourne, Australia). Data collection and analysis took take place simultaneously and involved coding, constant comparison, and generating categories (Charmaz, 2014; Bryman, 2015). This process of analysis is thus aligned with Charmaz's (2014) principles of constructive grounded theory, using thorough and systematic procedures to generate insights grounded in the perspectives of participants.

A visual representation of the constructivist grounded theory model of data gathering and analysis can be seen in Figure 3.8.
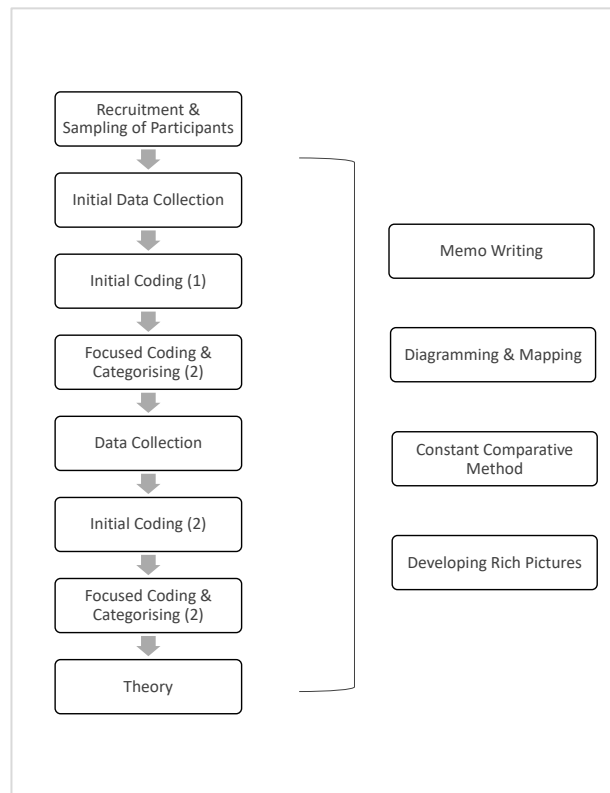
Figure 3. 8 A visual representation of the data gathering and analysis procedures used in this thesis (Adapted from Charmaz, 2014)

Data analysis was iterative and commenced with immersion in the raw data. This was accomplished through a phone-recorded voice note and written notes on initial recollections, which included contextual information, being taken after each interview. This was accompanied by an interview summary for each research participant (See 3.8.1). Audio recordings of the interviews and voice notes would initially be listened to, and on the second listening, all of the interviews and voice notes were transcribed verbatim using Express Scribe Transcription Software for Mac, and then checked for accuracy (Bryman, 2016). Where needed, I returned to the audio recordings to capture characteristics such as tone. Transcripts and field notes were read and reread on several occasions.

Transcripts were coded manually and electronically, usually starting with a hard copy of the transcript and handwritten annotations. In addition to handwritten annotations, I utilised the annotation function on NVivo, resulting in (n=378) individual annotations

across the data set. All transcripts and additional data sources were read before coding to gain a better contextual understanding. Consistent with recommendations by Charmaz (2014) the coding process commenced with initial coding to engage and define the data. This involved a line-by-line analysis of the data which helped to break-open (Timonen et al, 2018), "fracture", and develop familiarity with the data and what it means (Birks and Mills, 2011). An excerpt of initial line by line coding during the pilot interviews can be seen in Figure 3.9 where different colours were used as part of the initial coding process (i.e., pink for perception, red for HRH specific challenge etc.)

Figure 3.9 Initial stages of line-by-line coding

This initial coding process later led to the creation of multiple codes which were eventually sorted into focused codes and then broader categories that emerged from the data (Patton, 1999; Charmaz, 2014). Focused coding often involved the use of gerunds (for example, "enduring", "feeling", "suffering", "feeling", "blaming", "supporting"), as advocated by Charmaz (2006), as a way of focusing on process, meaning and action within the data. In a memo entitled "Coding Process", I reflect on how these elements were starting to emerge from the data:

What I'm starting to see in the data through the coding and breaking up the text into components, are the processes that are going through the mind of the participant. With P4, for example, it's clear to see how she thought through the intervention. Breaking it up allows me to see the assumptions that are being made, and the decisions that are taken as a result.

While some initial codes were kept intact, others were collapsed under one and coded as focused codes, depending on how accurate a reflection they were of that which was happening in the data, as well as apparent themes and patterns (Charmaz, 2014). Appendix 5 provides a snapshot of the coding process.

I also used the constant comparison method throughout the process of coding and category development to compare incoming data with existing data, to determine whether similar concepts or codes were apparent in the data (Glaser and Strauss, 1967; Charmaz, 2014; Birks and Mills, 2015). For example, verbatim quotes from the interview transcripts were initially recorded into individual codes (or "in vivo" codes) or concepts and these were then compared with newer transcripts, or codes compared with codes, codes within categories, categories with concepts and so forth (Charmaz, 2014). Additionally, the in vivo codes ensured that concepts stayed as close as possible to the participants own use of words and feelings.

Findings from the data were combined with and examined alongside issues from the extant literature (including the desk review) on health systems, HRH, health leadership and management, together with questions raised from the research objectives, and synthesis was further aided through the aforementioned diagramming, which enabled me to "see the relative power, scope and direction of the categories" (Charmaz, 2014, p. 218) and helped to identify patterns and connections (Birks and Mills, 2011).

3.8.1 Memos

Memo writing made a significant contribution to the data analysis process. Reflexive, participant specific and analytic memos were developed in tandem with review of the early

interview transcripts and throughout the writing of the thesis (Charmaz, 2006; Glaser & Holton, 2004). Characterised as "the cornerstone of quality" (Birks and Mills, 2015, p. 39) in grounded theory, memo writing consisted of informal note taking, allowing for connectedness with the data, critical thinking and reflexivity. These memos were also cross-referenced to the transcripts (Charmaz, 2006). A total of 107 analytic memos were created in NVivo (some of which were later combined or developed into new memos. This process aided to continuously move to a higher conceptual level in the analysis, as well as to take note of patterns between interviews. As outlined above, individual participant memos were also created to allow for reflection on the interview itself, the rapport between myself and the participant, the interview context, the background and characteristics of the individuals being interviewed, as well as other observations or links to what other participants might have said or made reference to. An extract from a participant memo is illustrated in Figure 3.10.
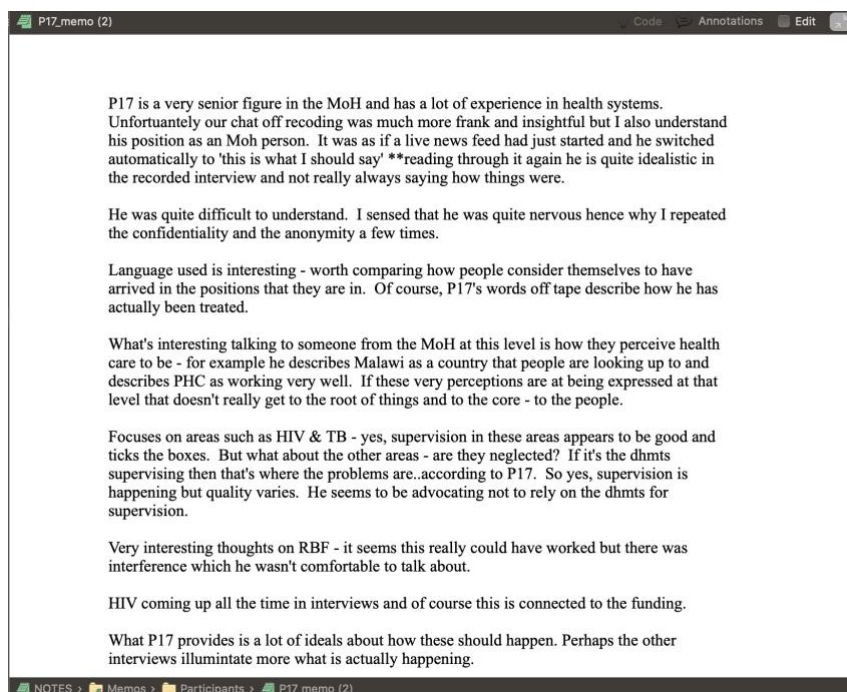
Figure 3. 10 Example of a participant memo

3.9 Trustworthiness and rigour in Qualitative Research

In qualitative research, the development of trustworthiness encompasses four major concepts, which include credibility, dependability, transferability, and confirmability

(Bryman, 2004; Lincoln & Guba, 1985). Throughout the research process I employed several strategies to address the multiple criteria of trustworthiness and rigour.

One such strategy was "triangulation"; a process and practice which refers to the use of multiple methods and data sources to develop a comprehensive understanding and view when answering the research aims and objectives to enhance the credibility of the research study (Patton, 1999). With producing knowledge on different levels from different sources, I thus went "beyond the knowledge made possible by one approach [to] contribute to promoting quality in research" (Flick, 2008, p. 41). The multiple methods applied in the research process and outlined in this chapter and included a desk review, interviews, observations during attendance at meetings/workshops/trainings (formal and informal), sharing and discussing with participants and other stakeholders, observations, notes, journaling, mapping, and diagramming. Additionally, I used investigator triangulation by sharing findings with other research colleagues and research supervisors which allowed for both confirmation of findings and reflection on different perspectives and observations (Denzin, 1978). Involving additional researchers in the HPSR field throughout each stage of the research process further helped to ensure constancy and thus dependability of the data (Bryman, 2016).

The research process itself was thorough, from the data collection through to field work and data analysis, incorporating strategies that facilitated prolonged engagement through each phase. As an embedded health system researcher, significant time was dedicated to building trust and rapport with others, including research participants. This involved attending various trainings and MoHP meetings on developing health leadership and management in the sector. Related to transferability, this embeddedness contributed to the "thick" description and interpretations emerging from the research, towards an in depth understanding of the complex patterns, meanings and relationships across the health system in the context of Malawi, allowing others to assess whether the research findings could be transferred to another context. All of the materials, notes, memos and voice recordings collected throughout the process further provided an audit trail to enhance credibility of the research, with clear documentation of my decision-making processes and assumptions (Ryan-Nicholls & Will, 2009). Such thorough documentation also enhanced the dependability of the research findings (Korstjens & Moser, 2018). The recordings of my

thoughts, feelings, values, biases, and background are discussed in more detail in Section 3.9.1 on reflexivity.

Following Charmaz's (2014) guidelines to constructivist grounded theory, the analysis of the data was technically rigorous with interpretation remaining as close to the data as possible. The coding process was iterative rather than pre-determined, which further added to the credibility and trustworthiness of the data (Pope et al., 2000). The repeated review of transcripts and the use of thick, rich quotes from the participants' responses evidence that findings and conclusions are supported from the data and grounded within the context of Malawi (Patton, 1999).

3.9.1 Reflexivity

A key strategy for researchers to enhance trustworthiness and credibility in qualitative research is reflexivity (Denzin and Lincoln, 2017). Moreover, researcher reflexivity is central to a constructivist grounded theory approach (Charmaz, 2006). Reflexivity in research "involves reflection on self, process, and representation and critically examining power relations and politics in the research process, and researcher accountability in data collection and interpretation" (Sultana, 2007, p. 376). When considering doctoral research, Brodin (2015) speaks of the value of the work being firstly located in the process, rather than the product. This is echoed from a Global Health perspective, where researchers are being encouraged to reimagine approaches to research culture that only see excellence in that which is achieved and not about how it is achieved, towards a need to be honest and reflexive about the processes involved (Farrar, 2019). Aligned with the constructive approach to research, my own reflexivity and perspective formed part of Charmaz's argument of multiple realities and role as co-constructer of knowledge with the participants.

When commencing the research, I already had ten years' experience of both working and living in Malawi as a project manager and HPSR researcher. This was a familiar setting to me, with long established relationships and friendships, and an awareness of local customs and a working knowledge of Malawi's national language, Chichewa. While exploring the health system within Malawi would become the focus of my doctoral

research, I was very aware of my own prejudice and bias from my previous experience and knowledge of health systems in this context. For example, in the years previous my research involved identifying bottlenecks in the health system for referrals between primary level and tertiary level care. Based on my experiences, I already had preconceived ideas about health leadership and management in Malawi albeit that my experiences had only been in a few districts, with specific teams. I had also interacted with different stakeholders in the health system in Malawi so my experiences, positive and negative, contributed to initial biases entering the field. It was important that I addressed this as best possible to protect the integrity of my research findings. To do this, I relied on a reflexive journal (written and audio) to examine personal beliefs, assumptions, and biases in relation to the research. These reflections guided decision making in designing the research, the fieldwork, conducting the analysis and the writing, and further proved to be a useful mechanism in tracing interactions with both the participants and the data, as well as a tool for learning from experiences.

By drawing on the concepts and tools of soft systems thinking and constructivist grounded theory, I engaged in methods that I thought would best allow for openness and transparency about the nature of the research, draw out the voices of the participants, such that the reality of the context of Malawi would be prioritised. One of the first challenges I faced was to document all of the assumptions and biases that I thought that I had, identifying those that I thought may be detrimental to the research. At times I felt both the insider and the outsider (Merriam et al., 2001) and I had to remind myself of my position as a white, European female, and of my position as a non-health worker and full-time student. It was useful to be clear about my own expectations of health systems and to remain conscious of the different concepts of leadership and management, formed predominantly from a Global North perspective. This awareness helped to maintain my focus and set a routine which I maintained throughout the research process.

Guillemin and Gillam's (2004) popular text *Ethics, Reflexivity and "Ethically Important Moments" in Research* supports the importance of reflexivity being an ongoing and active process in research, rather than a single event or single act of scrutiny. The memos often reflected times in the research process when I would stop and question my own assumptions or biases. For example, in one interview I found myself being critical of a participant's viewpoint on DHMTs however, I noted in a memo that "this is something I

need to recognise myself; that my own preconceived ideas about the DHMTs definitely make my own biases come out. I need to try and be more balanced in my thinking" (Memo_28). In another memo, I noted during one interview that "I'm finding it hard to stay neutral in my feelings when listening to the stories of those health workers on the ground…there's a sense that people are not being given a chance…but I need to continue to listen and hear from all sides" (Memo_34).

As HPSR is centrally concerned with people and their relationships, engagement with people in the research process and the importance of genuinely building trust was considered paramount. To this extent, it required me to be "embedded in the ecosystem in which the decision-makers operate" (WHO, 2012, p. 19) rather than remotely and at a distance. Similar to the ethos of grounded theory and the co-construction of knowledge between researcher and the participant, the 2012 *WHO HPSR Strategy* highlighted the need for HPSR to be bidirectional, "teaching each other and learning from one another" (p. 15). This was sometimes easier in theory than in practice. Having a pre-understanding of the research area and experience of living and working in Malawi did aid the research process in certain ways. For example, having knowledge of the context, with both practical and personal examples, helped when identifying and recruiting participants. There was an element of commonality between myself and some of the research participants based on this familiarity with context, which contributed to the facilitation of rapport. On occasions, both myself and the participants shared "inside knowledge"' of people we both knew, or about different regions of Malawi where participants had lived or worked. At times I reflected on whether or not too much personal information was being disclosed with the participants, but I think that the transparency contributed towards building trust, having open and honest discussions. I wrote in a memo that "Initially I didn't think it was a good idea to share my own thoughts, but this was noted as a good thing by one of the participants and I think helped the participants to share more" (Memo_16). Such openness was aligned with the flexible nature of the interviews. For example, I was very flexible during the sampling process and took the time to talk with all individuals suggested by participants. I was also open to modifying the research in response to the ongoing and unfolding situation during and in between interviews, when questioning how techniques might change or the topic guide altered for the next participant.

As the research unfolded, the complexity of the different actors involved in health systems strengthening increased. It became clear that participants and other actors in the field not only had their own roles, positions, and priorities but also had their own sets of values and understandings that all needed to be navigated and negotiated sensitively. Taking part in different trainings, meetings and workshops provided an opportunity to observe participants and other stakeholders in different settings, often illuminating the power dynamics across the different levels of the system. At the same time, taking part in such events did facilitate personal engagement with those involved in developing health leadership and management. For example, such activities involved interacting with others on joint activities and presentations, collaborative writing, reflective practice, theories of change and developing a situational analysis. This allowed for additional insight into how people were thinking about using health leadership and management as an overarching mechanism for health systems strengthening, bringing both personal and tacit knowledge into the conversations.

As outlined in Chapter 1.3.1, this thesis falls within a broader programme of ongoing research. I was aware from the beginning that this may bring its own challenges. For example, there was concern that some participants may behave differently as they knew that they were being observed, as suggested by the Hawthorne effect (Festinger & Katz, 1953). While not clear if this was the case, my position as a researcher embedded over a longer period of time may have mitigated or minimised this (Baxter et al., 2015). This was evident from the trust that was built over time. That said, issues about my own positionality may not always have been eliminated and thus also formed an important part of the research. During data analysis, I created a memo which was specifically for 'reflexivity' during the coding process. This was important for recording the process of analysis and to understand how interpretation matured and coding progressed conceptually (Charmaz, 2014). Additionally, it allowed space to distinguish what specifically was being constructed in my interpretation and understanding of how health leadership and management was being developed in Malawi, compared to how the participants were constructing this knowledge. In my own personal notes, in the latter stages of analysis, I wrote:

> My own position in this interview, through the analysis, has been quite
> difficult as obviously I know this project quite well. I can feel myself
> becoming more invested in the broader areas and needs that are beyond

the scope of the project but I need to draw a line and not let this impact on my analysis. My assumptions must be distinguished from the participants (Memo_17).

This passage demonstrates the challenge of being part of a larger programme of research and managing a broader awareness that I had of relationships and processes within the MoHP and how that impacted on my role in co-constructing knowledge, and the implications of what I did and did not share with the research participants.

3.10 Ethical Considerations

Ongoing reflexivity is not just a matter of rigour but also an integral part of ethical research practice (Guillemin and Gillam, 2004; Sultana, 2007). As a global health systems researcher, it was important that reflection played a role in addressing ethical dilemmas before, during and after the research process. I drew on guidance from Guillemin and Gillam (2004) and Molyneux and Marsh (2019) when considering ethics as more than just a procedure and process of approval through relevant committees but rather as a daily consideration to reflect on and be mindful of when conducting research. This was especially relevant considering my position as somewhat embedded throughout the research process.

As highlighted in Section 3.9 on "Reflexivity", ethical considerations or dilemmas were recorded and often formed part of my daily reflections. The relationship between reflexivity and ethics is apparent in my example of feeling a responsibility to a larger project, yet also feeling an ethical responsibility to the research participants. I was fortunate to have numerous opportunities to feedback and discuss my research locally. This included dedicated time to reflect and raise ethical issues. During these occasions I was cautious not to identify anyone so that this did not lead to further challenges however, the areas of concern were always helpful to talk through and often led to broader discussions. One such example from a dissemination meeting that took place during my data collection focused on competition between partners, lack of coordination, and duplication of efforts in different districts within the area of leadership and management development. As a group, we discussed how the complexity of power and politics often impacted on other areas of research that colleagues were focusing on. We therefore decided to collectively think of

how we might make specific recommendations to the MoHP to align allowances (e.g., attendance/travel allowances) for training and workshops across all partners.

As outlined in detail in Section 3.5.2, the process of conducting the research was transparent through informed consent and data collection, and research findings were disseminated back to research participants and stakeholders throughout the process. Informed consent was sought through providing potential participants with a participant information leaflet (PIL) via email or in person (Appendix 6). PILs were provided in both English and Chichewa and provided further information about the research, explaining potential risks and benefits, outlining the study protocol, and describing potential issues of confidentiality, and anonymity. The PIL was written broadly because I was following the principles of the grounded theory approach. This was explained to each of the research participants.

Participants were also informed that their participation was entirely voluntary, and that their responses would be pseudo-anonymised and kept confidential. This meant replacing participant's identity with a participant ID number. It was also explained that they may ask questions at any time, as well as being informed of their rights to withdraw from the interview or research at any point. In line with the General Data Protection Regulation (GDPR), participants were informed that by consenting to the interview they were also consenting to the processing of their data. It was made clear that participants would also have access to the transcript of their audio recording, if they so wished. Potential participants were then informed that they would be given seven days to consider their participation, before they would be recontacted by phone or email to ask if they were still interested in taking part in the research. If they were still interested, a time and date was set to have an in-person (Britten, 1995), Skype or telephone interview as determined on the participant's preference

Written consent was then obtained from participants prior to interviews taking place. Where the interview took place via phone or Skype, the participant was asked to sign a consent form (Appendix 7) and return it via email. I also signed the consent form and returned it to the participant. Otherwise, participants were asked to sign two consent forms immediately before the start of the in-person interviews, of which one was also signed by myself and returned to the participant.

At the end of interviews, participants expressed positive thoughts about the interview and appeared to recognise the value in having the opportunity to reflect on their own involvement with health systems strengthening and the development of health leadership and management. While no participants reported any ethical issues during the study, some participants did seek additional reassurance that they would not be identified in anyway. This was attributed to the close working relationships that many of the participants had with others and fear of offending people with their views.

During the course of the research, Malawi was involved in considerable unrest around political elections. This resulted in frequent discussions around allegations of corruption, of which political party to vote for and why things may or may not have been working within the health system as per the political governance structures. On one occasion I was warned about who I was seen to be politically aligned with in terms of personal relationships and how this may influence others in authority when choosing who to invite to meetings. This was not surprising and reinforced the importance of health systems being understood as political and social constructs, with leadership and management as processes taking place within a social system (Kempster and Parry, 2011). I was careful to navigate these conversations sensitively.

Ethical approval was first obtained from the Health Policy and Management/Centre for Global Health Research Ethics Committee, Trinity College, University of Dublin, Ireland, and thereafter the Malawi National Health Science and Research Committee (NHSRC), Lilongwe, Malawi. Copies of the ethical clearance letters from both research ethics committees are included in Appendix 8. I had the opportunity to present my research protocol to key people in the field and received advice regarding the overall study from my research supervisor and the Research Support Unit at the MLW Trust before submitting my ethics application. The NHSRC of Malawi notified all investigators that studies approved through their committee were required to pay all study research participants a Malawi Kwacha equivalent of $10. On the grounds of being a student, I did initially appeal the decision to provide financial incentives for participation in accordance with published guidelines on research study participation remuneration in Malawi (Gordon et al., 2018) however, the NHRSC rejected the appeal and an amendment was submitted to the Health

Policy and Management/Centre for Global Health Research Ethics Committee at TCD citing that participants would be renumerated.

3.11 Chapter Summary

This chapter provided a detailed overview of the methodological approach adhered to in this thesis. Positioned within a constructivist approach, justification is also provided for the choice of a qualitative case study approach which draws on the tools and concepts of soft systems thinking and grounded theory as valuable methods to keep the research socially engaged. The use of these different tools also reflects the methodological pluralism inherent in systems thinking, which in the context of the current research spans a comprehensive desk review of over 200 documents, 37 key informant interviews, observational data, and the use of mapping and diagramming. Aligned with Charmaz's approach (2014) to analysing grounded theory, analysis was thorough and systematic, contributing the construction of a theory that was grounded in perspectives of participants. Together, this overall research approach was chosen to maximise the likelihood that results were, in as much as possible, grounded in the practical reality of a real world setting as well as being empirically informed. Throughout the chapter I have attempted to make explicit my positionality as the researcher and demonstrate how reflexivity was an active practice throughout the design, implementation and analysis of this study. Finally, the current chapter presents the ethical and quality considerations for this research.

Chapter 4: Understanding Malawi

4.1 Chapter Introduction

> We must all accept that our health facilities do not have the capacity to treat the numbers of people being infected. Because of decades of neglect and plunder in the health sector, this pandemic has found us at a time when our hospitals and clinics are in a sorry state. The dysfunctions of the health sector are systemic, and so, by their very nature, they will take years of investment and discipline to fix. For this reason, we must accept that any measures we put in place now to relieve the pressure our health facilities are under will be temporary and imperfect at best
>
> Dr.Lazarus Chakwera,
> President of the Republic of Malawi, January 2021

As one of the world's 57 HRH crisis countries, facing one of the most acute shortages of HRH in the African region (WHO, 2014), Malawi provided an opportune context within which to situate this research. This chapter presents the results of a comprehensive desk review, drawing on the empirical literature, government reports, local and international documents, media and communication, field notes and memos, observations and interviews, to address research objective 1: *To offer an in-depth description of current leadership and management for health systems strengthening efforts in the context of Malawi, including the identification of key stakeholders involved.* This objective is achieved through an in-depth description of the current state of health care and the health system in Malawi; the HRH crisis and current efforts to address it; Malawi's efforts to prioritise, develop and strengthen health leadership and management as a concerted effort towards health systems strengthening; and '*how'* health leadership and management is being conducted in Malawi. The results of this chapter are used to offer a comprehensive account of the multiple stakeholders currently involved in HRH for HSS in Malawi, including initiatives aimed at developing health leadership and management.

4.2 Country Profile

Malawi is a small, landlocked country in south-eastern Africa, sharing its borders with Tanzania, Mozambique and Zambia (Figure 4.1). It is divided into three administrative regions (North, Central and South) which are further divided as part of a decentralised system into twenty-eight districts, each administered by a district assembly. Malawi's capital, Lilongwe, is in the Central region, but its largest city and commercial centre, is Blantyre, in the Southern region. The country's five lakes comprise 21% of Malawi's territorial surface area. As of 2019, Malawi's population was 18.6 million, with an expected growth to 37 million by 2038 (World Bank, 2020). There was an increase in life expectancy between 2008 and 2018 from 58.8 years to 62.4 years (NSO, 2020). The population is ethnically diverse with the Chewa constituting over one-third, and the remaining comprised of Lomwe, Ngoni, Yao and Tumbuka tribes, as well as smaller groups. The population is predominantly Christian (87%), followed by a large Muslim population (12.5%; Central Intelligent Agency, 2017). A large majority of the population lives in rural areas (82%) while the remainder (16%) live in urban centres (NSO, 2017). Of the total population, 49% are males and 51% are females (United Nations, 2020). While some progress on women's rights has been achieved, less than 50% of indicators needed to monitor the SDGs from a gender perspective were unavailable as of December 2020 (UN Women, 2020). Accordingly, gender-equitable development in Malawi has been highlighted as urgent, with concerns and recommendations highlighted in many national policies and programmes, including the National Gender Policy (2018-2023) (NGP).

Figure 4.1. Map of Malawi showing the provinces and districts

Despite making significant structural and economic reforms to sustain economic growth, Malawi ranks as having one of the lowest per capita spending on health of 32.9 USD (World Bank, 2020), which is considerably lower than the SSA average of 98 USD (Chansa et al., 2018). Despite increases in life expectancy, and decreases in fertility rates, inequality and poverty remain extremely high (Kanyuka et al., 2016). The country has shown vulnerability to environmental threats, and only around 11.4% of the population has access to electricity. The economy is dependent on agriculture, employing almost 80% of the population (World Bank, 2020). Although the long-term impact is not yet known, COVID-19 has interrupted and delayed economic growth (Baulch et al., 2021).

The country is a democratic, multi-party government with executive, legislative and judicial branches, based on a two-tier system of Central and Local Government. Malawi has been independent from the British since 1964, with a one-party rule ending in 1993 following the introduction of democratic multi-party elections and a newly elected President taking over from Dr Kamuzu Banda. Political unrest has been more of an issue in recent years, with the sixth tripartite elections being nullified by the Constitutional Court

in June 2020. This saw the Tonse Alliance, a new coalition government, taking office following accusations of foul play by the previous ruling party, the Democratic Progressive Party.

4.3 Healthcare in Malawi

Like much of SSA, Malawi has seen notable health improvements, including declines in maternal mortality, child mortality, infant mortality, and neonatal mortality. Notably, and despite limited resources, Malawi was one of the few countries to meet the MDG for child health (Kanyuka at el., 2016). Under five mortality has declined from 75.4 deaths per 1,000 livebirths in 2012 to 49.7 in 2018, which is lower than most peer countries in the Southern African Development Community (SADC) (UN Inter-Agency Group for Child Mortality Estimation, 2018). Moreover, Malawi has sustained a high coverage of immunisation at well above 80%, which is above the SSA average of 75% for DPT. That said, Malawi still has one of the highest rates in Africa for maternal mortality, largely due to obstetric complications, as well as general challenges around health system capacity (WHO, 2018). Malawi also maintains a high disease burden evidenced by high prevalence of diseases such as HIV/AIDS, tuberculosis, malaria, respiratory infections and diarrhoeal diseases. Much like elsewhere on the continent, the burden of NCDs is also growing.

Although the Government of the Republic of Malawi (GoM) committed 15% of the national budget to health through the signing of the Abuja Declaration, only 9.4% was committed in 2019/2020 (UNICEF Malawi, 2021) falling short of national and international targets. Given its low-income country status however, Malawi's health system would still be significantly underfunded even with a higher health allocation (UNICEF Malawi, 2021).

4.4 The Health System

4.4.1. Decentralisation of the Health Sector

Malawi's constitution of 1994 and the 1998 Local Government Act (LGA) devolved political and administrative authority to the unitary governments (O'Neil et al., 2014). Although political decentralisation has largely stalled along the way, administrative and fiscal decentralisation commenced in the health and education sectors in 2004 when the

government started implementing a health sector-wide approach (SWAp) (MOH, 2010). As illustrated in Chapter 2.2.6.2.1, processes of decentralisation can have vast benefits for countries, but these are often accompanied by challenges. Challenges to decentralisation in Malawi are well documented in the literature, including politicised decision-making, policy inconsistence, ambiguity over roles and responsibilities, slow implementation of the process, and accountability of resources (Bulthuis et al., 2021; Chikaphupha et al., 2021; Dulani, 2004; Jagero et al., 2014). The process of decentralisation in Malawi is therefore still considered to be in transition, resulting in only partial devolution of power and authority (Chikaphupha et al., 2021; Jagero et al., 2014).

On paper, the delivery of health services has been decentralised and management and implementation of health service provision at district and lower levels falls under the responsibility of the Ministry of Local Government and Rural Development (MLGRD). The MoHP has a mandate to provide direction on all national health policy, including setting standards and quality assurance, strategic planning, resource mobilisation and monitoring and evaluation. The previous health zonal structure has recently been replaced with satellite offices for quality assurance under the Quality Management Directorate (QMD) of the MoHP, providing technical assistance on quality improvement to the districts. The transition from zonal to satellite is still in a period of transition. Together with stakeholders, the MoHP develops 5-year strategic plans of health interventions, while at district level, district implementation plans (DIPs) are developed by the district council. The DIPs include health plans for the district. External partners and the MoHP are still, however, inputting to the development of the DIPs.

As argued by Chikaphupha and colleagues (2021), partial devolution is especially evident in the health sector, where the process of decentralisation has not only caused considerable confusion over roles and responsibilities as well as decision-making, but there is a reported reluctance to relinquish power from central level to local government, further delaying this transition (Chikaphupha et al., 2021; Jagero et al., 2014). Although decentralisation in Malawi should already have led to more autonomy and responsibility given to the District Health Office, Makwero (2018) argues that the progress of decentralisation has been "thwarted by lack of capacity and resources at the decentralised platforms" (p.2) for the DHMTs to carry out their respective duties.

4.4.2. Structure of the Health System

introduced an overview of the structure of the Malawian health system, highlighting four individual levels that are connected through a patient referral system: community, primary, secondary, and tertiary. The following sections provide a brief overview of the structure of each level.

4.4.2.1. Community Level

Medical services in Malawi expanded significantly after independence, with a 50% increase in medical staff and increased expenditure on health (Baker, 1976). The establishment of Village Health Committees (VHCs), which initially trained health assistants and volunteers to tackle a cholera outbreak (Namilaza, 1998) can be traced to as early as the 1970s. VHCs eventually transitioned into what are today known as CHWs or Health Surveillance Assistant (HSA), securing their positions permanent and expanding their scope of work to provide additional forms of healthcare within their communities (Kadzandira & Chilowa, 2001). HSAs provide community health services such as health education, immunisation, HIV care, family planning, malaria prevention and disease surveillance, and they are supervised by Senior HSAs (SHSAs).

In addition to HSAs, community health volunteers, Assistant Environmental Health Officers (AEHOs), and community midwives, also fall under the umbrella of CHWs, each with their own level of responsibility for delivering community-based health services in Malawi. CHW-related care in Malawi is usually available through health posts, maternity clinics, village clinics, and dispensaries. Malawi's first National Community Health Strategy, 2017-2022, defines a new community health system for Malawi, which includes a package of essential health services to be delivered at the community level by the aforementioned CHWs. Developed by the Community Health Services Section (CHSS) of the MoHP, the community health strategy is considered key strategy to bring health services closer to Malawians. Some of the key challenges identified at community level include shortages of trained CHWs, inadequate infrastructure, inadequate funding and poor coordination among stakeholders (MOHP, 2021).

4.4.2.2 Primary Level

Primary care in Malawi is implemented through the Essential Health Package (EHP) programme, which was introduced in 2004 and revised in 2017 (MoHP, 2004; MoHP,

2017). Primary care level includes health centres, maternity facilities, rural hospitals, and dispensaries. Primary health centres are the principal delivery system at primary-level, responsible for the delivery of primary health care, and mostly staffed by mid-level providers (WHO, 2016). Staffing consists of frontline healthcare providers including medical assistants, clinical officers, nurses/nurse midwives, and HSAs. It is also not unusual to find ground staff assisting with tasks that fall considerably outside of their remit. Health centres in Chikhwawa, for example, reportedly had trained guards assisting with triaging patients (Gondwe et al., 2021). Other HRH, depending on the services available, may include lab technicians, data clerks, and pharmacy assistants. Skill-mix however, is more common within urban centres, with rural health centres having both fewer staff and a narrower range of cadres. While designed to serve an average population of 10,000 people, some urban facilities reportedly serve up to 237,000.

As described in previous chapters, primary care is considered essential to accelerate progress towards UHC, including in Malawi, where primary care is said to be the inspiration behind Malawi's Health Sector Strategic Plan II WHO, 2018). While many in Malawi continue to struggle with access to care caused by out-of-pocket expenses on health, which are known to push people further into poverty (Wong et al., 2020) and distances to health facilities (Palk et al., 2020; Varela et al., 2019) more health centres have recently been constructed, with the proportion of the population living within an 8km radius improving from 81% in 2011 to 90% in 2019 (MOHP, 2021). Access to care is also inhibited by poor quality of primary care in Malawi, including poor experiences of care at first contact, weak formal accountability measures, low comprehensiveness of the services available and relational continuity of care (Dullie et al., 2019; Lodenstein et al., 2017). Similarly, varied patterns of performance and factors influencing patients' reports of primary care performance include funding, policy, and clinic level interventions (Dullie et al., 2019).

At facility level, delivery of primary health care is hindered by lack of teamwork within health facilities (Makwero, 2018), an emphasis on vertical programmes rather than facility wide programming, poor clinic flow (Nyondo-Mipando et al., 2021), and little support provided for PHC delivery more generally (Makwero, 2018). Speaking of their experience, Makwero surmised:

While Malawi strives to base its health service delivery on the principles of PHC with community participation as a central approach in addressing health needs of its people, in practice PHC delivery remains fragmented and community participation is poorly coordinated (Makwero, 2018, p.3)

From the literature, other health systems barriers at primary level identified in Malawi have included heavy patient workloads, inadequate supervision, inadequate infrastructure and equipment, and limited clinical case management (Desmond et al., 2013; Gondwe et al., 2021; UNICEF Malawi, 2021). While many of the barriers to PHC highlighted here are also seen at other levels of the health care system, primary health care is often cited as shouldering the heaviest burden (Gondwe et al., 2021; Makwero, 2018).

4.4.2.3. Secondary Level

Secondary level services are delivered primarily through community hospitals, district hospitals (where the District Health Office is usually situated), and CHAM facilities. Together, secondary-level services provide outpatient and inpatient care to the surrounding populations, with catchment populations ranging from 14,000 to 1,400,000 (UNDP, 2015). There is a limited number of specialist physicians, with larger numbers of clinical officers, medical assistants, nurses, nurse midwives, laboratory and radiology technicians, and other core operational staff. Districts hospitals in LMICs have been exposed as often neglected by the Global Health community, facing heavy patient burdens and numerous other health systems challenges (Rajbhandari et al., 2020). Such challenges have also been noted in in district-level facilities in Malawi (Kawaza et al., 2020; Kinshella et al., 2020; Nyondo-Mipando et al., 2020).

While CHAM facilities provide 75% of service delivery in rural areas, the introduction and gradual scale up of service-level-agreements (SLAs) between the GoM and CHAM since 2006 has seen the EHP extend beyond public facilities, with CHAM facilities now contracted to provide EHP services at no cost to patients. Specifically, the user fee exemption has improved the utilisation of selected maternal and child health (MCH) services, and has been evidenced as cost-effective in Malawi from the government's perspective (Manthalu et al., 2016). As outlined in Section 4.4.1, while the

delivery of health care services may be decentralised in line with the Decentralisation Act, district councils are not yet in total control of health delivery services. Additionally, it is widely accepted that despite Malawi having a decentralisation process, there remain concerns around the strength of management at district level: the DHMT's decision space is still considered limited, primarily because of power imbalances, but also due to other factors that are explored in greater detail throughout the remainder of the thesis (Bulthuis et al., 2021).

4.4.2.4 Tertiary Level

There are five central hospitals located across Malawi providing tertiary level care. These hospitals are designed to provide specialised care and referral services to facilities within their specific regions. That said, a UNDP (2015) report indicated that 70% of the services currently offered within tertiary care should, in actuality, be managed at the lower levels of the system, attributing inadequate triage and referral systems at health centres as the reasons why patients seek primary and secondary level services at central hospitals. The hospitals also serve as national teaching hospitals and work closely with the KUHeS, KCN, and CHAM training colleges.

As part of decentralisation, central hospitals are now semi-autonomous, increasingly making independent decisions. Central hospitals have optional paying wards, which generate about 2-3% of their budget. However, due to HRH shortages, managing accounts in wards remains a struggle (MTR, 2021). Of the revenue that is collected, central hospitals are focusing on improving quality of care and improving HRH availability.

4.5 Tackling HSS

Malawi has included strengthening its health system and achieving UHC as priorities in its National Health Policy (II). Objectives to be met between 2017 and 2030 as part of this policy, are laid out in Table 4.1, with objective 2 targeted at providing effective leadership and management.

Table 4.1 Objectives for strengthening the health system in Malawi

Objectives for Health Systems Strengthening and meeting UHC in Malawi by 2030	
1	Improve service delivery by ensuring UHC of essential health care services paying particular attention to vulnerable populations
2	Provide effective leadership and management that is accountable and transparent at national, and local authority levels
3	Increase health financing equitably and efficiently and enhance its predictability and sustainability
4	Improve availability of competent and motivated human resources for health for effective, efficient, quality and equitable health service delivery.
5	Improve the availability, accessibility and quality of health infrastructure, medical equipment, medicines and medical supplies at all levels of healthcare
6	Reduce risk factors to health and address social determinants of health and health inequalities
7	Strengthen capacity in health research and health information system management for evidence-based-policy making

While Malawi's HSSP II is primarily concerned with increasing access to the EHP at all levels of the health system, there remain concerns about how realistic these objectives are in light of other current health system challenges that fall within the WHO Building Blocks (as outlined in the HSSP II). These challenges include, but are not limited to: a funding gap of 88% for the EHP in the FY2019/20; resource shortages including drug stockouts; supply chain bottlenecks; parallel information systems and poor information sharing; critical health worker vacancy rates of more than 50% and uncoordinated in-service training; weak leadership and management; barriers to access to care; slow implementation of the decentralisation process; inadequate infrastructure; poor quality of care; little progress achieved in equitable access to quality health services particularly in rural areas; weak community engagement, poor health governance and lack of accountability; lack of specialisation is some critical areas; reliance on donor funding; and other causes for concern (Abiiro et al., 2014; Banda et al., 2021; Kawaza et al., 2020; MOHP, 2018; MOHP, 2021; Nyondo-Mipando et al., 2020)

While there has been some progress and improvements made in addressing these health system challenges, many of the gaps still remain, hindering significant advancement in strengthening the health system in Malawi. Cutting across all of these identified health system challenges are the issues of inadequate funding and donor dependency, as well as the critical shortage of HRH, combined with weak leadership and management, all as significant barriers to health systems strengthening. Together, these challenges impact on the overall performance of the health system including across indicators of equity, quality, responsiveness, efficiency and resilience, and ultimately, health outcomes (MOHP, 2021, 2017; UHC2030, 2018; UNICEF Malawi, 2021).

4.5.1. Health Financing and Donor Dependency

Between the FY2017/18 and FY2019/20, health sector budget allocations fell short of the HSSPII estimates by an average of 60% (MOHP, 2017). Figure 4.3 demonstrates the financial gaps across the health sector, EHP services and social determinants. Consequently, health sector financing in Malawi is currently dependent on donor funding. In specific, an estimated 85% of the total health development budget is expected to be financed by external donor support, generally assigned towards specific health interventions and diseases (Adhikari et al., 2019; MOHP, 2017; UNICEF Malawi, 2021). In 2013, however, a financial corruption scandal known as "Cashgate" led to donors withdrawing direct funding to the MoH, and resulted in limited government control over the funding priorities (EHP meeting, MLW, 2020; WHO, 2018). Cited as one of the largest financial scandals in the history of Malawi (BBC, 2014; Dulani et al., 2021), Cashgate involved large-scale looting of public resources through the government's Integrated Financial Management System (IFMIS). One of the many consequences of Cashgate was the collapse of SWAp, which had existed to make the functioning of development partners more transparent, with the aim of ensuring resources were fairly distributed across Malawi (Adhikari et al., 2019). A 2019 study by Adhikari, Sharma, Smith and Malata (2019) evidences the high levels of mistrust amongst key stakeholders as a result of Cashgate. Cashgate was thus detrimental to the relationships between donors and the government, with the EU ambassador to Malawi stating that it was a "crisis of confidence, and unless there is transparency and everybody has the feeling and trust that crisis has been addressed with full determination, confidence will not return" (BBC, 2014).
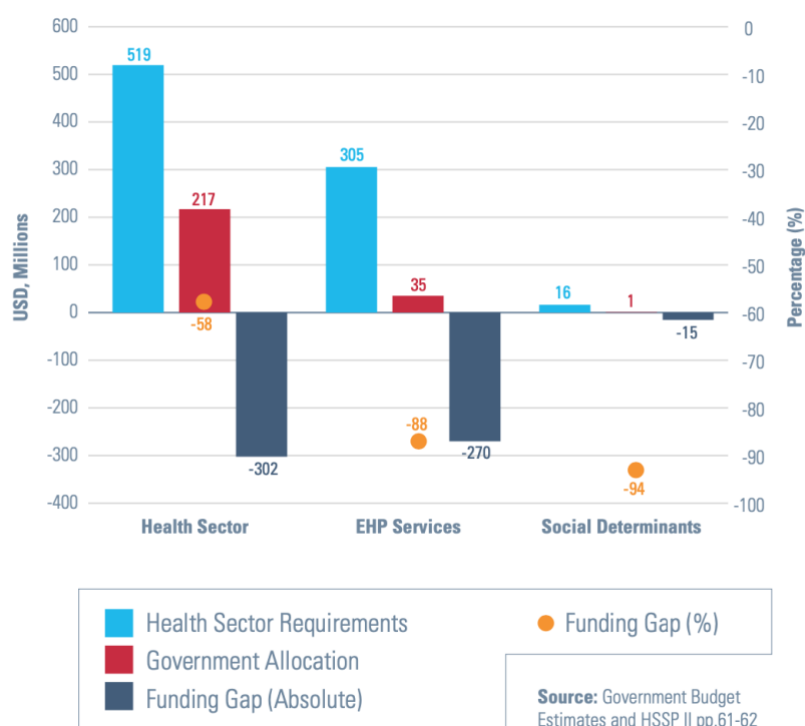
Figure 4. 2 FY2019/20 health sector allocations compared to HSSP II estimates
(Source UNICEF, 2021)

Donors moving away from the GoM also marked a return to vertical disease-based funding channels, as well as donors wanting to maintain a separate financial record of their specific funding (Adhikari et al., 2019). According to key thinkers, this amounts to a regrettable regression, given the noted improvements in service delivery observed during the SWAp era (Adhikari et al., 2019. It is important to note, however, that relationships between donors and the GoM did not suddenly become fraught as a result of Cashgate, nor do the concerns lie just with the donors. Malawi is known for its "crowded landscape" when it comes to donors, external development partners (EDPs), researchers, NGOs and other global health system actors, including those described in Chapter 2.2.5. For example, the Health Economics and Policy Unit (HEPU) at Malawi's KUHeS reported over eight hundred institutions in Malawi involved in research alone (MOHP meeting, October 2019). Similarly, specific areas in Malawi are particularly crowded with donors and NGOS "because of their beautiful locations, easy access to major road networks and other facilities" (Adhikari et al., 2019, p. 6). The exact number of NGOs is unknown but a recent estimate suggested more than 680, 30% being international NGOS (UNICEF, 2021).

Moreover, while there is evidence of some partner coordination, "this is evidently not fully effective, as rampant programme duplication still exists in districts, due to ineffective coordination and lack of trust amongst stakeholders" (Adhikari et al., 2019, p.6). Such issues, introduced in the broader literature review (see 2.2.5), echo challenges that exist not just in Malawi but across SSA and other LMIC settings. Moreover, donors and external development partners have revealed a lack of understanding of how relationships work in the country, none of which bodes well for rebuilding the trust lost as a consequence of Cashgate (Adikhari et al., 2019).

4.5.1.1 Efforts to address Health Financing and Donor Dependency

In spite of major setbacks, progress has been made in addressing health financing in the health sector. The GoM has committed to improving access, equity and quality of primary, secondary and tertiary healthcare services in the Third Malawi Growth and Development Strategy (MGDSIII) (2017-2022). Additionally, the MoHP demonstrated its commitment to implementing the 2017 National Community Health Strategy (NCHS) by committing a small, but symbolically significant, amount of MK31 million (£28,000) in 2019/2020. To address the inequitable distribution of donor funding across districts, the MoHP has committed to reviewing the health resource allocation formula to improve equity in health financing. Additionally, the GoM has been urged to engage in discussions with key donors to understand the low absorption rates for externally financed health sector projects reflected in the large variances between approved and actual expenditures. For example, of the $33 million allocation to malaria in 2015-2017, Malawi absorbed only 68% of the costs (UNICEF Malawi, 2021).

While the health sector remains a high priority for the GoM, budget allocations are still insufficient to meet financing needs. Overall, health sector resources are expended at District level, calling for more efforts to strengthen health financing systems to ensure value for money. More recently, the GoM received a budget brief based on the FY2019/20 budget that concluded with a set of recommendations for how the GoM can improve the quality of public spending (UNICEF Malawi, 2021). Among these recommendations is that to sustain any progress on improving health outcomes so far, continued public investments in strengthening the national health system as well as finalisation of the health sector

financing strategy are required (UNICEF Malawi, 2021). There have also been some efforts to improve donor coordination, at least at district level. For example, the DDHSS has been supported by the MOH with tools to help map the several partners working within the health sector at district level as a way of establishing who, among implementing partners, is financing health care delivery.

4.5.2 The HRH Crisis in Malawi

Kruk et al. (2017) identified Malawi as one of the countries where staffing levels, staff experience and facility management impact considerably on quality of care. Accordingly, critical barriers to Malawi's progress in HSS, both in the short and long term, are often because of HRH related challenges. The HRH crisis was first tackled through the implementation of a six-year Emergency Human Resources Plan (EHRP, 2005-2010) which saw a 50% increase in the health workforce however, one only has to look at the mid-term review of the HSSP II to see the continued impact that the crisis is having on both the EHP and the health system. For example, the report highlights that HRH shortages and lack of training are directly impeding progress on the following: implementation of the Integrated Management of Childhood Illness interventions; malaria prevention and treatment services; integration of community health services; implementation of leprosy interventions; TB control; implementation of NCD interventions; implementation of RMNCH interventions; implementation of EPI interventions; national response to health emergencies; medical product procurement, including essential medicines; effective management of accounts; implementation of Quality Management interventions; and supportive supervision. This list is not exhaustive.

As discussed in Chapter 2.4.5 people, including HRH, are at the heart of any health system. Challenges with any country's HRH will therefore have inevitable knock-on effect on the health system overall. While SSA faces one the largest global challenges with health worker shortages, Malawi, in particular, is ranked by the WHO as a country in the African region suffering most from the acute shortages (UNICEF Malawi, 2021) prevalent across all levels of the health system). Specifically, Malawi has only 0.5 health workers per 1,000 people, falling short of the WHO's estimate of at least 4.45 health workers per 1,000 (WHO, 2016). Of 62,269 positions in the public sector and CHAM facilities, of which

39,494 (63%) are medical, nursing, allied services, technical services staff, and education and environmental health staff, only 25% of these specific cadre positions are currently filled. There is a shortfall of 7000 HSAs against the recommended ratio of 1 HSA to 1,000 population. The highest vacancy rates overall are for nursing/midwifery officers, with a 62% gap between current staffing levels and required staffing levels (MOHP, 2018). A shortage of HRH is especially an issue in more rural areas, where the vacancy rates are up to five times higher than in more urban areas (MOHP, 2018).

While health worker maldistribution, or a geographically uneven distribution of health workers, is not unique to SSA, Malawi has long been recognised as one of the more extreme examples (World Bank, 2017). IntraHealth International (2018), for example, reported that only 29% of nursing professionals deliver services in the areas where almost 85% of the population live. Although there are concerns about HCWs moving from rural to urban areas, or even from the public to the private sector, empirical studies also highlight the vast number of workers moving abroad (Mandeville et al., 2016). The literature highlights several reasons why staff consider leaving the health service in Malawi including poor leadership and management, lack of resources, limited chances of promotion, poor renumeration and excessive workloads (Bradley et al., 2013; Chimwaza et al., 2014). While the MoHP Development Section has overall responsibility for the management of training and staff development, there is a recognised need to improve pre-service training of the health workforce, as well as improving in-service training, and staff development overall. Financial resources however, tend to focus more on in-service than pre-service training, with a need to improve coordination of trainings and to align them with national priorities (Kanyuka et al., 2016; MoHP, 2018).

Consistent with the HRH literature in Malawi, and in addition to the absolute shortages of staff, Table 4.2 further identifies some of the main HRH challenges identified in Malawi's HRH Strategic Plan 2018-2022 as well as those published in a country report conducted by the Health Systems Advocacy Partnership (involving a consortium of stakeholders focused on advocating for sustainable and accessible health systems in SSA) (WEMOS, 2018). The WEMOS (2018) report appealed to stakeholders to collaborate for an "increase in public spending to help finance HCW salaries, to ensure the optimal use of existing and new resources in the health sector and to create a more conducive

macroeconomic environment that prioritises equity and recognises the importance of public health investment" (WEMOS, 2018, p5).

Table 4. 2 Summary of HRH Challenges identified from the desk review

HRH Challenges identified in Malawi
Planning discrepancies
Quality of pre-service training
Poor absorption of trained workforce
Maldistribution of available staff across cadres, levels of care, and in rural areas
Staff retention especially in hard-to reach and high need areas
Uncoordinated or limited in-service training
Lack of continuing professional development (CPD) and clear career path
Tasking-shifting without required training or capabilities
Inadequate supportive supervision, discipline & performance management system
Challenges tracking HR information
Limited planning, management and leadership capacity at all levels
Insufficient funding
Limited presence of regulatory bodies at district level
Fragmented information systems, not routinely updated
Long and uncoordinated recruitment processes
Weak accountability mechanisms within government and between government and donors

Many of the challenges highlighted in Table 4.2 are consistent with those discussed and noted as areas for concern in the broader academic and grey literature, as illustrated in Chapter 2. For example, the impact of insufficient HRH capacity at the district level for Human Resource Management was evidenced to result in poor retention and motivation of staff (Bradley & McAuliffe, 2009; Willis-Shattuck et al., 2008). Such concerns are also reflected in a 2015 study of Health Sector Efficiency in Malawi, with Carlson, Chirwa and Hall (2015) identifying weaknesses in the performance management systems, with evidence that the MoHP were found more likely to promote people on the basis of their length of service rather than based on their performance. As a result, the authors recommended that team performance indicators be developed, focusing on management efficiency, with a need to ensure that supervision and monitoring of performance occurs regularly (Carlson, Chirwa and Hall, 2015). In another publication that appeared as a

Malawi Country Case Study in the Lancet Global Health, Kanyuka et al. (2016) also expressed concerns about HR planning and heavy reliance on junior staff in the absence of senior support at primary and community level. Moreover, Kanyuka et al (2016) highlighted challenges around the number of health system bottlenecks identified at district level in Malawi, claiming that "massive investment will be needed in the health workforce to reach the minimum recommended density and standards" (p. 212). Kanyuka and colleagues (2016) further identified the need for more mentorship and skills improvement of HRH, as well as improved supervision, including immediate feedback to health workers on their performance, particularly around case management.

Discussions around improving performance of HRH are varied and commonly focus on the negative impacts of poor HRH performance on the community, rather than unpacking the causes and effects of poor performance (Aibiro et al., 2014; Dullie et al., 2019; Lodenstein et al., 2019; MoHP, 2017). Such arguments were bolstered with the introduction of Health Centre Management Committees (HCMSs; formerly Health Centre Advisory Committees), seen as playing an important role in restoring social accountability, promoting healthy interactions between health workers and the communities they serve. Usually comprised of elected community representatives and one of the primary health centre staff members, there are over four hundred HCMCs in Malawi. The role of an HCMC is to "help communities to demand the quantity and quality of services that they expect by monitoring the performance of health centres" (MoHP, 2011, p. 90). One recent study illustrated the impact that some HCMCs in northern Malawi have had on identifying key issues with HRH so as to hold health workers to account (Lodenstein et al., 2019). Some of the performance issues that have been identified as a result of the introductions of HCMCs include health worker absenteeism, refusal to treat patients, demanding informal payments from patients, physical abuse of patients, poor medical treatment and staff frequently appearing drunk on duty. To counter criticisms from the HCMCs, primary health facility staff expressed some concerns about how qualified the HCMCs were to be fault-finding their work performance (Lodenstein et al., 2019).

When discussed in the context of Malawi, health workforce is commonly discussed with regards to poor performance, often in reference to what frontline health workers are doing wrong, with little attention directed to understanding HRH from a soft systems perspective. Moreover, it is only more recently that senior positions are being highlighted

and publicised as problematic. Maternity health care workers described a system where respect, praise and support are lacking, expressing fears of hierarchy, and feeling demotivated by the lack of leadership on hospital wards (Merriel et al., 2018). And while HCWs reported drawing on intrinsic motivation and being committed and proud of their profession, there was an expressed need for motivating incentives and opportunities for career development (Merriel et al., 2018). Apart from promotions and a 52% salary top up introduced in 2005 as part of Malawi's Human Resource Emergency Plan, there have been no new incentives to promote retention or motivate health workers.

In the workplace, Chipeta et al. (2016) identified leadership styles as affecting working relationships between obstetric care staff and their managers, resulting in staff withdrawing from work, feelings of being treated unfairly, lack of interest, diminished motivation, lack of trust, and intention to leave. Chipeta et al's (2016) study painted an overall negative picture of the management and staff relationships within Malawian health facilities, with the author concluding that a transactional laissez-faire leadership style and behaviour seemed to be prevailing with detrimental consequences. Chipeta et al., (2016) appealed that:

> The MoH needs to urgently reconsider its HRM policy and set in motion
> focused and explicit efforts to train managers at all levels in requisite
> skills, knowledge and, most importantly, attitudes, to support, motivate
> and engage the health workforce (p. 5)

Additionally, Lohmann et al (2019) found evidence to suggest that there is a concerningly high proportion of health workers in Malawi with poor wellbeing (Lohmann et al., 2019). While wellbeing is generally linked with work performance the study noted that more research was needed to draw such conclusions (Lohmann et al., 2019). Poor wellbeing scores have also been associated with burnout among health centre staff providing HIV care in Malawi, with HCWs complaining of dissatisfaction with work relationships, and further expressing disappointment at the lack of supportive supervision (Kim et al., 2019). The authors recommend to improve health facility leadership and management, especially as a means to provide more supportive supervision, and concluded that there is a critical need for strategies to manage HCW burnout in Malawi, especially for those on the frontline (Kim et al., 2019). Additionally, there is a need for the development of an effective

performance appraisal system for health workers as the current version is problematic and not user friendly (MOHP, 2021).

4.5.2.1 Efforts to improve HRH

Earlier efforts to improve HRH in Malawi such as CapacityPlus, a USAID-funded global project which took place in 27 countries, including Malawi, focused on strengthening the health workforce to achieve the MDGs. In Malawi, CapacityPlus-related programmes included a focus on education and training, health workforce information systems, and retention and productivity. For example, working in collaboration with CHAM, CapacityPlus conducted a productivity assessment using the Health Workforce Productivity Analysis and Improvement Toolkit. They identified low levels of productivity in most of the assessed facilities, which were associated with health facility inefficiencies, health worker absenteeism, and low patient demand for services (Mwenyekonde & Makoka, 2015). Qualitative interviews further revealed that the latter category was related to quality and access issues, including poor staff attitudes, favouritism, delayed referrals, lack of confidentiality, old infrastructure, inadequate staffing, and lack of physical examination, as opposed to lack of demand due to a low need for services. As a result, CHAM leveraged donor support and prioritised interventions such as customer care to improve staff attitudes, improving ambulance services, supportive supervision, increased staffing and increasing knowledge of the rights of patients as well as health workers. However, it remains unclear how successful these interventions were (Mwenyekonde & Makoka, 2015).

A new HRH Strategic Plan for Malawi for 2018-2022 outlines its overall aim of improving availability, retention, performance, and motivation of HRH for effective, efficient and equitable health service delivery, underpinned by four strategic objectives:

1) Strengthen the capacity for evidence-based workforce policy and planning
2) Strengthen governance, leadership and management systems for HRH
3) Improve the production and quality of HRH

4) Cross-cutting issues (involving strengthening the workforce through inter-sectoral collaboration)

Similarly, Malawi's HSSP (II) also has as one of its key strategies to "improve availability, retention, performance and motivation of HRH for effective, efficient and equitable health service delivery" and health systems strengthening.

Put together by a sub task force appointed by the HRH TWG including the CHAM, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Clinton Health Access Initiative (CHAI), HRH2030, Centres for Disease Control and Prevention (CDC), United States Agency for International Development (USAID) and Médecins Sans Frontières (MSF), in partnership with the MoHP, the most recent strategic plan builds upon the previous *HRH Strategic Plan (2012-2016)* and aligns with other relevant international and national policy documents and frameworks such as the *WHO AFRO Framework on HSS for UHC and the SDGs (2017),* the SDGs, *Global Strategy On HRH for Health: Workforce 2030* and the *Global Fund HRH Guidelines, Malawi's Growth and Development Strategy III, 2017-2022, the National Health Policy (2017), the National Decentralisation Policy (1998), the NCHS (2017), the NQMD 2017-2030, Human Resource Management Standard Operating Procedures (2016), Performance Management Policy and Procedures Handbook for Malawi Civil Service and the Public Service Training Guidelines and Procedures (2014).*

Led by the MoHP and the Directorate of Human Resources Management and Development (DHRMD), involving the collective thinking of key stakeholders, the most recent HRH Strategic Plan does outline some key successes of the previous strategic plan. Namely, in the scale up of training and deployment of nurses, which included support from partners to address shortages. In a discrete choice experiment study conducted by CHAI to assess motivational factors to retain nurses in rural areas in Malawi, investments in housing were found most likely to influence health worker job choice, with 62% of health workers opting to take a rural job over an urban job if superior housing was offered (Berman et al., 2021). A combination of facility quality and supportive management are also cited as highly incentivising. Based on the DCEs, CHAI also identified that workload and management improvements have lowest overall costs while salary and management have the lowest marginal cost per impact (Berman et al., 2021). CHAI have also supported the

MoHP with an optimal health workforce distribution analysis, included in the HRH Strategic Plan. Optimal distribution is based on the burden of disease and demand for health services, and it has helped the MoHP to model the health workforce pipeline to establish an understanding of how many health workers can be expected to enter the health workforce over the next five to fifteen years.

Taken together, these efforts evidence significant investments made to try to strengthen the HRH situation in Malawi. The HRH strategy alone identifies 64 different stakeholders and institutions, some with similar focus areas. Common focus areas include training, funding, technical support or assistance, infrastructure and management development, advocacy, coordination and research, development and scale-up of training HRH in the use of the Human Resource Information System (HRIS). Temporary funding of salaries and funding for recruitment has come from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the US Government via HRH2030 (USAID, 2020). Aligned with the decentralisation policy, the MoH and referral hospitals have new staffing norms as well as hospital autonomy. Such functional reviews remain to be done for staff at the districts, including district hospitals. Together with help from the Global Fund, the MoH recently recruited 2096 HRH of different cadres, towards lowering the vacancy rates slightly. In addition, 3,745 HSAs were trained in Community Case Management (CCM) and are now seeing and treating cases of malaria, pneumonia and diarrhoea in hard-to-reach areas, which were previously neglected. Health workers were trained in other areas such as the provision of friendly services to key populations, and on TB diagnosis, treatment, and prevention. Numerous other trainings have taken place, delivered by different partners. Additionally, health infrastructure saw some new staff housing constructed under the Joint Health Services Fund, and 14 health centres were rehabilitated, providing a better working environment for staff. The development of infrastructure has also received financial support from EDPs. While the MoH has yet to update or institutionalise training and deployment policies, pre-service and in-service training continues, some of which is supported by GoM, as well as some by partner funding.

The CHSS in the Directorate of Preventative Health Services has been particularly active in efforts towards building an adequate, equally distributed and well-trained community health workforce. As a way of strengthening human resources, a one-year training programme has been drafted for HSAs to replace the twelve-week training that

they were receiving. Additionally, various other recruitments of other HRH, including administrator and community health coordinators have taken place. To support CHWs in their jobs, twelve key documents were developed by the CHSS and these are currently being used in the health sector, including documents outlining role clarity and an integrated supervisory checklist. One of the key achievements for the CHSS was the development of guidelines for HCMCs as well as a draft of a community health scorecard, which will assess the delivery of community health services and provide some social accountability in community health service delivery and facilities, with the aim of facilitating problem solving. Social accountability has further been bolstered by the introduction of time-limited pilots that provide funding to HCMCs and train communities and individuals in budget analysis and monitoring to hold service providers to account (MOHP, 2018; OPTIONS, 2017). Malawi has also made some efforts to try and improve governance of the health sector and to establish better relations, as well as social accountability. This is best exemplified by the introduction of the Office of the Ombudsman to ensure improved service delivery which also serves to enhance social accountability between communities and facilities (Figure 4.3).
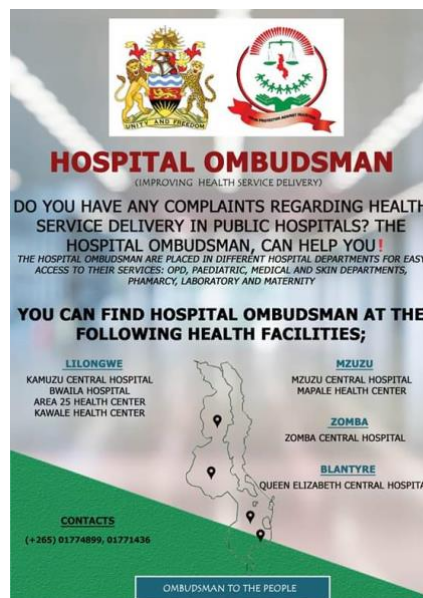
Figure 4. 3 Poster appearing in health facilities for increasing accountability

Malawi's efforts to improve governance of the health sector are integrated with the country's efforts to develop and strengthen health leadership and management capacity, as part of health systems strengthening.

4.5.2.2. Health Leadership and Management Development in Malawi

As introduced in Chapter 2.5, good leadership and management of health systems is a prerequisite for the successful implementation of health interventions and health policies, especially in a setting where resources are constrained. As health systems are also human systems, health leadership and management (involving HRH) is cross-cutting, impacting on all levels of a health system. Weak leadership can therefore also impact on operational and financial planning, use of strategic information, cause weak procurement and distribution systems for medical products and technology, result in poor accountability structures as well as poor workforce planning and human resource management, leading to poor quality and suboptimal service delivery.

Table 4.4 presents the results of the desk review and situational analysis described in Chapter 3.6.1 and 3.6.4.1. which, in partial fulfilment of research objective one, offers a comprehensive list of those stakeholders currently investing in and working towards health systems strengthening, through developing capacity of HRH in leadership and management in Malawi across the different levels of the health system.

Table 4. 3 Identification of leadership and management development stakeholders and initiatives

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
African Institute for Development Policy (AFIDEP)	Strengthening Capacity to Use Research Evidence in Health Policy (SECURE) (Supported by DFID) 2013-2017	Strengthen technical capacity in health sector in LMICs in using research evidence Optimise institutional leadership and capacity to enhance evidence use	Evidence-informed Policy Making Training Curriculum Engaging MoH leaders + evidence champions to strengthen promoting evidence use in decision -making	Health policy makers + legislators
	Heightening Institutional Capacity for Government use of Health Research (HI-Res) (Supported by Alliance for Health Policy and Systems Research at the WHO and Wellcome Trust) 2019 -	Strengthen institutional capacity for use of health research in policy + programme design	Design, implementation + continuous evaluation of innovative and politically responsive interventions within the MoH	Health researchers + implementers
	The Malawi Parliament Enhancement Project (MPEP) (Norwegian Ministry of Foreign Affairs and Royal Norwegian Embassy in Malawi) 2017-	Improve performance + effective delivery of the Parliament's functions	Inspire supportive political behaviour + reforms that strengthen capacity	All leaders across political spectrum
	Malawi Parliamentary Support Initiative (MPSI) (Supported by USAID) 2018/2019	Improve capacity + performance of parliament	Strengthen support systems, technical knowledge + skills + provide informative non-partisan budget analyses	Parliamentarians
Amref Health Africa and Malawi College of Health Sciences	eLearning for midwives (Bread for the World (BftW) + GSK) 2014-2019	Contribute towards reduction in maternal mortality	-e-Learning Training Course	Training Institutes Nurse-Midwives, tutors + Mentors

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
Amref Health Africa, Africa Centre of Global Health and Social Transformation (ACHEST), Health Action International (HAI), Dutch Ministry of Foreign Affairs	Health Systems Advocacy Partnership Programme: 2017-2020 (HSAP) (Supported by Dutch Government)	Advocating sustainable + accessible health systems in SSA Strengthen linkages between national, regional + international advocacy	Use innovative practices that combine advocacy, research + civil society engagement to strengthen health systems from bottom up	Stakeholders across the health system
Centre for Disease Control (CDC)	See CHAM projects (supported by PEPFAR)	Working with local + international partners to strengthen health systems and build workforce capacity (HIV, TB and Malaria)	Improve health facility efficiency + healthcare quality by establishing medical record system (EMRS) Increasing capacity for evidence-informed decision making	Health workforce
Chemonics International	HRH 2030 Malawi Project 2016-2020 (Supported by USAID and PEPFAR)	Addressing Malawi's central-level health systems bottleneck that impede effective HRHH activities	Provides ongoing technical assistance for critical HRH strategic planning processes to the Ministry of Health Human Resources to strengthen evidence-based planning and management, including enhanced data use for HRH Supports recruitment, deployment, and management of health workers + salary payments on behalf of the Ministry of Health for USAID-supported workers in selected PEPFAR priority sites to address health workforce shortages impeding HIV/AIDS service delivery Focus at district level on DHMTs and HR managers.Transitioned 293 HCWs to the GoM payroll	MoH, frontline HCWs, DHMTs, HR managers, CHAM

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
Christian Health Association of Malawi (CHAM)	Strengthening the Delivery, Coordination, Scale-up, and Monitoring of HIV services 2009-2020 (Supported by CDC-Malawi, PEPFAR)	Coordinating health service provision + health worker training -	Supporting DHMTs to supervise both CHAM and government facilities as a team Training HRH Infrastructural, technical + HR capacity building Placing doctors as in-charges in facilities in Blantyre + clinical Officers in smaller and more rural facilities Empowering management at facility level to make efficient use of the resources. Mentorship. Investing in pre-service training.	HCWs, DHMTs
	Health Systems Support Technical Assistance Program (Supported by DIFD and Options) 2014-2016	Capacity building, systems strengthening	Improving programming, managing guidance, expanding the skills of human resources and partnership building.	Finance, Management HR managers
Clinton Health Access Initiative (CHAI)	Human Resources for Health Infrastructure Project Transition in Malawi (Supported by Royal Norwegian Embassy (RNE) of the Government of Norway) General support	Reducing disease burden in LMICs and working with partners to strengthen capabilities of government + private sector to strengthen health systems	Technical advisors to the MoH Developing a health worker training programme including new infrastructure Scholarship provision and pre-service training Supports Malawi's HRH agenda including modelling the health workforce pipeline + doing optimal health workforce distribution based on burden of disease + demand for health services. Mentorship skills building. Nurse retention study New work coming focused on health workforce planning and management	Nurses/midwives + other cadres, DHMTs

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
College of Medicine		University committed to scholarly + professional excellence to enhance sustainable health, well-being + equity in Malawi	Health working training + research Pre-service training in MPH curriculum Leadership Development Programme	Students and professional in the health sector
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Malawi German Health Programme (Co-funded by The Bill and Melinda Gates Foundation) 2017-2020 General support BACKUP Health (Commissioned by the German Federal Ministry for Economic cooperation & Development (BMZ) (2020-2023)	Health System strengthening with a focus on reproductive health Implementing Global Hralth financing	Technical advisors to the MoH Management strengthening at both national and district level HR Management Focused on strengthening pre-service + in-service training (skills labs, eLearning) Working with training institutions Developed mentorship guidelines Leadership + governance Support establishment of quality management secretariat + establish quality management teams at district level	HRH
Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)	Technical Assistance to Community-Based Organisations (CBOs) (Positive action for Children's Fund) 2017-2020	Providing technical assistance for provision of adult + paediatric HIV prevention, care + treatment services to the MoH and CHAM.	Support trainings Capacity building on governance + organizational management Capacity building for MoH staff	CBOs MoH staff
ICAP at Columbia University's Mailman School of Public Health, MoH and KCN	Nursing Education Partnership Initiative (Supported by PEPFAR)	Addressing the critical shortage of health care workers in sub-Saharan Africa by strengthening the quality + capacity of nurses and midwives.	First doctoral program for nurses + midwives in Malawi PhD program in Inter-Professional Health Care and Leadership	Nurses
IntraHealth International	CapacityPlus (supported by USAID) 2015	Health Workforce Productivity Analysis + Improvement Toolkit	Training managers in CHAM + MoH to carry out an improvement process	Health managers
Kamuzu College of Nursing		Public Nursing + Midwifery College	Training Leadership Programme	Nurses

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
Local Government Accountability and Performance (LGAP) 2016-2021	(supported by USAID, CDC)	Governance + decentralisation	District strengthening Uses systems approach Works to improve local government performance and transparency, increase citizen engagement, + strengthen the enabling environment for decentralization Improving human resources + management systems Institutional capacity building	Local stakeholders, public servants
Malawi Leadership Programme	Consultancy	Delivering engaging training + coaching programmes that build emotional intelligence + leadership skills	Multidisciplinary Leadership + management skills for health professionals Improving leadership + governance across the health sector Incorporates coaching Trains professionals across the sector Longitudinal approach	Professionals in the health sector, research institutions, NGOS
Management Sciences for Health	District Health Performance Improvement project 2012-2017, District Health System Strengthening and Quality Improvement for Service Delivery in Malawi (2012-2018) + Organised Network of Services for Everyone (ONSE) 2016-2021 (Supported by USAID)	Strengthening health systems and community structures	Technical advisors to the MoH to promote District Health Planning Guidelines (DHPG) amongst the DHMTs. Supportive supervision + support management structures at health facility level, supervision skills Focused on DHMTs and DHMT interactions with facilities at community level Identify + prioritise challenges at facility level Support district with allowances for staff shortages and cover Mentorship Programme Focus on leadership, management + governance	HCWs + managers across the health system

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
MoHP	Leadership and Management Task Team (Supported by The Bill and Melinda Gates Foundation through UNICEF) 2017-	Developing leadership + management capacity to improve the quality of services	Developing, implementing + evaluating a programme for training health leaders	Health managers
National Evidence Informed Decision Making Network for Health Policy and Practice in Malawi	(Supported by DFID)	Strengthening systems' + individuals' capacities to use evidence to improve health policy and practice	Engaging with + facilitating the interface between the "supply" of knowledge + the "demands" of policy and practice	EVIDENT network: MoHP, Knowledge Translation Platform, College of Medicine, Malawi-Liverpool Wellcome Trust, AFIDEP
Options Moved to ONSE	Malawi Health Sector Programme, Technical Assistance (MHSP-TA) (Supported by DFID) 2011-2016	Enhancing implementation of Malawi's HSSP	Supporting health facilities financially through Health Centre Advisory Committees plus training them to mobilise their own resources Health Centre Improvement Grants Focus on accountability Partner coordination Strengthening health service planning + monitoring	HCMCs, HCWs, DHMTs

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
Partners in Health	Abwenzi Pa Za Umoyo	Building + supporting a model of integrated care in Neno District	Provide a model for best practice at strengthening health systems at district level Online programme for Leadership + Management on Global Health at University of Washington Building leadership + management capacity of DHMTs through training programmes Improving decision making processes Mentorship at all levels University of California collaborating with them to support nursing leadership – training mentors who support nurse midwives in health facilities	All cadres
REACH Trust	The REACHOUT project (One of 6 partner healthcare organisations) (Supported by European Union) 2014-2015	Healthcare research project supporting + strengthening work of close-to-community-providers	HRM issues including supervision, training + motivation Training in improving quality data through action planning Trained + established quality improvement teams	Multidisciplinary teams, HCWs, Community volunteers, CHWs
	PERFORM2Scale One of consortium of 7) (Supported by EU Horizon2020) 2016-2021	Health systems strengthening research project scaling up a management strengthening intervention to improve health workforce performance	Scaling up of a problem-based district level management strengthening intervention using Action research Focuses on HR and Health system strategies Engaging + working closely with stakeholders for ownership	DHMTs, stakeholders across the health system + local government

179

Main Stakeholder	Project Name + Funder	Area of Interest	Methods	Target
Staff Development Institute	Malawi Leadership and Management Training Programme for District Health Management Teams (Supported by Bill and Melinda Gates through UNICEF)	Local training, consulting + research government institution	Coordinating Malawi Leadership and Management Training Programme for District Health Management Teams Training for health workers Part of future School of Governance for all in-service trainings along with Malawi Institute of Management	
UNICEF	DHSSi Supported by The Bill and Melinda Gates Foundation		Supporting district strengthening across Malawi Focus on leadership + governance through the Leadership + Management skills Development Programme	District
Jhpiego	Support for Service Delivery Integration-Services (SSDI) (USAID) 2011-2017	Increasing access to, and strengthening the delivery of, EHP services both at the health facility and in the community.	Developed & disseminated behavior change communication materials Provided financial and technical assistance to the MoHP	District

4.5.2.2.1 Commitment to Health Leadership and Management Development

With support from the Bill & Melinda Gates Foundation's District Health Systems Strengthening Initiative (DHSSi) (2019-2021), UNICEF partnered with the MoHP in 2018 towards strengthening management capacity of DHMTs to improve health system performance in Malawi. In recognition of the 'weak' leadership and management across the health sector, with a critical need to harmonise efforts and to build capacity across the health workforce to address broader system challenges, meet global health goals, and improve performance, a Leadership and Management Task Team was formally established as part of this initiative in September 2019 by the MoHP's QMD. The establishment of the task team resulted in the launch of a Leadership and Management Training Programme for Health Managers which was launched in September 2020 (See 4.5.2.2.3).

However, efforts and discussions around developing health leadership and management in the health sector had commenced some time before, accompanied by both national and international commitments to supporting the development of health leadership and management in Malawi. The WHO's Country Cooperation Strategic Agenda (2017-2022), for example, states a strategic priority to support the "strengthening of health systems [in Malawi] and advancing UHC through revitalised primary health care approach and sustainable service delivery while ensuring financial risk protection" (WHO, 2018, p. 2). Accordingly, the main focus areas of the WHO's commitment include strengthening of district health systems, advocating for HRH capacity development, enhancing leadership and governance and promoting evidence-based policies and interventions (WHO, 2018).

Nationally, Malawi's HSSP II (2017-2022) has objectives to strengthen leadership and management, introduce management training initiatives, and improve management support systems. Planned interventions detailed in the HSSP II for strengthening health leadership and management as part of health systems strengthening efforts include improving use of evidence in decision making, strengthening financial management, strengthening compliance with the Public Procurement Act, supporting the decentralisation of health care delivery and supporting hospital autonomy. Likewise, contained within Malawi's 2018 National Health Policy are clear intentions to strengthen management and leadership capacities; strengthen management support systems; empower communities to provide effective oversight; improve governance and accountability structures; and measure the proportion of health managers who have been

trained in leadership and management. The Malawi National Quality Management Policy and Strategy (NQPS), 2017-2030, also includes leadership and governance as a key priority for improving quality of care. Specifically, one of QMD's key intended interventions was to build the capacity of the DHMTs in leadership and management by 2022. This effort has already commenced via the Leadership and Management Task Team and training for DHMTs. Moreover, one of the four objectives in the HRH Strategic plan 2017-2022, aims to achieve strengthened governance, leadership and management systems for HRH. Taken together, these documents evidence the recognition and demand for health leadership and management in Malawi that precede the establishment of the Leadership and Management Task Team. Such recognition was further highlighted by Chipeta and colleagues in a 2016 critical incident analysis of relationships between health care workers and their managers:

> Health managers with effective leadership skills are an essential component of the solution for ending staff shortages, but explicit attention to training of these cadres in leadership skills and behaviour is currently inadequate. Implementing strategies to ensure effective leadership is paramount (p. 6)

In their most recent mid-term review of the HSSP II, the MoHP expressed concerns about the availability of funding for implementing leadership and management interventions, stating that funding has more recently been redirected to other sectors affecting the implementation of the DIPs (pre COVID-19). Another reported challenge, despite the drive and support from the QMD, was the absence, or 'dormancy', of a Health Sector technical working group (TWG) to provide leadership and to coordinate inputs from different stakeholders. Resistance to change has also been noted in the context of transitioning DHOs to the position of DHSS, as part of the decentralisation process, as well as to the cross-cutting role of the newly established QMD, with ongoing struggles to integrate quality improvement in different departmental activities across the MoHP.

There is little documented evidence of how health leadership and management has been approached both in the past or present in the context of Malawi. However, results of the desk review evidence that the majority of efforts and strategic priorities focus on *district* strengthening and *district* level managers, with fewer examples of leadership and management development at central, primary or community level, nor are there known examples of system wide approaches. This is consistent with the broader literature on developing leadership and

management, as a key component of HRH and health systems strengthening in SSA, as described in greater detail in Chapter 2.

4.5.2.2.2 Past and present efforts to develop health leadership and management

In previous years, leadership and management training was led by the DHRMD in the Office of the President and Cabinet (OPC), through a three-week modular internship course on management, offered through the Mpemba Staff Development Institute (SDI) for health managers. This stopped functioning however, due to a lack of finances for sponsoring placements. The USAID's Support for Service Delivery Integration Services ran from 2011-2017 and as part of its remit, assisted the MoH in improving policies, management and leadership, and fiscal responsibility to advance Malawi's health system and the sustainable impact of the EHP. SSDI worked on building relationships with DHMTs and included DHMTs in project activities that took place with their own SSDI staff such as mentoring, supervision, training, service delivery, planning and review. As part of SSDI, the MoHP was supported to develop a curriculum alongside the Malawi Institute of Management (MIM), which consisted of seven modules for a Health Leader and Management programme. Likewise, in 2015 a three-day Executive Leadership and Management course for MoHP Senior Managers was conducted in collaboration with MIM, funded by USAID. However, this was only delivered within the specific districts USAID was supporting and stopped when the project funding was over. The Management Sciences for Health (MSH) ran a District Health Performance Improvement Project (2012 – 2017), again funded by USAID, alongside a focus on District Health Systems Strengthening and Quality Improvement for Service Delivery in Malawi (2012-2018). Additionally, in 2016, the WHO supported the first District Health Systems Management training for DHMTs from 13 districts in Malawi. The focus of this training was on enhancing the capacity of DHMTs in health services management aligned with the decentralisation of human resources, and in response to the 2014/2015 Joint Annual Review Reports that revealed district health system inefficiencies. The then WHO representative, Dr Eugene Nyarko, appealed to the MoH and trainees to "consider this training session as a solution centre, where you learn the skills and the know-how of finding solutions to address the challenges as you implement the District Implementation Plans" (WHO, 2016). While focusing on leadership skills and conflict management, the impact of the training is unclear, and the programme was not institutionalised, as had initially been suggested. The KUHeS and the KCN offer modules

in leadership and management, and in 2014 Columbia University of Mailman School of Public Health (formerly the International Centre for AIDS Care and Treatment Program) partnered with the MoHP and KCN to develop and implement the first doctoral program for nurses and midwives in Malawi, later known as the PhD Program in Inter-Professional Health Care and Leadership.

At national level, building capacity in the use of evidence-informed decision making (EIDM) has also featured as a target area for developing leadership and management as part of health systems strengthening. And while several initiatives on Knowledge Translation took place from 2013, there was an absence of a national body to link these initiatives. As such, the National Evidence Informed Decision Making Network for Health Policy and Practice in Malawi (EVIDENT) was formulated in 2016 by the then College of Medicine, University of Malawi, the MoHP, MLW, the Public Health Institute of Malawi (PHIM), the Liverpool School of Tropical Medicine (LSTM) and other invested stakeholders to develop capacity for health systems and implementation research, including a ten year roadmap for implementing evidence informed-decision making in health more broadly. This approach is currently being evaluated by the Evidence-informed Policy Network (EVIPNet).

The EVIDENT network includes the African Institute for Development Policy (AFIDEP), as an African-led, regional non-profit research policy institute working to help bridge the gaps between research, policy and practice in development efforts in Africa. More recently, AFIDEP has played an important role in Malawi to engage health researchers, implementers, policy makers and various leaders across the political spectrum in several forms of training to support and enable Malawi to develop effective policies and programme interventions for health. The methods employed by AFIDEP are varied, but examples include: using an evidence-informed policy making training curriculum delivered through workshops - but also through the integration of modules - into existing pre-service and in-service training programmes; implementing and evaluating interventions such as incorporating EIDM tools and practices into routine processes and procedures within the MoHP; piloting innovative sessions at conferences that discuss evidence on priority health sector issues with policy makers; and coordinating efforts around policy engagement and strategic communications for health related programmes and consortia.

More recently, and as part of the MoHP's first National Digital Health Strategy 2020-2025 (2020) QMD is piloting the roll out a digital platform that displays data in real time to assist with decision making on the frontline, helping health facilities connect to the national digital network.. While still in its infancy, however, little is known about the success of this initiative to date. Additionally, HRH2030, supported by PEFAR and USAID, has also played a critical role in working to address central-level HR systems bottlenecks that impede evidence-based planning and management, including enhanced data use for HRH. HRH2030's role has involved providing technical assistance for critical HRH strategic planning processes, with a particular focus on building capacity of the district itself, specifically in building capacities of the HR managers in the human resources management planning and development, and ensuring HR managers are able to interpret and understand their data for EIDM.

Such technical advisory roles to the MoHP are not unique to HRH2030 however, also extending to other key stakeholders. On the same challenge of strengthening HR management, GIZ has come in to advise on improving the weak performance management system, including training more HR managers for more efficient planning. Building capacity for HR management is also being supported by GIZ's BACKUP Health project, which aims to advise partners in Malawi on the implementation of global health financing, as a component of health systems strengthening. Part of this project is to support the institutions of national health systems in making use of their scope to influence global financing and to strengthen their national health systems, including developing and enabling HR and organisational skills. Other supportive roles that GIZ has played in strengthening leadership and management have been through the development of a training manual and mentorship guidelines that focus on Maternal and Reproductive Health.

Another key technical advisor to the MoHP has been CHAI. CHAI supports health workforce planning and management through advising the Directorate of Planning and Policy Development (DPPD) on the DIP process as well as on budgeting, evidence generation, and coordination of partners. CHAI has recently supported revision of the DIP guidelines and tools, streamlining the tool for the situation analysis to monitor progress at district level. This has also involved a Training of the Trainers (ToT) approach so that the DIP tools can be implemented across Malawi. The tool has been integrated into the new Leadership and Management training for DHMTs. While the tool focuses on progress at district level it does not extend to primary health facility level.

PERFORM2Scale (P2S) is another example of a programme targeting DHMTs towards strengthening health systems. Detailed in Chapter 2.5.8.4, with its predecessor PERFORM, P2S is the implementation and scaling up of the PERFORM management strengthening intervention (MSI) using action research across Malawi, Ghana and Uganda (2017-2021). While the study is still ongoing, preliminary findings emerging from Malawi have demonstrated a mix of success and challenges for the project. Namely, there has been significant support and championing of the P2S project by the QMD, as well as by the MLGRD in Malawi. This is attributed to the project as being seen as strongly aligned with the QMD's objective to build capacity in health leadership and management. Moreover, P2S in Malawi brought key stakeholders together such as the District Councils and the health sector. This is said to have been instrumental in improving relationships between the different ministries at a local level. On the other hand, the slow decentralisation process has limited the DHMTs' decision making, with high staff attrition and vacancy rates negatively impacting on the HRH required to implement and scale up the programme. Moreover, despite plans for institutionalising P2S and aligning with the existing Leadership and Management training for DHMTs, this has yet to happen. Importantly, at the time of writing, there is little evidence to suggest that P2S had improved health workforce performance and service delivery at primary health level.

When it comes to primary health level, the focus is often on strengthening district level capacity to conduct supportive supervision. Supportive supervision models in Malawi tend to be programme specific and largely coordinated by national level teams. For example, as service delivery partners, CHAM is supported by the CDC to strengthen the delivery, coordination, scale-up and monitoring of HIV services. Part of this programme is designed to support DHMTs to supervise both CHAM and government facilities. DHMTs in Blantyre and Mangochi, for example, have been encouraged to start supervision at the district level and then move out to the primary facilities, working collaboratively with CHAM HR experts. Emphasis has also been placed on encouraging DHMTs to sit down with PHC managers as a team and to talk through issues, towards finding solutions together. CHAM also organises quarterly review meetings for PHC managers, implementers, and donors to come together and discuss what is working well and what is not. Under MSH, the Organised Network of Services for Everyone's (ONSE) Health Activity has also focused on strengthening health leadership and management through supportive supervision. This is part of ONSE' support to the MoHP to reduce maternal,

new-born, and child morbidity and mortality through a package of health interventions to strengthen the health system.

As part of QMD's efforts increase to increase efficiency of supportive supervision and to revise the supportive supervision paper-based tools, ONSE was responsible for developing the digital integrated CommCare-based Integrated Supportive Supervision (ISS) toolkit and dashboard, with the aim of improving MoH supervision and oversight roles at the district level by providing options for health managers to respond quickly to issues as they arise. ONSE conducted a ToT for Health managers on how to conduct the supportive supervisions through the development of a checklist, which all departments and programmes at the MoHP fed into. The digitised checklist also allocates a specific individual responsibility for each action, as a means of increasing accountability. To further support supportive supervision, ONSE also includes allowances for transport, fuel and lunch for DHMTs in 16 districts. In a more recent study, remote supervision via WhatsApp was introduced in Mangochi district to improve HIV service delivery in Malawi (Masiano et al., 2020). While the findings from the study did show that remote supervision via a WhatsApp platform can improve Viral Load testing coverage, it was not evidenced as a good substitute for in-person supervision.

Even less commonly reported are those interventions that target community level supervision. One example is the EU-funded, mixed-methods REACHOUT study (Kok et al., 2018) which described and sought to improve supervision practices at community level in Malawi through training and mentorship of supervisors from 2014-2015. Introduced at a time when there was considerable negativity around supportive supervision practices in Malawi across different levels of the system, REACHOUT was conducted to assess the effects of the supervision intervention on HSAs' perception of supervision and their motivation-related outcomes. Existing challenges and negativity around supervision practices are highlighted by Chikaphupha (2016), when he describes that HSAs commonly viewed supervision as being far from supportive, but rather perceived as unsupportive, uncoordinated, and top-down. Findings indicated that the supervision intervention, involving group supervision with individual and/or peer supervision of HSAs, was a positive contributor to motivation and could yield improved HSA performance (Kok et al., 2018). These findings are aligned with previous studies conducted in Malawi that also highlighted the role of supportive supervision as key to motivating HSAs (Chikaphupha et al., 2016; Kok & Muula, 2013). Despite REACHOUT's

promise however, the intervention was only for a period of one year, with no evidence of it being embedded into broader health systems strengthening approaches.

Consistent with Chikaphupha (2016), Bradley et al.'s (2013) also found that district health managers in Malawi centred their discourse more around control and inspection, but also explained the challenges they face with conducting regular supervision visits, such as staff shortages and multiple and conflicting responsibilities at district level (Bradley et al., 2013). It also emerged that those supervising had no systematic, accountable supervision structure, and lacked clarity on what the ethos of supportive supervision should be (Bradley et al., 2013).

Although not as widely publicised, attention to community level has also come through MSH, in the form of the same ONSE project. As a form of holding leadership and management accountable at primary level facilities, ONSE has put efforts into encouraging and engaging communities to tackle their own health issues and hold the system accountable for maintaining the availability and quality of services. This has involved carrying on the work started by the UKAID funded Options Malawi through the 2016-2018 Malawi Health Sector Programme - Technical Assistance (MHSP-TA). Options supported the idea of sustained change for the Malawi health system through focusing on strengthening leadership, enhancing financial management and democratic accountability and strengthening health service planning and monitoring. Namely, Options focused on strengthening local-level accountability through an assessment of the roles and functions of the existing government structures, HCMCs. This work subsequently fed into the 2017 piloting of Health Centre Improvement Grants (HCIGs) at primary health facilities in three districts in Malawi (Mwanza, Mulanje and Rumphi), where HCMCs were restructured and trained in management processes, including budgeting. The purpose of the HCIGs was to help improve access to essential health services at a primary health centre; to help improve efficiency in the delivery of healthcare services at a health centre; and to help improve quality of services offered at a health centre. Overall, HCIGs were designed to improve accountability and transparency; two key principles attached to good leadership and management. Outcomes for the pilots have been positive attracting attention from funders, including USAID. With regards to health leadership and management, the HCIGs empowered health facilities to prioritise expenditure and to make decisions in such a way that resolved issues quickly, without waiting for the DHMT to intervene. Such examples include building toilets at a maternity ward, or purchasing minor medical equipment and stationary. Furthermore, HCMCs found effective ways of achieving their outcomes as they had

direct control over negotiated prices and contractors. Recommendations from the project included integrating HCMCs into the health system, provided they could avail of support, supervision, and mentorship from district offices (OPTIONS, 2018).

Another of the few recorded examples of developing health leadership and management at primary facility level was the introduction of an mHeath Emergency Triage Assessment and Treatment (ETAT) intervention designed to build capacity of all PHC level staff to recognise and response to severe illness in children (Gondwe et al., 2021). The approach focused on working with the whole PHC team, both clinical and non-clinical, to collectively map out the patient journey within the health clinic and implement the triage intervention, drawing on the strengths and capacities of different individuals across the team. Building capacity of HRH in ETAT reinforced staff capacity to diagnose, with the potential of reducing health systems costs and improving health outcome through more appropriate referrals (Majamanda et al., 2022). Acceptability of the intervention was high among health workers and the implementers suggested that the ETAT be integrated with regular government training to ensure sustainability (Gondwe et al., 2021).

While there is no standard approach to develop health leadership and management across the whole health system concurrently, an example from the rural district of Neno, implemented by Partners in Health (PIH), has been reported as "best-practice" in Malawi (Researcher notes, field visit, August 2019). PIH has been operating in Neno district since 2007, building and supporting a model of integrated care through two hospitals, two health centres, and a network of 1300 CHWs. Accordingly, PIH have not only invested a considerable amount in the health infrastructure but also in HRH. Moreover, PIH considers health systems strengthening as a combination of "Five S's": staff, stuff, space, systems, and social support. While funding support enables PIH to achieve positive results for HSS, there are components of their approach to health leadership and management development that are considered replicable by the MoHP. For example, focusing on improving retention of DHOs, PIH turned their focus to creating a strong and stable leadership while investing in building leadership and management capacity through sitting and working with the DHMTs, as well as through formal programmes such as leadership and management training and fellowship programmes. Here, and in addition to investment in the DHMT through a *Leadership and Management in Global Health* course, health centres are also supported in terms of mentorship and supervision. From the nursing side, PIH have collaborated with the University of California on a mentorship

programme to support nursing leadership at both the main hospitals as well as the health centres. As a result, the health centres in Neno have onsite nurse-midwife mentors and supervisors. Similarly, the health facilities have onsite HSA supervisors to support the CHWs.

4.5.2.2.3 Health Leadership and Management Development Programmes

Chapter 2.5.8.1 introduced the increasingly popular concept of LDP's in SSA. In Malawi, there are two current programmes that closely align with those described in Johnson et al.'s (2021) scoping review of interventions to strengthen the leadership capabilities of health professionals in SSA. One such approach, the Malawi Leadership Programme, is mentioned in Johnson's review. The second is the Leadership and Management Training Programme for Health Managers, introduced in Section 4.5.2.2.1 as part of UNICEF's and QMD's drive to develop capacity in health leadership and management.

To the best of my knowledge, there is currently only one peer-reviewed paper citing an example of developing health leadership and management capacity in Malawi. Entitled *Equipping leaders in health in Malawi: Some reflections from a leadership skills-building workshop, held at the College of Medicine, Blantyre, Malawi* (Bates et al., 2018), and referred to by Johnson and colleagues in their scoping review, the paper details a five-day multidisciplinary leadership training course facilitated by a leading expert in Global Health, leadership and management from the University of Malawi and the University of Melbourne. Interestingly, the recipients of the training were not just DHMT members but also included people from diverse health related settings as part of the course's intention to promote networking within the multidisciplinary training course.

Some of the key elements of the course outlined in the paper include:

1) The need to be intentional in building your leadership skills
2) To define your values as a leader
3) To give and receive feedback for personal leadership development
4) To take risks to achieve your goals.
5) Creating a more resilient and responsive health system
6) Importance of relationship management

Bates et al., 2018

As the first of multiple cohorts to take part in the workshops, participants were encouraged to continue to regularly meet-up after the conclusion of the course. As well as detailing the structure and contents of the course, Bates et al (2018) offer insight into how the course participants experienced the process through their own personal reflections. It is clear from the reflections of the participants that the course embraced many of the elements that contribute to effective leadership and management such as developing greater capacity and resilience to manage adversity, communication, people management and emotional intelligence. The course was a unique and new experience for the participants, challenging their own assumptions of what it means to be a leader. Johnson et al. (2021) described the programme as one of three programmes in SSA that infer an individualised approach to leadership, while also emphasising the importance of working in teams. While commencing at the then College of Medicine, the programme has since grown into a consultancy leadership development and coaching programme, now under the name of the Malawi Leadership Programme (MLP). At the time of writing, the programme is still in its infancy, but it has expanded to also training multidisciplinary groups in health research institutions, and health related NGOS, and more recently a cross professional women's research leadership group at KUHeS.

The larger of the two programmes, however, remains the MoHP's Leadership and Management Training Programme for Health Managers, with those heading the Malawi Leadership Programme also taking part in the Leadership and Management Task team for Health Managers as consultants focused on the coaching and mentorship component of the training. As part of UNICEF's DHSSi programme, coupled with QMD's relatively newer role to the MoHP, there was a reported need to build the capacity of the MoHP to develop and implement interventions to improve quality of health care (MOHP, 2018). In response, QMD trained 81 DHMT members in quality improvement between 2017-2020 as part of management strengthening and trained other health workers in protocols that fall under clinical practice. Despite initial disputes over who would coordinate this programme, it was eventually decided that it would be run by the SDI who were engaged to develop a Leadership and Management training course targeting DHMT members. Since the course was launched at the end of 2020 (See Figure 4.4), it has trained three DHMT teams in leadership and management.

Figure 4. 4 Launch of Leadership and Management Training Programme by the Minister of Health

As a starting point and leading up to the launch of the training programme, a Leadership and Management Task team was formed to work together to design, implement and validate a Leadership and Management Training Programme, tailored to the specific ongoing needs of the DHMTs. The idea being that the current programme would be designed as pre-service training and then later expanded to in-service training as part of induction for new personnel in the MoHP. According to planning documents from the task team, the course was designed to achieve a shared understanding of the correct leadership and management methods to attain the stated goals in the Malawi Health Sector Strategic Plan II (2017-2022) and the Malawi Quality Management Policy by creating a tailor-made programme that addresses the contextual issues that shape the public service and, in particular, the health system in Malawi. An overview of the course curriculum is in Figure 4.5. The Task Team was also advised to incorporate additional 'soft' leadership skills related to emotional intelligence as part of the training programme. Due to funding limitations, the programme will run for one year, with delivery to include two weeks of classroom teaching, practicum, on-going coaching and mentoring as well as continuous online learning.
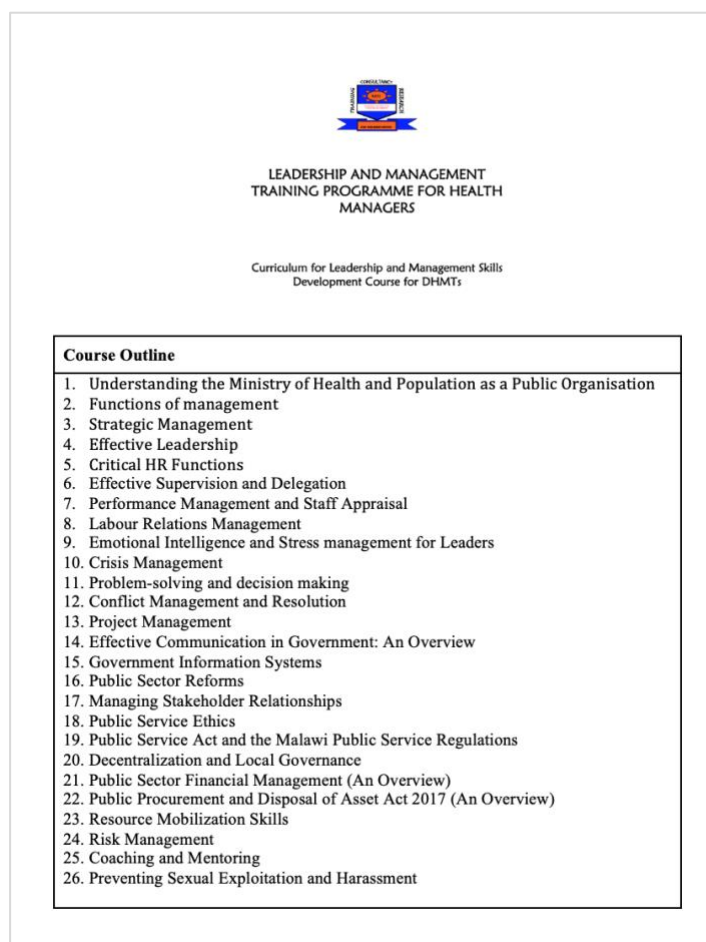
Figure 4. 5 Overview of Leadership and Management Training Programme

4.5.2.2.4. Health Leadership and Management Development Through Rich Pictures

Figure 4.6 represents a rich-picture developed to capture the complexity of initiatives and methods used to develop health leadership and management for HSS in Malawi. This picture involved diagramming and mapping of the context, to understand 'how' health leadership and management was being developed through the outcomes of the documentary review and descriptive overviews provided by stakeholders. It is therefore a progression from the initial images displayed in Chapter 3.6.4. The explanatory visual describes current efforts and processes to strengthen the health system in Malawi.

Figure 4. 6 Rich picture of the different methods and approaches being used for health leadership and management development

4.6 Chapter Summary

This chapter introduces Malawi as the case study for this thesis and presents the results of the desk review towards offering a comprehensive description of the healthcare system in Malawi; the structure of the health system under decentralisation; how health systems strengthening is being tackled, focusing on (i) health financing and (ii) efforts to develop Health Leadership and Management as part of addressing key gaps in human resources for health. The results are synthesised to put forward a thorough description of key stakeholders working to strengthen leadership and management in the context of Malawi. Results also highlight challenges and strengths to previous and current efforts to HSS and evidence a need for a greater understanding for how health leadership and management is being developed in this context.

Moreover, results evidence that current leadership and management efforts are seemingly focused on some districts and not others, with a prevalence of donor dependency when it comes to financing and supporting current types of interventions being used by the MoHP and its partners to develop health leadership and management. So, while many methods are currently being employed in a concerted effort to strengthen health leadership and management, underpinned by a range of strategies and documents highlighting the importance of leadership and management for HSS, evidence for how these approaches are implemented in practice, however, are unclear. Consequently, and consistent with the broader literature, the evidence for the effectiveness of strengthening health leadership and management in Malawi remains scarce. Moreover, it is unclear how health leadership and management is conceptualised within the context of Malawi. The following Chapters 5 and 6 therefore draw on a range of methodologies, as outlined in Chapter 3, to elucidate how people understand health leadership and management in the context of Malawi, as well as "why" and "how" these various leadership and management practices are being implemented, *from the perspective of key stakeholders themselves*.

Chapter 5: Perceptions of Health Leadership and Management

5.1 Chapter Introduction

Having introduced and described efforts to develop health leadership and management within the context of Malawi, as emerging from the desk review, Chapter 5 reports the findings in response to objectives two (To describe how key stakeholders conceptualise and understand health leadership and management) and three (To identify why health leadership and management approaches are being used to strengthen health systems within this context) of this thesis.

Understanding how people conceptualised health leadership and management within the context of Malawi, required exploring the different language used and examples of experiences shared, towards constructing meaning as related to the multiple perspectives, definitions and experiences presented in the data gathered through the research interviews and observation. The use of mapping and diagramming (See Chapter 3.6.4.1) as an analytical tool contributed to making sense of the complexity of the health systems by using a systems lens to visualise relationships, connections and commonalities across the data. Additionally, objective 3 required exploration of people's expectations of the types of outcomes that one might observe following strengthened health leadership and management as a way of understanding why one might want to work towards this. Again, using the tools of soft systems thinking and grounded theory, contributed to identifying these assumptions both implicit and explicit in the data. Specifically, I relied on mapping and diagramming to identify the processes and actions that people assumed would lead to health systems strengthening. Moreover, the use of rich pictures (see Chapter 3.6.4.2 and Section 5.6.6.) developed from the analytical process, contributed to illustrating common assumptions associated with the outcomes of developing health leadership and management, thus provoking insights from others when sharing the findings for discussion, input and refinement towards the construction of theory.

Towards objective two, Section 5.2 introduces the people who have informed the findings of this thesis; Section 5.3 looks at perceptions of effective leadership and

management; Section 5.4 presents findings related to who people think should be the target of health leadership and management development; and Section 5.5 identifies common traits, characteristics and factors associates with ineffective leadership and management. In fulfilment of objective three, Section 5.6 offers insights into why, according to key stakeholders, health leadership and management is being implemented as a strategy for HSS in Malawi as well as what key stakeholders expect will change as a result of strengthening leadership and management in this context.

5.2 Voices Behind the Findings

Core to this thesis are the findings that emerged from the conversations and interactions that took place with the 37 participants who agreed to take part in an interview. Qualitative interviews were conducted with a diverse group of individuals, with the intention of drawing on a wide range of perspectives across the health system as a way of gaining a more holistic understanding of the context. While participants had varied backgrounds and a different range of professional seniorities, all had experiences of health leadership and management in Malawi. Participants therefore included individuals from HRH programmes (both MoHP and external), national and international research institutions, funding bodies, health council representatives, NGOs and development partners, MoHP government directorates, and health workers from health care institutions at all levels of the health system in Malawi. Roles varied from desk-based to implementation, senior management to middle management, health facility in-charge to supervisor, principal investigator to research assistant, programme management to project management, clinical to non-clinical, policymaker to practitioner, funder to non-funder, district to primary, and primary to community. Moreover, participants often had overlapping roles.

Most of the participants were from Malawi (23) and the remainder from countries in SSA and Europe, as well as North America and Australia. Some individuals mentioned that they had worked in health-related roles in other countries such as the Philippines, India, Ireland, UK, Uganda, Ghana, South Africa, Sierra Leone, Ghana, DRC, Zimbabwe, Senegal, Canada, USA, Sudan, Tanzania, Kenya, Swaziland, Ethiopia, Mozambique, Lesotho, and The Gambia.

Years of experience working in health ranged from a minimum of six years to forty years. Such work experience spanned across many different fields and disciplines, as illustrated in Figure 5.1.
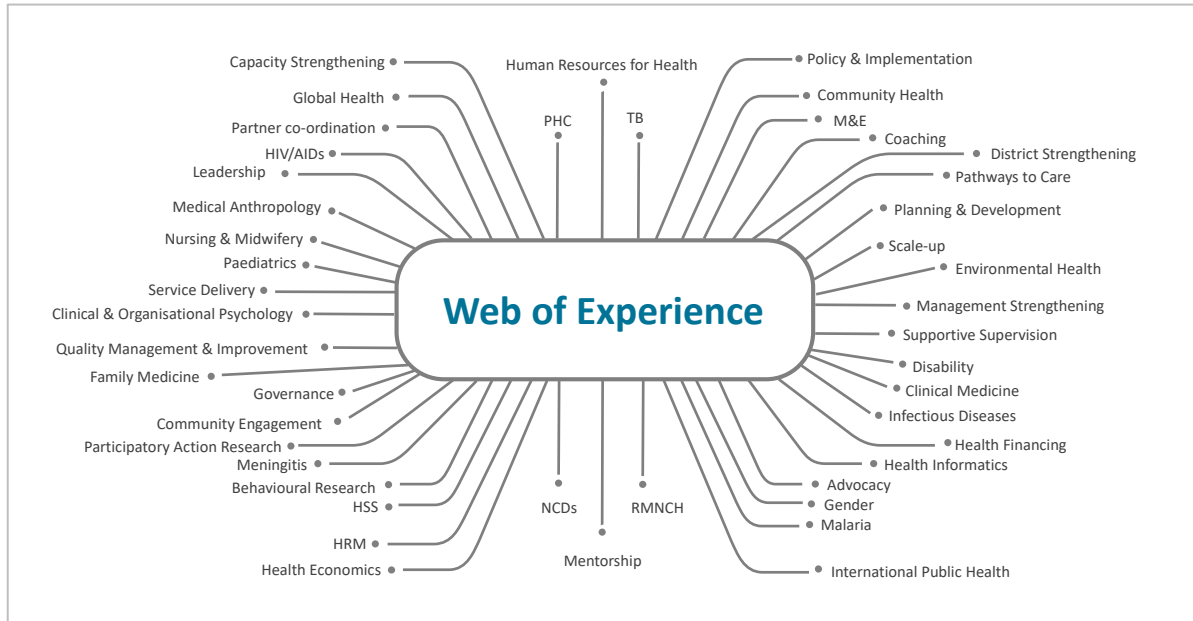
Figure 5. 1 Participants' Expertise

5.3 Meanings of Effective Leadership and Management in Malawi

As discussed in Chapter 2, there are many definitions, styles and understandings of leadership and management. As such, it is important to explore and identify how these concepts are understood and expressed within the context of Malawi. Generally, leadership and management were seen as similar constructs, with participants using these terms interchangeably across interviews. Only in the case of who should be "in-charge" did a distinction arise (see Section 5.4). This interchange between the terms was also observed in the leadership and management taskforce meetings as well as in government policy documents and strategies. Unless otherwise stated, findings therefore reflect a range of perceptions of what comprises effective leadership *and* management, as communicated during interviews, as well as through my own observations and informal discussions.

5.3.1 Common Characteristics, Styles and Traits

While those individuals (e.g., researchers, leadership coaches, some senior MoHP representatives) more familiar with the theories and literature around leadership and management had a tendency to refer to specific leadership and management styles, those less familiar with the terminology (implementers, frontline HCWs) were still able to allude to or mention common characteristics and traits associated with effective leadership and management. These mentioned traits and characteristics associated with effective leadership and management are presented in Figure 5.2, with those in larger font representing traits that were frequently cited. The following section discusses the results for those traits that were most commonly mentioned.

Figure 5. 2 Identified Characteristics and Traits of Effective Leadership and Management

Across the dataset, participants had various individual opinions on what they considered to be an effective way or example or "model" of what constitutes an effective leader or manager. With experience working on both the frontline in Malawi and as a health systems researcher, one of the participants spoke of *transformational leadership* as "a perfect model of a leader…who can lead by example, that is leading by being with the people and learning together, and correcting mistakes together" (P13_Female_Healthcare Worker). In her experience, there was a need for leaders and managers in Malawi to focus on interpersonal relationships and to have more contact with people on the ground. While the participant referred to the "perfect model", she also acknowledged that all those in leadership and

management positions should also be ready to learn from others and "appreciate that I have my subordinates but there is something that they can bring that I can learn from" (P13_Female_Healthcare Worker). In contrast to this view point, other participants considered hierarchy to be an important factor in determining an effective leader to be someone who "is getting people to do what they do and look up to them" (P6_Female_Researcher) or "There is that up down relationship that what is said above is what is supposed to be done down there" (P34_Male_Healthcare Worker). Yet again others, such as those working on the frontline, perceived an effective leadership and management style to be one where a leader "leads by example": "When you are in charge of the ward or you are supervising others, if you are working hard I think the rest of the team also works hard, and if you don't work hard the rest of the team won't work hard" (P5_Female_Healthcare worker).

Another participant introduced the concept of *servant leadership* to the interview, explaining it as: "how do I help you guys do your job properly…and making sure that everybody is working to the same idea of what we as an organisation are trying to do here" (P7_Female_Researcher). From the meetings that I attended, those involved in developing the leadership and management curriculum for DHMTs identified *strategic leadership* as an appropriate style for the Malawian setting. While there was no point in which "strategic leadership" was specifically defined, it was made clear that the task team envisaged "public servants [as effective leaders and managers] to put public interest above self-interest, demonstrate high standards of professionalism and ethics…and to acquire necessary knowledge, skills, and attitudes that will initiate a process of change" (Leadership and Management Training Programme for Health Managers, 2020). Moreover, participants deemed both technical and soft skills as essential for effective health managers.

5.3.2 One's own style

Effective leadership and management were also referred to through examples of one's own style of leadership and management, and how people perceived their own individual styles to demonstrate best practice. One nurse participant, recalling a time that she initiated a nurse-led hypertension clinic after receiving numerous stroke patients to the clinic, felt that using her initiative in work had proven to be so effective in getting support from others and buy in from her colleagues that it was scaled to other districts. Another nurse participant

spoke of how she had spent time establishing a motivated team and a well-equipped ward, citing this as the reason for why other departments in the hospital were referring others to her and her team's care:

> I remember one time there was a clinician in OPD, orthopaedic clinician. There was an accident. They said 'no, this is a child, let's go to the paediatric ward because they are more organized, they have a nice emergency room, I think even the team is supportive we will manage well with the child there'. Then they rushed from the OPD, but in real sense the OPD should be the one that is well equipped, the ward is just the ward. Then they rushed the patient to the ward where we managed that patient because we set a system where we wanted to motivate them [the staff]. (P5_Female_Healthcare Worker)

When probed on what aspects of her style of management she thought were motivating, she responded that "it's because of how you work with them [the staff], what the relationship is like, that is also what matters a lot" (P5_Female_healthcare worker). A former nurse-in-charge spoke of her efforts to ensure that she checked with her colleagues when she was unsure of a decision she was about to make. Talking of times when she had to cover management of unfamiliar hospital wards, she would take the time to ask the staff for advice on how challenges that arose are usually dealt with in their particular ward. A researcher with theoretical expertise in leadership and management development identified with the perspective of the former nurse-in-charge, stating that "one of the fundamental skills for any successful leaders, is having insight to their own capabilities and weaknesses" (P4_Female_researcher).

Commonly, other individuals exposed to health leadership and management training were more reflective on their own styles of leadership. This was apparent at meetings that I attended where advocates of strengthening leadership in the health sector would be keen to share their reflections. Another example provided was of a DHO who had attended leadership training outside of Malawi. The participant described a change in how the DHO was able to manage partners in the district using the example of an NGO partner who had come into the district wanting to implement an intervention at the health centre, without passing through the DHMT. While reportedly not uncommon for NGOs to do this,

the DHO, in this instance felt he had the "confidence" to manage the situation by calling everyone together in a meeting which led to "a very good outcome where everybody was happy with the next steps" (P32_Male_NGO).

5.3.3 The Privilege of Skills and Training

While "inspiring" people with the "right personalities" (P10_Female_Researcher) were acknowledged as desirable traits, another common view across the dataset was that effective leadership and management is not innate, but rather learnt through experience, and therefore requiring training and the acquisition of skills. One participant involved in designing leadership and management programmes stressed that such skills are not necessarily unique to certain individuals, citing "we call them leadership skills but basically they are the skills you need to do your job well, whatever that job happens to be" (P2_Male_Implementer). At a leadership and management training session that I attended with health researchers in Blantyre, a similar sentiment was expressed by the facilitators of the training. The facilitators emphasised the importance of people opening their mind to what being an effective leader means and how everyone has the potential of learning how to be an effective leader through skills acquisition.

A health-centre in-charge also talked of leadership as something that you learn, and by learning, he explained that there will be a change in one's own perspective as well as in the perspectives of your peers. His thinking is illustrated in the following quote:

> If you send me to school today, when I come back, the way I see things will be different. Let me give you an example of theology. If someone is just a known evangelist, then you send him to school, when he comes back, the perception that he had towards the pastors will change because him now, is a member of the pastorship. So, it means that even the conceptualisation of things will change. (P34_Male_Healthcare Worker)

While this individual had not received any official leadership or management training within his current role in the health system, he had taken the initiative to study to gain some knowledge on leadership skills. Describing the opportunity to be an in-charge and a

manager, as a "privilege", he also referred to those who had received leadership and management training in the health sector as being privileged to have received the opportunity of education. This idea that one is privileged to receive training in their role of work was also perceived as a debt that should be repaid: "When I come back from school, I need to pay back a loyalty to say that these people owned me. Let me serve them over this period…it means I am giving back what I received from them" (P34_Male_Healthcare Worker). Similarly, the concept of "privilege" appeared in an informal chat with a senior MoHP director and doctor who described his opportunity to study as something that he recognised as an opportunity only very few people would be selected to do in Malawi.

Providing people with an understanding of what skills they might need, how they might develop them, and how they might support each other, were all considered contributing factors to effective leadership and management and doing a job well. These skills were also reflected in a leadership training I attended in Malawi, described under the following domains of visions and decisions; communication; managing people; and emotional intelligence.

5.3.4 Strength in Numbers

Multiple stakeholders expressed the effectiveness of leadership and management as either the power of the individual or the strength of a team. While it was acknowledged that "the literature around developing leaders usually focused on the notion of an individual" (P4_Female_Researcher), there was consensus across the dataset in the strengths of teamwork. One participant had the viewpoint that "one leader, whether it's a CEO or manager or whatever cannot know what's happening and be responsible for everything that's happening in every aspect of the organization all the time" (P4_Female_Researcher). This thinking was echoed by another who felt "that in as much as you are a leader, you can't do it all by yourself. For you to make the health system work…you also have to understand the fact that it's all about teamwork, so you need these people to work together with you, to produce the right results" (P6_Female_Researcher). Teamwork was also associated with "power" bringing with it "a synergy that comes with multi-disciplinary" groups (P11_Male_Researcher).

One participant spoke of how effective leadership and management should comprise of skills that lead to individuals' thinking of others rather than themselves "because people need to see how they can potentially inspire others to do better and know how another person doing better isn't going to make you look bad" (P1_Female_NGO). In contrast, a senior researcher from the UK, saw the value in thinking of oneself in terms of reflection: "It's not just about how you behave towards other people but also about yourself, and change can only come when you also change yourself" (P37_Female_Researcher). A couple of participants involved with health leadership coaching and mentorship, perceived effective leadership to be the combination of focusing on the individual to the degree that they can understand what skills they might need and take responsibility for their own learning, and then proceed by working on supporting others in their team or within a group. The idea of knowing one's strengths, but also supporting the strengths of others, also formed part of discussions at the various meetings I attended around developing health leadership and management in Malawi, as reflected in teaching focusing on the individual (as an effective leader and manager) as well as on team building and group dynamics.

With experiences of working in research around HRH in both SSA and other settings, a researcher from Europe talked at length about the "newer" concept of collective leadership as a model of leadership "that takes pressure off of the leader and it uses the collective intelligence of the team" (P4_Female_Researcher). The participant spoke of team effectiveness as a key component of health care performance, covering areas such as effective communication, effective goal setting, responsiveness in a crisis and decision-making. While she acknowledged that there was little written about this type of leadership style in SSA, her experience in Malawi led her to believe that it would be valuable in a context that had limited resources, "where you have leaders who don't necessarily have great skill sets" (P4_Female_Reseracher) or access to proper training. Giving an example of a European country where it has just been introduced as in intervention within a hospital setting, she emphasised the distinctiveness of the approach from other leadership approaches in that collective leadership approaches can be simultaneously introduced at different levels of the system, ensure that it is not solely for introduction within districts, for example. She described the idea of collective leadership as getting away "from the individual impact assessment, looking at collective impact and looking at how people, how agencies, how individuals can complement each other in terms of development or improvement or whatever they are doing" (P4_Female_Researcher). Taking a collective

approach, also contributed to "creating a sense of ownership" across a team (P37_Female_Researcher).

Across the dataset, there were several examples provided of how focusing on the whole team, rather than just on an individual, had been effective in Malawi. Based on a training that I attended, a participant involved in leadership development training spoke of the impact of the leadership management training on a group of individuals involved in health research. Following the training, he stated that "they now really work for each other, and they don't compete against each other, and that's why they have such high success rates in getting international fellowships because they support each other" (P2_Male_Implementer). A former DHO spoke of the effectiveness of her own management team when going to conduct supervision at a primary health facility. She said shared teamwork worked well because, as a clinician, she would understand the challenges that the clinicians were facing, and the District Nursing Officer would, in turn, understand the challenges that the nursing staff were facing in such a way that the expertise was spread across the team. Another participant involved in implementation research at primary level, witnessed a transformation in teams at primary health facilities after introducing a triage intervention that required the whole team to come together in different capacities to identify, prioritise and respond to severe illness in children. Taking a context-driven approach to each individual health facility, the participant felt that the intervention worked well because:

> Everyone was focused on something that they could all contribute to and
> something that they could all say that 'we think this is important'…it was
> creating a sense of ownership and I think there was a collective ownership
> because it was at all different levels (P37_Female_Researcher)

Whether an individual or a team, the importance of effective leadership and management involved impartiality and balance: "as a leader you are not supposed to be siding with only one side. As a leader, you need to balance it up, like even a small cake, you make sure that you are sharing it to all programmes at the district level (P21_Female_MoHP). The emphasis on displaying equality, was also combined with the need for "consistency" and "stability" at central level (P32_Male_NGO).

5.3.5 Supporting Others

Effective leadership and management was perceived across the dataset to include supporting your teammates as well as supporting others at different levels of the health system. Such thinking also extended to include support for leaders and managers, ensuring that they are also nurtured and that any training on effective leadership and management was more than just a one-off exercise or cross-sectional training. When discussing the duration of the training for the health managers in Malawi, the same point was made by individual consultants who stressed the need for programmes to have significant longevity to ensure sustainability, ongoing coaching and mentoring and time for trust to be built. The consultants also argued that "individual skills as well as work culture take time and constant reinforcement to develop and grow" (Researcher's notes, 2020). One participant echoed this thinking:

> I mean it's a bit like saying well, I have my anti-hypertension medication you know for three months and then I will stop…you know the dose of the intervention has to be sufficient, as I say, in skill and quantity and duration and consistency so really when you are talking about whatever the management intervention is, that has to be defined really well, rather than just assuming that somehow a one off course will work (P2_Male_Implementer)

This idea of ensuring leadership and management development has ongoing support was also reflected in what other participants said about effective leadership and management requiring elements of coaching and mentorship. In this sense, not only do the health workforce require coaching and mentorship but so do those in leadership and management positions.

Overall, effective leadership and management emerged as requiring a supportive environment. Development partners and those in senior positions within the MoHP, including doctors and policy makers, mentioned supportive supervision frequently as one of the key areas targeted in response to strengthening leadership and management practices. Supportive supervision was described as something "transformative" (P13_Healthcare

Worker), "part of motivation" (P28_Female_Development Partner), and able to bring about change within a system. A senior MoHP supervisor, described supportive supervision from personal experience as "very ideal…the doing it together" (P17_Male_MoHP). Another participant considered supportive supervision to be an output of strengthened management and a tool for strengthening performance and service delivery. While supportive supervision was most often raised as the responsibility of the DHMTs, some participants did mention supportive supervision in relation to other cadres across the health sector.

The same senior MoHP supervisor, also a medical doctor, spoke of what effective supportive supervision meant to him:

> Ideally, we are all supervisors. Equally the HSAs themselves, they have got volunteers (village health committees), they supervise as well. So basically, every health worker, be it the front-liner, they are supervisors, supportive supervisors (P17_Male_MoHP)

This participant explained his style of supportive supervision, emphasising the best way to do it in Malawi:

> So, it depends on us the supervisors, that the approach is not fault-finding. If you are going there by virtue of trying just to get data to please your boss then usually that approach is not advisable. You should accept that you are part of the problem and part of the solution. So, when you are approaching there, once you have finished with the supportive supervision you don't start with the negatives, you always start with the good things. They are doing well, and you also make commendation that because we also supervised district A or health facility B in the same district they are not doing well as here. You are doing well, so we recommend to other health workers, DHMT members etc to come here and be mentored by you. That is the first thing, as a supervisor, that you need to encourage them. When we approach like that usually they really take the ownership of the exercise and they feel they are doing something worthy and they really enjoy. Whatever plans you put across, they will

be doing them with an openhanded approach. So that's the first thing of

the supervisors, to encourage them" (P17_male)

In an additional account of effective supervision, another medical doctor viewed supportive supervision differently, emphasising how supportive supervision helped to keep people in primary health facilities in check: "So, I think it was difficult for one person to misbehave at the health centre because they knew someone else was going to report them. That was what was important about supervision" (P29_Female_Healthcare Worker). In contrast to this, effective supervision was understood by one participant as DHMTs being able to go to PHCs and:

> Monitor whatever is happening, coach even the health centre management, ensure that the health centre management, for example, are conducting even the staff meetings, that the rosters are always there, but they are able to make sure that people are in uniforms, at the right time they are coming to work (P24_Female_NGO).

Those involved in the implementation of supportive supervision interventions, emphasised how their approaches focused on supporting DHMTs to sit down with health centre teams to provide feedback: "When we are supervising, we supervise as a team and we sit all of them down and we discuss with all of them, come up with issues and a work plan" (P25_Female_NGO). One implementer described how they included mentoring and coaching as part of the training on supportive supervision, and ensured that all members of the health facility, including the security guards and cleaning staff, would be briefed on what challenges were present and asked what they thought could be done to address these at the end of their supportive supervision visits.

While there were fewer examples of supportive supervision interventions taking place at community level, those actively involved in these interventions mentioned positive experiences emphasising, for example, how well HSAs responded to different approaches to supervision that involved their peers, such as senior HSAs or health centre supervisors. For example, one participant explained that the HSAs felt safe in expressing that they could not do something and to be able to ask for help or guidance, unlike when DHMT members were coming to supervise. As one participant said, "it's about your

colleagues, your peers, keeping an eye on you because if one of you did badly it will reflect on everyone and therefore people will be more inclined to try to hold each other to account or help each other" (P7_Female_Researcher). The same participant described effective supportive supervision as a mechanism to "feel skilled and competent and to have some level of agency, and pride in the work that they were doing" (P7_Female_Reseacher).

In understanding how participants evaluated the effectiveness of supportive supervision, the most common response was connected to visible impact reflected in "improving indicators" (P17_Male_MoHP). One intervention lead said: "we will go to look at impact…and we should see that this supervision has improved performance of the health staff which we can only ascertain if we go with a survey (P18_Male_Implementer). The focus of another intervention was on how many actions had been completed between one supervision visit and the next: "we are emphasizing that we would want to see how many actions have been implemented, so we are getting those documentations that indeed in these facilities, the last we went, we found these issues but next time we went, they had been resolved" (P24_Female_NGO). Another way of ensuring supportive supervision was to assess whether problems identified and subsequently addressed within one specific disease area (i.e., HIV) were also addressed in other disease areas (i.e., TB,). In this case, DHMTs were supported to integrate the supervision and to supervise all disease programme areas, which reportedly "improved the whole morale of all the health workers available at that site" (P28_Female_Development Partner).

5.3.6 The Hardware and Software of Performance

Where supportive supervision is effective it was largely assumed, by researchers, development partners and senior MoHP stakeholders, that this would translate to improved health workforce or system performance. This perspective was commonly expressed both in interviews, apparent in the documentary review and observed at different forums during the research process. Contemplating what performance means, a health researcher from Europe stressed the importance of understanding what performance might mean to different people and how it may vary across different leadership styles. For example, this same participant was of the opinion that in Malawi, DHMTs tend towards looking at overall

performance in terms of health indicators. She explained that performance is not so easy to measure and may also include how people engage with their job, their enthusiasm and competency levels, but also agreed that others "might consider performance to not be making any huge cock-ups rather than doing your job well and making people feel entitled to be in the health facility" (P7_Female_Researcher). Several participants, however, did mention that performance is typically monitored using custom indicators, whether it is to see whether the addition of health workers has made any difference to health indicators or to assess the quality of data gathered in the districts. On the same topic of quality, one participant mentioned that "when you talk about health workforce performance what would come to my mind is the ability of the healthcare workforce to provide quality care" (P13_Female_Healthcare Worker).

One HRH technical advisor described individual performance as how people perform according to their job description, "so if they are doing things less that what is required of them, it means then they are not performing" (P20_Female_NGO). She went on to emphasise the importance of performance appraisals in motivating staff "because if someone is working and there is no performance appraisal, they will just be doing what they feel like doing" (P20_Female_Development Partner). Reflecting on performance, a health systems researcher involved in management strengthening admitted that effective leadership and management really means paying attention to the "software of performance" (P11_Male_Researcher) and not just declaring that a district is performing well based on reporting on all key indicators. In his understanding, this meant to consider "what is their (HRH) relationship with the people they work with, with the population they serve, what is the context within which they work, is it enabling enough, do we need to do something to improve on that" (P11_Male_Researcher).

5.3.7 Building Relationships as Motivation

The "software of performance" was most evident when participants working on the frontline shared similarities and examples of effective leadership and management from their own work experience and relationships. When reflecting on experiences of good management within the health system, one participant provided an example of a manager that she had once worked with, describing his style of management as different in that "he

believed that every health worker should be given an opportunity to manage a certain programme within the district", which motivated her to try something that she did not feel she had the confidence to do (P36_Female_Healthcare Worker).

One medical assistant described a DHO that he had been working with in Zomba whom he valued based on the way he treated others: "The DHO has decided to buy you shoes like they know your sizes, so you were going there to say I put on this size, to you it was a motivation to you, like these people really care but still the same money from the government" (P34_Male_Healthcare Worker). The quote emphasises that the DHO was getting paid the same money as other DHOs but was still prepared to invest in his staff. Talking about another effective DHO, a healthcare worker provided an example of a DHO who took the time to go out into the primary health facilities at random times to check on how activities were on the ground:

> There was a certain DHO, that DHO was able to go in the facility at any time, even during the night just to see what is happening, and he could identify that some clinicians have been caught. I remember another scenario he called for a clinician, he was like a patient sitting in the queue then the clinician came, and when he came in the clinician was just on the phone for about 20 minutes or so. Then when he went to come and start consulting he just identified that it was the DHO (P05_Female_Healthcare Worker)

This participant stated that effective leaders in Malawi needed to be as "provocative" as this DHO was, and that his actions were perceived as motivating to both the support staff at the facility and to the community members. This former DHO in question, also shared some of his own reflections on his perception of effective leadership and management during an informal conversation where we met, describing his own style of management as involving the community as "watchdogs" in holding HRH to account. One of his first actions as a new DHO was therefore to focus on the health committees at primary facilities as a way of establishing more accountability in the system.

5.3.8 Accountability Breeds Responsibility

The concept of accountability emerged frequently, both in interviews and in interactions at meetings, both formal and informal, on the need to strengthen accountability mechanisms in Malawi. For example, one participant stressed the need for organisational leadership to ensure the provision of quality of care; improvements in quality being associated with accountability. This participant emphasised for people to not only know that they are accountable but to "feel" (P13_Female_Healthcare Worker) that they are accountable for their actions. With accountability thus came the importance of both assigning responsibility as well as being responsible. Such levels of responsibility should be reflected in "whatever we do. We are accountable to the people who we are providing care to and also to the community at large" (P13_Female_Healthcare Worker).

Moreover, accountability was raised as important to ensuring trusting relationships with colleagues. As one participant described:

> I feel where the management is transparent, the DHMT members are transparent, they are accountable, they support their staff and they involve their staff in planning and what have you, you will find out that there is, you know, a good working relationship with the staff but where staff see that, you know, they are not really sure about their DHMT members, they are not accountable, they have doubts in these areas then they start to, you know, react (P16_Female_MoHP)

The above quote recalls elements of collective leadership, which also emphasises the importance of collective leadership. It was felt that with collective leadership comes "collective accountability" to "each other [colleagues] and also collective accountability towards communities you serve" (P37_Female_Researcher) such that "collectively we have a responsibility to ensure that this is a safe environment" (P4_Female_Researcher). This emphasis on collective accountability was based on ensuring that it is not just one person's responsibility to be accountable, but that each and every person should be responsible, and therefore accountable.

Accountability to the community was said to be most effective when community members were actively encouraged and empowered to get involved with their own health. Social accountability was therefore put forward as an example in Malawi of an effective way to ensure that leaders and managers are involved in addressing health system inefficiencies. As one participant said, "it's the role of the community which we expect the governing structures to leverage and take advantage of" (P17_Male_MoHP). In this sense, community representatives were also described as being "accountable to demand the services" they need through existing structures, such as the HCMCs. With community members being in closer proximity to the primary health facilities, there were more opportunities for the providers to work closely with those who use the health facility. HCMCs were thus considered to be "a bridge between the health workers and the community" (P35_Female_NGO). Participants largely involved in development work and NGOs shared similarities in their enthusiasm for social accountability interventions. A participant involved in training the HCMCs, explained how she had witnessed relationships improving between providers on the frontline and community members: "People have gained trust in the health workers, if they tell them there are no drugs, they know, okay, our friends are in the committee, so they know there are no drugs" (P35_Female_NGO). The participant went on to tell the story of the aftermath of introducing HCIGs and strengthening the HCMCs:

> After we had done the pilot, we saw the potential in them (HCIGs). There was a change because people could just come to the facility to clean up the facility. People could come to the facility and see if they can buy batteries for a BP machine and see if they can help in some way or the other. It has achieved much in little time (P35_Female_NGO)

Another participant connected to social accountability initiatives spoke of the "overwhelming" (P27_Male_NGO) change from leaders at the health facilities and within the community. For example, one health facility collaborated with its HCMC and managed to purchase medical equipment such as BP machines, thermometers, maternity gumboots, and torches; items that they had did not have nor did they think they would have for years to come.

5.3.9 Having Space to Think and Authority to Decide

Common across the dataset was the idea that effective leadership and management involved having the space and authority to make decisions. While decision-making autonomy was most often discussed in terms of the district level, some participants also stressed the importance of this at other levels of the health system. Reflecting on what effective leadership and management means, in her experience, a researcher from outside of Malawi commented on the need for health facility managers to have enough "decision space" to be able to implement change and thus be effective. She explained that when managers have limited resources, there is a need for them to be "more creative" (P10_Female_Researcher), but that creativity also requires space and autonomy.

In Malawi, the DHMT was consistently identified as the place "where all the decisions happen. It's their job to make things happen, that's where the power is" (P4_Female_Researcher). To make effective and evidenced-based decisions, it was also deemed important to possess the knowledge and skills on effective data utilisation. For example, a leader in a district 'should be able to make decisions, and to see where the problems are coming from [based on being able to] look at their epidemiological data of all disease areas and see where these problems are coming from" (P28_Female_Development Partner).

5.4 Who are the leaders and managers

In addition to the key characteristics that define leaders and managers, participants across the dataset also alluded to *who* is considered as leaders and managers in the context of Malawi, as the primary targets of efforts to develop and strengthen health leadership and management in this context. While it was acknowledged that there are various people in the health sector in leadership positions, for example programme co-ordinators "are leaders in their own way" (P16_Female_MoHP) and health centre in-charges "are leaders in their communities" (P37_female), those individuals or team most commonly identified as leaders and managers were the DHO (now DDHSS) and/or DHMT. Rarely were participants more general when talking about leadership and management positions, though

one participant did note that leadership and management is about having the "credibility" and the "skills" to lead (P7_Female_Researcher), rather than thinking of specific positions at the district level. Similarly, a senior nurse in the MoHP, argued that who should be in charge or leading should be determined by pre-determined criteria such as appropriate qualifications and experience, rather than cadre, such that "whoever fits into that criteria should be the leader" (P30_Female_MoHP).

Described by many participants as "hierarchical", the health system in Malawi was described (both directly and indirectly) as a network of power differentials across the health system, often including intersecting inequalities such as gender, race, class, education level, cadre, age, stakeholder status, and patient/provider relationships. Hierarchy was described by one participant as part of Malawi's "tradition" (P13_Female_Healthcare Worker), with another participant referring to those in "top leadership" positions when contemplating effective leadership and management in Malawi: 'If the top leadership realise or recognise that their role is very, very important they then can bring everybody on board and make sure that they are performing" (P16_Female_MoHP).

5.4.1 DHMTs as the Obvious Choice

Consistent with the number of health leadership and management strengthening interventions targeted at district level over the years, the DHMT repeatedly came up as health leaders and managers. This was apparent not only in the interviews but in the numerous interventions targeting DHMTs in Malawi. Using systems mapping, some of the key reasons given for focusing on the management team at district level, are presented in Figure 5.3. The most obvious reasons given were because of the managerial nature of the team as well as their perceived proximity to frontline health workers under decentralisation. Moreover, it was often felt that it should be the "responsibility" of the DHMT to "make sure that they are leading well…and improving the working conditions of the staff not just in terms of salary…but where you have good working relationships …and working within your means" (P13_Female_Healthcare Worker). Given the resource constraints within Malawi, a senior MoHP official agreed that DHMTs need to better make use of resources:

Most of the problems that happen don't really require big resources, but it just needs the management to be you know, to have the right attitude to make the right decisions you know, to manage their staff, to discipline their staff, to put policies in place and make sure that the policies are being adhered to (P16_Female_MoHP)

While there was enthusiasm for DHMT members to be the focus of such efforts (often by development partners and senior MoHP staff), there was a sense among some of the participants with experience on the frontline that "many of the DHMTs may be being led by the wrong person in the sense of the DHO" (P2_Male_Implementer). Another participant involved in HRH research, stated that:

The kind of person that you get, and the skills that they have determines whether they can do the job well or not and somebody who is a fantastically good senior doctor might be rubbish at the logistics, or you know miserable with the paper work, and so I think the wrong people are being squeezed into the DHMT who perhaps shouldn't be there… people getting shoved up, and promoted up into District Health officer or District nursing officer roles without the management experience sometimes without the gravitas and age that you need to be a leader in a society like Malawi (P7_Female_Researcher)

On the same subject, this particular participant felt that "some DHMT members were far too young to be going out and telling older nurse midwife technicians how to behave…so some of it it's about seniority in terms of ability being misplaced (P7_Female_Researcher).

"They are the ones that are closely linked to the [PHC] facilities"

P5_Nurse

REASONS GIVEN TO FOCUS ON DHMTS IN MALAWI

"The DHMT is where all the decisions happen. It's their job to make things happen. That's where the power is"

P4_Health Systems Researcher

Figure 5.3 Reasons to develop leadership and management capacity at district level

5.4.2 Who should be in Charge: "It's a Thorny Issue"

Also apparent when discussing the subject of "who should be in charge", was that this was a "thorny issue" (P18_Male_Implementer), and a source of ongoing debate and conflict in Malawi. One participant described the question of who should be in leadership and managerial positions as an "enormous problem" (P32_Male_NGO), while another felt that their viewpoint might be too "radical" (P34_Male_Healthcare Worker) on the issue. A health systems researcher also described it as "a constant battle about who is in charge and who can tell the other what to do" (P1_Female_Researcher). One participant from an NGO stated that it was "unfortunate, the in-charge, is always a medical person…he has to be" (P25_Female_NGO). By "medical person", the participant was referring to medical assistants, who are generally less qualified than nurses. Certainly, nurses-midwives were most often the subject of debate. For example, it was not uncommon for registered nurses and midwives who are skilled and autonomous practitioners to be under the charge of less qualified medical assistants or clinical officers. As one participant explained:

"You would not have a midwife as a facility in charge, it always tends to be clinical cadres and usually the men…It's incredibly demoralising that you've got somebody who doesn't understand your job and your role, trying to tell you how to do it, with less skills and less knowledge and a lower qualification than you" (P7_Female_Researcher)

When asking participants why they thought it would be unlikely for a nurse-midwife to be the in-charge at a primary health facility, there was a common view from a Malawian perspective that nurse-midwives are seen as less professional than the clinicians. One participant surmised that this might be because, traditionally, women are perceived in the role of carer and used to delivering babies in villages. Therefore, and despite nursing and midwifery being a professional, skilled job, there remains the idea that these roles are lesser than clinical staff, such that the role of "carer" is not valued. Another participant explained that, historically, the nursing profession in Malawi has been largely female, whereas males tended to take on more clinical roles. She proceeded to explain that while there are now more female clinicians, there remains an existing trend of males going for one kind of (more clinical) role, and females, another more care-taking role. Moreover, "someone, somewhere put a policy that says the clinical services are the ones who are supposed to be in charge of the whole health centre" (P20_female). Similarly, a senior female in the MoHP, when asked why she thought there were strong objections to nurses being in-charge of the PHC facilities, suggested that the same question should be asked to the senior men at the MoHP. In her view, the health system is "paternalistic" such that "medicine is selfish. They think only men can run it" (Informal meeting, May 2019), and while she did not agree with the structure, she concluded that this was just "how things were". Similarly, this structure seemed to be something participants felt was something that just had to be "accepted" and "appreciated". As another participant put it:

We appreciated that it was our structure that permitted them to be in-charge regardless of education level because from the health centre like the one it meant that the most person who was most educated there was from the nursing side, at that level I had the masters and other nursing officers had degrees, the in-charge himself had a diploma in clinical medicine but that is how structures are and we appreciated that (P36_Female_Healthcare Worker)

Similarly, another participant highlighted that clinicians are entitled to be in-charge, even in cases where a nurse has already been a leader in his or her health facility: They want to be in-charge because they are a clinician" (P31_Female_Development Partner). Another participant from an NGO said, "we hear that sometimes that there are those talks but you know why is it the [medical assistant] is an in-charge and yet the senior one is a nurse? Why can't the nurse be in-charge? It seems people actually accepted it that way" (P24_Female_NGO).

Talking about the same issue, a participant with experience at both primary and district health level acknowledged that there are plenty of examples of nurses being better trained than the medical assistants "and I think at that point, you should start to think, who should lead the team…but there is a lot of mindset change that needs to happen on both sides…to accept the nurse as in charge" (P32_male_NGO). Referring to the nursing staff within PHCs, this same NGO participant explained that some nurses may lack the confidence to take charge because of the status quo, whereas other individuals or the collective still perceive the role needing to be fulfilled by a medical assistant, clinical officer or medical doctor.

Reflecting on the perceived impact of inaccessibility of leadership positions for nursing staff, participants identified this as "demotivating" (P13_Female_Healthcare Worker):

> It causes job dissatisfaction among the nurses. Some of them run away
> from there. They would rather come and stay in urban areas where the
> senior management is above them but to be supervised by someone with
> a   lesser   qualification   sounds   like   a   demotivation
> (P18_Male_Implementer).

Another participant described the set up of management structures at the primary facilities as "frustrating". Having gone to visit a PHC and finding the only qualified person there was a nurse prescribing medication – as a task she was not meant to perform - he recalled:

> The clinic was running and I said, 'How is this health centre running
> without a medical assistant?', and she [the nurse] said she had been there

for eight months, services were delivered and when I enquired I was told that she was doing that illegally but I said 'the DHO knows that there is no medical assistant?' and she said, yes they were doing that for the sake of service provision but there is a need for an MA to take charge (P19_Male_Implementer)

The same participant also said that nurses have since been allowed to head facilities, but that this arrangement largely exists "on paper; in practice it is not yet there". (P19_Male_Implementer). This reflects a broader sentiment that things may be starting to change. As one medical doctor commented that "I think nurses are rising and coming into leadership now" (P14_Healthcare Worker). This change, however, may not be preferrable to all. As one female medical doctor (and former DHO) responded:

I would leave [the current structure] as it is because it is always good if a clinician is overseeing everything. I know nursing is becoming more important but at the moment I think I would recommend for the medical officer or the clinical officer to be in charge. It would be better that way. I might be saying this because I'm a clinician, but I think it's better to have a clinician. I don't have much experience on that (nursing) so I wouldn't say much on that but I have much experience in terms of being a clinician, looking after a health facility, and if they are serious with their work they really do well and I have never had a problem with that, but if you put a nursing officer there I don't know what level of school it would be but I think you would have problems in terms of the clinical officer and nursing officer. You would have a little bit of problems there. But I don't have any experience of having a nurse being in charge, but for me I've always preferred being that way" (P29_Female_Healthcare Worker)

Taken together, and while there were some differences of opinion on the "who" of health leadership and management, there was a general consensus that training on and understanding of health leadership and management was fundamental. As one non-clinical participant put it: "I know of managers that are totally non-clinical or don't have any nursing background and they are doing a tremendous job" (P11_Male_Researcher). Results from these findings and my observations, however, suggest that the strongest emphasis is

placed on the DHMTs as the first port of call for "who" to target to strengthening leadership and management in Malawi. Under decentralisation, however, it was also put forward that leadership and management development should extend to the MLGRD.

5.5 Meanings of Ineffective Leadership and Management in Malawi

As with effective leadership and management, common traits and characteristics of what people associated with ineffective leadership and management were identified and presented in Figure 5.4, as in Section 5.3.1, with those in larger font representing traits and characteristics that were frequently cited. The sub-categories presented in this section centre on leadership and management being perceived as *weak across the health system*, and therefore requiring strengthening.

Figure 5. 4 Identified characteristics and traits of ineffective leadership and management

5.5.1. "The Blind Leading the Blind"

When asked to recall how health leadership and management was previously nurtured in Malawi before the institutionalised approaches stopped, a common view amongst Malawians was that things were no longer how they used to be in terms of investment in

health leaders and managers. This was mostly with reference to how government-led leadership and management training would have been conducted as part of SDI, as well as training that previously delivered by MIM. Individuals across the dataset largely agreed that, in the past, the government valued civil servants more than they did presently. Such value was reflected in the attention given towards ensuring that people knew what was expected of them such that you would "clearly get guidelines on how the government is run. Every position knew what was expected" (MoHP meeting, June 2019). Speaking of the current situation, I observed one senior MoHP official describe a shift from a previously "effective" system to one that had since been "paralysed" (MoHP meeting, June 2019). By this, he explained that although expectations of the health workforce were very high, the same level of training was not there, resulting in individuals being appointed into positions of leadership and management without training, and without understanding how to fulfil their role successfully:

> The issue is most of our health workers today are appointed and working and nobody trains them on what to do. There are DHOs' appointing in-charges at health centres…so you are an in-charge but nobody has trained that person on what they should do. Most of the DHOs, nobody has trained them on what they should be doing. On how to manage problems that they face. Even at ministry level, we have directors, we have senior officers who don't know how the government systems works. So, it's the blind leading the blind (Senior MoHP official, DHSSi meeting, June 2019)

This quote is consistent with previously mentioned concerns (see Section 5.4) about the "wrong people" being in leadership and management positions. In this example however, the emphasis is on the lack of training and orientation that people are receiving to be able to do their jobs well; not just at district level, but at all levels of this system. Moreover, this quote evidences another commonly shared perspective across the dataset that those appointed are expected to make decisions without being properly prepared or knowing how the government system works. One nurse participant spoke of the orientation and management training that she had received some years before "but I don't see them nowadays…now if they have just come out from school they are managing" (P5_Female_Healthcare Worker). Similarly, another participant explained that, "many

people assume their positions without knowledge or management skills and learn on the job" (P32_Male_NGO). Another participant actively involved in leadership and management training in Malawi spoke of the "classic case in Malawi", also reflected in Section 5.4.2, where the average medical practitioner graduate who does six years of medicine and then internship, and then "two years later they are the District Health Officer because they are a doctor, not because they've actually got any leadership training or potential, it's just simply because they are a doctor" (P2_Male_Implementer). He used the following example to further illustrate his point: "It's like training people to be psychiatrists and asking them to do neurosurgery, you know, it's just not fair to shove people into these situations, without any semblance of the right skills" (P2_Male_Implementer).

The perceived unfairness attached to putting people into positions without skills was further emphasised by a medical doctor, who expressed how "overwhelmed" she felt going into facilities without leadership skills (P14_Female_Healthcare Worker). This sentiment was not unique to medical doctors, however. One participant, working in community health on the ground, stated that the shortfall with leadership and management skills is "the same with the medical assistants and the clinical officers. You find that we have a lot of problems in the health facilities and most of the time it takes a lot of time of the DHMT…they lack these [management] skills, how to solve conflicts, how to supervise" (P21_Female_MoHP). This view was also shared by one of the funding partners: "They [facility staff] don't have those skills to manage the facilities" (P28_female_Development Partner). A medical assistant who was now an in-charge described the feeling from his own perspective: "Even an in-charge acts like a kid because they do not know what to do when they face a situation" (P34_Male_Healthcare Worker).

5.5.2 Unhelpful System of Support

Failure to support others was frequently discussed in relation to ineffective leadership and management. This often came up in discussions around lack of supervision and mentorship: "supporting and mentoring people, at the facility level just wasn't there" (P4_Female_Researcher). One nurse participant could not "recall a time that [she] was supervised by my boss just to see the way I was performing or maybe even for the DHMT to come and supervise" (P36_Female_Healthcare Worker). Implementers on the ground

corroborated the idea that supervision coverage of PHCs by the DHMTS was very low and as "not something that is routinised or that the health worker can count on and it's not always so constructive" (P22_Female_NGO).

When supervision was happening, several participants referred to a "checklist mentality" (P7_Female_Researcher) alluding to the idea that people were afraid to go outside of the box, which thus impacted on quality of supervision:

> I know certainly from the Malawi perspective I felt very strongly that people were doing a tick box exercise but without having the sort of insight into human behaviour, and how supervision is important, to see it as a valuable thing that they were doing, it would improve service delivery. Because the way that the system was set up it was just to assess the facilities themselves (P7_Female_Researcher)

> So, the district management teams spend their times or their time just visiting health facilities and using a check list to say this is here, this is not here, you are doing this, you are not doing that (P4_Female_Researcher)

> I think it would be interesting if you go to the district, just ask for their supervision checklist that they use to supervise the health centres, you will notice that it is more of, I can say, maybe they are interested in supervising the structure: 'the toilet, is it there?' But monitoring on the real care that they are giving to the patient, that is the part that it's lacking so they are just interested in, 'is there drugs in the pharmacy? In the maternity, are there beds there?' (P5_Female_Healthcare worker)

Aside from the "checklist mentality", there was a feeling that approaches to supervision were more about fault-finding and "more of a punitive approach" (P22_Female_NGO). Participants described this approach to supportive supervision as one that attributes blame. From her own experience, a participant described health leadership in Malawi as "transactional; when you catch people doing the bad things you punish them but never remember when you catch them doing the good things and reward them"

224

(P7_Female_Researcher). Another participant working at a primary health facility argued that the term "supportive supervision" should not be used to describe the nature of supervision in this context. In her words:

> I hate that word now, 'supervision' because they go and point out 'here is the mistake, here do this, do this, do that' and there's very little interaction to say, 'what do you think? why do you think this went wrong? How do you think we can do this better?' and I think when there's enough contact and a relationship built, then they can open up and for you to understand that they too have solutions (P14_Female_Healthcare Worker)

The absence of supportive supervision, some participants outlined, resulted in a range of adverse behaviours, including theft, demotivation, over referral, low job satisfaction, poor quality of care and mismanagement of patients. Linking quality of supervision to quality of care, one health systems researcher based in Malawi stated that to most supervisors in Malawi "the focus is treating the patients. How they are treated is not as important" (P19_Male_Implementer).

The identified areas of over referral and mismanagement of patients were also associated with a lack of mentorship, as a key component of supportive supervision. One senior MoHP official agreed that "the issue of mentorship needs to be looked at seriously and focused on" (P17_Male_MoHP). Another MoHP participant spoke of past years when "a lot of senior people were there to support you, to mentor you until you were now also ready to take up that role…but this is now lacking this time because there are fewer nurses on the ground" (P16_Female_MoHP). She went on to explain that this current lack of mentorship means that staff "can't make decisions" (P16_Female_MoHP). One health systems researcher spoke in an informal context of her research around improving recognition of and response to severe illness in children at primary level, noting that many PHC facilities were over-referring because they were not mentored well in managing the children at the health facility, therefore increasing the workload at tertiary level. She also noted that there was a notable lack of encouragement for people to work together as a team within the health facilities, whereby encouragement would generally form part of an effective supportive supervision approach.

5.5.3. Me, Myself and I

Discourse around teamwork was also often raised in connection with perceptions of individualism and collectivism. There was a sense amongst those focused on developing health leadership and management that teamwork was an area of concern and that there was a "need to be thinking about the whole team" (P32_Male_NGO). The majority of participants commenting negatively on the individual versus the team were from outside of Malawi. One participant commented that "what I have noticed in Malawi is, particularly amongst medical and health people, they are not trained to work in teams" (P2_Male_Implementer). Similarly, one DNO agreed with this observation, commenting during a district strengthening meeting, that those in charge were carrying the burden alone because they were not willing to become part of a team.

A participant from Europe who had been working in Malawi for some time spoke of the institution she worked in as having "suffered a lot from individualism" (P1_Female_Researcher). In her view, the individualism in Malawi stemmed from one's need to make enough money to support one's extended family, as well as a perceived need to ensure others did not impact on their own career progression:

> I think as a country, even if you're a doctor, you are still earning a pittance and you're the one in the family that's done really well and now it's your responsibility to send all your brothers and sisters and siblings and their children to school and university as well etc. etc. so you are always fire-fighting…it's nice in the way that family supports each other but it's damaging in terms of anyone showing any real altruism on any level, in terms of their job or in terms of their capacity building others…I think that's when the leadership and management training is so needed because people need to see how they can potentially inspire others to do better and know how another person doing better isn't going to make you look bad (P1_Female_Researcher)

A number of participants argued that individualism was not restricted to Malawi stating that "there is very little focus on team development in any health care system" (P4_Female_Reseracher). Another agreed, commenting that "the health service itself has traditionally been quite individualistic" with health professionals usually being encouraged to "believe in themselves as individuals" first and foremost (P37_Female_Reseracher). This participant understood individualism as something inherently "western" and contradictory to a "commonality" that is more inherent, in her opinion, to SSA or Malawi. When asked to explain her thinking with examples she discussed the "constant battle between an individualistic approach and team approach" (P37_Female_Healthcare Worker) to health care in Malawi. This clash was attributed to the belief that there was an "imposition" of an international system onto a national system because many clinicians had been trained outside of SSA and therefore "been exposed to an individualistic attitude that they bring back here" which clashed with the "concept of commonality" in settings like Malawi. This "clashing", she surmises, represents a current "clash between traditional values and modern values within the health system" (P37_Female_Researcher).

5.5.4. Protecting Power

Individualism, in turn, was further linked to the perceived associated power that comes with being in leadership and management positions. As one Malawian implementer put it:

> if you're in power, I think it feels good, it's like you own everybody and so even though we embraced democracy you will still see traits of that in people each time they assume leadership positions (P15_Male_Implementer)

The same participant explained that people wanting to "protect their power" was associated with leadership from the past. Instead of focusing on how to bring others onboard or to work together he concluded that "things failed miserably…because they are all concentrating on the power and how to protect the power not to be taken away from them" (P15_Male_Implementer). He used the example of a chairperson: "Starting from the village, a mere chairperson will give people problems simply because he's a chairperson.

So, you see it happening at each and every level" (P15_Male_Implementer). In his opinion, there was too much "pomposity" in the system.

Relating this to the health system, other examples were provided of how people protecting their power ᵥᵥas perceived to constitute ineffective leadership and management. A medical assistant provided the example of his former boss who refused to work his evening shifts (P34_Male_Healthcare Worker). His boss' attitude was that he was only there to "supervise people working…and the rest of you are just like hoes to be digging" (P34_Male_Healthcare Worker). When the participant then brought the matter to the DHO, asking for extra clinicians to help support him in the shifts at the health facility, he recalled that the DHO refused to help as the in-charge was his friend. In his own words: "It's intense knowing that they have the privilege of being heard and yourself is the one who cannot be heard…the in-charge is always guiltless and innocent" (P34_Male_Healthcare Worker). Another participant spoke of a similar issue, stating that favouritism such as illustrated in the previous example, was linked to the "big man idea which allows corruption and blurring of the public and private purse, where somebody gives out bonuses and gifts to reinforce their status and prove how powerful they are" (P7_Female_Researcher).

5.5.5. Gaps in HRM

The responsibility for Human Resource Management (HRM) under decentralisation in particular was one function that raised considerable criticism in both the interviews and in participant interactions. This criticism, which emerged not only in interviews but also during field visits, often came from MoHP senior officials as well as funding partners who were specifically supporting capacity strengthening in HRM. Several participants mentioned HRM as a health system bottleneck, contributor to ineffective leadership and management, and as a target area in need of further development. The head of an international NGO and technical advisor on HRH issues, while explaining the work that they had been doing to build capacities in HRM, Planning, and Development at district level, also emphasised that there was still some way to go "because the HR data is very dirty" (P23_Female_NGO). By this she explained that the data was often inaccurate or incomplete. Similarly to issues raised in Section 5.5.1, others identified the lack of HR training among managers at district level as problematic: "I think we have been hampered

in a lot of ways by not having appropriately qualified people in those key positions who will be able to make important decisions (P32_Male_NGO).

With those responsible for HR having little training, challenges extended to data utilisation "for decision-making, to look at their data, interpret it, understand and make decisions which are evidenced-based" (P23_Female_NGO). Moreover, the participant stated that managers did not know how to make "efficient use of the resources they get", such as additional health care workers. There was a strong feeling that staff were not being utilised efficiently as a result of poor monitoring: "You find out that there is maybe a lot of absenteeism in the hospital but people claim that they don't have staff but yet people are just absenting themselves" (P16_Female_MoHP).

Reflecting on the reasons why the DHMTs might be struggling with decision-making around resource management, the following viewpoint surfaced from a development partner:

> One of the biggest challenges, if I was at DHMT, is all of these sources of data. How do I bring them together and actually make a decision? Cause each partner comes with theirs, so what I have noticed with the districts is that they have compartments, so when HRH come, they only open the HRH component and they do not link it with another partner. It's a problem (P23_Female_NGO)

This quote highlights the difficulties facing the DHMTs in choosing what to prioritise, especially in the face of competing priorities across NGOs and implementing partners, and their struggle to integrate the different data sources towards more effective resource management.

Concerns were raised from another participant from central level pointing out that the lack of an official performance appraisal was also contributing to the challenges with HRM:

> The performance appraisal, which is just on the paper, we have not rolled out. People don't know what to do because I cannot just say I want to appraise you,

when the appraiser does not know how to carry herself during the appraisal meeting (P33_Female_MoHP)

The same participant went on to highlight that HR issues and the need for leadership and management training was needed not just on the ground, but "we need to start with top leadership" (P33_Female_MoHP) highlighting a variety of inefficiencies at central level:

So, they say the training is like when you want to send someone for the training, you want to fill a gap which might be identified through the appraisal that we normally do, which we do not do… so now to be honest, training has been done, when we get the training funding, we check for the departments, 'what are your training requirements?' so they are not genuine per say. It's about who went last time and who should go this time, so they give us and we consolidate that and then we came up with a training plan and when it is approved, when funds are available, we send people to the training (P33_Female_MoHP)

This quote indicated that training is therefore not based on need. Furthermore, the participant indicated that there is a general lack of accountability around these processes.

5.5.6. Lacking Accountability

Decentralisation was often discussed as a reform expected to resolve the HRH crisis in Malawi. This is reflected in notes taken during a district health strengthening meeting, where it was discussed that HRH recruitment, deployment and remuneration were envisaged to be devolved from the central government to the local government. Specifically, several raised the point that the DHMTs were expected to have more functional and effective leadership and governance structures as a result of decentralisation, but that the process still existed more "on paper than in practice" (P15_Male_Implementer).

Others agreed, expressing that they felt that accountability was still lacking. One participant described the situation as one where people have been given "authority who

don't have the skills and literally lead people backwards" (P2_Male_Implementer). Having authority but not being accountable was linked to "people not feeling like it was their responsibility or if they don't do it well, it really doesn't matter (P37_Female_Researcher). Participants provided a variety of examples to make their point. One participant stated that "one example I use with people to just show them how the DHMT is not working is the issue of staff members not wearing name tags in the hospital" (P7_Female_Researcher). She spoke of how it is mandatory for people to wear badges so that people can hold them accountable and know their name and rank: "But people don't wear their badge. I never saw anybody wearing a name tag" (P7_Female_Researcher). This concept of leaders and managers not enforcing the rules came up more than once during the research process, suggesting a lack of disciplinary procedure for government staff members.

Absence of accountability was not only reserved for central level or DHMTs, but it also extended to management teams within PHCs. Some participants, especially healthcare workers, assigned this to the fact that DHMTs were far removed from everyday reality and not present enough: "You see that patients are mismanaged at the health centre because they don't monitor them frequently" (P5_Female_Healthcare Worker). One participant with experience of management in the health sector in Malawi stated that "some of the leaders were like somewhere else, aloof, they were not in contact with the people on the ground, they were only getting in contact when there was an issue" (P13_Female_Healthcare Worker). Another participant felt that "the higher the qualification the further away from the patient mentality which is really damaging in terms of leadership" (P7_Female_Healthcare Worker). She went on to illustrate her point with the following example:

> Like people who are working in labour ward, with the District Nursing Officer coming in who hasn't done any midwifery practice for 10 years, so who the hell does she think she is? She is coming in, she doesn't know how we work, she's got no clue, yet this is the person who is supposed to be managing us and checking if we are doing our jobs properly (P7_Female_Researcher)

Focusing on the PHC staff, the need for developing health leadership and management was further highlighted as part and parcel of patient centred care:

We provide health services within the context of the community, so the communities are part and parcel of our work… in whatever we do, we are accountable to the people who we are providing care to, and also to the community at large, but most of the times you hear stories about providers being rude, their approach, mmm, not being friendly, all sorts of stories we have heard about providers being very neglectful when patients/clients have come but they are doing their own things, just taking their time before they can even attend to a patient. So, the relationship between the providers with the community I think that's an area that needs to be looked into (P13_Female_Healthcare Worker)

Some of the reasons outlined in this previous quote support what others such as development partners mentioned when talking about why there was a need to strengthen social accountability mechanisms as a way of ensuring leadership and management was more effective. There was a sense that staff at PHCs felt that "it doesn't matter if the community don't like that because no one is going to hold you to account" (P7_Female_Researcher). Some of the other examples provided were of medical assistants closing the health facilities early, outreach clinics being cancelled, and the in-charge being drunk on duty, or completely absent.

5.5.7. "If we fix leadership, we will fix everything else"

Through observations, context mapping and interviews, people did not shy away from the identified gaps in health leadership and management: "One of the major, major gaps, even mentioned in the Quality Management Policy…they all point to the fact that we have a weak management system and it's cross cutting" (P16_Female_MoHP). A participant heading one of the larger NGOs in the country stated:

I think what is encouraging is the acknowledgement of the challenges that the current system faces. Just acknowledging that part of our many problems is having leadership that is poorly prepared for the positions that they currently hold, that is a starting point (P32_Male_NGO)

At a stakeholder meeting to discuss leadership and management development, the MoHP clearly stated that there is "weak leadership across the health sector, necessitating the need for a leadership programme to address the systems challenges" (MoHP meeting, September 2019). Moreover, there was a sense that "if we sort out the leadership issue, we will sort out the problems that we are facing" (DHSS meeting, June 2019). Sorting out the leadership was therefore one of the reasons given for the MoHP trying to move towards an institutionalised programme to be a core part of the health system "and a fundamental part of the basic medical, nursing and public health training" (P2_Male_Implementer), as it is in other settings.

5.6 Expectations

Common across the dataset was the view that health leadership and management was weak and therefore required dedicated efforts towards leadership and management to contribute towards a strengthened health system. There was, however, variation in what people expected in terms of the outcome(s) of building capacity in leadership and management in Malawi. Therefore, and in a continued effort to develop our understanding of "why" leadership and management approaches are being used to strengthen health systems in Malawi, the following section presents the results of findings exploring expected outcome of leadership and management development approaches, for health systems strengthening.

5.6.1 The Bigger Picture

Asking people to reflect on their perceived outcomes of developing health leadership and management in Malawi most often resulted in responses connected to the "bigger picture" and desired long-term goals. One of the most mentioned goals was UHC and the need for it to be realised as part of the SDGs. Already part of Malawi's HSSP II and a goal of the National Health Policy, emphasis was placed on the "significant reforms" (P17_Male_MoHP) the health system in Malawi was undergoing as part of progress towards UHC. At a leadership and management planning meeting, one individual praised the MoHP's initiative, stating that focusing on leadership and management would be "for better health care in the country" and "for the good of our health system" (MoHP meeting, September 2019). Another participant involved in implementing management

strengthening interventions also felt that focusing on HRH and leadership development would contribute significantly to Malawi achieving UHC.

Finally, the working towards UHC is also reflected as an outcome and goal across programme evaluations that were shared or sourced as part of this research. Interestingly, participants involved in the planning of interventions that had an explicit evaluation component were more often likely to present their thinking within the context of theory than practice. For example, a Theory of Change was introduced into an interview "as a guidance" (P11_Male_Researcher) for the project. In this case, the participant opened a Theory of Change document on his computer, outlining that the work that he was involved with was assumed to first improve workforce performance management at district level, and therefore improve workforce performance in lower levels of the health system, including community level, and therefore leading to improved service delivery as a contributing factor to the achievement of UHC. Another participant, a technical advisor on HRH issues, said that "the theory, you would have it that if you strengthen the DHMT, things will automatically change on the ground" (P20_Female_NGO). While probing other participants on the bigger picture of developing health leadership and management, one development partner felt that clear change should be seen in health indicators, such as the district health indicators: "If they were not doing well in issues of like maternal deaths, we should be able to relate that to leadership changing, then we could directly accredit it to the fact that now they are not able to supervise their people" (P24_Female_NGO).

5.6.2. The Trickle-Down Effect

So far, the evidence generated by this thesis highlights the importance people attach to focusing on capacity development within the DHMTs as a lynchpin for strengthening health leadership and management. Many of the reasons for focusing on the DHMTs are presented in Section 5.4 of this chapter. Exploring this reasoning in more detail, however, a common expectation among participants was that strengthening the DHMTs' capacity for leadership and development would inevitably trickle down to the other levels of the system, resulting in an overall strengthening of district health. This assumption mostly came from participants involved in research as well as participants from some of the larger NGOs. Not only was this common assumption apparent in interviews but it also formed the basis for

successful funding applications that supported interventions targeting DHMTs. The following quotes illustrate this common assumption of a trickle-down effect:

> I think the theory or the assumptions made are that you start at the district level and it might trickle down in terms of management strengthening and work force performance (P12_Female_Researcher)

> It will translate to the frontline health workers (P1_Female_Researcher)

> We expect a lot from these managers, and that it will trickle down to the work force and that it will ultimately improve quality of care (P10_Female_Researcher)

> We can say that the strengthening of the capacity will really show some impact and the issue of raising awareness or reminding them, showing them exactly what can be done to make things change (P19_Male_Implementer)

> When we trained the district health management team, our thoughts were that they needed to cascade the skills down to the health centres (P24_Female_NGO)

> We strengthen the DHMT to start the supervision at the district level, at the district hospital and then go out to the facilities (P28_Female_Development Partner)

> I think there were trainings and trainings and trainings that go on at district and there is this kind of supposition that it's having this effect on the system (P8_Female_Researcher)

In her reasoning of why district level was the best place to start, one participant from Malawi working for a development partner was of the opinion that "if we look at the district level these people at least, at least these ones are better educated than those managing the facilities" (P28_Female_Development Partner). Interestingly, this participant justified the

reasoning for first focusing on DHMTs by explaining that not only were PHC managers not educated enough, but that they did not have the right skills or abilities to make good decisions. She further expressed concern about how management at facilities struggle to make decisions about managing patients:

> The complaint that the DHO always raises when we are meeting the facility managers is that it's lack of competencies in the facility managers to make decisions. It's like at facility level we just post someone, you are the medical assistant, so you look at the education of the medical assistant compared to the education of a nurse/midwife technician. A nurse/midwife technician is at diploma level and this one is at certificate level so their skills are quite different, their knowledge yea its quite different. So, most of the medical assistants you find that it takes time for them to make a decision, a simple decision to refer someone to a higher level for better treatment. It becomes a challenge for them, so it's like they don't have don't have those skills to manage the facilities (P28_Female_Development Partner)

A differing perspective on the importance of focusing on the district level came from a participant from outside of Malawi, who felt that it was "ethically complicated" to focus on those healthcare workers on the frontline who should be providing care and not "tying people up who should be on duty" and "absorbing" them in trainings and leaving the health facilities empty (P8_female).

5.6.3. Improvements at the Frontline

In understanding more about the assumed relationship between the trickle-down effect from district level to primary level and health systems strengthening, individuals often mentioned improved health workforce performance or dimensions of health workforce performance, such as improved quality of care, as an outcome. This included addressing HRH issues more broadly, including those issues related to health workforce performance

presented in Chapter <u>2.4.6</u>. Participants involved in management and leadership interventions at district health level, for example, stated their expectations that the DHMTs would make more of an effort to go for routine and supportive supervision. Likewise, improved motivation and job satisfaction, better relationships between staff and between staff and patients, and improved retention rates were also expected as a result of improving leadership and management at the district level. As one participant said: "If we strengthen this DHMT, it will be the responsibility of the DHMT to make sure that the people they are leading are well motivated, and they are satisfied, and they have the confidence to do the work very well" (P13_Female_Healthcare Worker). Another felt that if "we can empower the managers, we can empower the supervisors. If we do so, it will have a knock-on effect on their job satisfaction and also on their intention to leave (P6_Female_Researcher). It was also expected that with supportive supervision, DHMTs would start to conduct performance appraisals and "visit you regularly and give you feedback on your performance" (P22_Female_NGO). Moreover, it was expected that staff at the facilities would develop work plans that could be monitored regularly.

Participants were also confident that healthcare workers would want to stay in their jobs longer, and to "stay in the job more effectively" (P2_Male_Implementer), feeling supported to do their job well. As one participant said:

> There was also the view that with improved supervision from the district end, those working on the frontline would understand the role of the DHMT better, which would help those at both primary and community level to work together and to improve that relationship, you know within the health centres and the districts (P6_Female_Reseracher)

There was also an expectation that better decision making around efficient use of resources would have positive results in terms of population-level health outcomes: "When you are adding new healthcare workers, our intention is to make sure we improve on some of those (district health) indicators" (P28_Female_Development Partner). It was also thought that staff would be willing to stay if they were motivated, not just through incentives, but by improving the following:

> Working environment, the supervisor staff relationships, issues of
> feedback where staff feel like I'm not alone, yeah, feeling supported,
> feeling that even their own personal welfare is taken care of
> (P13_Female_Healthcare Worker)

Such issues of motivation and job satisfaction were mentioned frequently as areas that effective leaders and managers should focus on towards health systems strengthening. There was a sense that by motivating the staff and improving job satisfaction, job performance would also improve. This was a viewpoint commonly expressed by frontline HCWs:

> If we increase or improve their job satisfaction, and you know, they are
> more relaxed in their job and they want to stay in their job and they want
> to stay and work within the district, then the possibility is that you know,
> their performance level or whatever output they are giving will be
> actually better than what it is at the moment (P6_Female_Healthcare
> Worker)

It was thought that improving the working environment within health centres, and not just with additional HR resources, would lead to management prioritising supplies and equipment for health care workers to do their job, saving lives, and managing patients more effectively:

> Even if you are a nurse on the ministry side, and this comes out quite
> often, like being able to know that I have the medication that I need for
> this patient, and you can have it (P32_Male_NGO)

A similar example from a nurse participant arose: "If I could have oxygen, maybe this child could be saved, this patient could be saved" (P5_Female_Healthcare Worker).

There was also an assumption by a participant involved in implementation at primary and community level that by focusing on DHMTs, there should be an opportunity to improve preventative care by ensuring DHMTs are more aware of communities outside of urban areas and the need to think of health as more than just treatment:

Strengthening the DHMT, we will make them to understand the importance of reaching each and every individual in their district. They should not look just at one side, the curative side, they should know that if we do a lot in the preventive health sections, we have few diseases, few outbreaks and we will save a lot for the curative services (P21_Female_MoHP)

5.6.4. Increasing Demand Side

Often noted by researchers, with increased motivation, better job satisfaction and a better working environment it was expected that service delivery and quality of care would therefore improve. Accordingly, if health centre management teams and staff are "happily engaged in their jobs, performing well with patients" (P7_Female_Researcher), and more accountable to each other and to the community, the impact will also be evident in-patient safety and satisfaction, "stimulating demand for health services" (P11_Male_Researcher).

Here too, while much of the focus of the participants was on the responsibilities of the DHMTs, several participants drew attention to the perceived outcomes on the health system when driven by the PHC teams. Examples provided were largely based on evidence from countries within SSA. One health systems researcher from SSA, for example, compared the resulting benefits of developing health leadership and management of PHC teams to the following saying from his country: "Where the carcass is, the vultures will gather" (P11_Male_Researcher). Here, the participant meant that by investing in leadership and management at primary level, the service will improve and therefore more clients will "trust the facility" (P11_Male_Researcher) and will access the clinic. In terms of service improvement, this same participant spoke of the importance of managers at facilities having the decision space to be able to mobilise their own resources and make needed purchases, such as for bicycle ambulances or drugs. A participant from Europe, also involved in health research, expressed similar sentiments related to leadership and management at the level of facility, and the increased decision-making powers that should come with that, leading an improved environment for both staff and patients:

If you invest a bit in that facility, if I invest a bit and try and make this facility, you know, I paint the walls, I put some curtains up, I try and at least put a mattress on the bed, if they have a few beds. There are some facility managers that if you do invest in that facility, if you have a way to do that, you know the people will say 'you know, okay, things at least, it's looking like people are taking care of the place, let's go and try it again' (P8_Female_Researcher)

Those involved on a smaller scale in the newer social accountability interventions in Malawi, share similar views on the positive results that can be achieved by focusing on the health centre management teams. These views are discussed in more detail in Chapter 6.

5.6.5. Helping People to Cope Better

Health leadership and management development was also expected to impact on the leaders and managers themselves, in what was viewed by many as an important part of health systems strengthening efforts. Only one participant made explicit reference to developing health leadership and management "as it's good for their mental health" (P2_Male_Implementer). In this sense, the participant explained helping people to cope better, and helping them to be more functional in their roles, would ultimately contribute to better mental health. Much of this was attributed to equipping people with the skills and competencies to be able to manage and lead well. As with other HRH, this same participant explained that the same theory applied:

Certainly the theory is if you do that properly then they stay in the job longer, and they stay in the job more effectively and they have more control, and we know this from good research that people have more control over the issues that affect their job, and then they are much happier in their job and if people feel more competent in what they are doing then they would generally do better in the job as well (P2_Male_Implementer)

In this way, investing in people, whether through training or scholarship provision, would result in "getting more than expected" from people (P35_Female_NGO). Talking of the potential impact on an individual in Malawi, a medical assistant reflected on his own experience explain the value attached to training someone in leadership and management skills. It means:

> You will be doing things in a different way, you will be seeing things in different angles, it means that I will manage people that I was mismanaging before but when I do that, it will not only do good to me only, but will do good to the whole country because people will now behave in a way that, people will be becoming literate (P34_Male_Healthcare Worker)

Another participant with experience in delivering leadership and management training reflected on how such development can encourage people, with an implicit reference to one's mental health and ability to cope:

> I think if people are getting enough out of the process, if it is solving their problems, if it is alleviating their stress and worry, if they feel less alone than the problems they are trying to address, then they will go the extra mile (P4_Female_Researcher)

It was also assumed by some individuals, particularly at the MoHP meetings, that leaders and managers were expected to "step up" at district level under the increasing decentralisation process. For example, one participant who had been involved in the decentralisation process as a technical advisor, anticipated that with the development of health leadership and management at the district level, there were expectations of improvements in accountability, transparency and so on within the district (P27_Male_NGO).

5.6.6. Rich Picture

Developed as part of context mapping, the following rich picture (Figure 5.5) represents the most common assumption related to the outcome associated with developing health

leadership and management in Malawi: Developing capacity at district level will trickle down to primary level, improving heath workforce performance, service delivery, and patient and HCW satisfaction, contributing towards a strengthened health systems and UHC.
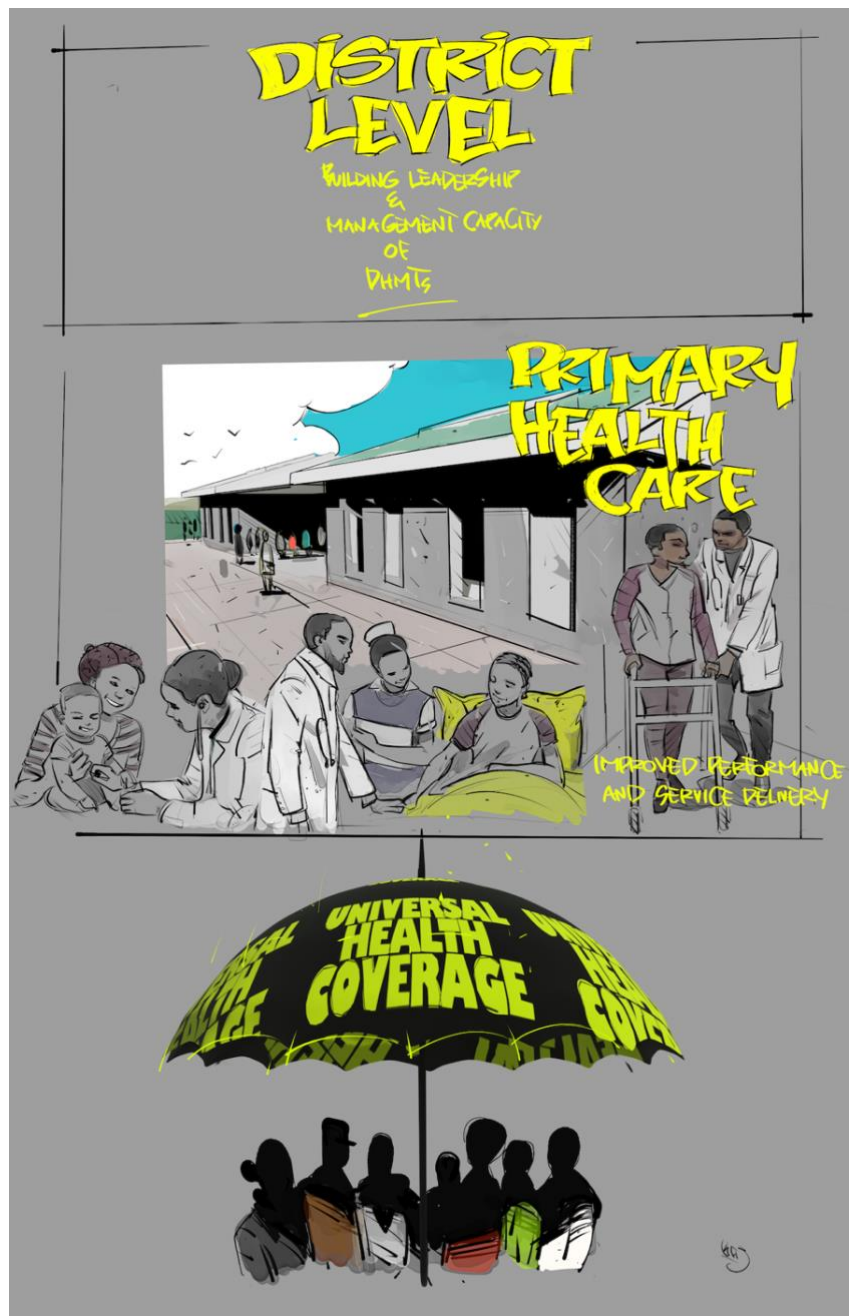

Figure 5. 5 Rich picture of expected outcomes from leadership and management development

5.7 Chapter Summary

This chapter introduced the research participants and reports the results in fulfilment of research objectives two and three, offering an in-depth analysis of how people

conceptualise and understand leadership and management within the context of Malawi. Moreover, results detail why leadership and management approaches are used as a strategy to strengthen the health system within this context.

Accordingly, results provided insight into the values that people attached to effective leadership and management (e.g. teamwork, relationships, mutual respect, decision-space), whilst also revealing common negative traits and characteristics participants ascribed to ineffective leadership and management (e.g., lack of training, support, accountability). Here, results suggest an element of individualistic framing of leadership in this context; in the sense that it was noted as important to focus on one's own leadership style first, before turning to others, but ideals of effective leadership and management principally emerged in the eyes of the participants and others, as being more relational in nature, and aligned with the principles and styles of a collective or distributed leadership approach.

Many individuals expressed frustrations at the lack of opportunity and space made for nurses to be in-charge at primary health facilities, with preference still favouring those considered to be "clinical", albeit with less qualifications. There was however, consensus from participants that health leadership and management was weak across the health sector, with an indication that perceived political interference and bureaucratic inertia at central level was stalling the decentralisation process, with an evidenced reluctance from central level to devolve power and enable autonomy further down the health system structure. Accordingly, a common expected outcome of developing health leadership and management at district level in Malawi was that any efforts to develop health leadership and management would "trickle down" to primary level, leading to improved workforce performance, better service delivery, rises on the demand side of healthcare with increased patient satisfaction, and a happier and well-motivated health workforce, to name a few. While this assumption may have been common across the dataset, the frontline healthcare workers were more inclined to question the validity of this viewpoint when considering the trickle-down effect through a more practical lens. The following Chapter 6 goes beyond the theory, to explore in-depth, how leadership and management development is happening in practice in Malawi.

Chapter 6: When Health Systems Talk

6.1 Chapter Introduction

> The day starts and the day ends. It's just a matter of finishing your clients. How you finish them, it does not matter, that's sad. Now things are trying to improve to say that 'be careful when you are seeing patients', and that's even good, but the approaches are not nice, they cannot take us far because something cannot be done under fear. The juniors, like the medical assistants, people they are working tirelessly. If you can consider their working conditions, their working environment, their payments and the job they do, you would appreciate that people are sacrificing a lot but then for them just to have an encouragement from the seniors, it's a problem (P36_Male_Healthcare Worker)

Thus far, the findings presented offer a better understanding of how leadership and management is conceptualised in the context of Malawi, both "on paper", as reflected in the desk review (Chapter 4), and as experienced and perceived by key stakeholders. In addition, findings to date offer a deeper understanding of why health leadership and management is being prioritised towards health systems strengthening in this context, including the expected outcomes of implementing leadership and management programming, particularly at district level, in this context (Chapter 5).

This third and final empirical chapter describes how the development of health leadership and management approaches are being implemented *in practice* in Malawi (i.e., research objective 4), towards advancing our understanding of how leadership and management practices, or lack thereof, are manifested "on the ground". Findings therefore offer an understanding of the everyday reality of frontline healthcare workers, as illustrated in the above quote by an in-charge of a health facility in a southern district of the country. Moreover, it reveals insight into the working environment and organisational culture of the health system in Malawi.

Responding to research objective 4 required in-depth exploration of the everyday reality of the health system to understand health leadership and management at a granular level, through the interpretative lens of the research participants. Moreover, I went beyond the qualitative interviews, to also draw on sources such as observations, field trips, informal meetings and conversations, which were often part of my own every-day reality, to understand more about context-based factors and underlying mechanisms related to health leadership and management development. As well as contributing towards triangulation of the data, drawing on other methods such as observation provided me the opportunity step back, visualise and explore the discrepancies between what people said was happening, or think should be happening, versus what was happening in practice. Again, the use of mapping and diagramming contributing to the elucidation of the findings and learnings presented in this chapter.

Accordingly, and towards objective 4, Section 6.2 (The Problem is the System Itself), Section-6.3 (Politics at the Top) and Section 6.4 (From Vision to Reality) focus primarily on the perceived changes and recurring challenges of implementing leadership and management initiatives at district level, from the perspective of implementing NGOs/partners, MoHP officials, and researchers. Section 6.5 (What you don't Know (or see) won't Hurt You) explores the perspectives of individuals operating primarily at primary and community level, and Section 6.6 (What People Really Want) turns to summarise thoughts shared by individuals on what they thought ought to be happening to develop health leadership and management in Malawi.

6.2 The Problem is the System Itself

In addition to perceptions of effective and ineffective health leadership and management (see Chapter 4), attention was also drawn to the context of Malawi and its health system. As one interviews participant advised, "the type of leader and the impact that they have on the way the health system runs, you have to set that in a cultural context" (P7_Female_Researcher). Another participant stressed that "the organisational culture plays a big role" (P13_Female_Healthcare Worker) in determining how successful efforts will be in strengthening the health system. Moreover, emphasis was placed on the need for a "conducive environment" (P37_Female_Researcher) as people" appreciate working in a

kind of structured, predictable environment where there is also support for the working environment and what they are able to do" (P32_Male NGO).

The health system in Malawi was often portrayed in a negative light, ranging from "unfair" (MoHP meeting, June, 2019), "unattractive" (P8_Female_Researcher), "corrupt" (P34_Male_Healthcare Worker), and as "not working very well" (P1_Female_Implementer). Observed during a leadership development meeting, one member of the MoHP expressed his support for the Health Leadership and Management Programme as the current "system was broken and needed revamp[ing]" (L&M, Sep2019). Another healthcare worker felt that "the problem is the system itself" (P34_Male_Healthcare Worker). Similarly, reference was made by a health systems researcher to "blocks" in the system, describing the system as not being "joined up" (P7_Female_Researcher).

There were also examples where some participants, particularly Malawian participants, made negative and generalised statements about how they perceived Malawi and Malawians, more generally. These statements were often offered as an explanation for why the system was perceived as "broken" or laden with challenges. One participant reflected on what she perceived to be a never-ending sea of challenges so overwhelming that people often failed to establish vision and goals. She said:

> I think it's easy in Malawi to believe that everything is still really terrible…and so looking at the bigger picture, but society here doesn't look at the bigger picture. It looks at survival and firefighting and we need to get past that. I don't know how, the way the economy is right now, that just makes me sad. (P1_Female_Implementer)

There were similar comments made by two of the Malawian participants from international NGOs that referred to Malawians no longer caring about things. The first comment was made within the context of those who are working for the government, and the second directed at those in leadership positions:

> I think in the time I have worked with government people, one thing I have noted is that they don't care what they are doing, what they care for

is their own interests, so when we change our attitude as people, things will get better (P35_Female_NGO)

I think another challenge there is, I don't know what has come to us as Malawians where we mostly have a laissez-faire attitude towards everything. We don't really seem to care, sorry to say so, but that is what is happening because it's like people these days don't care what is happening around them… that's why people they do whatever they want to do (P28_Female_Development Partner)

Another viewpoint that surfaced implied that it had always been predictable that the health system would have problems because it was shaped by colonial history and subsequent decades of political regimes and economic choices: "If you go back and look at the history and the genesis of the health systems in sub-Saharan Africa, the colonial way that they were set up has made it almost inevitable that they would be dysfunctional" (P7_Female_Researcher).

6.3 Politics at the Top

Malawian participants also raised the issue of the health system in Malawi being controlled and shaped by external influences, particularly through donor control: "Remember, a health system is not driven by itself, it's driven by everyone else externally, isn't it?" (P37_Female_Researcher). Similarly, donor control was often spoken about during more informal interactions. Another participant felt that:

It's the lack of resources that drives decisions. That's all political and economic decisions that are being made. They [decisions] are not about working of the system at all, they are about doing what you can with what you've got and not having to make too many changes or ruffle too many feathers in case there is personal consequences for you (P7_Female_Researcher)

The interconnecting concepts of power, influence, ownership, and control featured prominently throughout the research process. These concepts not only emerged in the

interviews, but were also apparent in the numerous meetings that I attended, and the different interactions that I had. Two of the more obvious examples of how these power dynamics played out were visible through the relationships between the stakeholders investing in leadership and management and the Malawian Government (Section 6.3.1), and relationships within the Malawian government, specifically within the MoHP (Section 6.3.2), both of which are explored further in the following sub-sections (6.3.1 and 6.3.2).

6.3.1 Distinction without a Difference

One of the first objectives of this thesis was to identify the different initiatives and approaches to developing health leadership and management in Malawi, as reported in Chapter 4. Evident from very early on in the research process, was that the health sector was awash with stakeholders invested in the area of leadership and management development, with little harmony between the approaches, and evidence of duplication across partners. As one implementing participant from Malawi observed and commented:

> I think that one thing that came out clearly to me, learning about all the existing management strengthening interventions it occurred to me that I think almost all projects or programmes, they were kind of implementing a similar model really with different terminologies and semantics but if you looked at their documents it was all purely based on PDSA (Plan-Do-Study-Act cycle) but then one programme would just give it a different acronym…and I think it was interesting for me because the bigger question was why? Why are people implementing a similar kind of thing, different names, probably different style of workshopping, or training that they are providing to the districts…I think it's a huge concern for me (P15_Male_Implementer)

Not only was Malawi considered a victim of "pilotitis" (Researcher's notes, May 2021), with projects having a life span of three-five years and then stopping, but many organisations were applying the same types of interventions or ideas over and over again as well as targeting the same positions and cadres. Speaking informally to an NGO senior staff member who was involved in providing technical assistance to the MoHP, commented

that his organisation was feeling less interested in getting involved in new leadership and management initiatives as government commitment went from one initiative to the other. Another participant, who had been involved in developing the HRH Strategic Plan for Malawi, noted her concern at the prospect of yet another partner presenting another leadership and management strengthening intervention to the HRH TWG at the MoHP:

> When X [organisation] presented this X [project] I think the feedback from the HRH TWG was that so many partners with decentralisation are now doing management interventions and leadership interventions and I have been part of so many different ones at different times. How do you make them sustainable? How do you coordinate them? (P22_Female_Development Partner).

Likewise, I often found myself during interviews informing participants of similar initiatives to develop health leadership and management in Malawi, to which there was often surprise. Knowledge is therefore lacking between stakeholders and within the MoHP of *who* is doing *what*, and *where* for health leadership and management in Malawi. Consequently, there was little evidence of collaboration, communication, or linkage between these initiatives.

6.3.1.1 We don't need more research; it's implementation that's the issue

In light of the above, there was a concerted effort to bring stakeholders together for the planned Leadership and Management Development Training Programme for Health Managers; a consultative workshop for District Health Systems Strengthening held in June 2019 by a leading development partner. During this meeting, I was able to observe publicly aired challenges to the development of health leadership and management through the DHSSi.

The DHSSi grant stipulates that attention should focus solely on targeted districts and DHMTs, with part of the workshop designed to invite external partners to help identify

capacity gaps for DHMTs. The agenda for the workshop provoked considerable debate and disgruntlement from the MoHP. Firstly, there was a sense that the tabled agenda was a waste of time given the existing evidence for capacity gaps and training needs for DHMTs. These gaps had, according to participants, already been identified in a 2015 survey, compiled together with consultants from the WHO and shared among health managers. Moreover, one MoHP director stressed that training materials were already developed and that "good documents" existed. In a statement directed at the organising development partner as well as the external partners and researchers present from a variety of institutions, this same MoHP director went onto specify:

> When we come to health systems strengthening, there is nothing new that you will not find in the national health policy, even in the health sector strategic plan. When we sit here now, I wonder what new things do we want to bring? Why are we not moving into implementation? We want to develop another document side by side the HSSP II? It's a waste of time and resources…Colleagues, I think it's time we start implementing, not sitting down to keep on documenting…. It will be embarrassing in five years' time if we are coming again with the same material and the same stakeholders' meetings, but we did not implement (DHSSi meeting, MOHP, June 2019)

These sentiments were also reflected in some of the participant interviews, which hailed the quality of Malawi's policy documents: "there's lots of things that are nice on paper in Malawi" (P1_Female_Implementer), also admitting that implementation was the challenge. It was noted that the duplication of documents, all with a similar approach, albeit sometimes using different terminology, was one of the reasons for the failure in implementation. One senior MoHP participant told the story of the Minister of Health from Rwanda who took Malawi's health sector strategic plan and said that while Rwanda is now implementing it, Malawi is still delaying. The participant's concern was that "everyone is talking of Rwanda, but they don't have time to sit and write documents and here in Malawi we have very good documents, but implementation is an issue" (P17_Male_MoHP). The same participant went on to agree that there are systemic challenges in Malawi:

But in terms of the structure, the curriculum, the content, everything…it's there systematically. We have that within the ministry, but it's in terms of the actual monitoring and drilling, steering them and equally monitoring their performance, in terms of that, it's still a challenge (P17_Male_MoHP)

At another meeting that I attended on evidence-informed decision making EIDM, the vast amount of research being conducted in Malawi was also raised as a concern regarding the issue of how much of the evidence that is produced is actually getting into policy or being used by policy makers. One of the participants recited the following quote, from a speech by Julius Court at a meeting on evidenced-based policy making: "The good news is that evidence can matter. The bad news is that it often does not". There was also a sense that Malawi should be focusing on the existing evidence first, ensuring that it is of high quality and digestible, before rushing to add more of the same. On this same topic, one NGO participant explained that politics at the top is often the way it is because "usually at the top level people are not well informed on what is happening at the bottom level" (P20_Female_NGO), and therefore are not aware of all forms of evidence. In the absence of evidence there is therefore "less political will to say we can take this much further" (P20_Female_NGO).

6.3.1.2 Whose Agenda is it Anyway?

A second issue apparent across the data and arising at the DHSSi meeting was deciding Malawi's agenda for health governance, leadership and management. Here too, the DHSSi meeting provided a forum for frustrations to be aired around control of the health agenda, prioritisation, and decision making "at the top" or at central level. A common viewpoint across individuals within the MoHP was that power around significant decisions rested in the lap of the funders:

What is coming out clear at times is that whoever's money would want to push the agenda, it works. When the money is finished, they stop. Another person will come in and do the same (DHSSI, MoHP, June 2019)

It also arose that there is a need to distinguish between the different development partners, and their power and influence relative to one another, as well as their power within the government. In specific, the higher the profile of the organisation, the more funding behind it, and therefore the more say over what should and would be prioritised they hold at central level. When it came to the development of health leadership and management, many of the projects that were at the forefront of efforts were funded by partners from the United States and UN agencies, with funding drawn from funds allocated to HIV and AIDS. Here, partners were keen to make clear that while HIV/AIDS was always a target, they were also interested in HSS across the system.

Tensions were heightened at the DHSSi meeting when a senior MoHP official openly challenged the donors and partners in the room, questioning their integrity:

> Unfortunately, most of the donors are not interested in investing in the right leadership because they know if we strengthen the right leaders, they will lead us [as opposed to the donors] (DHSSi, June, MoHP, 2019)

Furthermore, there was a sense that the plans being developed did not include the expected recipients of the training:

> Instead of going to the basics, we sit here and design programmes for the district, even we don't know that district and we think we can design a good system for the DHO, without the DHO telling us what they want (DHSSi, MoHP, 2019)

Both of these comments, made in the context of Malawians not having sufficient capacity to be able to lead the agenda of the country, led to one MoHP official adamantly declaring that donors and partners should not be dictating the agenda:

> When we want to talk about progress, let's only have one name which is Malawi government. The partner is designing something for the ministry without the ministry… Any partner who is not working to support our agenda, we will say 'go'. Malawi needs to move forward. Let us respond

to the needs of the districts. Let's not assume, let's give a platform that is helpful for our colleagues. I know partners you may not like this but you have to move with us. We are not apologetic. If you don't want, take your money. We don't want to waste time when we know the problems. We have decentralised let's make sure we are working in the spirit of decentralisation. As government, we are not supposed to bend to you but you bend to us. We shouldn't be moved by the money that partners have but partners should do according to what we have (DHSSi, MoHP, June 2019,).

The conversation around this quote did not suggest that support from donors and partners was not needed nor wanted, but rather expressed a need to work together, to respect the position of the country as well as those leading the government. Some of the individuals present at the meeting, who were also participants in this study, expressed that they did not think much would change following this meeting: "If that's where the money is then they will do it because they don't have the power to hold the donors to account" (P7_Female_Researcher). As one MoHP deputy director put it: "Donors don't follow what the country needs, but they follow what they want and this is why Malawi is still poor" (DHSSI meeting, MoHP, June 2019). This thinking was corroborated by the head of a large NGO in Malawi. Sharing his feelings after the meeting, he said: "As a partner, you know a typical NGO, we know what we want to do. We can come here and do what we want to do" (P32_Male_NGO). This impression that partners do what they want to do echoes stories told of partners bypassing DHOs' to go straight to health facilities with their interventions. One former DHO participant told of the challenges she faced, often telling NGOs: "You should focus on this and this area, not just the area you want to that is closer and has no challenges" (P29_Female_Healthcare Worker).

6.3.2 Infighting

Some of the partners also spoke up during the DHSSi meeting, expressing that it was their first time hearing about plans or funding for a DHSSi or a new programme for DHMTs. One participant challenged the point of having all the different partners present at the meeting to contribute, if decisions had already been made without them. This reaction

sparked a constructive dialogue that resulted in an agreement that a task force and subsequent steering committee for health leadership and management would be established, where partners and other stakeholders would have a chance to contribute and to take part in discussions.

The DHSSi meeting not only highlighted concerns between the partners and the MoHP, but perhaps more so, evidenced infighting between the different directorates of the MoHP as well as unhappiness between the MLGRD and the MoHP. Some months before attending this meeting, I had informally been made aware that the different directorates at the MoHP had been "fighting" over who would be responsible for the leadership and management programme. Some of the directorates, for example, were not happy with QMD leading the programme. Moreover, other directorates at the DHSSi meeting expressed that they were not happy with who QMD had selected as the institution to deliver the leadership and management training.

As a newer department, the QMD had taken the leading role in driving the development of health leadership and management, seeing it as part of its mandate in coordinating strategic leadership and quality management improvement initiatives. It was observed that some of the other directorates felt that this decision was unfair and that too much blame was being placed on other directorates' perceived lack of capacity rather than trying to work together. As one development partner put it:

It's not bad pointing fingers at people but you need to discuss solutions but if you start pointing fingers at people – we are human beings we don't like it most of the time. It has to come in a constructive way but if it is so destructive people pull out (P28_Female_Development Partner)

Similarly, it was both observed and expressed that there were concerns from some of the directorates in the MoHP that they had been "forced" to take part in something that they had not been consulted on, nor did they agree with "trying to reinvent the wheel when there is already an institution that government put in place to do the management courses" (P33_Female_MoHP). One senior official at the MoHP, angry at being left out of the decision making, stated: "If we personalise these things, it's not going to work and the problem I see is that they are personalising this programme, that is why they don't want us

to take it through, they want themselves to be the leaders" (P33_Female_MoHP). Inter-directorial fighting also had the negative effect of having certain directorates step away from this process. Speaking of one example, the same MoHP participant said: "They are not turning up, last time they did, I know there was an exchange of fire, that is why they are at loggerheads" (P33_Female_MoHP).

Another perspective shared on the conflict between the directorates came from some of the partners sharing their own experiences with the apparent infighting. One leading development partner explained that the DHSSi meeting had been called as a way of trying to heal some of the conflicts, with a purpose of creating one system rather than lots of separate systems and projects: "At that time they were not talking to each other, they were all working in silence" (Researcher notes, May 2021). In an informal meeting with a development partner from the leadership and management task team, it was explained that the overall government structure made it so that different departments in the MoHP were functioning in silos, competing with each other to get additional funding for the leadership and management programme, creating conflicts that were palpable when these different departments were brought together. According to one partner, "that's how the ministry often operated, and they work with individual partners, and they don't try to bring the different pieces together" (P22_Female_NGO).

The DHSSi meeting was also one of the first times the MoLGRD had been invited to discuss leadership and management, provoking disagreements between the two ministries. It was observed at the DHSSI meeting that when complaints were raised about mismanagement at district level being related to poor understanding of data and a subsequent lack of evidence-based decision making, a senior representative from the MoLGRD argued that such challenges existed because of the reluctance of DHMTs to utilise the M&E officers at the District Council that were there to support them. The MoHP countered this argument by saying that the databases at the council were not yet "talking" to each other and that that local government was delaying the process by not being accessible and accommodating the DHMT at the district councils. In the words of the representative from the MoHP: "At the council, no meaningful data is being presented at the MoHP" (DHSSi, MoHP, June2019). The relationship between the two ministries is discussed further under 6.4.4.2, when looking at the impact of decentralisation on leadership and management.

This infighting, however, was not considered unique to the issue of leadership and management, but reflective of what one implementing participant referred to as being "incredibly challenging at central level" (P1_Female_Implementer).

6.3.2.1 The Missing link

Diary entries from the DHSSi meeting and summary notes taken at the end of the meeting capture some of the key observations that I made during this meeting (See Figure 6.1)

20-21 June, Summary
-Very clear tension between the different MoHP departments
-Anger about donors dictating what's happening
-Hr dept angry with partners
-Local gov angry with DHMTs
-Planning dept out of the loop
-Many partners didn't come
-Says more about who isn't there than who is there: preventative health missing
Still no idea how to coordinate all of this!!

Figure 6.1 Researcher's notes, June 2019

Notably, one of my key observations stated: "Says more about who isn't there than who is there: Preventative health missing" (Diary entry, June 2019). This initial observation would ultimately hold true throughout the research process. None of the meetings that I attended on health leadership and management had any representation from the Preventative Health Directorate at the MoHP. The absence of the preventative health directorate was most notable through the lack of discussion on developing health leadership and management at primary and community level. Being one of the largest directorates in the MoHP, the Preventative Health Directorate comprises of the following departments: Primary Health Care, Environmental Health, Public Health Institute, Preventative Health Programmes, Epidemiology Unit, Health Education Services, and the Health Reference Lab. When exploring why the preventative health directorate was not attending any of the planning meetings, I was informed that they had not been included in planning, nor had they been

invited. While explained by a lead development partner and a deputy director from the MoHP that the reason preventative health was not involved was because leadership and management "was a district strengthening initiative" (Researcher's notes with MoHP meeting, August, 2019), there was a strong sense that exclusion of the preventive health directorate was common across other district level programmes.

Moreover, several other sources of evidence point to clinical or curative services having a better relationship with the DHMTs, perhaps given their own medical backgrounds. One participant involved in preventative health told the story of how they would often struggle to get sign-off for community health meetings, as those in senior positions at the MoHP "think they are wasting the resources, maybe because the impact [of preventative services] is seen after a long time" (P21_Female_MoHP). She also commented on how a senior MoHP had declared that she was no longer a threat when she moved from her role as District Environmental Health Officer (DEHO) to a central level position: "I remember he said 'You are now at the central level, you are no longer my enemy because that time you working as a DEHO you were my enemy'' (P21_Female_MoHP). Additionally, the participant from the MoHP was keen to stress that clinical and preventative should not be completely separated, giving the example of PHC and the essential health package (EHP) being provided at the primary health care level. To her, all of the directorates are involved in PHC. This was echoed by another senior manager at another directorate within the MoHP. To her, it was important to include preventative health given that DHMTs "have a core responsibility on that one, because all the districts, their role is also to say what is happening in the community, even at the lowest centre where the services are being provided" (P30_Female_MoHP).

One health centre charge explained that traditionally Malawi "has had these dichotomies that community does not feed well into the curative services" (P14_Female_Heathcare worker) because of hierarchal issues and failure to recognise how preventative and curative have a bearing on each other. This hierarchy has been further reinforced by funding allocations, with "60%-70% going to curative services rather than preventative" (P21_Female_MoHP). In trying to address these hierarchies, one NGO explained how they were trying to find a way to ensure that information from community level is pushed up to central level through civil society organisations. These actions were considered necessary to ensure community is represented at national level as from the

participant's experience, the MoHP had made false claims about civil societies and service users contributing to health plans "which was not actually true" (P31_Female_NGO).

6.4 From Vision to Reality

In Chapter [5.6.2](#), a common expected outcome of developing health leadership and management at district level in Malawi was that these efforts would "trickle down" to primary level, leading to improved workforce performance, better service delivery, rises on the demand side of healthcare with increased patient satisfaction, and a happier and well-motivated health workforce, to name a few. The following section therefore seeks to go beyond the theory of developing health leadership and management, to exploring the reality of implementation, as experienced by individuals.

6.4.1 Numbers Don't Tell the Whole Story

As outlined in Chapter [2.3](#), a common way to test assumptions is to identify the data that will allow us to best evaluate whether assumptions are accurate, or, perhaps more importantly, to falsify what we believe to be accurate. As detailed in Chapter [2.5.8](#), evaluation methodologies vary across different approaches to developing health leadership and management. Specifically, data I gathered on the effectiveness of the approaches came from the research interviews, previous evaluation reports from partners and other forms of grey literature, as well as informal discussions. Many of the evaluations were short-term, or ongoing for those initiatives in their infancy or yet to finish and therefore unable to share. That said, it was clear from observations and from my conversions with key stakeholders, that many of the evaluation reports did not tell the whole story or adequately capture whether change was apparent as a result of introducing leadership and management programmes.

Moreover, it emerged that many of the approaches to developing health leadership and management targeted certain districts, rather than being applied across all of Malawi. Consequently, the same districts were often the target of interventions, especially the more urbanised districts of Blantyre and Lilongwe. Weighing in on why numbers seem to matter more and why funders are not always as interested to invest more in challenging or smaller districts, a head of an NGO explained that "it is much more than the desire to reach more

people. It's kind of much more sexy and attractive you know, if I say we are operating in this district with millions" of people (P32_Male_NGO).

A common view amongst participants was that what mattered most to funders, PIs, and those at central level were indicators; as being specific, observable, and measurable to show the progress towards achieving a specific output or outcome. As one participant said:

> It is why any epidemiological studies predominate over any qualitative studies, and this is why people want graphs and numbers over explanation and reality because they think they can then interpret and then prove that they have done something with it. It does not actually mean that they have done something because unless you do take account of the soft stuff, but I don't know what is going on in terms of the way that the ministry thinks about the soft stuff…you know any research project, in order to be considered to be effective and be translated into policy, has to prove that it has made a difference and if you cannot prove that it made a difference and if you cannot prove it made a difference by hard numbers, you are not considered (P37_Female_Researcher)

The "soft stuff" that this participant referred to was similarly referred to in Chapter 5.3.6, when a participant referred to the "software of performance" (P11_Male_Researcher) and the need to look beyond key indicators. Another participant agreed that current measures failed to capture the reality on the ground as "it's considered a dream though isn't it? It's considered to be too fluffy and it's hard to measure and it's all about intangible stuff" (P7_Female_Researcher). Taken together, and while I found evidence of approaches that did incorporate qualitative methods into their evaluations, what was less clear is how, if at all, these qualitative findings were being utilised or whether they impacted on decision-making at a higher level. As one participant explained, reflecting on the qualitative data that they were capturing:

> The reality of what happens at the co-face - and what people have to deal with in terms of their expectations - to the nice flow diagram that appears in the strategy is like two different planets I guess (P1_Female_Implementer)

Another participant involved in management strengthening across SSA critiqued the Theory of Change (ToC) for their project for not anticipating potential risks and moreover, citing that the TOC had left little room for flexibility or "true collaboration". The participant felt that:

> Many times this doesn't happen because of power relations that exist between researchers, between research communities, between donors…and then you see the end result is not that rosy…you don't see the difference it makes…so I believe that if you should use these things [ToCs], you should use them in their true sense (P11_Male_Researcher)

Several of the participants, namely from NGOs, also highlighted that though their initiatives and approaches may rely on numbers and indicators as an indication of success, there is often evidence to suggest that "there is something that you cannot see from the data" (P23_Female_NGO). A common example given was on the issue of adding healthcare workers to health facilities to support the team with service delivery and health systems strengthening: "The data here shows that we have health workers in this facility but actually when you go there you don't find them" (P23_Female_NGO).

Similarly, another participant explained that while, on paper, they had increased health workers as a way of improving HIV services in the facilities, staff played with the rota such that only one person would be on duty at any given time which they complained to the DHO about. This mirrors a warning from the MoHP to partners seeking to improve staffing numbers, whereby increasing staffing can have a negative impact in instances where the rules and regulations on salary, incentives etc., may differ from those of the government. The result may therefore be an increase in numbers, but a reduction in efficiency from staff members who have different working conditions.

6.4.2 The MoHP's Flagship Approach

Over the latter half of 2019 and onwards the MoHP's Leadership and Management training programme for health managers went from paper to practice. This transition included the formation of a task force, a steering committee, and a validated curriculum for the DHMTs. The course was launched by SDI and the MoHP at the end of 2020 (Chapter 4.5.2.2.3). Despite inputs about needing to invest in health leadership and management at different levels, including HRH at primary level, hospital management teams, ward in-charges and community leaders, among others, however, the training proceeded for DHMT members only. The focus on DHMTs was due to a range of factors, including the MoHP's Leadership and Management programme being impacted by serious budget cuts from some of the partners. There was, however, strong encouragement from the Minster for Health to scale-up the programme from five districts to all of Malawi's 28 districts, by applying to the health sector joint fund for support. At the time of writing, the QMD was still awaiting feedback on their application.

The initial training for DHMTs did commence, and included a classroom phase as well as online coaching and mentoring, before implementation was affected by COVID-19, funding, and the transition of government. Concerns on how to evaluate the training programme were introduced at the first meeting of the task team, with emphasis placed on being able to look at indicators of the different districts, and an identified need to improve how performance is being measured. Consistent with an overemphasis on quantitative/measurable approaches (i.e., under section 6.4.1.) one meeting participant made the point that it was important to look at efficiency gains resulting from the training programme, as he doubted that "financial stability was going to be attainable anytime in the future" (Researcher notes, Task Team meeting, 2019). He further stated that better resource management was an expected outcome of the training, offering the example of some districts performing better than others despite having the same resource challenges. One of the main challenges mentioned with the leadership and management training programme, apart from the financing, was the initial process of getting everyone onboard and on a "common platform", including the implementation partners. From my own observations and having attended many of these meetings from start to finish, the levels of collaboration improved significantly over the course of research.

Echoing thoughts shared in Section 6.4.1. the following evaluation tools were suggested by meeting attendees: performance appraisal reports, customer satisfaction surveys, audit reports, financial reports, and questionnaires. It was also mentioned by one of the meeting participant's that measuring the softer skills would prove more difficult. It was ultimately decided that a proper theory of change would be developed to determine the impact on health care service delivery.

The leading development partner reported that the decision to set up the taskforce and steering committee as a multi-sectional unit, had helped to bring the directorates together as well as the MoLGRD and other partners. Moreover, the decision to have the course run through SDI, a long-standing institute in Malawi, meant that unlike projects that come and go, there was a chance for stability. As a steering committee, there was also agreement that the committee would meet once a year to discuss progress.

6.4.3 Slow Progress is Better than no Progress

While the Leadership and Management training programme remained a key area for the MoHP to develop and to try and secure funding for, there was evidence of collaboration between the MoHP and partners, especially related to district health strengthening. One of the participant's warned that the MoHP was throwing its "weight" behind everything as "I heard the ministry saying if they are offered something, we are not going to say no to it because there are more funds, more money" (P7_Female_Researcher). Others felt that that the MoHP had displayed political will, had been very supportive in championing their initiatives, and there was an acknowledgement that any of these processes do take time. From my own observations, there had been progress made in many of the initiatives, as outlined in greater detail below, even if small and with remaining challenges.

6.4.3.1 Integration

The challenges encountered when trying to bring everyone onboard for the leadership and management task team extended to other projects/initiatives. That said, bringing different

stakeholders together and efforts to try and improve relationships was recognised by some of the development partners and funders as facilitating a certain degree of harmony. For example, there were efforts to integrate what others were doing as a way of supporting the overall objective of district strengthening, as led by the QMD and supported by one of the leading development partners. This drive demonstrated a tangible start to improving and monitoring quality across the system. Some of the key areas where progress was noted as part of efforts to integrate other approaches included support for HRM at district level, support with evidence-based planning for the DIP process and supporting the development of a scale-up strategy and plans for institutionalisation of management strengthening of the DHMTs in Malawi.

One example of the MoHP championing a smaller initiative was the support and input given by the QMD towards the development of a scale-up strategy for management strengthening of the DHMTs for one of the partner projects. Participants from this management strengthening intervention felt that the QMD "was really taking X [project] as a good tool in terms of solving problems" (P18_Male_Implementer). At a workshop that I attended for this project, which took place almost a year before the DHSSi meeting, a deputy director from the MoHP publicly supported the approach to management strengthening of the DHMTs declaring, "this intervention will help us to take care of all of those [HSSPII objectives]. If we use this intervention, and compare it with mankhwala [medicine], this intervention is a higher level than a painkiller" (MoHP, Workshop, September 2018). According to participants from both the MoHP and partner institution, this support proved beneficial to both as it provided a useful platform for the MoHP and the Leadership and Management steering committee to consider how initiatives could be scaled up and how they could be institutionalised into the MoHP. While these meetings were therefore used to discuss institutionalisation of management strengthening more generally, they also included discussions on how to adapt some of the components of the management strengthening initiative, such as the action research cycle and approaches to team-work for problem analysis, into the MoHP and QMD's existing structures.

There was considerable support for HRM among the development partners and NGOs, particularly with regards for the HR component of general management, in response to the devolution of HR management to the district councils. This involved direct interaction with HR from the district council. Those participants involved in supporting

capacity building for HRM stated that the planning tool that had been developed to help the district managers with their HR needs was being used in many of the districts. Training programmes for managers on how to do the performance appraisal had also been rolled out in four districts, however, at the time of writing, there were still some challenges with getting support to roll this out to the remaining districts.

Training on the revised DIPs, guidelines and tools, was integrated into the Leadership and Management training programme, and I had an opportunity to attend one of the training sessions with DHMTs from three districts. The DIP training was led by the planning department at the MoHP, and delivered at SDI, with support from a development partner. At the training, it was mentioned that it was essential for DHMTS "to have the capacity to manage people, and the capacity to manage DIPs" (DHMT training meeting, May 2021).

In a later discussion with a research participant, the DIP was described as something that districts cannot get away from, providing a foundation to build and anchor on. The training itself appeared to be extensive, using a training of trainers approach and working analysis with the whole DHMT to ensure evidence-based planning. In the past, districts had faced challenges with the DIP and their budget, usually resulting in little money for district programmes, and a higher dependency on partners, who "often had their own agenda" (Researcher's notes, 2021). A change ushered in to address this involved the DDHSS's playing a more significant role to ensure that donors in the district are coming together and taking part in the DIP planning process, towards a broader alignment with partner activities. At the time of writing, however, it was not clear how successful the implementation of this had been. From speaking to different individuals, and from my own experience, partners attending meetings at the district level are not usually those with decision-making power, but project managers or representatives. It was discussed that DHMTs would need to display strong leadership in communicating with the DCs' under decentralisation, urging commitment, and alignment from partners with the DIP.

6.4.3.2 Small Changes from Partners

Based on the perspectives of a number of interview participants, it was felt that while there was some support for the DHMTs to have a better hold on resource mapping and partner coordination, there was also evidence of small changes in implementation practices in response to concerns from the MoHP. One development partner from Malawi had witnessed a change in thinking and practice among some of the larger development partners, stating that programmes were becoming "more willing to compromise" (P31_Female_Development Partner). For example, partners being more willing to align with Government of Malawi systems when it came to funding set aside for a specific area. For her organisation, they had wanted their work on HRH to focus exclusively on HIV, but it was finally agreed with the MoHP that 50% would go towards HIV and 50% offering other services. The participant explained that, together with other partners, they also made the decision to align salaries of the HRH that they employed with those of government staff to prevent challenges such as demotivation among government staff. Speaking of discrepancies in HRH salaries across partners and government, she explained:

> It demotivated everyone else, so that is the main difference, we have done it the old way, that is project staff and this time around we said 'no,' we are funding a lot of people, we are paying the salaries….and then we said, well, HIV can provide this, pay salaries for these people now but what happens when X[partner project] has no money? So, if we want this programme to transition smoothly into a government owned thing, we have to recognize that these people have to be treated as government staff now" (P31_Female_Development Partner).

The same issue came up with two of the other participants. One mentioned that government health workers felt that project staff were not part of the system because of the disparities in pay and other allowances. One development partner participant shared the following reasons for the recent changes:

> Whatever incentives the government is providing to the mainline health care workers is also what we provide. If we try to go outside that package it becomes difficult, because these people they will work together, they

will integrate with the whole system so when we try to come up with a different package it becomes a challenge (P28_Female_Development Partner)

The same participant noted change to how supportive supervision was now being conducted:

Now, we integrate when we go for supervision. If the DHMT goes to the site, they will supervise everybody. They supervise all disease programmes areas, they will supervise what is happening in malaria, what is happening in TB, what is happening in diarrhoea, across the board, so it's like one supervision. With that now it has become a system in Blantyre, whenever its supervision it's not just X [project specific] , it's everybody at the site, so it has at least improved the whole morale of all the health workers available at that site (P28_Female_Development Partner)

Other noted changes came from an NGO, relating their attempts to try and refrain from taking HCWs away from the facilities for training, while also noting that this is "what people like" (P20_Female_NGO). From the MoHP 's side, there was a tightening of procedures for research to take place in the districts, insisting that all proposals first got approval from newly formed research committees at district level such that "a bunch of researchers can't just request a letter from the DHO anymore, they have to present the research for approval and get approval" (P1_Female_Implementer). While positive changes were observed, it was still acknowledged by a number of development partners that to a large extent "each partner is [still] coming with their own thing and all of these are going to the few DHMT members, they are only five/six (P23_Female_Development Partner), rather than extending to other HRH. Another partner acknowledged that "it's mission impossible, for the government to coordinate so many partners in a fundamental landscape" (P20_Female_NGO). Challenges around coordinating stakeholders therefore held true across the majority of individuals involving in efforts to develop health leadership and management.

6.4.4 Problems Hindering Progress

In addition to partner coordination, several other areas provoked concern from individuals. Three of these key problem areas included challenges for implementers (6.4.4.1), decentralisation (6.4.4.2), and unrealistic expectations of the DHMTs (6.4.4.3). One of the most significant areas of concern was the lack of evidence demonstrating a trickle-down effect from district health level to primary health level, discussed in greater detail in Section 6.5.

6.4.4.1 Challenges for Implementers

> It would just seem like it was one kind of an adventure for people. A project comes and goes, and another one comes and goes, they profit out of it and then it comes and goes. There is no uptake, there is no even sustainability of interventions. One thing simply because people tend to see stakeholders, international NGOs, local NGOs as we are coming with interventions we are not coordinated at the top (P15_Male_Implementer)

The above quote demonstrates the varied perspectives of challenges faced by implementers on the ground in terms of leadership and management initiatives. The viewpoints shared often included issues around logistics and gaining commitment from healthcare workers, as well as the struggle to decipher if people were just telling the project leads and implementers what they wanted to hear. One implementer discussed the battle of competing with other projects with "interventions in the health sector having just turned to be like extra income for health workers, and probably that's one issue that relates to the management strengthening interventions" (P15_Male_Implementer). The participant went on to explain that in Malawi there had been no standardisation of allowances (i.e., travel or participation allowances) given to HCWs. Consequently, "some interventions are suffering because health workers tend to choose where to go based on, you know, what is in it for them" (P15_Male_Impementer). He went on to give the following example of a supervision intervention that he had been implementing:

When we were implementing X [project]…we went on a day that we had

agreed with the district. Everyone assured us that this day is okay with

us, then we got into the district a huge number of people do not turn up

and then we were asking, 'where are the people?'… 'aah you know there

is also another organization, (I will not mention its name), there is also

another organization that has come, it is also doing its activities and they

have gone there'. Then I was like, but when we were planning this thing

we were together and everyone else was like no this day is okay, so

meanwhile they knew that there was this other project on the same day

but they couldn't you know, own or shift our activity, but deep down in

their hearts they knew they had nothing to do with my activity because I

paid them less than what they were getting from the other side It's really

a very, I think a difficult issue if you look at it from a perspective of an

implementer. You look at the waste of resources, like that time this

example we just suspect that, that day fuel allowances and nothing really

of substance came out of that and then you have to replan, to

accommodate people" (P15_Male_Implementer)

Implementers also expressed concern for the sustainability of interventions in terms of the sincerity of those on the receiving end of interventions. These fears were reflected in a comment made by the health centre in-charge, when asked what occurs during an implementation visit: "I just say things that will please you in line with what you want but I am not going to be there to work" (P34_Male Healthcare Worker). This same health worker also said that PHC workers often take this approach when senior officers from the MoHP came to visit the facilities as well: "they are just people [more] interested in money than the service" (P34_Male_Healthcare Worker).

6.4.4.2 The Slow Transition of Decentralisation

The ongoing process of decentralisation in Malawi remains one of the key reasons for focusing on district level strengthening and DHMTs. One participant from Malawi with considerable experience with the decentralisation process, however, expressed strong

feelings about the threat the ongoing decentralisation process posed to health systems strengthening, stating that central level does not want to "let go":

> I see it in a different lens that probably the central is not too interested because what I have seen for example, one of the key issues in decentralisation. You have a centre which is strong, but it's the leader. They are looking at having new structures at this level, but the centre wants to remain the same. It wants to remain exactly how it is today, it has always been like that (P27_Male_Implementer)

Somewhat in agreement, and from the perspective of a senior officer in the MoHP, "we are not seeing but we are championing the reforms" (P17_Male_MoHP). A diverse mix of individuals also conveyed a sense of uncertainty about the decentralisation process in terms of people being confused about where they are meant to be physically situated or conflicted over "whether they should channel resources to the health centres or the district" (P16_Female_MoHP). This is consistent with what I observed when visiting some of the district hospitals and district councils. For example, in one district I would find that the DDHSS had been relocated to the district council, but within another district, the DDHSS would still be placed with the DHMT at the district hospital, with no immediate plans to relocate. In theory, the hospital management teams should have more responsibility over what happens at the district hospitals, but because they are not part of the DHMT, they have no access to financial resources. In a conversation with the head of an NGO, he too stated that there is a lot of confusion with the decentralisation process: "It's sort of, it takes you backwards. You go forward two steps, you go backwards three steps because of the power struggles in the whole landscape (Researcher's notes, May 2021). One participant told of his interaction with a director from the MoLGRD who had been in the system for a long time and provided insight into "why [decentralisation] worked then [turn of the 21st Century] and why it is not working now" (P15_Male_Implementer). According to the participant, there had previously been agreements between the MoHP and the MoLGRD that "recognised the district health management team as an integral component and a link between the two ministries so they used that agreement to empower the DHMTS' to do their mandate…at that level today in the absence of that agreement between these two ministries he thinks decentralisation doesn't work anymore because the ministry of local government now doesn't have the DHMT in their structure" (P15_Male_Implementer).

Moreover, the DHMTs were considered to still have little decision space at district level in this decentralisation process. This was certainly the view of a health care worker who considered the delays in decentralisation in the health sector as impacting on patient care or disciplinary action in the case of patient mismanagement "because most of the decisions are made at the central level, then they [DHMTs] are afraid of making some disciplines" (P5_Female Healthcare Worker). Several other participants agreed, mostly including researchers and development partners, referring to the ongoing lack of power that DHMTs have despite all of the efforts to develop their capacity in health leadership and management:

> They are in charge of managing the workforce but they don't have power, they don't have decision-making power, they don't have financial power or resources to actually put new midwives into places P10_Female_Researcher)

> You don't have so much decision power and the decisions are made for you by those above you (P3_Female_NGO)

> It's easy to point at the DHMT, people can say okay the DHMT is not doing ABC but when you take the issues to the DHMT what powers do they have to resolve those issues? (P20_Female_NGO)

6.4.4.3 Unrealistic Expectations of the DHMTs

High expectations of the decentralisation process meant that there were also high expectations of the DHMTs. This was reflected in the expectation that developing health leadership and management, more specifically at district level, would have a trickle-down effect to other levels of the health system. As mentioned in Section 6.4.4.2, DHMTs were still struggling with limited decision space, which was evidenced to be impacting on their capacity as leaders and managers. Moreover, it was apparent from my own observations as well as from feedback from individuals encountered during the research process that some of the interventions introduced to help develop health leadership and management at district

level were not necessarily welcomed or delivered as had been anticipated or even reported against.

A crucial example of how things were not quite as they seemed materialised in relation to supportive supervision (see Sections 5.3.5 and 5.5.2). Having identified a shortage of effective supportive supervision, several initiatives have thrown their weight behind improving supervision by providing DHMTs with funding support as well as accompanying the DHMTs on trips to PHCs to conduct the supportive supervision. While there was a common viewpoint that supportive supervision had improved as part of health leadership and management development, several observations were made that suggested otherwise. Following extensive mapping of the research data, an overview of these perceptions of supportive supervision feature in Figure 6.2

Firstly, any evidence of supportive supervision happening usually occurred when project staff or MoHP staff from central level accompanied DHMT members for supervision:

> The health workers don't get a lot of day to day or pre planned support from the DHMT, and it's really when the coordinators do their visits but those coordinator visits are donor driven so when there is money for that coordinator to do a round supervision they will but it's not necessarily something that is routinized or that the health worker can count on (P22_Female_NGO)

Secondly, there was very little evidence to suggest that supportive supervision continued beyond the life cycle of any of the targeted interventions. To the contrary, participants involved in funding supportive supervision visits, when probed, described falsified documents detailing visits that had not actually happened:

> They support the DHMTs to go for supervision…they just ask for fuel and the allowances from the office…so once in every three months or so, they go for supervision because what they said was that we do not have funds for supervision, but you see that a big chunk of money has gone for

supervision. When you look at their expenditure, which supervision did you go to? That is a problem we have (P35_Female_NGO)

Thirdly, there was a suggestion that DHMTs did not see supportive supervision as a priority, partly based on the value they attached to the process as well as their lack of capacity to offer supportive supervision. Understanding why DHMTs were not prioritising supportive supervision went beyond the usually cited lack of resources to justify lack of supervision. A participant from one of the larger NGOs with a focus on supportive supervision as part of leadership and management development admitted that despite providing ample resources to the DHMTs, "it's not been conducted as we would wish. There are a lot of excuses, there are a lot of other priorities that are really competing with this role of going out to supervise" (P24_Female_NGO). Another stated, "I do not know if this is right thing to say, but I think most of these people do not have a passion for what they do" (P35_Female_NGO).

Therefore, reasons for failure to provide supportive supervision varied from competing priorities, to not being able to face the primary health facilities without necessary resources, decision space or power to help with improvements. As one participant commented:

It was something that was very often put at the bottom of the pile. It was something that was done if they had some space left over to do it rather than being a key thing in terms of health service delivery… They were avoiding going out to health facilities because they knew what the problems were, but they had no power to do anything to address them, so they didn't want to go to see health workers who they couldn't support (P7_Female_Researcher)

This particular participant dwelled on the fact that there is little point in developing leadership and management capacity of DHMTs or others in the absence of a joined-up system that gives them the supplies and the resources and skills that they need. This was illustrated by the following example:

I had midwives telling me that they were constantly hounding the DNO or the DHO because for example they didn't have any sutures, so they were having to transfer people to the central hospital for perineal stitching because somebody hadn't got sutures into them which is an upstream thing from central supplies making sure that these things are in place (P7_Female_Researcher)

Consistent with ineffective models of supervision identified in Chapter 5, one participant involved in research on supportive supervision stated that while it is easy to be negative about the DHTMs, we are reminded that they are still following the "checklist, tick boxes and only gave people feedback when it was negative feedback" (P4_Female_Researcher) model of supervision. As this same researcher noted:

The DHMTs are under huge amount of pressure, and this is a model that they have. This is the structure. This is the culture that they are embedded in, so they are not seeing it but it's not their fault that they are not seeing it (P4_Female _Researcher)
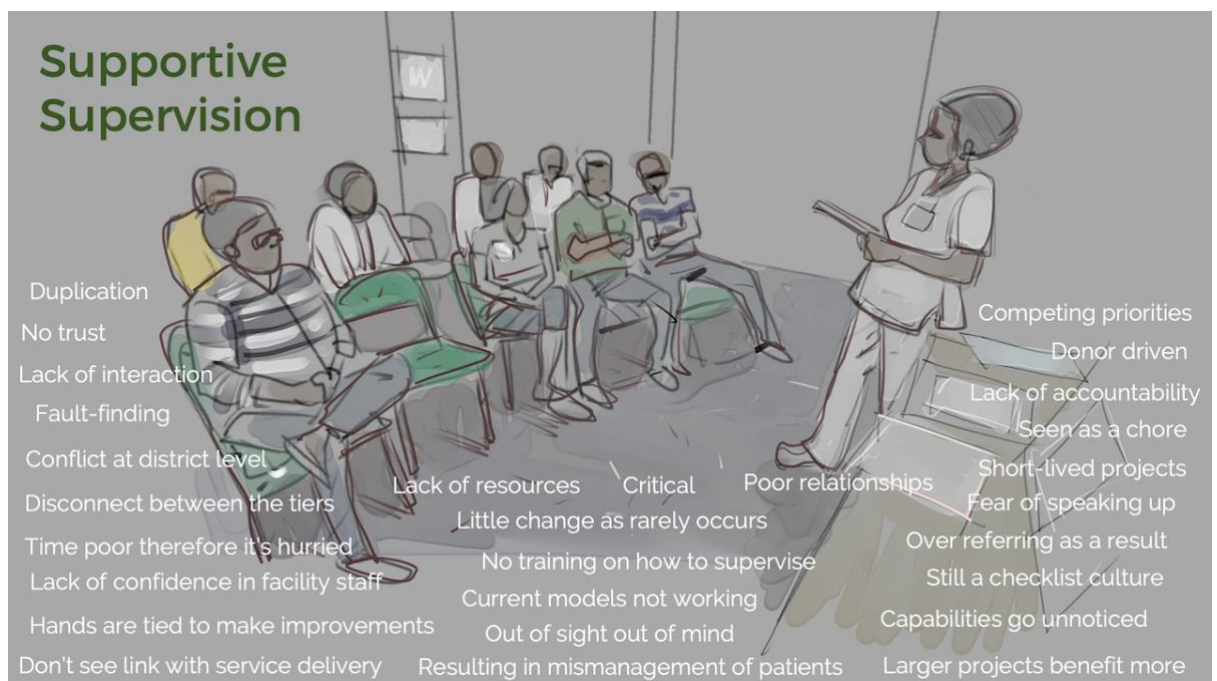

Figure 6. 2 Perceptions of Supportive Supervision

6.5 What you don't Know (or see) won't hurt you

Whereas the previous section has focused primarily on the perceived changes and recurring challenges of implementing LMP at district level, from the perspective of implementing partners, MoHP officials, and researchers, the following section explores the perspectives of participants operating primarily at primary and community level.

6.5.1 Wanting someone to Blame: Negative perceptions of PHC

Despite ongoing efforts, past and present, to develop health leadership and management, there are still many negative perceptions of primary level health care in Malawi. These negative perceptions, such as the belief that management at PHC are incapable of solving their own problems, were often the reasons people provided to justify intervening at district level. Many of these negative perceptions stemming from the data set are captured in Figure 6.3. Additionally, there was a sense that blame was usually attributed to primary level, whether it was from district, tertiary and central level, or from community members, and community healthcare workers. One example came from an NGO participant who had been working closely with the PHCs. She told the story of a pregnant woman who had lost her baby on the way to the district hospital. The in-charge from the PHC was blamed for the death because he allowed the expectant mother to go on a motorbike, rather than wait for an ambulance which if you are "lucky it will come, but if you not, it will not come" (P35_Female_NGO). In her own words:

> She goes on a motorbike with the relatives and on the way boom! The uterus burst and the baby died on the way and the uterus was damaged. Now, when they came to the district they faulted the in-charge, they said 'no, you are the problem'. But it was not his problem, not at all. When this issue came on the forum at the district level, they said no, we have to call the in-charge and summon him, then I said no, I got this news and I called Dr X, and I said this is completely not the fault of the person…I said 'look, what would you do? You are the in-charge, you have called for an ambulance and it's 8 hours already and the ambulance is not

coming. The person is saying no, I will go on the motor bike, I'll go to the district hospital and the person is in pain, then they take the motorbike and go. There is nothing else you can do, what would you do? Was he supposed to stop the people?" (P35_Female_NGO)

There was a sense that the HRH at the health centres were consistently perceived as incompetent. This was reinforced by staff in the district hospital who were frequently criticising frontline staff for how they were managing patients. This criticism was apparently rarely constructive. One health care worker told of a colleague who had recently assisted a baby who had serious health issues, who was then later referred to tertiary level after being stabilised. He stated that the hospital contacted him not to congratulate his quick action but to complain about why he did not refer the child in the first place. Another healthcare worker, a PHC in-charge, expressed anger at the lack of feedback the HCWs were getting: "just to send feedback to say that you managed this child well, that goes a long way. So, they don't feel appreciated at all" (P14_Female_Healthcare Worker). Rather, the in-charge said that the only feedback they get is "you killed this child" (P14_Female_Healthcare Worker). She said that she went to the medicine department at the hospital to discuss the lack of support the medical staff were providing to the PHC staff she was told that "health centre people are not teachable" (P14_Female_Healthcare worker). Feeling frustrated, she said to them:

> We have conducted a lot of training on how to manage diabetes but probably I think it would be ideal if we just go and manage patients with them [the PC staff] so they can learn and we can appreciate their problem too. 'No, that will not happen'. And it was an outright no. So, then you sit down and say, you know, you don't understand where are these people coming from, like, are you from this earth?? (P14_Female_Healthcare Worker)

With such negative perceptions of service delivery and health workforce performance at PHC level, there was also little evidence to suggest that those in more senior positions were willing to take the time to understand what was really happening at the facilities. This also meant that nobody was taking the time to build relationships or trust: "You can't expect to build a relationship and know what challenges they have and for people to open

up and trust them" (P14_Female_Healthcare Worker). Assuming that the frontline healthcare workers were simply incompetent was perceived as an easier option than facing the reality. For example, PHC staff were often responsible for people's lives, but they were not entrusted with other responsibilities such as payment for electricity and water. Moreover, it was not uncommon for the district level to delay in purchasing electricity units for the primary health facilities, in what felt like a blatant disregard for the challenge(s) of working without electricity. As one health worker put it, "people up there never had an experience of putting a drip in by candlelight, and it's really frustrating to work like that" (P14_Female Healthcare Worker).

Figure 6. 3 Negative Perceptions of PHC

6.5.2 Not Being Able to Walk Away: The Daily Reality

As a DHO participant said of the DHMT, it was easier to deal with what was in front of them, rather than face what was happening on the ground at primary and community level. This implied that unlike the frontline health management teams, DHMTs could choose not to see what was happening. For PHC staff, they had no choice but to face the daily challenges of the working environment and the organisational culture of the health system. This idea of the daily struggles of healthcare workers at primary level was conveyed by

several participants on the frontline of healthcare delivery. One participant said that staff at the PHC facilities were used to getting on with things in the absence of support from higher up the system:

> They do things on their own like. They are able to think critically and see how they can have solutions to the problems. I think they are even better than the DHMTs because most of the DHMTs are like 'no, we are the bosses' but these ones are at facility level, and they have a lot of problems, and then they have to get rid of those problem because I'm telling you, there are problems in the health centres. Problems you would not even like to hear (P35_Female_NGO)

One researcher felt that healthcare workers at more senior levels in Malawi, had probably started at primary level, "hated it, and managed to get out…now they choose to forget what they felt like to be in those situations" (P37_Female_Researcher). Additionally, another participant emphasised the stark reality on the ground when explaining how resilient the PHC need to be:

> I think too often they just kind of are out there, and at the same time they have also got the most difficult task which is to kind of to engage with the patient, and the fact that these patients are totally poverty stricken and can come too late and come in a really bad way, and then can't pay and they are the ones that also have to also engage with that reality, which at the district level they have managed to put that one step away from them. I mean the rather unpleasant side, that you know dealing with the, you know what we deal with in the hospital or health facility with the broken bones, screening the kids and then all that. You know the sad sides of health care. In the end by the time you've made it to the district level you are one step removed from that, so which is also probably also a bit yeah because it's tough, I mean sometimes I'm sure it's not a nice place for these health workers to be (P8_Female_Researcher)

One senior MoHP official who was keen to improve continuum of care through to community level, conceded to how the challenges increase for those PHCs that are situated

rurally: "This is challenging, challenging work that they need to be doing there" (P30_Female_MoHP). She used the example of communication, and the absence of networks, phones, and electricity in the more remote areas. Moreover, some health facilities are located so far away that it is not possible to get advice or help from other facilities or the district. The question the participant posed was "Who are the people that they are interacting with? Apart from the traditional leaders…how are they communicating?" (P30_Female_MoHP).

6.5.3 It's Survival: Finding Coping Mechanisms

Communication emerged frequently as an identified challenge in the health system. This was often related to poor communication across the health system, but also at the health facilities, between colleagues and between staff, patients and the broader community or catchment population. At a meeting where I presented preliminary findings, I heard about difficulties in communication between staff and with others as a daily challenge. Faced with a challenging environment with little support (supervision, resources etc) or training - including training development of health leadership and management capacity - HRH at primary health level were forced to find ways to cope with the daily challenges of their health system. An in-charge described the situation for staff at her own facility: "They have coping mechanisms that are not conventional but it's survival…these people do think, and they have ideas except I think that they are broken down every day's work" (P14_Female_Healthcare Worker). An implementer who had worked mostly at primary level, stated: I think to be very honest with you, I wouldn't say that they can survive on their own but I think they tend to be seen to be surviving simply because they have just resigned to fate" (P15_Male_Implementer).

Speaking informally to a colleague who had previously been an in-charge at a health facility, he echoed the sentiments raised in the opening quote of this chapter. It was not that he or his team were not aware of how staff were sometimes perceived to be rude to the patients, or rude to each other, but most people were too overburdened to deal with the challenges, leading to "depersonalisation" (P7_Female_Researcher). Indeed, depersonalisation was described as a common coping mechanism. One example was given of antimicrobial resistance. While healthcare workers knew that antibiotics should not be

prescribed for certain health complaints, it was thought easier to just write the prescription instead of dealing with an angry patient, as one of two-hundred people that a PHC clinician will see in a day.

What was described as an often "traumatising" (P35_Female_NGO) working environment meant that many coping mechanisms had become normalised and part of the organisational culture. To "preserve their sanity" (P14_Female_Healthcare Worker) health care workers described situations, like overprescribing, where they found ways of doing things that they knew were wrong but felt that it was easier to do so. They therefore were willing to compromise their own values, and go against their training, as a means of survival. Other examples included manipulating the rota, absenteeism, or providing poor service to patients as they were "demotivated and just wanted to finish the queue" (P14_Female_Healthcare Worker). As one participant described:

> If you are working in an overburdened system, and you are exhausted, and you're trying to pay your child's school fees or trying to get your son through the university, and you are working two jobs. You are working as a private nurse at night and working during the day at the primary health clinic, of course you will be exhausted and of course you are going to resent all the patients coming in and of course you or going to treat them just badly because nobody cares about you (P37_Female_Researcher).

6.5.4 Risks of Being Effective: Push Back on Good Leadership

While there was little evidence of effort to develop health leadership and management at primary level, there was evidence to suggest that effective leadership and management already existed at this level, through examples such as the triage intervention. Against the backdrop of a challenging environment, however, there was repeated evidence across the dataset to suggest that displaying effective leadership and management within the health system, particularly at the lower tiers, often resulted in a strong push back from other staff members. Some participants expressed how challenging it was to be a good leader or manager because of the adverse consequences. There was a strong sense from participants,

particularly the healthcare workers, that fear was a deterrent to speaking up, preventing them from taking disciplinary action, delegating, asking for advice and being accountable.

Healthcare workers provided examples of how some of their colleagues reacted negatively to what they perceived to be effective leadership and management. The term often used to describe these reactions was "jealousy". A PHC in-charge quoted a proverb that his mother used to say to introduce his story: "The tree that bears best fruits receives more stones" (P34_Male_Healthcare Worker). Stones often used to knock mangoes down from trees, were compared to those people trying to knock down or ruin plans for those people who are doing well. Relaying an incident that occurred during his time as an in-charge the participant stated: "Either it was I'm a bad leader or it was that I am good, and people are not liking my style of leadership" (P34_Male_Healthcare Worker). He went on to recall a time when he was absent from work when donors came to meet with him after he had been advocating for new equipment such as scales, stethoscopes, and thermometers. They donors had wanted to present this equipment to him directly. He said, the staff "reported that this one is dead. He had been working here but now he is gone…people said this man has died, when I was alive" (P34_Male_Healthcae Worker). Following this incident, he left the job for some time. According to the participant, "some confessed, and they had to say I am sorry for whatever happened, it was just a matter of jealousy" (P34_Male_Healthcare Worker).

Other examples of leadership challenges included the perceived lack of authority among health centre management teams. One participant involved in health centre inspection told of a recent visit to a health centre where the in-charge was complaining that the HSA was refusing to give him the weighing scale: "so we called the HSA, we had to reprimand the HSA. The HSA had to give the weighing scale" (P26_Male_MoHP). There were frequent mentions of times in which those in positions of leadership or management felt that there was an absence of neutrality in the health system, and that they did not feel that they had a safe space to go and report concerns. There was therefore a fear associated with speaking up because of the consequences. In one interview I asked a participant, "how do the healthcare workers react to someone who is actually trying to make a change?". To which the participant replied, "they will strike in, they will move that person…what I have observed, they just respond by transferring that individual without maybe disciplining the healthcare workers" (P5_Female_Healthcare Worker). Moreover, another participant

stated that, in her experience, when those in-charge at health facilities took steps to hold people to account they were at risk of having their power neutralised or authority ignored in what she described as "horizontal violence" and "tall poppy" syndrome. In her own words:

> If you do your job, and if you take steps to hold people to account, not only will you be facing the possibility of witchcraft being used against you but there is also a type of horizontal violence that goes around the chain where people block out supervisors or management and don't allow them to do their job by just refusing to cooperate. That's the top tall poppies thing where they cut people down…people would gang up against somebody who is trying to, like I said, a new ward in charge comes in and wants to make people perform better, being frozen up by the rest of the staff who just refuse to cooperate and won't speak to them and basically neutralize their power or their authority by just refusing to acknowledge it (P7_Female_Reseracher).

A leadership and management consultant in Malawi said that he felt people were afraid to express any sense of vulnerability that they cannot do their or job or to ask for help therefore "both issues around delegation and asking for health are sort of in my view, endemic" (P2_Male_Implementer). To appear vulnerable may mean that you will lose your job. Related to vulnerability and perceived lack of authority, several of the participants' felt that because PHC level was not the target of heath leadership and management development, they were therefore considered overly dependent, or they felt dependent, on the district level, which she compared to the concept of "learned helplessness at the facility level" (P4_Female_Reseracher). This idea of learned helplessness was linked to a lack of decision space at primary level and the fear of making a decision without input from the district:

> At times you have staff but they lack decision making authority, you see, so they are faced with a situation and they will be waiting for their managers to make a decision, it's also another thing, where the stuff will feel basically not empowered (P13_Female_Healthcare Worker).

Let's just write a letter to the district health management team or to my superior in the team, or whatever and they wouldn't attempt to solve it themselves as they just wouldn't think they have the authority to do it I think (P4_Female_Researcher)

6.6 What People Really Want

Findings thus offer an analysis of what people have been doing in Malawi to develop health leadership and management as part of health systems strengthening, as well as their individual perceptions of why they are doing it. Findings also reveal a discrepancy between how people feel health leadership and management should be developed, versus how it is currently being approached or has been done in the past. Emerging from some of the workshops and meetings was the major realisation for those participants focused on district level, as well as among other stakeholders, that efforts needed to extend to different levels of the health system, and even to different management team structures at district level, including the district council. The final section of this chapter thus turns to summarise thoughts shared by participants on what they thought ought to be happening to develop health leadership and management in Malawi.

6.6.1 On Second Thoughts: What about the providers?

I guess what we do too little is to put ourselves in this perspective of a primary health care worker (P8_Female_Researcher)

Challenging the common assumption that strengthening district level would trickle to primary level and improve health workforce performance and service delivery, I often asked participants if they really thought that this had happened or was going to happen based on current efforts. On more than one occasion during the interviews, participants commented that this assumption had not been given much thought and it was referred to as "a black box" (P12_Female_Researcher). Others said:

I think a question that a lot of people are not asking is your question, how do you really link that with building capacity of the frontline health workers? (P22_Female_NGO)

Trying to unpack that management strategy to improve workforce performance is really important and I think it's good that you are doing this study (P12_Female_Researcher)

This is interesting to explore because often we are just looking from the management perspective from hierarchy from up to down. But not down to up…I think that our assumption was too big because we developed the tools really from the desk (P10_Female_Researcher)

Another participant stated that the reason that they included improving workforce performance on their grant application and in the theory of change was because that is what the funders were looking for and therefore concluded that the project was most probably funded on assumptions. I wrote in my research diary "epiphany??!!" after an interview had commenced with a participant first stating that it was essential for district level to be the target area (as per her project) and then mid-way through the interview and after some reflection, the participant shared the following thoughts:

You are right, everyone is focusing on the district, all of the interventions will go to the district level….I think if am to be asked which one would you start first to build the capacity I would first of all look at the facility level, because this is, we are receiving the problems, you know we are trying to encourage that we need to strengthen the tertiary level, tertiary level has to be a specialised health care system, the districts level, that one should make sure that they are able to receive cases from the facility level but if the facility level is so weak everything Is going to be weak because our system is bottom up, so if the bottom is weak it means that everything is going to be weak up there, so we need to first of all focus on the primary level. We want to make sure that the prevention part is strengthened so the prevention has to start from the primary level, so if we are to strengthen our health system we have to make sure that our

primary level is so strong, every case that is referred to district level must be a real case that has to go to district level but if we have a strong primary level, primary healthcare system, I think that one, I think it can really help as a country so my first priority would be primary level, so our managers at facilities level they need to have those skills that will enable them to manage their health centres well (P28_Female_NGO)

This passage captured the sentiments of others as well, however, and as further illustrated below, people were not necessarily advocating to stop targeting the DHMTs rather, it was said, "yes we can focus at the district level, we can focus working with the DHMTs but I think they are just one part of the solution…quality care can only change if we are focusing on the providers themselves who are in direct contact with the patients and clients" (P13_Female_Healthcare Worker). To further reinforce this perspective:

The health centre staff, the management should also be taken on board on X [project] so that we strengthen management at both district level as well as health centre level (P16_Male_Implementer)

The shortfall which we have seen with the leadership skills with the medical doctors, it's the same with the medical assistants and the clinical officers (P21_Female_NGO)

There is no point doing anything at district if you don't do anything at primary because one buys into the other…(P37_Female_Researcher)

Others were saying these cadre [from district] look down upon us. They think they are better in terms of their preparation. As much as I appreciate we are different levels, but when it comes to the care let us look at the different roles that individuals have so that we improve on that and serve the patients better (P30_Female_MoHP)

I think it has to cut across, so one of the key things is to get a buy in, like I'm saying both in the primary, the tertiary, you know the government every level should buy in and then how the intervention will be

approached for each level may differ, you know because their challenges are different I don't think it's something that we can do in silos, you know so I think it's something that we have to look at in a very holistic way (P6_Female_Researcher)

An important viewpoint emerging emphasised the importance of primary care and the reality that health centres are the first port of call for patients and therefore they should:

Start from the health centres, because we also have others, we except those maybe that are around the district hospital but mostly if they are far, they go first to the health Centre. So, the health Centre is the first contact of these patients so if we equip well, a lot of people can be saved, we cannot lose a lot of people (P5_Female_healthcare Worker)

It's got to be a first port of call and they have got to respect the patients and for that, they do need leadership and management training (P37_Female_Researcher)

Overall, there was a realisation that was happening at district level should also be reflected at primary level.

6.6.2 Small but Mighty: What We Know is Working

It was evident from the findings that there were examples of initiatives, albeit fewer and with a smaller profile, of how developing health leadership and management at primary and community level can build a strong foundation towards health systems strengthening. These initiatives were varied but with the commonality of investing at both community and primary level as part of health systems strengthening. There was a shared vision to empower primary and community level through social accountability initiatives and moreover, there was a greater sensitivity towards what people are facing on the ground and what HRH really want, in addition to or beyond remuneration. Three key categories emerged when asking participants what it was that drove the focus to develop health leadership and management at other levels of the health system: Patient disengagement

with health care at primary level (6.6.2.1); Not asking healthcare workers what they want (6.6.2.2), and the value of a systems approach (6.6.2.3). All three of these categories resulted in positive and tangible outcomes which presented as strong advocacy, enthusiasm and passion from the participants involved for more investment and backing from the government and development partners. These participants were more convinced of what they were doing as part of health systems strengthening than many of the other interview participants who had been advocating for a 'district first' approach.

6.6.2.1 Patient Disengagement with Healthcare at Primary Level

Responding to an identified gap in breakdown in communication between community level and primary level, there was evidence that taking action towards fostering mutual respect between the health facilities and community members, resulted in evidence of collective accountability, and health centre management teams trying to solve their own problems. As one participant stated, beforehand "these people [community members from community structures] are shunning away from helping the health sector because they see it as an imposed thing. It's closed, so can we open it up and see what will happen" (P35_Female_NGO). An implementer adamantly stated:

> It's better to train these people [HCMCs] than wasting resources training the DHMT because I'm telling you one of the things that I'm proud of is that one of the facilities were able to raise funds on their own and build a ward, so if we put our resources in training these people, we can even get more than expected. It is a fight but by and by it will be won as we go (P35_Female_NGO)

This participant went on to explain that while the PHCs were demonstrating and taking more responsibility, there had also been efforts to sensitise community members of the burden experienced by staff, which had resulted in less complaints and more engagement from those in the catchment area. Recalling an interface meeting held with the HCMCs:

> We explained these to them to say okay, if you were in-charge, what would you have done? One person may be catering for over one thousand

people a day, had no time to rest, that's why they had attitude. What can
we do to help? Can you understand the in-charge and maybe try as much
as possible to come to the health centre in good time, so he can have time
to rest? If you see a person is sick in the night and can wait until morning,
at least he can take a pain killer and let him rest in the night and in the
morning you can go to the health centre?" (P35_Female_NGO)

Given the reality that "resources don't usually trickle down to the facilities"
(P27_Male_NGO) improved relationships with the HCIGs meant that HCWs were now
able to purchase or borrow from a local grocery something as small as a lightbulb, as
making the difference between a woman delivering in the dark or by light. And over time,
one participant stated that this increasing trust had resulted in increased confidence:

I think over time there was capability of them doing more because to say
the truth, health centres around here have improved very much, people
are taking chances to help, like, "what can we do?" (P35_Female_NGO).

Another example given by a different participant was that of a stolen water pump. The
facility in-charge sat with the traditional leaders to discuss how they were going to make
sure that water could get to the health facility. In the end, together with the traditional
leaders, they all came up with a solution to have community members assist with bringing
water to the facility: "they have sourced money up to three hundred thousand to replace the
water pump. Now they are organising a big walk to source additional money before they go
to the government to ask for money. So, I look at it as something that there is a big trust
between the facility manager and the community, they are able to be together and solve
problems of their facility" (P28_Female_NGO).

6.6.2.2 Not Asking Healthcare Workers What They Want

Many of the challenges identified at primary and community level resulted from
assumptions about what was required at primary and community level. As one health care
worker stated: "Why don't they ask us what we want?" (P5_Female_Healthcare Worker).
This was a common view amongst healthcare workers, who commonly emphasised that

when healthcare workers are given the opportunity to speak up, they will often place emphasis on wanting more support, better relationships and more opportunities to learn. Hearing from a health centre in-charge, she said:

> I've come to know it's not about money. I think it's about being with them and appreciating that relationship because when you talk to them, they do think that the DHO has a lot of money, but I've talked to the DHO too. The DHO too is struggling with resources so it's about that mutual relationship about what is possible and what is not (P14_Female_Healthcare Worker).

Moreover, some of the implementers found that healthcare workers, especially HSAs, wanted more supervision from their peers. One participant researched current satisfaction of HCWs said:

> One of the key things they all said was 'we would really like to be supervised more, have more support, helped', and you can't help but think if people were just happy hiding and doing a crap job that then they wouldn't be saying they want people to come and check on them (P1_Female_Implementer)

One researcher commented that she had found, in another SSA country, that if you listen to what people actually want and "people are getting enough out of the process, if it is solving their problems, if it is alleviating their stress and worry, if they feel less alone than the problems they are trying to address, then they will go the extra mile" (P04_Female_Healthcare Worker). Another participant focused on lifting the HCW out of a lonely place where they "feel supported, feeling that their own personal welfare is taken care of" (P13_Female_Healthcare Worker). Additionally, healthcare workers stated that "they should be sending in-charges on courses, then they should be coming to the clinics and once the in-charge has been trained, supporting the in-charges to do leadership trainings within clinics" (P37_Female_Researcher).

6.6.2.3 The Value of a Systems Approach, Not Project Approach

There was little evidence of the use and application of systems thinking as part of health leadership and management development in Malawi. However, there was evidence of a mindset that illustrated a desire for "approaches not projects" to prevail (Researcher's notes, May 2020), towards development that was more widespread and long lasting. In particular, those involved in other leadership and management training programmes highlighted the need to invest in individuals from the moment that they enter the system:

> I think we have to think about where these people will end up and then
> prepare them appropriately to those positions…so it becomes the way we
> do things (P32_Male_NGO)

Moreover, it was stressed that leadership and management should be a core subject for all those involved in healthcare training so that people do not end up in "situations where they cannot cope" (P2_Male_Implementer). Here, the implication was that focusing exclusively on existing management teams results in unequal opportunities for others across other levels of the health system to develop their skills in leadership and management. The same participant stressed there was a need for "weeding" (P2_Male_Implementer) out the ineffective leaders and managers and to focus on developing the good ones and to make the training part of the system. This same participant also stated that this approach should be over a ten-year timeframe, as he saw "no value in doing it only for a year" (P2_Male_Implementer). He also advised that such approaches should "scaled up and aggregated rather than saying 'ours is the best way and we have the truth and you haven't" (P2_Male_Implementer).

Another individual involved in health leadership and management training in Malawi, who is also the head of an NGO, provided insights into the successful outcomes from his organisation's systems approach to health systems strengthening. Despite operating remotely, the district the NGO was operating in had one of the strongest referral systems in the country, whereby referral is considered an indicator of good performance. The approach focused on strengthening all levels of the district concurrently, not limited to a particular disease, but looking at the whole breadth of the district health services and

different elements of health systems from infrastructure to HR support, logistics and supply chain, and direct clinical service provision.

The participant painted the picture of an approach that was invested in staff to ensure that they also saw the value of good health leadership and management, with emphasis placed on supporting primary facilities through mentorship. The approach also saw mentorship of HSAs to help with referrals back and forth between the community and the health centre. This investment in the staff was reflected in several comments made by the participant. He mentioned that staff turnover was very low and that they had the longest running DHO in all of Malawi, allowing for consistency and "stability of presence" (P34_Male_NGO). This was in contrast to District Commissioners, for whom there was rapid and frequent turnover, as another ongoing challenge of decentralisation. The participant also shared the following quote from his church pastor who had joined the district in the last six months to illustrate the strength of the system: "you know what, I have not had to attend a funeral since I came here" (P34_Male_NGO). He went on to explain that this was an indication of change through focusing on developing the leadership and management across the district:

> You ask the local people, they will tell you the same because not long
> ago health services were so basic, there were so many challenges that
> people were busy, basically, you know, with the funerals and all that, and
> you see now the shift (P34_Male_NGO)

When asked why the MoHP was not scaling up this kind of model the NGO participant stated that it is usually about cost, even though the cost of doing nothing was much greater. In his words, "we are still going to pay the cost at some point for what we are not doing today, and it will still eat up a lot of resources when it comes to that" (P34_Male_NGO).

6.6.3 Pang'ono, pang'ono (Little by little)

So far, Section 6.6 has highlighted the principal areas that participants' think should be incorporated into the continued development of health leadership and management in

Malawi as part of efforts towards health systems strengthening. These and other prominent suggestions across the dataset are captured in Table 6.1.

Table 6. 1. Participant suggestions for Leadership and Management Development going forward

Suggestions for Health Leadership & Management Development

Encourage Asking for Help
"Seek help & seek support"

Align with National Priorities
"Work directly with the ministries at district level, so you are able to sit alongside the local leadership here & draw plans together & see them implemented"

Capacity Needs at PHCs
"Ability of the facility level managers to solve their own problems"

Assess Supervisory Capability
"360-degree assessment of supervisory capability"

Avoid Duplication
"Don't duplicate & let's build on work that was happening before"

Improving Working Environment
"Got to have a conducive environment"

Ask the HCWs
"Ask from their perspective"

Establish Trust
"Bring in some trust "

Soft systems
"Capture the software of performance"

Challenge what's happening
"Directly challenging the model that's there"

Teamwork
"It's the power of the team rather than the individual"

Invest in Education
"If you send me to school today, when I come back, the way I see things will be different"

Collective Impact
"Looing at how individuals, agencies, can complement each other"

Collective Responsibility
"Collectively we have a responsibility to ensure that this is a safe environment"

Draw on strengths
"We need to think about the composition of the team"

Empower to Support
"Empower those at the bottom of the chain to contribute to decisions that are being mad "

EIDM
"To apply evidence to all the decisions we make in health"

Work as One
"Function as one unit"

Suggestions for Health Leadership & Management Development

Team Effectiveness
"You have to be measuring team effectiveness"

Ongoing Monitoring & Support
"You need long term follow up"

Coordinate Efforts
"Come up with a consortium because you are people of the same mind, each partner gets their component"

Systems Thinking
"Having much more of a holistic approach

Provide Tools to do the Job
"Support for the working environment & what they are able to do"

Build Confidence
"We need to build confidence, to raise their motivation"

How to Capture the Intangible
"It's hard to measure & it's all about intangible stuff"

Integration
"Getting them together, discussing their issues together"

Merging of Ideas
"We need to have interprofessional collaboration"

Learn from Others
"Learning from other sectors, and how they do it"

Decentralisation
"Link them up with managers outside the health sector"

Longitudinal
"The intervention needs to be done at length and at scale "

Make materials available
"Make them open access"

Guidance on Implementation
"The in-charges at the health centres need proper implementation guidance"

Enough Research
"We should go a step further to help in addressing some of the issues that we found"

Consensus
"People need to have a share problem identification and a shared problem way of thinking"

Change Agents
"Need a critical mass of change agents"

Transparency
"We need honesty to help us move on"

Mentorship
"The issue of mentorship needs to be looked at seriously & focused on "

Need more than Hope
"Need to engage more at that level"

Need to be Realistic
"Circumstances will hardly change but just how to cope with the situation"

Not just the Leader
"We need to be thinking about the whole team"

Always have a Plan B
"Let not some simple hiccups because of the gadgets or app stop the supervision"

Prioritisation
"Not about resources, it's about prioritisation"

Direct Donors
"If any donor is coming to the district they need to point to the primary level"

Encouragement from Senior Staff
"Just to have an encouragement from the seniors"

Recognise Limitations
"DHMTs should be able to recognize their limitations"

Support Each Other
"Help them recognize each others' strengths and weaknesses"

Share what's Happening
"In case there are good things happening out there, what are the new trends coming in"

Collective Leadership
"Create less dependency on an individual leader"

Sustainability
"Consider sustainability given the funding availability"

Sufficiently Engage
"So that they take responsibility for their own learning"

Best way to Measure Impact
"Thinking about the measurements that are in the system"

Consider patient safety
"Safety is a big focus"

Challenge Culture
"Don't just accept that's the way things are"

Work Within Means
"Need to work with what we have in Malawi"

Theory of Change
"It should be created collaboratively"

Instilling Pride
"Making it a good place for everybody to be in the health centre"

6.7 Chapter Summary

In fulfilment of the fourth and final objective, this chapter presents the findings from an in-depth exploration of how health leadership and management approaches are being implemented in practice in Malawi.

This chapter highlights a stark contrast between what stakeholders assumed to be happening and the lived experiences of those intended to benefit from leadership and management interventions. Moreover, while assumptions were explicit, and implementation was ongoing, there was limited evidence to suggest that evaluation of efforts, often short-term, provided strong linkages between the development of health leadership and management and HSS more broadly. Findings also indicated that priorities in the health system are often determined by external interests and investment. While there was tussle and power-play between decision makers in government and external partners, as well as infighting within government and across ministries, there was an eventual coming together of key actors (mostly international funding partners) to harmonise some of the efforts towards district strengthening, as part of the MoHP's leadership and management training programme.

With much of the focus being directed at DHMTs, it was evidenced that these already overburdened teams faced unrealistic expectations as health leaders and managers. Moreover, despite encouragement by those involved in developing health leadership and

management to include the preventative health directorate in planning, this directorate was largely excluded from this process. This was observed as a long-existing hierarchical challenge concerning curative health services taking precedence over preventative health. The resulting impact of this "missing link" mirrors a specific and tangible lack of attention directed towards HRH at primary health care level. Additionally, findings presented in this chapter further highlight the negative impact of a poor working environment and organisational culture on health leaders and managers at lower tiers of the health system, as well as on other HRH, and patients. These contextual factors resulted in a push back on effective leadership.

Grounded in the data, there was an identified desire for efforts to focus on developing health leadership and management at all levels of the health system, leveraging existing, yet often ignored strengths and resilience at primary health care level. Thus, the development of health leadership and management in Malawi should be inclusive, system-wide, collective, integrated, more supportive and attentive to the needs of the healthcare worker, as well as being open to learning and mindset change.

Chapter 7 will synthesise findings from across empirical chapters 4-6, discussing these findings in the context of the broader literature as well as contributing a theory for how health leadership and management can be understood and developed further for HSS in Malawi.

Chapter 7: Discussion and Conclusion

7.1 Introduction

The overarching aim of this thesis was to develop a theoretical model for how health leadership and management can be understood and further developed for health systems strengthening in Malawi. So far, chapters 4-6 offer an in-depth description of leadership and management for HSS in the context of Malawi, including a comprehensive stakeholder analysis, interpretation of how and why leadership and management is conceptualised, implemented, and delivered, and identification of strategic suggestions from stakeholders on how the development of health leadership and management can be further adapted and strengthened. Using a qualitative case study approach, underpinned by a social constructivist epistemological stance, and drawing on the concepts and tools of soft systems thinking and grounded theory, facilitated an exploration that was cognisant of the factors, at different levels, which influenced and impacted on the development of health leadership and management in the Malawian context. The current chapter synthesises these results to put forward a comprehensive theory for how leadership and management is developed and could be further developed going forward to strengthen the Malawian health system.

Accordingly, Section 7.2 discusses the main inter-related issues emerging from the empirical work, with reference to the relevant literature presented in Chapters 2, 3 and 4 and; Section 7.3 synthesises the research to present a theory for how leadership and management can be understood and further developed for health systems strengthening in Malawi, illustrated by a theoretical model. The final sections of this chapter and thesis discuss contributions to knowledge and implications of the research (7.4); limitations and recommendations for future research (7.5); and finishes with concluding remarks (7.6).

7.2 Key Emerging Issues

Given the limited evidence base within this context, this thesis aimed to advance knowledge and understanding on developing health leadership and management capacity for health systems strengthening in Malawi. Through the experiences of stakeholders involved in health systems, and health systems strengthening in Malawi, and in my own capacity as an embedded health systems researcher, multiple qualitative research methods were used to provide an in-depth exploration of how health leadership and management is being

developed within the context of Malawi, from conceptualisation through to implementation and lived experiences on the ground.

Four research objectives were identified, and each objective investigated and responded to across empirical chapters 4-6. As a reminder, the objectives of this thesis were:

1) To offer an in-depth description of current leadership and management for health systems strengthening efforts in the context of Malawi, including the identification of key stakeholders involved

2) To describe how key stakeholders conceptualise and understand health leadership and management in this context;

3) To identify why health leadership and management approaches are being used to strengthen health systems within this context;

4) To explore how the development of health leadership and management approaches are being implemented in practice in Malawi.

The central ethos of this thesis was attentiveness to the role of context in Malawi and its influence and impact on health leadership and management development. Context was a cross-cutting consideration across all empirical chapters, demonstrated to be comprised of and influencing a range of factors at different levels across the working the ecosystem of the health system. Emerging from this thesis, within the context of Malawi, are 4 key issues with implications for health leadership and management development within Malawi, and possibly further afield. In this section, I discuss these interrelated issues with reference to the relevant literature:

(i)   A System of Disconnects: Fix Systems, not People

(ii)   Impact of the Political Economy on HSS

(iii)   Rethinking Leadership and Management Development Approaches

(iv)   The Elephant in the Room: Neglect of PHC Providers

7.2.1 A System of Disconnects: Fix Systems, not People

The opening sentence of Chapter 1 explicitly declared the content of this thesis as being "about systems thinking, health systems strengthening, and approaches to developing health leadership and management in SSA settings, and more specifically, Malawi" (Chapter 1.1). It is therefore appropriate to forefront this discussion section of the thesis with attention to "the system", both within the context of Malawi and situated within the context of the broader literature. The findings of this thesis are consistent with those of numerous other studies within HPSR, as well as relevant health systems theories, frameworks, experiences and thinking that acknowledge that health systems are "complex, messy, hard to understand and even harder to change" (Agyepong et al., 2012; De Savigny & Adam, 2009; Hoffman & Frenk, 2012; Hunter, 2015, p. 1; Jackson & Sambo, 2020). In fact, it would have been an anomaly to find that Malawi did not conform to this description of health systems. Moreover, understanding health systems as more than just building blocks, but rather made up of the multiple relationships and interactions between the different blocks, guided the use of a soft systems thinking lens to try and identify, unpack and understand how things were connected to each other within the system as a whole and how these connections impacted on health leadership and management development for health systems strengthening (DeSavigny & Adam, 2009; Gilson, Elloker, Olckers and Lehmann, 2014; Peters, 2014). Accordingly, in paying close attention to the connections within the health system in Malawi, as part of understanding how health leadership and management was being developed, it became increasingly apparent that the health system was often perceived to be dysfunctional, weak, or underperforming due to there being more fragmentations and disconnections than connections. Understanding what these disconnections were, what was causing them, and why they were not being resolved, therefore emerged, and formed part of the process of qualitative inquiry of this thesis.

Disconnects appeared everywhere: between the different tiers of the health system, in communications and patient referrals; between Ministries; between cadres; between stakeholders; between stakeholders and government; between leaders, management and staff; between preventative and curative health; between policy and implementation; between communities and health providers; between who had power and who did not; between organisations; between theory and practice. There was a disconnect between

assumptions made, and what was happening on the ground. There was a disconnect between what people knew, and the subsequent decisions that were made with that knowledge. These disconnects were often caused by blockages in the system, preventing flow and inevitably hindering progress towards health systems strengthening.

Within this complexity, was a reminder that health systems are also complex "social systems", with a need to draw on soft systems approaches to decipher people complexity and thus construct meaning from the myriad of different perspectives from the stakeholders involved in the health system (Checkland, 1981; Jackson, 2019). Moreover, and as evidenced in Chapter 2.2. through the assortment of health system frameworks, there is never only one way of seeing things or doing things. Therefore, the use of soft systems thinking was critical to this thesis, particularly for facilitating a deeper understanding of the behaviour of the system, including an appreciation of the relationships, values, norms, principles, ideas, interests, and goals within it (Checkland, 2000; Jackson & Sambo, 2020; WHO, 2020; Whyle & Olivier, 2020). This was challenging however, and drawing also on Charmaz's (2006) constructivist grounded theory approach to analysis, helped to break the data down further to see meanings and processes within the multitude of perspectives that were gathered as part of this research. Also adopting a constructivist grounded theory approach to explore management strengthening from multiple perspectives, such as Tetui et al. (2016) did in Eastern Uganda, allowed this thesis to go beyond the health system statistics to engage with people and context, but also to grapple with the software of the health system at a more granular level, as well as to challenge assumptions that the participants had about health systems strengthening.

There are many people/institutions in Global Health and HPSR who claim to be using a systems-thinking lens to understand the complexity of health systems. Numerous global health actors even claim systems-thinking to be the most efficient way to approach health systems complexity and health systems strengthening (Agyepong et al., 2012; Paina and Peters, 2011; Peters, 2014; WHO, 2020; Wilkinson et al., 2017). What was evident in my own research, however, was that bridging theory to practice and applying systems thinking to real-life situations is complex in itself and requires much more than a tokenistic box ticked, as was sometimes seen with some of the development partners in Malawi, and as noted elsewhere (Carey et al, 2015; Rusoja et al., 2017; Wilkinson el., 2017). Challenges with applying systems thinking in Global Health were discussed at length in

Chapter 2.3.3, therefore, it was not surprising to see some of the same challenges appear in this thesis (e.g., underutilisation of tools and methods for systems thinking; lack of knowledge on health systems complexity and systems thinking; little evidence of rigorous evaluation of initiatives). When looking at programme evaluations for leadership and management development and health systems strengthening initiatives, for example, many had included a Theory of Change, or other evaluation components to note changes that were presumed to occur in the system as a result of intervening, but these were not often reflective of the reality on the ground. A key example of this was the assumed impact at primary level, however, there was minimal evidence of change as a result of strengthening management at district level. In sum, as also often identified with use of SSM, there was evidence of systems thinking being used for problem structuring and/or defining and identifying the intervention, with less evidence for its implementation and outcomes (Augusston et al., 2019). Therefore, if we are truly going to use systems thinking approaches for health systems strengthening, we need to be rigorous and transparent about what we did and what emerges as a result. Ideally, this should be the case, even if the findings are not necessarily favourable to funders or other stakeholders. This challenge is not unique to Malawi, however, and promises of systems thinking have not been fully realised in Global Health, particularly in the form of practical solutions across sub-systems (Adam, 2014). One suggestion towards practical application of systems thinking may be to learn from the approach used in a recent leadership development initiative in Kenya, where a locally adapted taught course on complex health systems was integrated into the training for health managers (Nzinga et al., 2021). The course included learning on conceptual skills and practical tools for understanding and navigating health system complexity.

While disconnects were observed between theorising about systems thinking and systems thinking application, there are, however, challenges in capturing more distal impact, as illustrated by one implementer from Malawi who expressed dismay at always being told what beneficiaries think they want to hear, and as confirmed by a health centre in-charge when he agreed that this is exactly what they do. Moreover, there has to be a sincere desire to want to know about the lived experiences and the reality on the ground if real change in the system is expected to happen. Again, it is often the case with short-lived projects that it is more a matter of getting the project activities done within the timeframe, with little evidence of interest in long-term change (Adhikari et al., 2019; Rwabukwisi et al., 2017).

Consistent with the literature, the need for interventions to target the long-term development of health leadership and management was reflected across participants involved in health leadership and management development programmes in Malawi (Bates et al., 2014; Bates, 2018; Daire et al., 2014; Gilson & Agyepong, 2018; RESYST/DIAHLS, 2020). This was perhaps best evidenced by two of the participants independently declaring that Malawi needs "approaches, not projects". Moreover, while there was an expressed desire for institutionalisation, there were few examples of this happening in Malawi. Reasons for this are discussed further in Section 7.3.2. It should be noted that there is still some hope for the Leadership and Management Training Programme for health managers to be institutionalised, however, it is currently still dependent on external funding. These findings critiquing the longevity of projects and lack of integration into the existing systems are not novel, and are reflected across other examples of implementation for HSS (Rwabukwisi et al., 2017). Specific to health leadership and management development, Johnson et al's (2021) scoping review of interventions to strengthen the leadership capabilities of health professions in SSA found similarities across the region related to lack of institutionalisation, with the majority of LDPs ranging between six months and two years in length. It is worth noting however, that while the findings from my research did not demonstrate institutionalisation of an entire programme, there was evidence of certain elements of interventions being integrated into practice. An example being with the revision of the DIPs or the supportive supervision integrated tool.

Many of the research participants involved in research within other development programmes talked in "systems" language, acknowledging the challenges of using systems thinking in practice, and further outlining the numerous disconnects identified within the system. Findings offer insight into why current expectations and assumptions of the impact of health leadership and management should be managed realistically, with a view to adapting how this is being governed at a macro level, and paying attention to, and leveraging what processes are working well within the system. This, however, involves confronting the stark reality, as well as accepting the influence of the softer elements of the health system, such as social values (Whyle and Oliver, 2020). Afterall, Agyepong et al. (2017, p. 59) stated that values "shape the outcomes of health systems". If, as claimed to be the case, Malawi wants its health system to become increasingly integrated and people-centred, then there is a required responsibility across many of the key actors to confront

and embrace the need for change in how things are being done and to recognise what people, for example HRH, value in the health system. Moreover, this also means valuing HRH too.

Accordingly, findings from this thesis suggest that although there have been countless efforts to develop health leadership and management in Malawi over the years, as well as other efforts towards HSS (which are often repeated from before), the health system is still experiencing many of the same challenges present a decade ago. One only has to look at the recent mid-term review of the Malawi Health Sector Strategic Plan II or indeed other literature sources, to see that many efforts towards HSS are problematic and not having the desired effects (Makwero, 2018; Masefield et al., 2020; MoHP, 2021;). For example, as of 2020, the MoHP was only at 12% on implementation of the EHP because of bottlenecks on both the demand and supply side (EHP meeting, 2020), and while some progress was observed for some indicators, critical gaps were noted around HRH and other health systems building blocks. The EHP is therefore proving impossible in the face of a severe shortage of staff to implement it. This serves as a call or reminder for those in decision-making positions to take note that approaches to HSS need to both learn and evolve if overall health system performance is to improve (George et al., 2019; Masefield et al., 2020). This involves significant and purposeful efforts (Reich et al., 2016; Roberts et al., 2003), with attention to equity, quality, responsiveness, efficiency and resilience (Agyepong et al., 2017; Barasa et al., 2018; Kruk et al., 2018; UHC2030, 2018; Walsh et al., 2020).

Based on the findings observed in this study, and consistent with other research (Bradley et al., 2015; Gilson & Agyepong, 2018; Kwamie et al., 2014; Martineau et al., 2018), several approaches to developing health leadership and management in Malawi claim to have their foundations in systems thinking for health systems strengthening. However, the focus, or cause, or blame often points towards the people in the system rather than the system itself. A possible explanation for this may be that it is perceived less complicated to have linear interventions that "fix people, not systems" rather than tackling the system itself, which involves delving deep into the working environment and organisational culture. Another explanation may be that people are used to hearing the narrative that "we, Malawians" are the problem. This negative attitude that the Malawian participants presented of themselves, and most often in relation to healthcare workers,

being "lazy" or "uneducated" and "not caring", may well perpetuate the idea that the problems stem from people and not the system. This may be countered by the teachings of systems thinkers like W.E. Deming (2003) who demonstrated that transparency, in this case, involves acknowledging that issues are rarely as simple as "health workers providing poor quality of care" or "staff being unresponsive to patient needs because they do not care". There is therefore a need to consider other aspects of the system that may be contributing to the identified problems, blockages or disconnects, as well as considering how the different factors interact in unexpected or unpredictable ways. This is stated with repeated recognition that systems thinking is difficult, but necessary if realistic plans are to be made. Consequently, one of the key considerations of this thesis is for how to go about reconnecting some of the identified disconnects in the Malawian health system, as will be outlined in Section 7.3.

7.2.2 Impact of the Political Economy on HSS in Malawi

Findings from this thesis evidence the need for contextualised approaches to HSS, rather than blue-print approaches (Bertone & Witter, 2015; Gilson & Agyepong, 2018; Pfadenhauer et al., 2017; Rogers et al., 2020). Contributing to the identified disconnects within the system, or one might argue largely *responsible for* the critical disconnects, was the political economy of the Malawian context. Evidence from the desk review, research participants and my own observations and interactions, highlight the complex power relations across the health system, largely consistent with other recent studies conducted in Malawi (Bulthuis et al., 2021; Loffreda, 2021; Masefield et al., 2020; Walsh et al., 2020). Inevitably, findings illustrate the extent to which the political economy impacts and influences decision making, prioritisation, stakeholder relations and resource allocation across the whole spectrum of the health system (Bulthuis et al., 2021; Topp et al., 2021; Walsh et al., 2020).

One of the more challenging aspects of this research, was observing the power dynamics play out between the development partners and the Government of Malawi (mainly the MoHP). The primary reason being that notwithstanding attempts to openly challenge an agenda that was largely donor driven, the balance of power did not favour the MoHP, resulting in uncertainty about the future of programmes such as the Leadership and

Management Training Programme. Moreover, it was disappointing to witness financial commitments that had been made to pilot and extend the training to health managers at other levels of the health systems, completely dissipate. Consistent with other contexts, findings evidence that whoever held the purse strings, dictated the agenda (Hoffman & Cole, 2018; Mwisongo & Nabyonga-Orem, 2016; Walsh et al., 2020).

During the time I have spent in Malawi, it is often more common to hear of frustrations that Malawians have with external partners through informal conversations or confidential and anonymous interviews. It has very often been the case that what is discussed behind closed doors rarely surfaces in a confrontational manner. Related, Adhikari et al. (2019) wrote about Malawi often being taken advantage of and being attractive to donors and external development partners because of the "loopholes in the system that can be exploited" (p.6) to bypass the MoHP to implement their own programmes and agenda, regardless of whether these align to priorities and needs of local populations. It was therefore surprising, in my own experience, to witness senior members of the MoHP publicly challenge donors and development partners to stop trying to control Malawi's health agenda and to align with the country's own priorities. It was disappointing, though not unexpected, to see these attempts to speak up, somewhat fall on deaf ears. As revealed in findings from another study in Malawi interested in how actors, processes, context and evidence influence strategic plans in the health sector, development partners often gain ownership because the government is afraid of losing their continued involvement (Walsh, Mwase and De Allegri, 2020). This reinforces the power of funders in a context that remains extremely donor dependent. It should be emphasised that donor dependency should not equate to initiatives being predominantly donor-led and controlled (Khan et al., 2018; Mwisongo & Nabyonga-Orem, 2016; Swanson et al., 2015; Van Olmen et al., 2012).

First introduced in Chapter 2.2.5, the impact that external partner relations have on HSS in Malawi should not be understated, with primary areas of concern emerging from findings including unequal research collaborations between the Global North and Global South, and a lack of locally-led initiatives, being just as apparent in Malawi as they were in other SSA countries (Agyepong et al., 2017; Dossou et al., 2016; Goldberg & Bryant, 2012; Ibeneme et al., 2020; Mwisongo & Nabyonga-Orem, 2016; Swanson et al., 2015; Van der Veken et al., 2017). While the relatively newer WHO AFRO framework provides

crucial insights into what countries in the African region should be doing to increase ownership over programmes designed to strengthen health systems, there was little evidence to suggest that this framework was being utilised within the Malawian context, suggesting that Malawi still has work to do in charting its own sustainable path to strengthen health systems (Agyepong et al. 2017).

As evidenced from the stakeholder analysis presented in Chapter 4.5.2.2 (in fulfilment of research objective 1), there exists a plethora of stakeholders with a keen interest in Global Health, including health leadership and management development for HSS in Malawi. Developing health leadership and management was often cited as one of the key strategies for addressing HRH challenges, not just in Malawi but also globally (WHO, 2018). It was apparent that the stakeholders had different levels of interests and influence, and some were more connected to each other and to the government than others (Bulthuis et al., 2021; Masefield et al., 2021). There was a sense that stakeholder engagement was not always meaningful, and findings from this research suggest that there is a strategy behind which stakeholders are selected for certain meetings, with some stakeholders deliberately excluded, and others invited as a tokenistic gesture. This stakeholder hierarchy meant that some organisations who would have made valuable contributions, were not included. This finding is consistent with Masefield and colleagues (2021), who also identified similar challenges in their research around stakeholder engagement and effective inclusion in Malawi, as well as being noted in other SSA countries (Kapiriri & Razavi, 2017).

Findings further evidence a significant drive to prioritise district health systems strengthening, above all else, which was often justified by a logical need within the ongoing decentralisation process. This overwhelming drive appeared to be at the expense and neglect (Section 7.3.4) of other levels of the health system. Similarly, the same districts were being chosen for intervention time and time again, leading also to the neglect of more remote districts. While extant theory suggests a clear connection between strengthening the district and having this trickle down to primary level, for example, findings in this thesis suggest this is not the case, exposing critical disconnects between the levels. Organisations were obviously aware of geographical areas of Malawi that were being neglected, or health systems gaps, but how those with influence and sufficient decision-making space prioritise, poses more questions about the role and intentions of some of the global health initiatives

present in Malawi. Moreover, it is also not surprising why HRH were hesitant to work in some of these more neglected districts, predominantly located in more remote areas, and given their lower prioritisation and insufficient support.

It should be noted that while development partners played a part in determining key aspects of the agenda for HSS, findings also highlight disagreements within the government as well as evidenced distrust as playing a part in delaying implementation (Erasmus et al., 2017). Consequently, these disputes hindered progress towards efforts to strengthen the health system, as seen with the leadership and management training programme. Many of the delays in implementing the training stemmed from conflict over ownership of the programme within the MoHP. These disputes between the directorates were not earmarked for leadership and management development only but also impacted on decision making around other key areas within the health sector. The disputes were political, and detrimental to the health sector, including those HRH on the ground and the wider population. This is perhaps best evidenced by the absence of the preventative health directorate at these meetings, which only served to reinforce a focus on international donor priorities and vertical, largely curative, programmes, over other forms of, mostly preventative, care (Fieno et al., 2016; MacPherson et al., 2021). With the directorates working in silos, and the ministries, such as the MoHP and the MoLGRD refusing to work together, and accompanying lack of communication, it is hard to visualise how the system is meant to function. In a study conducted by Erasmus et al (2017), on the influences of organisational culture (discussed further in 7.3.3) and trust on the implementation of interventions in the health systems in South Africa, we are once again reminded of health systems as human systems that function according to the decisions people make and actions they take. Such decisions are informed by the relationships between the different actors across a health system and if the trust is not there, and values are not negotiated, HSS will remain a challenge (Erasmus et al., 2017; Gilson et al., 2017; Gilson, 2019).

In light of discontentment at central level, it is not surprising that findings evidence the decentralisation process as a challenge to HSS (Bulthuis et al., 2021). A possible explanation for these findings is that Malawi is still transitioning into decentralisation and needs time to iron out some of the hierarchical blockages. How much time this will take, and how effective current approaches to facilitating this process, however, has raised doubts in the minds of those who have witnessed the process to date (Chikuphupha et al

2021; Chiweza, 2018; Jagero, Kwandayi and Longwe, 2014). Consistent with other research, existing power imbalances and perceived undermining of autonomy by development partners and players at central level were also present at central level and district health level in Malawi (Frumence et al., 2013; Kigume & Maluka, 2018; Molyneux et al., 2012; Nxumalo et al., 2018; Panda et al., 2016). Similarly, and specific to the context of Malawi, Bulthuis et al (2021) also highlighted the substantial influential that the MoHP at central level has over district level decision making because or "dispositional power based on financial resources and hierarchy" (p1). They also found that given the different power dynamics present, DHMTs reported feeling disempowered, with a very narrow decision space (Bulthuis et al., 2021). The failure to address these imbalances will likely contribute towards destabilising the decentralisation process (Tostensen, 2017). Furthermore, and despite the years of delays, findings reveal high expectations of the decentralisation process. The power at central level, and its apparent influence over the process however, hints towards a strong resistance to change, which will inevitably have a knock-on effect for health systems strengthening (Bulthuis et al., 2021; Tostensen, 2017). Against this backdrop and resistance, however, the district level is still expected to experience more autonomy, improve accountability to the local population and act as a critical driver for better health care delivery (Couttolenc, 2012).

Findings therefore offer support for the influence of a context's political economy on HSS, as something that is important to consider, and with implications for how we might confront political challenges in the health sector, in specific, ensuring that programmes are aligned as best as possible with the political context and political realities. This recalls ideas within systems thinking for HSS, and the need to be realistic and truthful in our approaches, while also thinking and working politically (Whaites, 2017). Some scholars argue that challenges for HSS will continue so long as the political economy of global health and that of individual contexts across SSA continue to function as they are. That is: how leaders are accountable, how policy is made, how external donors intervene and influence, and how development objectives are prioritised in individual countries (Afriyie et al., 2019; Cometto et al., 2020; Fieno et al., 2016). While examples are few, the case study of Ethiopia's dramatic increase in HRH coverage and improved HRM, provides insights into how the country overcame and confronted some of these political and economic related barriers. Fieno et al. (2016) argued that other countries in SSA, like Malawi, need to learn from the Ethiopian example and "the status quo of institutional arrangements needs to be changed

for new policy choices to reach the top of the agenda, and ideas have the power to be the earthquake to disrupt the previous rules of the game" (p. 8). In the case of Ethiopia, HRH was prioritised within the development agenda resulting in a rationale for long-term political commitment, a decade before other countries in SSA had written a strategic HRH plan. This political commitment was said to be favourable to donors and resources to support the commitment were mobilised. While other countries were prioritising other issues in the health sector, Ethiopia prioritised and allocated resources to support HRH (Fieno et al., 2016). So while Malawi has expressed and shown commitment towards addressing the HRH challenges, the approaches themselves may require adaptation and revision.

7.2.3 Rethinking Leadership and Management Development Approaches

Findings evidence that the Malawian health system continues to struggle and that there is a real need to strengthen health leadership and management capacity across the health system. That said, findings also demonstrate that there are genuine efforts and funding being directed towards health leadership and management development, much of which draws on theories, methods or elements of other approaches that are being used across the SSA region (Johnson et al., 2021; Martineau et al., 2018; Nzinga et al., 2021; RESYST/DIAHLS, 2020). In light of Malawi's hierarchical structure, many of those targeting development of health leadership and management in Malawi demonstrated use of more participatory approaches, as a way of trying to equilibrate some of the power imbalances and to navigate the complexity of hierarchy (Bates et al., 2018; Bulthuis et al., 2020). Some examples mentioned included using action research for management strengthening of the DHMTs, tackling problems collectively or revising the supportive supervision process so that it is more inclusive. Although it has only just commenced, the MoHP's Leadership and Management training programme for health managers marks a progression from more didactic government run training programmes, towards programmes that include modules on softer skills in addition to technical skills, such as emotional intelligence, self-awareness and stress management. Guided by partners, modules such as preventing sexual exploitation and harassment, and coaching, and mentoring were also added to the training. The delivery mode took on feedback from the needs assessments that were conducted for the training, ensuring that there would be a good

mix of practical and classroom-based teaching as well as on-going coaching and mentoring for the DHMT members.

Given the scarcity of research or documented evidence in Malawi specific to health leadership and management development, it is not possible, without rigorous evaluation, to know how effective many of these approaches will be in the long-term. While not designed as an evaluation, findings from this thesis offer insight into the potential sustainability of current approaches and how these may or may not enable system change in Malawi. How approaches are deemed effective, as well as measured, did arise as a concern, but as discussed under section 7.3.2, and elaborated on further in section 7.3.4, just because something is effective does not mean that it will necessarily be taken up or supported, especially if it does not align with stakeholder priorities and agendas.

Among the knowledge gaps identified in Chapter 2.6, was the limited research conducted among health leadership and management in LMICs, and more specifically in African settings (Gilson and Agyepong, 2018). Moreover, the body of research that does exist largely focuses on other decentralised countries in the African region such as South Africa, Kenya, Ghana and Uganda, with fewer examples from other SSA contexts. That said, findings from this thesis contribute to the existing and growing empirical and experiential work about African health leadership and management for health systems strengthening. One finding is particularly consistent with the existing literature; for health leadership and management development to be effective, "the status quo [in Malawi] must be disrupted" (Gilson and Agyepong, 2018, pii2, 2018). To be more specific, findings from this current body of research illustrate a need to rethink and consider: (i) the expectations of DHMTs; (ii) how people conceptualise effective leadership and management and why this should matter; (iii) how the organisational context and working environment is impacting on effective health leadership and management; and (7.3.4) why approaches to health leadership and management development are not system-wide, contradicting any claims that the health system in Malawi is moving towards integrated people-centred care.

Expectations of DHMTs

Consistent with other approaches - stemming from a long history of concern for DHMTs in decentralised settings, more especially around lack of preparation for the roles - findings

from this thesis evidence that district level health professionals and DHMTs are often the target of health leadership and management development efforts (Cassels & Janovsky, 1991; Conn et al., 1996; WHO, 2007). There were justifications provided for focusing on district level strengthening in the Malawian context, which again aligned with reasoning provided across the literature, including the assumed trickle-down effect from district level to primary level (research objective 3) (Bonenberger et al., 2014; Bradley et al., 2013; Bulthuis et al., 2021; Fetene et al., 2016; Kwamie et al., 2014; Martineau et al., 2018; Mshelia et al., 2013; Tetui et al., 2018). What was clear within the Malawian setting, however, is that the disconnect or gap between the district level and the primary level was substantial. This finding is also consistent with disconnects already alluded to in earlier studies conducted in Malawi (Bradley et al., 2013; Chimwaza et al., 2014; Chipeta et al., 2016; Manafa et al., 2009). Moreover, some of the challenges previously identified between district level and primary level over a decade ago, such as inadequate supervision, no feedback on performance, bad relations, lack of communication, and lack of appreciation from district level managers of frontline HCWs being demotivated (Manafa et al., 2009), are still present in 2021.

There were various explanations given for this ongoing disconnect and blockage in the system, varying from DHMTs having a lack of resources or time to support the facilities, to their failure to prioritise PHC because district level staff felt powerless to do anything. It also emerged that there are often negative perceptions of staff at PHC level, suggesting a certain degree of distain and disinterest for the staff at primary level, including unwillingness to mentor on medical procedures. This may reflect that PHC staff are not valued, but could also suggest depersonalisation as a coping mechanism (Bradley et al., 2019). It is, however, difficult to attribute this disconnect between district level and primary level to one specific cause, including that district level staff are in need of more leadership and management training. Similarly, it is also not as simple as providing fuel to go out and conduct supportive supervision. While developing leadership and management capacity of district level leaders and managers is crucial, and should be ongoing, overburdened workloads, limited support, and limited decision space mean that district level managers will fail to meet and live up to the exceedingly high and unrealistic expectations placed on them. It is therefore important that decision-makers and partners be realistic in what can reasonably be expected of district level leaders and managers given the resource limited context and complex environment in which they operate (Bulthuis et al., 2021). In addition

to addressing issues related to the political economy, this further suggests that leadership and management development should extend to more than just a handful of people (Barasa et al., 2018; Chipeta et al., 2016; Daire et al., 2014; Gilson et al., 2017; Macarayan et al., 2019; Nyikuri et al., 2015; RESYST/DIAHLS, 2020; Tetui et al., 2016; Tsofa et al., 2017).

How people conceptualise effective leadership and management and why this should matter

In fulfilment of research objective 2, another important finding of this thesis is that how participants conceptualise effective leadership and management often does not align with or focus on what was happening or what they were experiencing in practice. This links to earlier observations in the thesis suggesting that there exists a dichotomy in what some stakeholders were doing to develop health leadership and management and what they *thought* should be happening (Haines et al., 2004). This raises the question of how much value, and therefore effort, has gone into understanding the most effective way(s) of developing health leadership and management in the Malawian context. Referring to definitions of leadership and management discussed in section 2.5.1, this dichotomy serves as a reminder of the health system as a social system, where values and practices are socially constructed and shared by actors. As House et al. (2004) put it: practices refer to how things should be done, and values refer to judgements of how things should be done. Interestingly, while participants did share thoughts on characteristics and traits of effective leadership and management, they more commonly referred to processes or types of approaches consistent with a desire for leadership and management that was more relational in nature, and more characteristic of shared or collective leadership (Cleary et al., 2018). Heath care workers in particular frequently expressed the value of being listened to, supported, mentored, and given the 'privilege' of learning. This is not to say that approaches to developing health leadership and management did not claim – on paper or at face-value - to embody many of the effective leadership and management characteristics that people claimed to value, rather that there was a disconnect between what was being done and how it was being experienced.

One of the most prominent examples to illustrate this is supportive supervision. Throughout the research process, supportive supervision arose many times as a mechanism by which health leadership and management was being developed, as a throughfare to a

strengthened health system through addressing many of the challenges at PHC level. In theory, supportive supervision is an effective intervention and approach to improving performance of HCWs, considered motivating and facilitating capacity building, whilst also involving joint problem solving and two-way communication (Bailey et al., 2016). Findings from this research, however, suggest that supportive supervision approaches in the Malawian context are, similar to other studies, more consistent with supportive supervision being more about fulfilling donor requirements (Onuka et al., 2015) ticking boxes, and inspection and control (Bradley et al., 2013). Performance appraisal is still not taking place in Malawi and quality of care is often called into question due to inconsistent supportive supervision, which mostly only takes place when accompanied by donors or partners. It has therefore difficult to attribute improved performance at the PHCs to supportive supervision, though it is often cited as a way in which Malawi is improving quality of care (Bradley et al., 2013; MoHP, 2017).

Findings from this thesis offer sufficient rationale for health leadership and management to focus more on the notion of a "team" in healthcare, rather than as a module in a training curriculum, or as ticking a box to say that feedback was given to the whole team at a healthcare facility. Concerningly, teamwork or the concept of a team did not emerge as an element of health leadership and management development approaches that has been given sufficient attention. Three points come to mind when reflecting on teamwork in Malawi. Firstly, is that despite being given the title of a 'team' (i.e., DHMT), Malawians are not being trained to work in teams. It is perhaps not surprising then that a lack of trust was perceived to be endemic. Secondly, is the possibility that the absence of management strengthening of PHC staff is due to the perception that "PHC facilities do not really have teams". Thirdly, are the important contributions that came from several participants who had positive experiences of shared or collective leadership in both SSA and further afield.

Taking the three points together, and situating them within the broader literature on health leadership and management development in SSA, findings strongly suggests that approaches in Malawi need to, and should, focus more so on models of more collective, relational leadership (Chigudu et al., 2018; Cleary et al., 2018; Cummings et al., 2018; Nyikuri et al., 2015; Pearce, 2004; Sheikh et al., 2014). This is not to suggest that the MoHP should abandon its vision and approach of building strategic leadership capacity

(Adair, 2009; Agyepong et al., 2018), but there should also be willingness to adopt and integrate more of the characteristics of leadership and management styles that people want, value and appreciate as a means to improving overall performance. In doing so, there is evidence to suggest that people will feel more valued and motivated, as going hand in hand with improved relationships, encouraging collective ownership, and accountability (Chigudu et al., 2018). Additionally, distributing responsibility across the health system, to more than just district level staff, but to other teams, could help empower others and to ease burdens on the referral system. In this vein, there are important lessons that can be learnt from the extant literature on how to challenge the status quo and introduce more relational, collective approaches to health leadership and management development in Malawi, drawing on more of the elements that we associate with soft systems thinking (Elloker et al., 2012; Purity et al., 2017; RESYST/DIAHLS learning site team, 2020). A recent systematic review conducted on collectivistic approaches to leadership in healthcare settings, identified benefits in team performance, staff satisfaction and staff engagement (De Brún et al., 2019). While collectivistic approaches to leadership and management aim to impact on patient outcomes and patient satisfaction, the approaches also centre on the healthcare worker, which appears to be a gap within the Malawian health system.

Moreover, and returning to the DIAHLs collaboration introduced in Chapter 2.5.8.2, Cleary et al.'s (2018) focus on the HCWs through interventions to enable relational leadership at primary level found that autonomy of facility managers was enhanced, mentorship helped to address some of the more hierarchical styles of leadership, with a positive impact on staff retention, with increased motivation (Cleary et al., 2018). Over time, managers started to understand the benefits of relational leadership, acknowledging the importance of relationships with their teams and each other, and with examples of facility managers becoming more engaged and assertive as trust was built through better relationships. This recognition only came as a consequence of the managers experiencing relational leadership approaches in order to first believe and see the benefits (Cleary et al., 2018). That said, Cleary et al. (2018) also found that the hierarchical nature of the health system and organisational culture in South Africa was often more of a constraint to such relational styles of leadership, despite the buy-in from the managers themselves.

Impacts of organisational context and working environment on effective health leadership and management

Cleary et al.'s (2018) experience of the context and working environment impacting on effective health leadership and management is consistent with findings emerging from this research, which also found the context as impeding health leadership and management development in Malawi. In addition to the contextual issues already mentioned in this chapter, the working environment and organisational culture, specifically, resulted in a perceived push back and resistance to effective leadership and management in this context. Findings from this thesis were therefore consistent with the need for systems thinking in health (Peters, 2014), and previous research stressing that leadership and management development cannot happen in isolation, without also paying attention to creating an enabling environment (Gilson & Agyepong, 2018; Johnson et al., 2021; Prashanth et al., 2014; Tetui et al., 2016; RESYST/DIAHLS, 2020; WHO, 2007).

Chapters 5 and 6 provide insight into what participants, including healthcare workers, perceived to be both enabling and constraining the professional practices of HRH, more especially those in leadership and management positions. A key constraint was the work environment at primary health care level, which was found to compromise the ability of those in leadership and management positions to work effectively, but also constituted disrespect for HRH in those positions. There was a perception that healthcare workers at primary level were not supported or valued, with a prevailing organisational culture which manifested itself as vertical violence against those in positions of authority. This is consistent with other studies taking place in the context of Malawi, suggesting that a challenging work environment and organisational culture can have a damning effect on performance (Bradley et al., 2019; Bradley & McAuliffe, 2009; Chimwaza et al., 2014; Kim et al., 2019; Kruk et al., 2018; Lohmann et al., 2019; Manafa et al., 2009). This research therefore contributes towards a greater understanding of health leadership and management in Malawi, incorporating the perspectives of those in leadership at management positions, particularly at primary level.

Specifically, findings from this research suggest that the working environment and organisational culture of the health system is resulting in a strong push back against effective health leadership and management in Malawi, more specifically at primary level.

Moreover, many negative behaviours towards those in leadership and management positions have become normalised within the culture of the system, and may contribute to the ongoing negative perceptions that others have of PHC more generally (Bradley et al., 2019).

Findings from this research are therefore consistent with the idea that the working environment and organisational culture impact on the psychological safety of those in leadership and management positions at PHC facilities, where people do not feel that the environment is safe enough to speak up without fear of negative consequences from colleagues, both senior and junior (Edmondson, 1999; Newman et al., 2017). This is reflected in Section 6.5.2, which evidenced the daily challenges that PHC staff are up against, together with a culture of fear where those in health leadership and management positions are afraid to be vulnerable, and where working effectively may be punished. Experiences drawn from the literature indicate that organisational cultures that enable an environment that fails to protect psychological safety of the health workforce, can impact negatively on quality of care as well as patient outcomes (Crowe et al., 2017; Edmondson, 1999; Kaufman & McCaughan, 2013). Efforts to create a more enabling environment, including interventions to improve psychological safety that enable health leaders and managers to be courageous and effective in their decision-making (O'Donovan & McAuliffe, 2020) are therefore required. Such interventions could be integrated into models of collective leadership, focusing on the teams rather than just the in-charges, for example.

The environment in which frontline HRH are working in Malawi reflect similar challenges faced elsewhere in the SSA region, illuminating the consequences of a health system that is under stress (Cleary et al., 2018; Johnson et al., 2021; Mbau and Gilson, 2018, Nyikuri et al., 2015; Topp and Chipukma, 2016). Many of the factors that form part of the organisational culture are considered the software of the health system, which often go unseen, yet are important to consider for their impact on HSS (Erasmus et al., 2017). As highlighted by Mbau and Gilson (2018), there is a dearth of empirical literature around organisational culture in LMICs, and therefore more research is needed to understand its influence on health system development. Moreover, creating an enabling environment is

one of five strategic goals of the WHO's (2015) *Global Strategy on Integrated People-centred Health Services 2016-2026.*

Given the numerous disconnects identified within the Malawian health system, and based on the more traditional, hierarchical leadership and structures within the system, it is proposed that a collective leadership approach to developing health leadership and management across the health system may help to address some of these hierarchies by moving the focus from the individual to the team. Moreover, a collective approach to leadership and management may also help to dissolve silos between professional groups and stakeholders to create a more inclusive and open environment. This can extend to collective sensemaking between researchers and health system decision makers to support collaboration and co-production of knowledge for HSS (Gilson et al., 2021).

7.2.4 The Elephant in the Room: Neglect of PHC Providers

Figure 7. 1 Rich Picture representing neglect of PHC

Throughout this thesis, findings have evidenced primary healthcare level as the invisible level of the health system. Findings also highlighted a gap in evidence to suggest that heath leadership and management development was happening at other levels of the health systems such as central level, tertiary level, and across other teams and roles at district level (including local government). While the need for health leadership and management development across all levels of the health system is critical, the neglect of PHC emerged

as a key concern in terms of HSS in Malawi. As such, exploring how health leadership and management was being developed in practice, helped to reveal this important gap (in fulfilment of research objective 4).

There is no shortage of literature to demonstrate renewed commitments to PHC and people-centred health systems across the globe and across the African region (Agyepong et al., 2017; Ibeneme et al., 2020; Kraef & Kallestrup, 2019; Landes et al., 2019; Mash et al., 2019; Sheikh et al., 2014) While Malawi is committed to PHC through the EHP, and features as part of the Preventative Health Services Directorate, there is no official PHC policy and moreover, it was difficult to establish who at central level was responsible for health care facilities (HSSP II). PHC facilities are supposed to be linked to community-based health services, however, there was a clear divide between community level services and primary level services, which some referred to as "fragmentation" between the two (Makwero, 2018). This is perceived as another disconnect in the health system. Strong commitment to community health is evident through the implementation of the first national Community Health strategy 2017-2022, together with a dedicated Community Health Services team at central level. PHC facilities, on the other hand, appear to fall in between dedicated efforts to district strengthening and dedicated efforts to community health strengthening. Additionally, more attention appears to be granted to the community health worker than the PHC worker. One example is the dedicated effort to ensure CHWs are supported with performance appraisals, supportive supervision, and efforts to ensure role clarity (Kok et al., 2018; MoHP, 2017; MoHP, 2021). As discussed in Chapter 2.2.4, Sacks et al. (2018) have argued for community health to feature more explicitly as part of health systems frameworks, claiming that communities should be recognised and visible within the system. The same could be said of the Malawian health system related to PHC, where PHC appears like a silent letter in a word, where it is seen but not heard.

Given that PHC is the foundation of the healthcare system, and PHC facilities are the first port of call for the majority of the population, it is concerning that frontline healthcare providers, health leaders and managers appeared to have been discarded as part of HSS efforts. This does not align with the said value that Malawi attaches to PHC and the fact that burn-out at PHC level is well acknowledged (Kim et al., 2019; Topp et al., 2014). In Malawi, very little emphasis was placed on the importance, wellness, and mental health of the healthcare provider, beyond the need for them to perform their duties and

perform well. This is not surprising given Lohmann et al.'s (2019) concerning findings demonstrating a high proportion of frontline staff with poor well-being. As evidenced in the findings, the assumption rests in strengthening the capacity of district level staff to address challenges at PHC level. This is not happening, however, and it is unlikely to happen any time soon unless there are substantial changes in the system. More efforts pouring into PHC facilities and staff may therefore work to address blockages in the system, such as devolving more power to the health facilities. Support for such an approach from the decision-makers has not, at the time of writing, been evidenced or forthcoming. One possible explanation for a lack of power devolved to the health facilities may be that the decentralisation process is proving challenging enough for power to be distributed from central level to district level, never mind from district level to primary level (Bulthuis et al., 2021). In the Malawian setting, little is known about the decentralisation process on PHC facility in-charges, as was also noted in Kenya under their devolution process, prompting research into the impacts of decentralisation on the frontline (Nyikuri et al., 2015).

Concerning though it is that PHC level rarely receives positive attention, there is evidence to suggest that some successful efforts to strengthen HSS in Malawi are happening at the level of PHC. Findings suggest that such efforts are largely focused on social accountability interventions with HCMCs in the governance of health services; taking onboard what health leaders and managers need according to what they value; building and nurturing trusting relationships; and providing genuine mentorship and support where people feel safe to be vulnerable and ask for help. While there are few examples of these types of interventions in Malawi, there was evidence that such initiatives were helping to build trust between community and primary level, as well as contributing to improved performance of HRH (Lodenstein et al., 2019). These findings were consistent with approaches to social accountability in primary care in other settings in SSA. That said, experience from other studies does warn that social accountability interventions should make up a set of activities rather than act as or be relied upon as a sole approach to health systems strengthening (Lodenstein et al., 2019; McCoy et al., 2012; O'Meara et al., 2011). In one district in Malawi, there was evidence of improved relationships between district and primary level based on the mentorship approach. These positive effects may be explained by the fact that the resilience, ability to problem solve, and capabilities of health leadership and management at PHC were being invested in and therefore contributing to

building self-worth and pride, rather than perpetuating overdependence on the district level. Moreover, such efforts appeared to effectively be engaging the community in the health sector.

While the empirical literature often makes the case for efforts to target the district level, Malawi was not unique in being recognised as a country that needs health leadership and management development at primary level. There are other examples in the literature in SSA that describe efforts that target, or need to target primary facility level leaders and managers as well as district level (Aberese-Ako et al., 2014; Cleary et al., 2018; Daire et al., 2014; Gondwe et al., 2021; Macarayan et al., 2019; Makwero, 2018; Nxumalo et al., 2018; Nyikuri et al., 2015; Purity et al., 2017; RESYST/DIAHLS, 2020; Sheikh et al., 2014). One of the notable differences between the PHC facilities in Malawi and the PHC facilities in some of the other countries, however, is that while professional nurses may be given the responsibilities of health leaders and managers, they are not assigned as "in-charges" of the health facilities (see Chapter 5.4). This lack of recognition among nurses also reflects what is found in the broader literature, as discussed in Chapter 2.5.5, with findings from this thesis supporting that professional nurses in Malawi need more recognition and support as part of health leadership and management development (Michel et al., 2018; WHO, 2020). Specifically, as proposed by Michel et al., (2018), attention should be paid to the framework for HSS in a PHC setting that is specifically nurse led.

Much of the broader literature also reflects the importance of support for facility staff from the district level (Elloker et al., 2012; Gilson et al., 2014; Nyikuri et al., 2015; RESYST/DIAHLS, 2020). While this would appear to be welcomed by PHC facilities in Malawi, the manner in which support is provided would need to reflect more relational aspects of leadership as well as involving efforts to improve relationships between district staff and PHC staff. Similarly, Gilson et al. (2014) suggests the need for leadership of sensemaking for PHC in South Africa, whereby frontline staff make sense of policy intentions and incorporate them into their everyday routines and practices (Gilson et al., 2014). Additionally, that frontline staff need to be supported by district staff and empowered to take ownership of PHC goals and promoting policies (Gilson et al., 2014). That said, there was no indication that support from district level managers was forthcoming in Malawi. In the interim, finding daily coping mechanisms as a way of

dealing with the complexity and the daily challenges of the health system at facility level is paramount (Cleary et al., 2013).

Further to this, research conducted by RESYST/DIAHLS (2020) supports the need for frontline health workers to be resilient, and for capacity strengthening of health leaders and managers to focus on both the hardware and software of performance, including improving the supervisory capacity of health facility managers (Barasa, Cloete and Gilson, 2017; Barasa, Mbau and Gilson, 2018; Gilson et al., 2017; Kim et al., 2019; Nyikuri et al, 2015). With resilience identified as one of the key elements of health system performance (UHC2030, 2018), it should not be ignored, though responses to improve resilience on the frontline would need to be tailored to the Malawian context (Barasa, Cloete and Gilson, 2017). Moreover, the concept of resilience is relatively new in HPSR and there are still lessons to learn beyond the theory and principles, of which applied examples are less yet called for (Turenne et al., 2019).

Unfortunately, there are fewer examples of leadership and management development at primary facility level that have been effective in the long-term and there is therefore a need for more evidence to inform efforts to develop leadership and management at PHC facilities specific to each context. Moreover, the focus tends to be on individuals rather than on the whole team, which again suggests that there is a need to adopt a more team-based and collective approach to leadership at PHC level. This is therefore a need to invest in and adopt a more collectivistic approach to leadership and management development of primary healthcare teams in Malawi. By extending health leadership and management development beyond the district level, the disconnects will begin to connect. This approach will help to address some of the hierarchical challenges that have been identified in LMIC contexts and across African health systems, which contribute to challenges in enhancing the quality of care in service delivery (Bradley et al., 20019; Kruk et al., 2017).

7.3 Reconnecting the Disconnects: Theoretical Model

Together, (in fulfilment of research objectives 1-4 as outlined), findings from the three phases of this thesis are synthesised to contribute towards a theory for how health

leadership and management, as an approach to health system strengthening, can be understood and further developed within the context of Malawi, with relevance for similar settings globally (see Figure 7.2). This theory therefore brings together principal findings of this thesis to suggest that for health leadership and management to be developed for health systems strengthening in Malawi, there is a need to create a culture of collective leadership, empowering all HRH at all levels of the health system. Applying the broader lens of collective leadership, or collectivistic leadership approaches, the assumption here is that everyone can and should lead. Meaning, a collective works together to achieve a common vision, with each individual having something to share and contribute (Ospina & Foldy, 2015). This is not to suggest that the MoHP's existing vision of strategic leadership should be replaced, but rather collective leadership should coexist and interact with it. Drawing on the literature presented in Chapter 2 and acknowledging that health systems are comprised of both hardware and software as system-related influencing factors (Sheikh et al., 2011), this theory therefore suggests intertwining soft systems approaches to HSS with hard systems approaches, rather than applying one over the other (Barasa, Cloete and Gilson, 2017; Checkland, 1999; Jackson, 2019). Moreover, the proposed theory recognises the real-world aspect of health systems as social systems with complex real-world problems (Augustsson et al., 2019 Sheikh et al., 2014). Importantly, the theoretical model does not visualise all of the hardware of a health system; however, as health leadership and management development are cross-cutting across the whole of the health system, it is assumed that the hardware of the health system is embedded within the theory as an integral part of HSS.
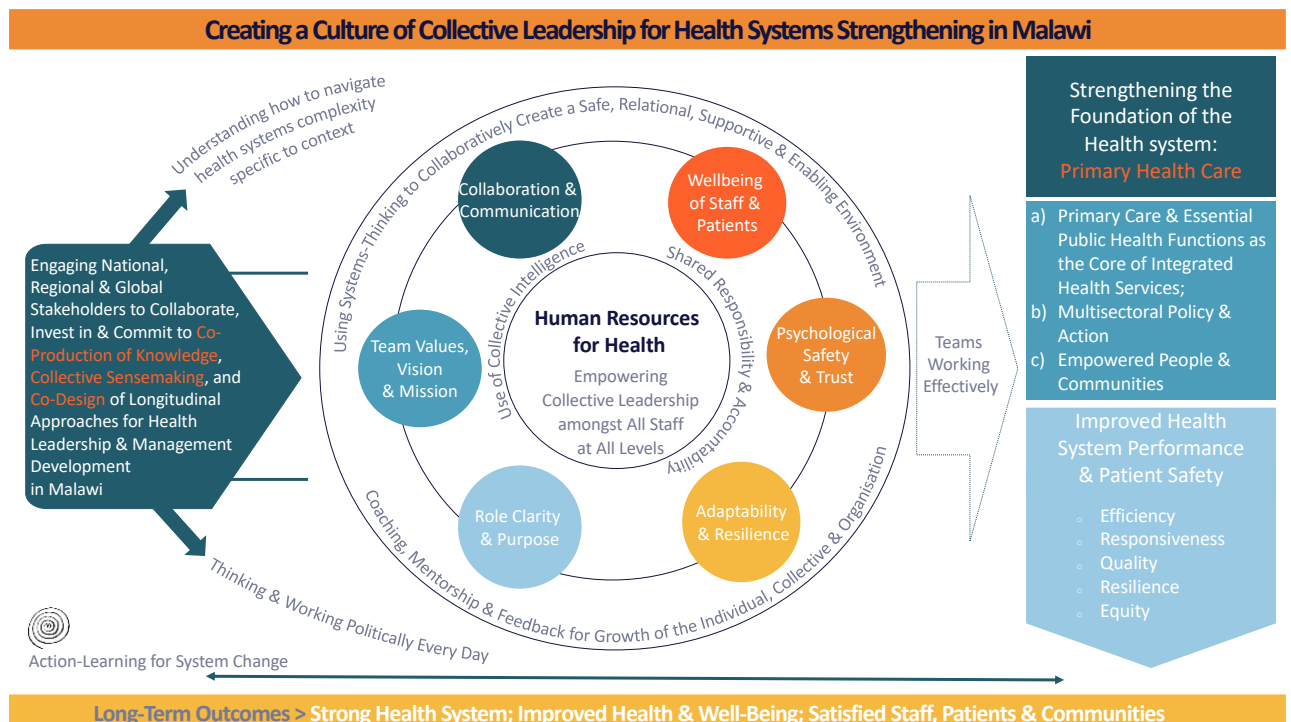
Figure 7.2 1 Theoretical Model for Creating a Culture of Collective Leadership for HSS in Malawi

To acknowledge people complexity within complex adaptive systems, as the multitude of actors engaged in health systems, the theory is further constructed around people and the plurality of perspectives and multiple realities that shape the health system in Malawi (Jackson, 2019). This means that for health systems to be strengthened, all actors should be included and feed into health system strengthening efforts. This includes actors on the supply side of healthcare as well as on the demand side. Accordingly, the key principles of the theory align with collectivistic leadership approaches, conceptualising leadership as a social process that is not limited to one individual (Denis et al., 2001).

In addition to being grounded in the findings of this body of work, this proposed theory draws extensively on existing theory and practice for developing health leadership and management as part of health systems strengthening within the African region, including but not limited to: WHO Regional Office for Africa's Framework: Leave no one behind: Strengthening health systems for UHC and the SDGs in Africa (2017); the extensive research from RESYST/DIAHLS (2020) collaboration spanning seven years; and the Government of Malawi's health policy documents and strategies, including the HSSP II, the *National Quality Management Policy and the Human Resources for Health Strategic* Plan (2018-2022). From outside of the region, the theory was informed by the *WHO's*

Global Strategy on People-centred and Integrated Health Services (2015), the *WHO's Vision for PHC in the 21ˢᵗ century: towards UHC and the SDGs*; and on collective leadership, I have drawn on the ongoing programme of research being conducted as part of Co-Lead (Collective Leadership and Safety Cultures) (De Brun et al., 2019; De Brún et al., 2020).

Taken together, the theoretical model presented in Figure 7.2 makes four central contributions to developing health leadership and management in Malawi for HSS. Firstly, the model advocates for the application of systems thinking to empower relational, collectivistic leadership amongst all staff at all levels of the health system for HSS. This focus on HRH aligns with Strategic Goal 5 of the WHO people-centred framework (2015) which centres on the health workforce and strengthening leadership and management for change, calling for the creation of an enabling environment that will positively shape the organisational culture. Secondly, the model emphasises the role of context and the support for collectively creating a safe, relational, supportive enabling environment for all, which considers ways in which to manage and navigate the political economy both nationally and internationally. This builds on the WHO AFRO Framework's proposal for HSS to align with the needs of the context of each country, rooted in a focus on communities and districts. Thirdly, the model proposes the use of action-learning approaches for health leadership and management development, encouraging openness to reflection, adaptation, and change. The premise is based on the establishment of long-term stakeholder collaborations at national, regional, and global level, that invest in and commit to co-production of knowledge, collective sensemaking, and co-design of longitudinal approaches for health leadership and management development in Malawi (RESYST/DIAHLS, 2020). These collaborations are to include members of the health workforce as well as community members. Lastly, the model stresses the need for PHC to be prioritised as the resilient foundation for HSS in Malawi, incorporating three inter-related and synergistic components included in the WHO's vision of PHC in the 21ˢᵗ Century (2018):

1. Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritising key health care services aimed at individuals and families

through primary care and the population through public health functions as the central elements of integrated health services;

2. Systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and

3. Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

By creating a culture of collective leadership in Malawi, it is assumed that this will contribute towards improved health system performance and patient safety, resulting in a strengthened health system, improved health and well-being and satisfied staff, patients, and communities.

7.4 Contributions and Implications of the Research

To my knowledge, this is the first proposed theory for understanding how health leadership and management as an approach to health system strengthening, can be understood and further developed within the context of Malawi. Moreover, this thesis builds on and contributes to the limited but growing evidence base in HPSR for how health leadership and management is conceptualised, and how approaches to developing health leadership and management may or may not lead to health systems strengthening, specifically within SSA (Daire et al., 2014; Figueroa et al., 2019; Gilson & Agyepong, 2018; Johnson et al., 2021; RESYST/DIAHLS, 2020; Witter et al., 2019). Additionally, this develops new knowledge about the limitations of district-level authority; the evidence base on decentralisation in Malawi has until now been limited. There have been calls for more soft-systems thinking approaches to understand health leadership and management development in SSA (Gilson et al., 2017; Jackson and Sambo, 2020), the methods applied in this thesis drew on the tools of soft systems thinking and grounded theory to explore the complexity of the health system through stakeholder perspectives and relationships, generating new insights into health systems strengthening in Malawi. Specifically, this research generates insights into how people think that leadership and management

development may enable system change, and which of these approaches may be best suited to the Malawian context, including who and where to target.

Several approaches in the SSA region have previously emphasised the need for strengthening leadership and management capacity for district health strengthening as part of decentralisation. This thesis provides evidence for the everyday resilience of the seemingly often neglected primary health care system and overlooked frontline HCW in Malawi, calling for leadership and management capacity to also be developed at this level, as well as at other levels of the health system. Therefore, for leadership and management development to contribute to HSS, it must be aligned to the principles of systems thinking and applied faithfully system wide to enable people to better cope with their contexts. Moreover, this research contributes to calls for commitments to reorientating health systems towards PHC to go beyond rhetoric to action, highlighting people-centred health systems to mean human resources for health as well as communities (see Figure 7.3).

Figure 7. 3 People-Centred means HRH, patients and the wider community

Findings from this thesis will have important implications for policy and practice, both within Malawi, and more broadly, including important learning that can be taken to similar contexts across the region. As such, the resulting theory could inform the design of leadership and management development approaches in SSA, underlining the need for efforts and interventions improve psychological safety of HRH and to be collaborative and collectivistic (encouraging teamwork), for the coproduction of knowledge, and commitment to creating a safe and enabling environment for HRH as well as communities. The importance of an enabling environment and conducive organisational culture cannot be overstated for health leadership and management to be truly effective and other contexts across SSA should carefully consider how the organisational context and working environment may be impacting on effective health leadership and management. Many of the factors that form part of the organisational culture are considered the software of the health system and are important to consider for their impact on HSS, particularly within hierarchical structures and systems. Moreover, this thesis has evidenced the need for contextualised approaches to developing health leadership and management for HSS with emphasis falling on the need for initiatives to be locally led. Such approaches are key for establishing trust and long-term collaborations across all levels of a health systems (internal, external, and multidisciplinary) that are dependent on donor funding or priority setting for support and success.

To date, findings from this thesis have already had a direct implication at central level of the MoHP through my appointment in 2019 to the Leadership and Management Task team. As a member of the task team, I was able to present the results of the stakeholder analysis conducted as part of this thesis to inform the development of the training curriculum for health managers. Moreover, I was part of the team involved in validating the curriculum for health managers. In response to the findings that I presented to the first meeting of the health sector leadership task team, it was agreed and recorded in the meeting minutes that efforts would be made to involve the Preventive Health Directorate, noting the following:

1) Strengthening leadership skills at primary and community level was noted as being important. Participants agreed on the need to include community health strategy as part of the Leadership Program
2) The importance of considering all managerial levels, i.e, top, middle and line management for the training Program was emphasised.

A leading development partner committed to piloting a leadership and management training programme at primary level. Unfortunately, due to budget cuts, this did not happen, but development of health leadership and management at other levels of the system has been tabled for the future. Additionally, I was asked to share the findings from my thesis with the Oxford Policy Management project team responsible for evaluating UNICEF's DHSS initiative to contribute understanding to the effectiveness of approaches to strengthen sub-national health systems through supporting district health planning and management in Eastern and Southern Africa.

7.5 Limitations and Recommendations

"We must grapple with the world we actually inhabit, not the one we wish we did"

(Braithwaite et al., 2018)

This thesis was subject to several limitations. Drawing on constructivist grounded theory facilitated the exploration of an area of high complexity, allowing knowledge of health leadership and management development in Malawi to emerge through the perspectives of a cross-section of health system actors. The codes and categories created led to the construction of theory that was grounded in the data, offering a unique insight into health leadership and management development for HSS in Malawi. That said, data analysis was bound to the limitations of the thesis, meaning that the narrow range of data and number of interviews may limit the credibility of the research (Charmaz, 2014).

The scope of the study was ambitious within the time frame, and the exploratory design prevents the study being generalisable across other settings. However, Malawi offered a suitable context, given its size and structure of the health system, helping to identify a wide and varied range of participants for interview. Moreover, while the findings may not be generalisable, the research shows the importance of in-depth study of the context of the Malawian health system, identifying contextual factors that may be relevant to other settings.

Although there was a broad mix of participants, representation from more healthcare workers, especially those in leadership and management positions may have presented a more holistic picture. Due to time and cost limitations the voice of the wider community was not represented. Further research is needed in the Malawian context to understand more about leadership and management practices at primary and community level, in both rural and urbanised areas of the country. In future research, it will be critical to capture the perspectives from those on the receiving end of healthcare service provision to engage with and inform efforts to strengthen the health system. Other initiatives to help development leadership and management of HRH may have been missed from the stakeholder analysis, potentially excluding other stakeholder perspectives related to health leadership and management development. The intention had been there to conduct

additional interviews with frontline health workers; however, timescale did not permit this. Future research with greater flexibility in timescales and resources could perhaps include a wider range of data gathering activities to pursue theoretical sampling further and allow the development of additional categories to offer a more holistic picture that includes voices from the community.

The epistemological and ontological underpinnings of the thesis were in congruence with the selected methodology and allowed the development of a constructed theory towards a theory for how leadership and management practices in Malawi can be understood and how they can be developed further for HSS. Whereas the aim of this research was met through a constructivist approach, future research could employ quantitative research and mixed method designs in order to test the applicability of this theory in practice (Birks and Mills, 2015).

While reference was made to the gendered dimensions of management and leadership in Malawi, this was not the primary focus of the research objective. Given that gender became a focus during the data collection and analysis, further research could draw more explicitly on a gender analysis framework to provide further depth and understanding.

Based on the research findings, the following recommendations are put forward:
- o Further exploration of the impact of the ongoing decentralisation process on primary level care. There is therefore a need for more evidence to inform efforts to develop leadership and management at PHC facilities specific to each context.
- o Stakeholders to include and empower HRH at all levels of the health system by investing in and empowering collective leadership training amongst all staff
- o Stakeholders to adapt and test the applicability of the theory outlined in Section 7.3. This requires the MoHP and partners to engage national, regional and global stakeholders to collaborate, invest in and commit to co-production of knowledge, collective sensemaking, co-design of longitudinal approaches for health leadership and management development in Malawi. Such approaches should adopt action-learning for system change.
- o Linked to the previous point, and given the limited but growing evidence base - not only in SSA, but across the globe - on collective leadership approaches and the resulting impact on factors such as team performance, healthcare safety,

quality of care, and improved staff and patient satisfaction (De Brún et al., 2019), there is an opportunity to learn from, collaborate with and build on existing and ongoing research, such as that of the RESYST/DIAHLS collaboration, or the Co-Lead programme (DeBrún et al., 2020) to understand how such approaches could be adapted for the Malawian context.

7.6 Conclusion

> It is the sturdiness of the system as a whole, with leadership exercised effectively at multiple levels, which will stand the test of a serious challenge. In health, this calls for a harmonious confluence of leadership across a wide array of actors, to collectively create a strong leadership for the health system (WHO, 2016, p. 15)

At the core of this thesis was a commitment to prioritising, collecting, and analysing stakeholder perspectives on health leadership and management development for health systems strengthening. Based on wide-spread acknowledgement of weaknesses in health leadership and management across Malawi's health system this thesis aimed to understand and subsequently construct a theory to advance our knowledge of how current approaches to improve health leadership and management can be understood and can be further developed to strengthen the Malawian health system. The findings presented in this thesis correspond closely with those documented in similar contexts, in highlighting the complexity of health systems strengthening, and the need for understanding how the workings of leadership and management are both constrained and enabled by their individual contexts. Despite the constraints that HRH face at a micro, meso and macro level, there is a resiliency in the Malawian health system that speaks to the software of the health system.

Evidenced in this thesis and considered one of the core elements of health systems performance, is the concept of health systems resilience. Interestingly, Malawi is rarely referred to as 'resilient'; this concept is usually directed towards health systems in other countries in the SSA region (e.g., Kenya, South Africa, Liberia, Sierre Leone etc.,). However, given the enormity of pressure that the Malawian health systems is under, this thesis argues that the strength of the health system in Malawi is very much in the resiliency of its human resources for health, who adapt and respond to the everyday challenges of the system. It is crucial that collective efforts are made at a global, regional and national level to support HRH at all levels of the health system for health systems to be strengthened.

Efforts to develop health leadership and management in Malawi claim to align with international and national policies and strategies aimed at strengthening health systems towards achieving UHC, with increased emphasis on the need for people-centred health systems. This thesis emphasises that health systems that are people-centred should include everyone: especially HRH, as the backbone of any health system. The introduction to this thesis stated that "there is no health system without a health workforce", with investment in HRH said to be one of the smartest investments that can be made in Global Health (Agyepong et al., 2017; Jamison et al., 2013). Efforts to develop an organisational culture of collective leadership, to support HRH, and to institutionalise health leadership and management development should be prioritised in Malawi to ensure current and future generations of HRH benefit from strengthened leadership and management capacity, thus contributing to better health outcomes and stronger health systems. As evidenced by the recent COVID-19 pandemic, it is not enough to simply praise and celebrate the critical role that HRH play without accompanying these platitudes with action.

References

Abdel-Wahab, M., Bourque, J.-M., Pynda, Y., Iżewska, J., Van der Merwe, D., Zubizarreta, E., & Rosenblatt, E. (2013). Status of radiotherapy resources in Africa: An International Atomic Energy Agency analysis. *The Lancet Oncology*, *14*(4), e168–e175.

Aberese-Ako, M., Agyepong, I. A., & van Dijk, H. (2018). Leadership styles in two Ghanaian hospitals in a challenging environment. *Health Policy and Planning*, *33*(suppl_2), ii16–ii26. https://doi.org/10.1093/heapol/czy038

Aberese-Ako, M., van Dijk, H., Gerrits, T., Arhinful, D. K., & Agyepong, I. A. (2014). 'Your health our concern, our health whose concern?': Perceptions of injustice in organizational relationships and processes and frontline health worker motivation in Ghana. *Health Policy and Planning*, *29*(suppl 2), ii15–ii28. https://doi.org/10.1093/heapol/czu068

Abiiro, G. A., Mbera, G. B., & De Allegri, M. (2014). Gaps in universal health coverage in Malawi: A qualitative study in rural communities. *BMC Health Services Research*, *14*(1), 1–10.

Abimbola, S. (2021). The uses of knowledge in global health. *BMJ Global Health*, *6*(4), e005802. https://doi.org/10.1136/bmjgh-2021-005802

Abimbola, S., Olanipekun, T., Igbokwe, U., Negin, J., Jan, S., Martiniuk, A., Ihebuzor, N., & Aina, M. (2015). How decentralisation influences the retention of primary health care workers in rural Nigeria. *Global Health Action*, *8*(1), 26616. https://doi.org/10.3402/gha.v8.26616

Ackoff, R. L. (1999). *Re-creating the Corporation: A Design of Organizations for the 21st Century*. Oxford University Press, USA.

Adair, J. (2009). *Not bosses but leaders: How to lead the way to success*. Kogan Page Publishers.

Adam, T. (2014). Advancing the application of systems thinking in health. *Health Research Policy and Systems*, *12*(1), 50, 1478-4505-12–50. https://doi.org/10.1186/1478-4505-12-50

Adam, T., & de Savigny, D. (2012). Systems thinking for strengthening health systems in LMICs: Need for a paradigm shift. *Health Policy and Planning*, *27*(suppl 4), iv1–iv3. https://doi.org/10.1093/heapol/czs084

Adam, T., Hsu, J., de Savigny, D., Lavis, J. N., Rottingen, J.-A., & Bennett, S. (2012). Evaluating health systems strengthening interventions in low-income and middle-income countries: Are we asking the right questions? *Health Policy and Planning*, *27*(suppl 4), iv9–iv19. https://doi.org/10.1093/heapol/czs086

Admasu, K., Balcha, T., & Ghebreyesus, T. A. (2016). Pro–poor pathway towards universal health coverage: Lessons from Ethiopia. *Journal of Global Health*, *6*(1).

Admasu, K.-B. (2016). Designing a Resilient National Health System in Ethiopia: The Role of Leadership. *Health Systems & Reform*, *2*(3), 182–186. https://doi.org/10.1080/23288604.2016.1217966

Adhikari, R., Sharma, J. R., Smith, P., & Malata, A. (2019). Foreign aid, Cashgate and trusting relationships amongst stakeholders: key factors contributing to (mal) functioning of the Malawian health system. *Health policy and planning*, *34*(3), 197-206.

African Union Development Agency. (2019). *Health Research and Innovation Strategy for Africa 2018-2030*.

Afriyie, D. O., Nyoni, J., & Ahmat, A. (2019). The state of strategic plans for the health workforce in Africa. *BMJ Global Health*, *4*(Suppl 9), e001115. https://doi.org/10.1136/bmjgh-2018-001115

Agarwal, S., Sripad, P., Johnson, C., Kirk, K., Bellows, B., Ana, J., Blaser, V., Kumar, M. B., Buchholz, K., Casseus, A., Chen, N., Dini, H. S. F., Deussom, R. H., Jacobstein, D., Kintu, R., Kureshy, N., Meoli, L., Otiso, L., Pakenham-Walsh, N., … Warren, C. E. (2019). A conceptual framework for measuring community health workforce performance within primary health care systems. *Human Resources for Health*, *17*(1), 86. https://doi.org/10.1186/s12960-019-0422-0

Agyepong, I. A., Kodua, A., Adjei, S., & Adam, T. (2012). When 'solutions of yesterday become problems of today': Crisis-ridden decision making in a complex adaptive system (CAS)--the Additional Duty Hours Allowance in Ghana. *Health Policy and Planning*, *27*(suppl 4), iv20–iv31. https://doi.org/10.1093/heapol/czs083

Agyepong, I. A., Lehmann, U., Rutembemberwa, E., Babich, S. M., Frimpong, E., Kwamie, A., Olivier, J., Teddy, G., Hwabamungu, B., & Gilson, L. (2018). Strategic leadership capacity building for Sub-Saharan African health systems and public health governance: A multi-country assessment of essential competencies and optimal design for a Pan African DrPH. *Health Policy and Planning*, *33*(suppl_2), ii35–ii49. https://doi.org/10.1093/heapol/czx162

Agyepong, I. A., Sewankambo, N., Binagwaho, A., Coll-Seck, A. M., Corrah, T., Ezeh, A., Fekadu, A., Kilonzo, N., Lamptey, P., Masiye, F., Mayosi, B., Mboup, S., Muyembe, J.-J., Pate, M., Sidibe, M., Simons, B., Tlou, S., Gheorghe, A., Legido-Quigley, H., … Piot, P. (2017). The path to longer and healthier lives for all Africans by 2030: The Lancet Commission on the future of health in sub-Saharan Africa. *The Lancet*, *390*(10114), 2803–2859. https://doi.org/10.1016/S0140-6736(17)31509-X

Ajeani, J., Mangwi Ayiasi, R., Tetui, M., Ekirapa-Kiracho, E., Namazzi, G., Muhumuza Kananura, R., Namusoke Kiwanuka, S., & Beyeza-Kashesya, J. (2017). A cascade model of mentorship for frontline health workers in rural health facilities in Eastern Uganda: Processes, achievements and lessons. *Global Health Action*, *10*(sup4), 1345497.

Alonso-Garbayo, A., Raven, J., Theobald, S., Ssengooba, F., Nattimba, M., & Martineau, T. (2017). Decision space for health workforce management in decentralized settings: A case study in Uganda. *Health Policy and Planning*, *32*(suppl_3), iii59–iii66. https://doi.org/10.1093/heapol/czx116

Anand, S., & Bärnighausen, T. (2004). Human resources and health outcomes: Cross-country econometric study. *The Lancet*, *364*(9445), 1603–1609. https://doi.org/10.1016/S0140-6736(04)17313-3

Anderson, R. A., Crabtree, B. F., Steele, D. J., & McDaniel Jr, R. R. (2005). Case study research: The view from complexity science. *Qualitative Health Research*, *15*(5), 669–685.

Angwenyi, V., Aantjes, C., Kondowe, K., Mutchiyeni, J. Z., Kajumi, M., Criel, B., Lazarus, J. V., Quinlan, T., & Bunders-Aelen, J. (2018). Moving to a strong(er) community health system: Analysing the role of community health volunteers in the new national community health strategy in Malawi. *BMJ Global Health*, *3*(Suppl 3), e000996. https://doi.org/10.1136/bmjgh-2018-000996

Antonakis, J., Avolio, B. J., & Sivasubramaniam, N. (2003). Context and leadership: An examination of the nine-factor full-range leadership theory using the Multifactor Leadership Questionnaire. *The Leadership Quarterly*, *14*(3), 261–295.

Antonakis, J., House, R. J., & Simonton, D. K. (2017). Can super smart leaders suffer from too much of a good thing? The curvilinear effect of intelligence on perceived leadership behavior. *Journal of Applied Psychology*, *102*(7), 1003.

Arah, O. A., Klazinga, N. S., Delnoij, D. M., Asbroek, A. T., & Custers, T. (2003). Conceptual frameworks for health systems performance: A quest for effectiveness, quality, and improvement. *International Journal for Quality in Health Care*, *15*(5), 377–398.

Asamani, J. A., Akogun, O. B., Nyoni, J., Ahmat, A., Nabyonga-Orem, J., & Tumusiime, P. (2019). Towards a regional strategy for resolving the human resources for health challenges in Africa. *BMJ Global Health*, *4*(Suppl 9), e001533. https://doi.org/10.1136/bmjgh-2019-001533

Atkinson, P. (2007). *Ethnography: Principles in Practice*. Routledge: London

Atun, R. (2012). Health systems, systems thinking and innovation. *Health Policy and Planning*, *27*(suppl 4), iv4–iv8. https://doi.org/10.1093/heapol/czs088

Atun, R., & Menabde, N. (2008). Health systems and systems thinking. *Health Systems and the Challenge of Communicable Diseases: Experiences from Europe and Latin America. Berkshire (United Kingdom): Open University Press, McGraw Hill Education*, 121–140.

Augustsson, H., Churruca, K., & Braithwaite, J. (2019a). Mapping the use of soft systems methodology for change management in healthcare: A scoping review protocol. *BMJ Open*, *9*(4), e026028. https://doi.org/10.1136/bmjopen-2018-026028

Augustsson, H., Churruca, K., & Braithwaite, J. (2019b). Re-energising the way we manage change in healthcare: The case for soft systems methodology and its application to evidence-based practice. *BMC Health Services Research*, *19*(1), 666. https://doi.org/10.1186/s12913-019-4508-0

Avortri, G. S., Nabukalu, J. B., & Nabyonga-Orem, J. (2019). Supportive supervision to improve service delivery in low-income countries: Is there a conceptual problem or a strategy problem? *BMJ Global Health*, *4*(Suppl 9), e001151. https://doi.org/10.1136/bmjgh-2018-001151

Ayanore, M. A., Amuna, N., Aviisah, M., Awolu, A., Kipo-Sunyehzi, D. D., Mogre, V., Ofori-Asenso, R., Gmanyami, J. M., Kugbey, N., & Gyapong, M. (2019). Towards Resilient Health Systems in Sub-Saharan Africa: A Systematic Review of the English Language Literature on Health Workforce, Surveillance, and Health Governance Issues for Health Systems Strengthening. *Annals of Global Health*, *85*(1), 113. https://doi.org/10.5334/aogh.2514

Bailey, C., Blake, C., Schriver, M., Cubaka, V. K., Thomas, T., & Martin Hilber, A. (2016). A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa. *International Journal of Gynecology & Obstetrics*, *132*(1), 117–125. https://doi.org/10.1016/j.ijgo.2015.10.004

Ballard, M., & Montgomery, P. (2017). Systematic review of interventions for improving the performance of community health workers in low-income and middle-income countries. *BMJ Open*, *7*(10), e014216. https://doi.org/10.1136/bmjopen-2016-014216

Banda, C. K., Hosseinipour, M. C., Kumwenda, J., Banda, N. P. K., Lutala, P., Makwero, M., & Muula, A. S. (2021). Systems Capacity To Conduct Non-Communicable Disease Focused Implementation Research In The Malawian Health Sector: A National Needs Assessment

Barabba, V. P., & Mitroff, I. I. (2014). Complex Messy Systems. In *Business Strategies for a Messy World: Tools for Systemic Problem-Solving* (pp. 44–58). Springer.

Barasa, Cloete, K., & Gilson, L. (2017). From bouncing back, to nurturing emergence: Reframing the concept of resilience in health systems strengthening. *Health Policy and Planning*, *32*(suppl_3), iii91–iii94. https://doi.org/10.1093/heapol/czx118

Barasa, E., Mbau, R., & Gilson, L. (2018). What Is Resilience and How Can It Be Nurtured? A Systematic Review of Empirical Literature on Organizational Resilience. *International Journal of Health Policy and Management*, *7*(6), 491–503. https://doi.org/10.15171/ijhpm.2018.06

Barasa, E. W., Molyneux, S., English, M., & Cleary, S. (2017). Hospitals as complex adaptive systems: A case study of factors influencing priority setting practices at the hospital level in Kenya. *Social Science & Medicine*, *174*, 104–112. https://doi.org/10.1016/j.socscimed.2016.12.026

Baser, H., & Morgan, P. (n.d.). *Capacity, Change and Performance Study Report*. 166.

Bass, B. M. (1997). Does the transactional–transformational leadership paradigm transcend organizational and national boundaries? *American Psychologist*, *52*(2), 130.

Bassett, M. T., Gallin, E. K., Adedokun, L., & Toner, C. (2013). From the ground up: Strengthening health systems at district level. In *BMC health services research* (Vol. 13, Issue 2, pp. 1–4). Springer.

Bates, I. (2015). Designing and measuring the progress and impact of health research capacity strengthening initiatives. *BMC Proceedings*, *9*(S10), S9. https://doi.org/10.1186/1753-6561-9-S10-S9

Bates, I., Boyd, A., Smith, H., & Cole, D. C. (2014). A practical and systematic approach to organisational capacity strengthening for research in the health sector in Africa. *Health Research Policy and Systems*, *12*(1), 1–10.

Bates, M. J. (2018). Equipping leaders in health in Malawi: Some personal reflections from a leadership skills-building workshop held at the College of Medicine, Blantyre, Malawi. *Malawi Medical Journal*, *30*(2), 134. https://doi.org/10.4314/mmj.v30i2.15

Baulch, B., Botha, R., & Pauw, K. (2021). *An update on the short-term impacts of COVID-19 on the Malawian economy, 2020–2021* (0 ed.). International Food Policy Research Institute. https://doi.org/10.2499/p15738coll2.134383

Baxter, K., Courage, C., & Caine, K. (2015). *Understanding your users: A practical guide to user research methods*. Morgan Kaufmann.

Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers'. *The Qualitative Report*, *544*.

Bekker, L.-G., Alleyne, G., Baral, S., Cepeda, J., Daskalakis, D., Dowdy, D., Dybul, M., Eholie, S., Esom, K., Garnett, G., Grimsrud, A., Hakim, J., Havlir, D., Isbell, M. T., Johnson, L., Kamarulzaman, A., Kasaie, P., Kazatchkine, M., Kilonzo, N., … Beyrer, C. (2018). Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: The International AIDS Society—Lancet Commission. *The Lancet*, *392*(10144), 312–358. https://doi.org/10.1016/S0140-6736(18)31070-5

Bennett, S., Agyepong, I. A., Sheikh, K., Hanson, K., Ssengooba, F., & Gilson, L. (2011). Building the Field of Health Policy and Systems Research: An Agenda for Action. *PLoS Medicine*, *8*(8), e1001081. https://doi.org/10.1371/journal.pmed.1001081

Bennett, S., Frenk, J., & Mills, A. (2018). The evolution of the field of Health Policy and Systems Research and outstanding challenges. *Health Research Policy and Systems*, *16*(1), 43. https://doi.org/10.1186/s12961-018-0317-x

Beran, D., Byass, P., Gbakima, A., Kahn, K., Sankoh, O., Tollman, S., Witham, M., & Davies, J. (2017). Research capacity building—Obligations for global health partners. *The Lancet Global Health*, *5*(6), e567–e568. https://doi.org/10.1016/S2214-109X(17)30180-8

Bergh, A.-M., Kerber, K., Abwao, S., Johnson, J. de-Graft, Aliganyira, P., Davy, K., Gamache, N., Kante, M., Ligowe, R., & Luhanga, R. (2014). Implementing facility-based kangaroo mother care services: Lessons from a multi-country study in Africa. *BMC Health Services Research*, *14*(1), 1–10.

Berman, L., Nkhoma, L., Prust, M., McKay, C., Teshome, M., Banda, D., Kabambe, D., & Gunda, A. (2021). Analysis of policy interventions to attract and retain nurse midwives in rural areas of Malawi: A discrete choice experiment. *Plos One*, *16*(6), e0253518.

Bertone, M. P., & Witter, S. (2015). The complex remuneration of human resources for health in low-income settings: Policy implications and a research agenda for designing effective financial incentives. *Human Resources for Health*, *13*(1), 62. https://doi.org/10.1186/s12960-015-0058-7

Berwick, D. M., Kelley, E., Kruk, M. E., Nishtar, S., & Pate, M. A. (2018). Three global health-care quality reports in 2018. *The Lancet*, *392*(10143), 194–195. https://doi.org/10.1016/S0140-6736(18)31430-2

Bhatnagar, A., Gupta, S., Alonge, O., & George, A. S. (2017). Primary health care workers' views of motivating factors at individual, community and organizational levels: A qualitative study from Nasarawa and Ondo states, Nigeria. *The International Journal of Health Planning and Management*, *32*(2), 217–233.

Bhatnagar, A., Scott, K., Govender, V., & George, A. (2018). Pushing the boundaries of research on human resources for health: Fresh approaches to understanding health worker motivation. *WHO South-East Asia Journal of Public Health*, *7*(1), 13. https://doi.org/10.4103/2224-3151.228422

Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide*. CQUniversity.

Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide*. Sage.

Bitton, A., Fifield, J., Ratcliffe, H., Karlage, A., Wang, H., Veillard, J. H., Schwarz, D., & Hirschhorn, L. R. (2019). Primary healthcare system performance in low-income and middle-income countries: A scoping review of the evidence from 2010 to 2017. *BMJ Global Health*, *4*(Suppl 8), e001551. https://doi.org/10.1136/bmjgh-2019-001551

Bodenheimer, T. (2006). Primary Care—Will It Survive? *New England Journal of Medicine*, *355*(9), 861–864. https://doi.org/10.1056/NEJMp068155

Bonenberger, M., Aikins, M., Akweongo, P., & Wyss, K. (2014). The effects of health worker motivation and job satisfaction on turnover intention in Ghana: A cross-sectional study. *Human Resources for Health*, *12*(1), 43. https://doi.org/10.1186/1478-4491-12-43

Borghi, J., Lohmann, J., Dale, E., Meheus, F., Goudge, J., Oboirien, K., & Kuwawenaruwa, A. (2018). How to do (or not to do)..Measuring health worker motivation in surveys in low- and middle-income countries. *Health Policy and Planning*, *33*(2), 192–203. https://doi.org/10.1093/heapol/czx153

Bosch-Capblanch, X., Liaqat, S., & Garner, P. (2011). Managerial supervision to improve primary health care in low-and middle-income countries. *Cochrane Database of Systematic Reviews*, *9*.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance. *Social Science & Medicine*, *47*(10), 1513–1527.

Bossert, T. J. (2014). Decentralization of health systems: Challenges and global issues of the twenty-first century. In *Decentralizing Health Services* (pp. 199–207). Springer.

Bossert, T. J. (2016). Decision Space and Capacities in the Decentralization of Health Services in FijiComment on 'Decentralisation of Health Services in Fiji: A Decision Space Analysis'. *International Journal of Health Policy and Management*, *5*(7), 443–444. https://doi.org/10.15171/ijhpm.2016.51

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*.

Boyatzis, R. E. (2008). Competencies in the 21st century. *Journal of Management Development*, *27*(1), 5–12. https://doi.org/10.1108/02621710810840730

Bradley, Kamwendo, F., Masanja, H., de Pinho, H., Waxman, R., Boostrom, C., & McAuliffe, E. (2013). District health managers' perceptions of supervision in Malawi and Tanzania. *Human Resources for Health*, *11*(1), 43. https://doi.org/10.1186/1478-4491-11-43

Bradley, S., & McAuliffe, E. (2009). Mid-level providers in emergency obstetric and newborn health care: Factors affecting their performance and retention within the Malawian health system. *Human Resources for Health*, *7*(1), 14. https://doi.org/10.1186/1478-4491-7-14

Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2019). Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. *Reproductive Health*, *16*(1), 116. https://doi.org/10.1186/s12978-019-0773-y

Bradley, Taylor, L. A., & Cuellar, C. J. (2015). Management Matters: A Leverage Point for Health Systems Strengthening in Global Health. *International Journal of Health Policy and Management*, *4*(7), 411–415. https://doi.org/10.15171/ijhpm.2015.101

Brakema, E. A., van der Kleij, R. M., Poot, C. C., Chavannes, N. H., Tsiligianni, I., Walusimbi, S., An, P. L., Sooronbaev, T., Numans, M. E., Crone, M. R., & Reis, R. R. (2021). A systematic approach to context-mapping to prepare for health interventions: Development and validation of the SETTING-tool in four countries. *BMJ Global Health*, *6*(1), e003221. https://doi.org/10.1136/bmjgh-2020-003221

Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health Disparities and Health Equity: The Issue Is Justice. *American Journal of Public Health*, *101*(S1), S149–S155. https://doi.org/10.2105/AJPH.2010.300062

Brenner, S., Wilhelm, D., Lohmann, J., Kambala, C., Chinkhumba, J., Muula, A. S., & De Allegri, M. (2017). Implementation research to improve quality of maternal and newborn health care, Malawi. *Bulletin of the World Health Organization*, *95*(7), 491–502. https://doi.org/10.2471/BLT.16.178202

Brinkerhoff, D. W. (2004). Accountability and health systems: Toward conceptual clarity and policy relevance. *Health Policy and Planning*, *19*(6), 371–379.

Brinkerhoff, D. W., & Bossert, T. J. (2014). Health governance: Principal-agent linkages and health system strengthening. *Health Policy and Planning*, *29*(6), 685–693. https://doi.org/10.1093/heapol/czs132

Brinkerhoff, D. W., & Wetterberg, A. (2016). Gauging the Effects of Social Accountability on Services, Governance, and Citizen Empowerment. *Public Administration Review*, *76*(2), 274–286. https://doi.org/10.1111/puar.12399

Britten, N. (1995). Qualitative research: Qualitative interviews in medical research. *Bmj*, *311*(6999), 251–253.

Brockbank, A., & McGill, I. (2003). *The action learning handbook: Powerful techniques for education, professional development and training*. Routledge.

Brodin, E. M. (2015). Conditions for criticality in doctoral education: A creative concern. In *The Palgrave handbook of critical thinking in higher education* (pp. 265–282). Springer.

Bryman, A. (2004). Qualitative research on leadership: A critical but appreciative review. *The Leadership Quarterly*, *15*(6), 729–769.

Bryman, A. (2016). *Social research methods*. Oxford university press.

Buckley, C. A., & Waring, M. J. (2013). Using diagrams to support the research process: Examples from grounded theory. *Qualitative Research*, *13*(2), 148–172.

Bukhman, G., Mocumbi, A. O., Atun, R., Becker, A. E., Bhutta, Z., Binagwaho, A., Clinton, C., Coates, M. M., Dain, K., Ezzati, M., Gottlieb, G., Gupta, I., Gupta, N., Hyder, A. A., Jain, Y., Kruk, M. E., Makani, J., Marx, A., Miranda, J. J., … Wroe, E. B. (2020). The Lancet NCDI Poverty Commission: Bridging a gap in universal health coverage for the poorest billion. *The Lancet*, *396*(10256), 991–1044. https://doi.org/10.1016/S0140-6736(20)31907-3

Bulthuis, S. E., Kok, M. C., Amon, S., Agyemang, S. A., Nsabagasani, X., Sanudi, L., Raven, J., Finn, M., Gerold, J., Tulloch, O., & Dieleman, M. A. (2021). How district health decision-making is shaped within decentralised contexts: A qualitative research in Malawi, Uganda and Ghana. *Global Public Health*, *16*(1), 120–135. https://doi.org/10.1080/17441692.2020.1791213

Bulthuis, S. E., Kok, M. C., Raven, J., & Dieleman, M. A. (2020). Factors influencing the scale-up of public health interventions in low- and middle-income countries: A qualitative systematic literature review. *Health Policy and Planning*, *35*(2), 219–234. https://doi.org/10.1093/heapol/czz140

Byskov, J., Maluka, S., Marchal, B., Shayo, E. H., Blystad, A., Bukachi, S., Zulu, J. M., Michelo, C., Hurtig, A.-K., & Bloch, P. (2019). A systems perspective on the importance of global health strategy developments for accomplishing today's Sustainable Development Goals. *Health Policy and Planning*, *34*(9), 635–645. https://doi.org/10.1093/heapol/czz042

Campbell, H., Duke, T., Weber, M., English, M., Carai, S., Tamburlini, G., & Pediatric Hospital Improvement Group. (2008). Global Initiatives for Improving Hospital Care for Children: State of the Art and Future Prospects. *Pediatrics*, *121*(4), e984–e992. https://doi.org/10.1542/peds.2007-1395

Campbell, J., Buchan, J., Cometto, G., David, B., Dussault, G., Fogstad, H., Fronteira, I., Lozano, R., Nyonator, F., Pablos-Méndez, A., Quain, E. E., Starrs, A., & Tangcharoensathien, V. (2013). Human resources for health and universal health coverage: Fostering equity and effective coverage. *Bulletin of the World Health Organization*, *91*(11), 853–863. https://doi.org/10.2471/BLT.13.118729

Cancedda, C., Farmer, P. E., Kerry, V., Nuthulaganti, T., Scott, K. W., Goosby, E., & Binagwaho, A. (2015). Maximizing the Impact of Training Initiatives for Health Professionals in Low-Income Countries: Frameworks, Challenges, and Best Practices. *PLOS Medicine*, *12*(6), e1001840. https://doi.org/10.1371/journal.pmed.1001840

Carey, G., Malbon, E., Carey, N., Joyce, A., Crammond, B., & Carey, A. (2015). Systems science and systems thinking for public health: A systematic review of the field. *BMJ Open*, *5*(12), e009002. https://doi.org/10.1136/bmjopen-2015-009002

Carlson, C., Chirwa, W. C., Hall, N., & Cammack, D. (2014). Study of health sector efficiency in Malawi. *Lilongwe: Ministry of Health*.

Cassels A, Janovsky K. Management development for primary health care: a framework for analysis. Int J Health Plann Manage. (1991) Apr-Jun;6(2):109-24. doi: 10.1002/hpm.4740060204. PMID: 10112478.

Chansa, C., Mwase, T., Matsebula, T. C., Kandoole, P., Revill, P., Makumba, J. B., & Lindelow, M. (2018). Fresh money for health? The (false?) promise of "innovative financing" for health in Malawi. *Health Systems & Reform*, *4*(4), 324–335.

Charmaz, K. (2000). Experiencing chronic illness. *Handbook of Social Studies in Health and Medicine*, 277–292.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. sage.

Charmaz, K. (2014). *Constructing grounded theory*. sage.

Chaskin, R. J. (2008). Dissemination and impact: Issues, lessons and future directions. *Research for Action: Cross-National Perspectives on Connecting Knowledge, Policy, and Practice for Children*, 131–157.

Checkland, P. (1981) Systems Thinking, Systems Practice. New York: John Wiley & Sons.

Checkland, P. (1994). Systems theory and management thinking. *American Behavioral Scientist*, *38*(1), 75–91.

Checkland, P. (1999). Systems thinking. *Rethinking Management Information Systems*, 45–56.

Checkland, P. (2000a). Soft systems methodology: A thirty year retrospective. *Syst. Res.*, 48.

Checkland, P. (2000b). Systems thinking, systems practice: Includes a 30-year retrospective. *Journal-Operational Research Society*, *51*(5), 647–647.

Checkland, P. B., & Haynes, M. G. (1994). Varieties of systems thinking: The case of soft systems methodology. *System Dynamics Review*, *10*(2–3), 189–197. https://doi.org/10.1002/sdr.4260100207

Checkland, P., & Poulter, J. (2006). *Learning for action: A short definitive account of soft systems methodology and its use for practitioner, teachers, and students* (Vol. 26). Wiley Chichester.

Chigudu, S., Jasseh, M., d'Alessandro, U., Corrah, T., Demba, A., & Balen, J. (2018). The role of leadership in people-centred health systems: A sub-national study in The Gambia. *Health Policy and Planning*, *33*(1), e14–e25. https://doi.org/10.1093/heapol/czu078

Chikaphupha, K. R., Kok, M. C., Nyirenda, L., Namakhoma, I., & Theobald, S. (2016). Motivation of health surveillance assistants in Malawi: a qualitative study. *Malawi medical journal*, *28*(2), 37-42.

Chikaphupha, K et al. (Accepted).Applying Systems-Thinking to understand the process of Decentralisation: A Malawi Case Study In Larkan, F., Mannan, H., Kodate, N. & Vallières, F. (Eds.) Reading across systems thinking for global health: How can systems-thinking contribute to solving key challenges in Global Health? Oxford: Oxford University Press.

Chimwaza, W., Chipeta, E., Ngwira, A., Kamwendo, F., Taulo, F., Bradley, S., & McAuliffe, E. (2014). What makes staff consider leaving the health service in Malawi? *Human Resources for Health*, *12*(1), 17. https://doi.org/10.1186/1478-4491-12-17

Chipeta, E., Bradley, S., Chimwaza-Manda, W., & McAuliffe, E. (2016). Working relationships between obstetric care staff and their managers: a critical incident analysis. *BMC health services research*, *16*(1), 1-9.

Choi, S. L., Goh, C. F., Adam, M. B. H., & Tan, O. K. (2016). Transformational leadership, empowerment, and job satisfaction: The mediating role of employee empowerment. *Human Resources for Health*, *14*(1), 73. https://doi.org/10.1186/s12960-016-0171-2

Chopra, M., Munro, S., Lavis, J. N., Vist, G., & Bennett, S. (2008). Effects of policy options for human resources for health: An analysis of systematic reviews. *The Lancet*, *371*(9613), 668–674.

Chu, K. M., Jayaraman, S., Kyamanywa, P., & Ntakiyiruta, G. (2014). Building Research Capacity in Africa: Equity and Global Health Collaborations. *PLoS Medicine*, *11*(3), e1001612. https://doi.org/10.1371/journal.pmed.1001612

Chunharas, S., & Davies, D. S. C. (2016). Leadership in health systems: A new agenda for interactive leadership. *Health Systems & Reform*, *2*(3), 176–178.

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction*, *26*(4), 553–576.

Clarke, A. E., Friese, C., & Washburn, R. (2016). *Situational analysis in practice: Mapping research with grounded theory*. Routledge.

Cleary, Molyneux, S., & Gilson, L. (2013). Resources, attitudes and culture: An understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Services Research*, *13*(1), 320. https://doi.org/10.1186/1472-6963-13-320

Cleary, S., Toit, A. du, Scott, V., & Gilson, L. (2018). Enabling relational leadership in primary healthcare settings: Lessons from the DIALHS collaboration. *Health Policy and Planning*, *33*(suppl_2), ii65–ii74. https://doi.org/10.1093/heapol/czx135

Clements, C. J., Streefland, P. H., & Malau, C. (2007). Supervision in Primary Health Care 128;"Can it be Carried Out Effectively in Developing Countries? *Current Drug Safety*, *2*(1), 19–23.

Cobos Muñoz, D., Merino Amador, P., Monzon Llamas, L., Martinez Hernandez, D., & Santos Sancho, J. M. (2017). Decentralization of health systems in low and middle income countries: A systematic review. *International Journal of Public Health*, *62*(2), 219–229. https://doi.org/10.1007/s00038-016-0872-2

Cole, D. C., Aslanyan, G., Dunn, A., Boyd, A., & Bates, I. (2014). Dilemmas of evaluation: Health research capacity initiatives. *Bulletin of the World Health Organization*, *92*(12), 920–921. https://doi.org/10.2471/BLT.14.141259

Cole, D. C., Boyd, A., Aslanyan, G., & Bates, I. (2014). Indicators for tracking programmes to strengthen health research capacity in lower- and middle-income countries: A qualitative synthesis. *Health Research Policy and Systems*, *12*(1), 17. https://doi.org/10.1186/1478-4505-12-17

Cometto, G., Ford, N., Pfaffman-Zambruni, J., Akl, E. A., Lehmann, U., McPake, B., Ballard, M., Kok, M., Najafizada, M., & Olaniran, A. (2018). Health policy and system support to optimise community health worker programmes: An abridged WHO guideline. *The Lancet Global Health*, *6*(12), e1397–e1404.

Conte, K. P., & Davidson, S. (2020). Using a 'rich picture' to facilitate systems thinking in research coproduction. *Health Research Policy and Systems*, *18*(1), 1–14.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, *374*(9692), 817–834.

Corbin, J., & Strauss, A. (2008). Strategies for qualitative data analysis. *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory*, *3*.

Coryn, C. L., Noakes, L. A., Westine, C. D., & Schröter, D. C. (2011). A systematic review of theory-driven evaluation practice from 1990 to 2009. *American Journal of Evaluation*, *32*(2), 199–226.

Couttolenc, B. F. (2012). *Decentralization and governance in the Ghana health sector*. The World Bank.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crisp, L. N. (2011). Global health capacity and workforce development: Turning the world upside down. *Infectious Disease Clinics of North America*, *25*(2), 359.

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. SAGE.

Crowe, S., Brown, K., Tregay, J., Wray, J., Knowles, R., Ridout, D. A., Bull, C., & Utley, M. (2017). Combining qualitative and quantitative operational research methods to inform quality improvement in pathways that span multiple settings. *BMJ Quality & Safety*, *26*(8), 641–652. https://doi.org/10.1136/bmjqs-2016-005636

Crowe, S., Clarke, N., & Brugha, R. (2017). 'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine*, *186*, 70-77.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, *11*(1), 100. https://doi.org/10.1186/1471-2288-11-100

Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., Micaroni, S. P., & Chatterjee, G. E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International journal of nursing studies*, *85*, 19-60.

Cunliffe, A. L., & Eriksen, M. (2011). Relational leadership. *Human Relations*, *64*(11), 1425–1449.

Currie, G., & Lockett, A. (2011). Distributing leadership in health and social care: Concertive, conjoint or collective? *International Journal of Management Reviews*, *13*(3), 286–300.

Curry, L., Taylor, L., Chen, P. G.-C., & Bradley, E. (2012). Experiences of leadership in health care in sub-Saharan Africa. *Human Resources for Health*, *10*(1), 33. https://doi.org/10.1186/1478-4491-10-33

Daire, J., & Gilson, L. (2014). Does identity shape leadership and management practice? Experiences of PHC facility managers in Cape Town, South Africa. *Health Policy and Planning*, *29*(suppl 2), ii82–ii97. https://doi.org/10.1093/heapol/czu075

Daire, J., Gilson, L., & Cleary, S. (2014). Developing leadership and management competencies in low and middle-income country health systems: A review of the literature. *Cape Town: Resilient and Responsive Health Systems (RESYST)*.

Dalglish, S. L., Khalid, H., & McMahon, S. A. (2021). Document analysis in health policy research: The READ approach. *Health Policy and Planning*, *35*(10), 1424–1431. https://doi.org/10.1093/heapol/czaa064

Daniels, K., Loewenson, R., George, A., Howard, N., Koleva, G., Lewin, S., Marchal, B., Nambiar, D., Paina, L., Sacks, E., Sheikh, K., Tetui, M., Theobald, S., Topp, S. M., & Zwi, A. B. (2016). Fair publication of qualitative research in health systems: A call by health policy and systems researchers. *International Journal for Equity in Health*, *15*(1), 98. https://doi.org/10.1186/s12939-016-0368-y

Darby, C., Valentine, N., De Silva, A., Murray, C. J., & Organization, W. H. (2003). *World Health Organization (WHO): Strategy on measuring responsiveness*.

Davidoff, F., Dixon-Woods, M., Leviton, L., & Michie, S. (2015). Demystifying theory and its use in improvement. *BMJ Quality & Safety*, *24*(3), 228–238. https://doi.org/10.1136/bmjqs-2014-003627

De Brún, A., & McAuliffe, E. (2020). Identifying the context, mechanisms and outcomes underlying collective leadership in teams: Building a realist programme theory. *BMC Health Services Research*, *20*(1), 261. https://doi.org/10.1186/s12913-020-05129-1

De Brún, A., O'Donovan, R., & McAuliffe, E. (2019). Interventions to develop collectivistic leadership in healthcare settings: A systematic review. *BMC Health Services Research*, *19*(1), 72. https://doi.org/10.1186/s12913-019-3883-x

De Brún, A., Anjara, S., Cunningham, U., Khurshid, Z., Macdonald, S., O'Donovan, R., Rogers, L., et al. (2020). The Collective Leadership for Safety Culture (Co-Lead) Team Intervention to Promote Teamwork and Patient Safety. *International Journal of Environmental Research and Public Health*, *17*(22), 8673. MDPI AG. Retrieved from http://dx.doi.org/10.3390/ijerph17228673

De Herdt, T., & Olivier de Sardan, J.-P. (Eds.). (2015). *Real Governance and Practical Norms in Sub-Saharan Africa: The game of the rules* (1st ed.). Routledge. https://doi.org/10.4324/9781315723365

De Savigny, D., & Adam, T. (2009). *Systems thinking for health systems strengthening*. World Health Organization.

Dean, L., Njelesani, J., Smith, H., & Bates, I. (2015). Promoting sustainable research partnerships: A mixed-method evaluation of a United Kingdom–Africa capacity strengthening award scheme. *Health Research Policy and Systems*, *13*(1), 81. https://doi.org/10.1186/s12961-015-0071-2

Deming, W. E. (1993). A system of profound knowledge.

Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.

Denzin, N. K., & Lincoln. (2005). The Discipline and Practice of Qualitative Research. In *The landscape of qualitative research* (Vols 1–43).

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research*. Sage.

Denzin, N. K., Lincoln, Y. S., MacLure, M., Otterstad, A. M., Torrance, H., Cannella, G. S., Koro-Ljungberg, M., & McTier, T. (2017). Critical qualitative methodologies: Reconceptualizations and emergent construction. *International Review of Qualitative Research*, *10*(4), 482–498.

Desmond, N. A., Nyirenda, D., Dube, Q., Mallewa, M., Molyneux, E., Lalloo, D. G., & Heyderman, R. S. (2013). Recognising and treatment seeking for acute bacterial meningitis in adults and children in resource-poor settings: a qualitative study. *PLoS One*, *8*(7), e68163.

Dhatt, R., Theobald, S., Buzuzi, S., Ros, B., Vong, S., Muraya, K., Molyneux, S., Hawkins, K., González-Beiras, C., Ronsin, K., Lichtenstein, D., Wilkins, K., Thompson, K., Davis, K.,

& Jackson, C. (2017). The role of women's leadership and gender equity in leadership and health system strengthening. *Global Health, Epidemiology and Genomics*, *2*, e8. https://doi.org/10.1017/gheg.2016.22

Dieleman, J., Campbell, M., Chapin, A., Eldrenkamp, E., Fan, V. Y., Haakenstad, A., Kates, J., Liu, Y., Matyasz, T., & Micah, A. (2017). Evolution and patterns of global health financing 1995–2014: Development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries. *The Lancet*, *389*(10083), 1981–2004.

Dieleman, M., Gerretsen, B., & van der Wilt, G. J. (2009). Human resource management interventions to improve health workers' performance in low and middle income countries: A realist review. *Health Research Policy and Systems*, *7*(1), 7. https://doi.org/10.1186/1478-4505-7-7

Dieleman, M., & Harnmeijer, J. W. (2006). Improving health worker performance: In search of promising practices. *Geneva: World Health Organization*, *1*(01).

Dieleman, M., & Hilhorst, T. (2011). Governance and human resources for health. *Human Resources for Health*, *9*(1), 29. https://doi.org/10.1186/1478-4491-9-29

Doherty, J., Gilson, L., & Shung-King, M. (2018). Achievements and challenges in developing health leadership in South Africa: The experience of the Oliver Tambo Fellowship Programme 2008–2014. *Health Policy and Planning*, *33*(suppl_2), ii50–ii64. https://doi.org/10.1093/heapol/czx155

Dooris, M. (2013). Expert voices for change: Bridging the silos—towards healthy and sustainable settings for the 21st century. *Health & Place*, *20*, 39–50. https://doi.org/10.1016/j.healthplace.2012.11.009

Dossou, J.-P., Assarag, B., Delamou, A., Van der Veken, K., Belaid, L., Ouédraogo, M., Khalfallah, S., Aouras, H., Diadhiou, M., Fassassi, R., & Delvaux, T. (2016). Switching the poles in sexual and reproductive health research: Implementing a research capacity-strengthening network in West and North Africa. *Reproductive Health*, *13*(1), 91. https://doi.org/10.1186/s12978-016-0203-3

Douthwaite, B., & Ashby, J. A. (2005). Innovation histories: A method from learning from experience. *ILAC Brief*.

Dulani, B. (2004) *The status of decentralisation in Malawi: report.* University of Malawi.

Dulani, B., Rakner, L., Benstead, L., & Wang, V. (2021, September). Do women face a different standard? The interplay of gender and corruption in the 2014 presidential elections in Malawi. In *Women's Studies International Forum*(Vol. 88, p. 102501). Pergamon

Dullie, L., Meland, E., Hetlevik, Ø., Mildestvedt, T., Kasenda, S., Kantema, C., & Gjesdal, S. (2019). Performance of primary care in different healthcare facilities: A cross-sectional study of patients' experiences in Southern Malawi. *BMJ Open*, *9*(7), e029579.

Dwicaksono, A., & Fox, A. M. (2018). Does Decentralization Improve Health System Performance and Outcomes in Low- and Middle-Income Countries? A Systematic Review of Evidence From Quantitative Studies: Decentralization and Health System Performance and Outcomes. *The Milbank Quarterly*, *96*(2), 323–368. https://doi.org/10.1111/1468-0009.12327

Eckert, R., & Rweyongoza, S. (2010). Leadership development in Africa: A focus on strengths. *Brussels: Center for Creative Leadership*.

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383.

Eisner, E. W. (2017). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. Teachers College Press.

Elloker, S., Olckers, P., Gilson, L., & Lehmann, U. (2012). Crises, routines and innovations: The complexities and possibilities of sub-district management. *South African Health Review*, *2012*(1), 161–173.

English, M., Moshabela, M., Nzinga, J., Barasa, E., Tsofa, B., Marchal, B., & Kruk, M. E. (2020). Systems and implementation science should be part of the COVID-19 response in low resource settings. *BMC Medicine*, *18*(1), 1–2.

English, M., Moshabela, M., Nzinga, J., Tsofa, B., & Barasa. (2020). Systems and Implementation Science should be part of the COVI-10 response in low-resource settings. *BMC Medicine*, *18*, 1–2.

Erasmus, E., Gilson, L., Govender, V., & Nkosi, M. (2017). Organisational culture and trust as influences over the implementation of equity-oriented policy in two South African case study hospitals. *International Journal for Equity in Health*, *16*(1), 164. https://doi.org/10.1186/s12939-017-0659-y

Evans, T., Nishtar, S., Atun, R., & Etienne, C. (2008). Scaling up research and learning for health systems: Time to act. *The Lancet*, *372*(9649), 1529–1531. https://doi.org/10.1016/S0140-6736(08)61634-7

Farrar. (2019). *Why we need to reimagine how we do research*. Wellcome. https://wellcome.org/news/why-we-need-reimagine-how-we-do-research

Festinger, L. E., & Katz, D. E. (1953). *Research methods in the behavioral sciences.*

Fetene, N., Linnander, E., Fekadu, B., Alemu, H., Omer, H., Canavan, M., Smith, J., Berman, P., & Bradley, E. (2016). The Ethiopian Health Extension Program and Variation in Health Systems Performance: What Matters? *PLOS ONE*, *11*(5), e0156438. https://doi.org/10.1371/journal.pone.0156438

Fieno, J. V., Dambisya, Y. M., George, G., & Benson, K. (2016). A political economy analysis of human resources for health (HRH) in Africa. *Human Resources for Health*, *14*(1), 44. https://doi.org/10.1186/s12960-016-0137-4

Figueroa, C. A., Harrison, R., Chauhan, A., & Meyer, L. (2019). Priorities and challenges for health leadership and workforce management globally: A rapid review. *BMC Health Services Research*, *19*(1), 239. https://doi.org/10.1186/s12913-019-4080-7

Finn, M., Gilmore, B., Sheaf, G., & Vallières, F. (2021). What do we mean by individual capacity strengthening for primary health care in low-and middle-income countries? A systematic scoping review to improve conceptual clarity. *Human Resources for Health*, *19*(1), 1–13.

Fischer, T., Dietz, J., & Antonakis, J. (2017). Leadership process models: A review and synthesis. *Journal of Management*, *43*(6), 1726–1753.

Flick, U. (2008). *Triangulation*. Sage

Franzen, S. R. P., Chandler, C., & Lang, T. (2017). Health research capacity development in low and middle income countries: Reality or rhetoric? A systematic meta-narrative review of the qualitative literature. *BMJ Open*, *7*(1), e012332. https://doi.org/10.1136/bmjopen-2016-012332

Frenk, J. (2010). The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. *PLoS Medicine*, *7*(1), e1000089. https://doi.org/10.1371/journal.pmed.1000089

Frenk, J., Gómez-Dantés, O., & Moon, S. (2014). From sovereignty to solidarity: A renewed concept of global health for an era of complex interdependence. *The Lancet*, *383*(9911), 94–97.

Fridell, M., Edwin, S., von Schreeb, J., & Saulnier, D. D. (2019). Health System Resilience: What Are We Talking About? A Scoping Review Mapping Characteristics and Keywords. *International Journal of Health Policy and Management*, *9*(1), 6–16. https://doi.org/10.15171/ijhpm.2019.71

Frumence, G., Nyamhanga, T., Mwangu, M., & Hurtig, A.-K. (2013). Challenges to the implementation of health sector decentralization in Tanzania: Experiences from Kongwa district council. *Global Health Action*, *6*(1), 20983. https://doi.org/10.3402/gha.v6i0.20983

Gagné, M., & Deci, E. L. (2005). Self-determination theory and work motivation. *Journal of Organizational Behavior*, *26*(4), 331–362.

Galer, J. B., Vriesendorp, S., & Ellis, A. (2005). *Managers WHO lead*.

García, P. J. (2019). Corruption in global health: The open secret. *The Lancet*, *394*(10214), 2119–2124.

Gauthier, B., & Wane, W. (2009). Leakage of public resources in the health sector: An empirical investigation of Chad. *Journal of African Economies*, *18*(1), 52–83.

Geertz, C. (1973). *Thick Description: Towards an Interpretive Theory of Culture*.

George, A., Olivier, J., Glandon, D., Kapilashrami, A., & Gilson, L. (2019). Health systems for all in the SDG era: Key reflections based on the Liverpool statement for the fifth global symposium on health systems research. *Health Policy and Planning*, *34*(Supplement_2), ii135–ii138. https://doi.org/10.1093/heapol/czz115

George, A., Scott, K., Govender, V., & Organization, W. H. (2017). *A health policy and systems research reader on human resources for health*. World Health Organization.

Ghebreyesus, T. A., Fore, H., Birtanov, Y., & Jakab, Z. (2018). Primary health care for the 21st century, universal health coverage, and the Sustainable Development Goals. *The Lancet*, *392*(10156), 1371–1372. https://doi.org/10.1016/S0140-6736(18)32556-X

Gile, P. P., Buljac-Samardzic, M., & Klundert, J. V. D. (2018). The effect of human resource management on performance in hospitals in Sub-Saharan Africa: A systematic literature review. *Human Resources for Health*, *16*(1), 34. https://doi.org/10.1186/s12960-018-0298-4

Gilson, L. (2012). Introduction to health policy and systems research. *Health Policy and Systems Research: A Methodology Reader. Geneva: Alliance for Health Policy and System Research: WHO*, *19*, 39.

Gilson, L. (2019). Reflections from South Africa on the value and application of a political economy lens for health financing reform. *Health Systems & Reform*, *5*(3), 236–243.

Gilson, L., & Agyepong, I. A. (2018). Strengthening health system leadership for better governance: What does it take? *Health Policy and Planning*, *33*(suppl_2), ii1–ii4. https://doi.org/10.1093/heapol/czy052

Gilson, L., Barasa, E., Brady, L., Kagwanja, N., Nxumalo, N., Nzinga, J., Molyneux, S., & Tsofa, B. (2021). Collective sensemaking for action: Researchers and decision makers working collaboratively to strengthen health systems. *BMJ*, m4650. https://doi.org/10.1136/bmj.m4650

Gilson, L., Barasa, E., Nxumalo, N., Cleary, S., Goudge, J., Molyneux, S., Tsofa, B., & Lehmann, U. (2017). Everyday resilience in district health systems: Emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health*, *2*(2), e000224. https://doi.org/10.1136/bmjgh-2016-000224

Gilson, L., & Daire, J. (2011). Leadership and governance within the South African health system. *South African Health Review*, *2011*(1), 69–80.

Gilson, L., Elloker, S., Olckers, P., & Lehmann, U. (2014). Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care. *Health Research Policy and Systems*, *12*(1), 30. https://doi.org/10.1186/1478-4505-12-30

Gilson, L., Lehmann, U., & Schneider, H. (2017). Practicing governance towards equity in health systems: LMIC perspectives and experience. In *International Journal for Equity in Health* (Vol. 16, Issue 1, pp. 1–5). Springer.

Gilson, L., Marchal, B., Ayepong, I., Barasa, E., Dossou, J.-P., George, A., Guinaran, R., Maceira, D., Molyneux, S., & Prashanth, N. S. (2020). What role can health policy and systems research play in supporting responses to COVID-19 that strengthen socially just health systems? *Health Policy and Planning*, *35*(9), 1231–1236.

Glaser, B. G. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, *1*(2), 23–38.

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *5*(2).

Glenton, C., Colvin, C., Carlsen, B., Swartz, A., Lewin, S., Noyes, J., & Rashidian, A. (2013). Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: Qualitative evidence synthesis. In The Cochrane Collaboration (Ed.), *Cochrane Database of Systematic Reviews* (p. CD010414). John Wiley & Sons, Ltd. https://doi.org/10.1002/14651858.CD010414

Goldberg, J., & Bryant, M. (2012). Country ownership and capacity building: The next buzzwords in health systems strengthening or a truly new approach to development? *BMC Public Health*, *12*(1), 531. https://doi.org/10.1186/1471-2458-12-531

Goodwin. (2000). Leadership and the UK health service. *Health Policy*. https://scholar.google.com/scholar_lookup?title=Leadership%20and%20the%20UK%20health%20service&author=N%20Goodwin&publication_year=2000&journal=Health%20Policy&volume=51&pages=49-60

Gondwe, M. J., Henrion, M. Y., O'Byrne, T., Masesa, C., Lufesi, N., Dube, Q., ... & Desmond, N. (2021). Clinical diagnosis in paediatric patients at urban primary health care facilities in southern Malawi: a longitudinal observational study. *BMC Health Services Research*, *21*(1), 1-10.

Gordon, S. B., Chinula, L., Chilima, B., Mwapasa, V., Dadabhai, S., Mlombe, Y., & Workshop, M. R. E. (2018). A Malawi guideline for research study participant remuneration. *Wellcome Open Research*, *3*.

Gosling, J., & Mintzberg, H. (2003). The five minds of a manager. *Harvard Business Review*, *81*(11), 54–63.

Gouda, H. N., Charlson, F., Sorsdahl, K., Ahmadzada, S., Ferrari, A. J., Erskine, H., Leung, J., Santamauro, D., Lund, C., Aminde, L. N., Mayosi, B. M., Kengne, A. P., Harris, M., Achoki, T., Wiysonge, C. S., Stein, D. J., & Whiteford, H. (2019). Burden of non-communicable diseases in sub-Saharan Africa, 1990–2017: Results from the Global Burden of Disease Study 2017. *The Lancet Global Health*, *7*(10), e1375–e1387. https://doi.org/10.1016/S2214-109X(19)30374-2

Greenhalgh, T., Annandale, E., Ashcroft, R., Barlow, J., Black, N., Bleakley, A., Boaden, R., Braithwaite, J., Britten, N., & Carnevale, F. (2016). An open letter to The BMJ editors on qualitative research. *Bmj*, *352*.

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: Desperately seeking an overdue paradigm shift. *BMC Medicine*, *16*(1), 95, s12916-018-1089–4. https://doi.org/10.1186/s12916-018-1089-4

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. *The Milbank Quarterly*, *82*(4), 581–629. https://doi.org/10.1111/j.0887-378X.2004.00325.x

Guillemin, M., & Gillam, L. (2004). Ethics, Reflexivity, and "Ethically Important Moments" in Research. *Qualitative Inquiry*, *10*(2), 261–280. https://doi.org/10.1177/1077800403262360

Gulland, A. (2016). Zika virus is a global public health emergency, declares WHO. *BMJ*, i657. https://doi.org/10.1136/bmj.i657

Haines, & Borchert. (2004). Haines: Bridging the implementation gap between knowledge... - Google Scholar. *Bulletin of the World Health Organization*, *82*, 724–731.

Haines: Bridging the implementation gap between knowledge... - Google Scholar. (n.d.). Retrieved 29 December 2021, from https://scholar.google.com/scholar_lookup?title=Bridging%20the%20implementation%20gap%20between%20knowledge%20and%20action%20for%20health&journal=Bull%20World%20Health%20Organ&volume=82&pages=724-731&publication_year=2004&author=Haines%2CA&author=Kuruvilla%2CS&author=Borchert%2CM

Haynes, A., Garvey, K., Davidson, S., & Milat, A. (2019). What Can Policy-Makers Get Out of Systems Thinking? Policy Partners' Experiences of a Systems-Focused Research Collaboration in Preventive Health. *International Journal of Health Policy and Management*, *9*(2), 65–76. https://doi.org/10.15171/ijhpm.2019.86

Haynes, A., Rychetnik, L., Finegood, D., Irving, M., Freebairn, L., & Hawe, P. (2020). Applying systems thinking to knowledge mobilisation in public health. *Health Research Policy and Systems*, *18*(1), 134. https://doi.org/10.1186/s12961-020-00600-1

Heaney, S. (1991). *The cure at Troy: A version of Sophocles' Philoctetes*. Macmillan.

Heerdegen, A. C. S., Aikins, M., Amon, S., Agyemang, S. A., & Wyss, K. (2020). Managerial capacity among district health managers and its association with district performance: A comparative descriptive study of six districts in the Eastern Region of Ghana. *PLOS ONE*, *15*(1), e0227974. https://doi.org/10.1371/journal.pone.0227974

Heerdegen, A. C. S., Gerold, J., Amon, S., Agyemang, S. A., Aikins, M., & Wyss, K. (2020). How Does District Health Management Emerge Within a Complex Health System? Insights for Capacity Strengthening in Ghana. *Frontiers in Public Health*, *8*, 270. https://doi.org/10.3389/fpubh.2020.00270

Hipgrave, D. B., Alderman, K. B., Anderson, I., & Soto, E. J. (2014). Health sector priority setting at meso-level in lower and middle income countries: Lessons learned, available options and suggested steps. *Social Science & Medicine*, *102*, 190–200. https://doi.org/10.1016/j.socscimed.2013.11.056

Hitziger, M., Esposito, R., Canali, M., Aragrande, M., Häsler, B., & Rüegg, S. R. (2018). Knowledge integration in One Health policy formulation, implementation and evaluation. *Bulletin of the World Health Organization*, *96*(3), 211–218. https://doi.org/10.2471/BLT.17.202705

Hoare, K. J., Mills, J., & Francis, K. (2012). Dancing with data: An example of acquiring theoretical sensitivity in a grounded theory study. *International Journal of Nursing Practice*, *18*(3), 240–245.

Hoffman, S. J., & Cole, C. B. (2018). Defining the global health system and systematically mapping its network of actors. *Globalization and Health*, *14*(1), 38. https://doi.org/10.1186/s12992-018-0340-2

Hoffman, S. J., & Frenk, J. (2012). Producing and translating health system evidence for improved global health. *Journal of Interprofessional Care*, *26*(1), 4–5. https://doi.org/10.3109/13561820.2011.577626

Hoffman, S. J., & Sossin, L. (2012). Empirically evaluating the impact of adjudicative tribunals in the health sector: Context, challenges and opportunities. *Health Economics, Policy and Law*, *7*(2), 147–174.

Hogan, R., & Kaiser, R. B. (2005). What we know about Leadership. *Review of General Psychology*, *9*(2), 169–180. https://doi.org/10.1037/1089-2680.9.2.169

House, R. J. (2004). *Culture, leadership, and organizations_ the GLOBE study of 62 societies*. SAGE Publications, inc.

Hsiao, W. C. (n.d.). *What is a Health System*. 33.

Hsiao, W., & Saidat, B. (2008). Health systems: Concepts and deterministic models of performance. *Unpublished Manuscript, Harvard School of Public Health, Boston*.

Hunter, D. J. (2015). Role of politics in understanding complex, messy health systems: An essay by David J Hunter. *Bmj*, *350*.

Hunter, P. R., Abdelrahman, S. H., Antwi-Agyei, P., Awuah, E., Cairncross, S., Chappell, E., Dalsgaard, A., Ensink, J. H., Potgieter, N., Mokgobu, I., Muchiri, E. W., Mulogo, E., Es, M. van der, & Odai, S. N. (2014). Needs assessment to strengthen capacity in water and sanitation research in Africa: Experiences of the African SNOWS consortium. *Health Research Policy and Systems*, *12*(1), 68. https://doi.org/10.1186/1478-4505-12-68

Hurst, & Jee-Hughes. (2001). *Performance Measurement and Performance Management in OECD Health Systems* (OECD Labour Market and Social Policy Occasional Papers No. 47; OECD Labour Market and Social Policy Occasional Papers, Vol. 47). https://doi.org/10.1787/788224073713

Hutchinson, E., Balabanova, D., & McKee, M. (2019). We need to talk about corruption in health systems. *International Journal of Health Policy and Management*, *8*(4), 191.

Ibeneme, S., Ongom, M., Ukor, N., & Okeibunor, J. (2020). Realigning Health Systems Strategies and Approaches; What Should African Countries Do to Strengthen Health Systems for the Sustainable Development Goals? *Frontiers in Public Health*, *8*, 372. https://doi.org/10.3389/fpubh.2020.00372

IntraHealth International (2018). *Nurses Needed: partnering to Scale up health worker education in Malawi*

Ison, R. (2017). *Systems Practice: How to Act: In situations of uncertainty and complexity in a climate-change world*. Springer.

Jackson, M. (2019). *Critical Systems Thinking and the Management of Complexity | Wiley*. Wiley. https://www.wiley.com/en-

gb/Critical+Systems+Thinking+and+the+Management+of+Complexity-p-9781119118398

Jackson, M. C. (2001). Critical systems thinking and practice. *European Journal of Operational Research*, *128*(2), 233–244.

Jackson, M. C., & Sambo, L. G. (2020). Health systems research and critical systems thinking: The case for partnership. *Systems Research and Behavioral Science*, *37*(1), 3–22.

Jagero, N., Kwandayi, H. H. and Longwe, A. (2014) 'Challenges of Decentralization in Malawi', *International Journal of Management Sciences,* 2(7), pp. 315-322.

Jamison, D. T., Summers, L. H., Alleyne, G., Arrow, K. J., Berkley, S., Binagwaho, A., Bustreo, F., Evans, D., Feachem, R. G. A., Frenk, J., Ghosh, G., Goldie, S. J., Guo, Y., Gupta, S., Horton, R., Kruk, M. E., Mahmoud, A., Mohohlo, L. K., Ncube, M., … Yamey, G. (2013). Global health 2035: A world converging within a generation. *The Lancet*, *382*(9908), 1898–1955. https://doi.org/10.1016/S0140-6736(13)62105-4

Johnson, O., Begg, K., Kelly, A. H., & Sevdalis, N. (2021). Interventions to strengthen the leadership capabilities of health professionals in Sub-Saharan Africa: A scoping review. *Health Policy and Planning*, *36*(1), 117–133. https://doi.org/10.1093/heapol/czaa078

Johnson, O., Sahr, F., Begg, K., Sevdalis, N., & Kelly, A. H. (2021). To bend without breaking: A qualitative study on leadership by doctors in Sierra Leone. *Health Policy and Planning*, *36*(10), 1644–1658. https://doi.org/10.1093/heapol/czab076

Kabene, S. M., Orchard, C., Howard, J. M., Soriano, M. A., & Leduc, R. (2006). The importance of human resources management in health care: A global context. *Human Resources for Health*, *4*(1), 20. https://doi.org/10.1186/1478-4491-4-20

Kadzandira, JM., & Chilowa, MR., (2001) The Role of Health Surveillance Assistants (HSAs) in the delivery of health services and immunisation in Malawi.

Kagwanja, N., Waithaka, D., Nzinga, J., Tsofa, B., Boga, M., Leli, H., Mataza, C., Gilson, L., Molyneux, S., & Barasa, E. (2020). Shocks, stress and everyday health system resilience: Experiences from the Kenyan coast. *Health Policy and Planning*, *35*(5), 522–535. https://doi.org/10.1093/heapol/czaa002

Kanyuka, M., Ndawala, J., Mleme, T., Chisesa, L., Makwemba, M., Amouzou, A., Borghi, J., Daire, J., Ferrabee, R., & Hazel, E. (2016). Malawi and Millennium Development Goal 4: A Countdown to 2015 country case study. *The Lancet Global Health*, *4*(3), e201–e214.

Kapiriri, L., & Razavi, D. (2017). How have systematic priority setting approaches influenced policy making? A synthesis of the current literature. *Health Policy*, *121*(9), 937–946. https://doi.org/10.1016/j.healthpol.2017.07.003

Karuga, R. N., Mireku, M., Muturi, N., McCollum, R., Vallieres, F., Kumar, M., Taegtmeyer, M., & Otiso, L. (2019). Supportive supervision of close-to-community providers of health care: Findings from action research conducted in two counties in Kenya. *PLOS ONE*, *14*(5), e0216444. https://doi.org/10.1371/journal.pone.0216444

Kaufman, G., & McCaughan, D. (2013). The effect of organisational culture on patient safety. *Nursing standard (through 2013)*, *27*(43), 50.

Kawaza, K., Kinshella, M. L. W., Hiwa, T., Njirammadzi, J., Banda, M., Vidler, M., ... & Goldfarb, D. M. (2020). Assessing quality of newborn care at district facilities in Malawi. *BMC health services research*, *20*(1), 1-11.

Kawonga, M., Blaauw, D., & Fonn, S. (2016). The influence of health system organizational structure and culture on integration of health services: The example of HIV service monitoring in South Africa. *Health Policy and Planning*, *31*(9), 1270–1280. https://doi.org/10.1093/heapol/czw061

Kebede, S., Mantopoulos, J., Ramanadhan, S., Cherlin, E., Gebeyehu, M., Lawson, R., & Bradley, E. H. (2012). Educating leaders in hospital management: A pre-post study in Ethiopian hospitals. *Global Public Health*, *7*(2), 164–174.

Kempster, S., & Parry, K. W. (2011). Grounded theory and leadership research: A critical realist perspective. *The Leadership Quarterly*, *22*(1), 106–120.

Khan, M. S., Meghani, A., Liverani, M., Roychowdhury, I., & Parkhurst, J. (2018). How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. *Health Policy and Planning*, *33*(2), 215–223.

Kieny, M. P., Bekedam, H., Dovlo, D., Fitzgerald, J., Habicht, J., Harrison, G., Kluge, H., Lin, V., Menabde, N., Mirza, Z., Siddiqi, S., & Travis, P. (2017). Strengthening health systems for universal health coverage and sustainable development. *Bulletin of the World Health Organization*, *95*(7), 537–539. https://doi.org/10.2471/BLT.16.187476

Kieny, M. P., & Dovlo, D. (2015). Beyond Ebola: A new agenda for resilient health systems. *The Lancet*, *385*(9963), 91–92.

Kigume, R., & Maluka, S. (2018). Decentralisation and Health Services Delivery in 4 Districts in Tanzania: How and Why Does the Use of Decision Space Vary Across Districts? *International Journal of Health Policy and Management*, *8*(2), 90–100. https://doi.org/10.15171/ijhpm.2018.97

Kim, M. H., Mazenga, A. C., Yu, X., Simon, K., Nyasulu, P., Kazembe, P. N., ... & Ahmed, S. (2019). Factors associated with burnout amongst healthcare workers providing HIV care in Malawi. *PLoS One*, *14*(9), e0222638.

Kinshella, M. L. W., Walker, C. R., Hiwa, T., Vidler, M., Nyondo-Mipando, A. L., Dube, Q., ... & Kawaza, K. (2020). Barriers and facilitators to implementing bubble CPAP to improve neonatal health in sub-Saharan Africa: a systematic review. *Public health reviews*, *41*(1), 1-16.

Kirigia, J. M., & Barry, S. P. (2008). Health challenges in Africa and the way forward. In *International Archives of Medicine* (Vol. 1, Issue 1, pp. 1–3). BioMed Central.

Kok, M. C., & Muula, S. (2013). Motivation and job satisfaction of health surveillance assistants in Mwanza, Malawi: an explorative study. *Malawi Medical Journal*, *25*(1), 5-11.

Kok, M. C., Broerse, J. E. W., Theobald, S., Ormel, H., Dieleman, M., & Taegtmeyer, M. (2017). Performance of community health workers: Situating their intermediary position within complex adaptive health systems. *Human Resources for Health*, *15*(1), 59. https://doi.org/10.1186/s12960-017-0234-z

Kok, M. C., Dieleman, M., Taegtmeyer, M., Broerse, J. E., Kane, S. S., Ormel, H., Tijm, M. M., & de Koning, K. A. (2015). Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy and Planning*, *30*(9), 1207–1227. https://doi.org/10.1093/heapol/czu126

Kok, M. C., Kane, S. S., Tulloch, O., Ormel, H., Theobald, S., Dieleman, M., Taegtmeyer, M., Broerse, J. E., & de Koning, K. A. (2015). How does context influence performance of community health workers in low-and middle-income countries? Evidence from the literature. *Health Research Policy and Systems*, *13*(1), 1–14.

Kok, M. C., Vallières, F., Tulloch, O., Kumar, M. B., Kea, A. Z., Karuga, R., Ndima, S. D., Chikaphupha, K., Theobald, S., & Taegtmeyer, M. (2018). Does supportive supervision enhance community health worker motivation? A mixed-methods study in four African countries. *Health Policy and Planning*, *33*(9), 988–998. https://doi.org/10.1093/heapol/czy082

Kolehmainen-Aitken, R.-L. (2004). Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders. *Human Resources for Health*, *2*(1), 5. https://doi.org/10.1186/1478-4491-2-5

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124.

Kraef, C., & Kallestrup, P. (2019). After the Astana declaration: Is comprehensive primary health care set for success this time? *BMJ Global Health*, *4*(6), e001871. https://doi.org/10.1136/bmjgh-2019-001871

Kramer, R. M. (1999). TRUST AND DISTRUST IN ORGANIZATIONS: Emerging Perspectives, Enduring Questions. *Annual Review of Psychology*, *50*(1), 569–598. https://doi.org/10.1146/annurev.psych.50.1.569

Kringos, D. S., Boerma, W. G., Hutchinson, A., van der Zee, J., & Groenewegen, P. P. (2010). The breadth of primary care: A systematic literature review of its core dimensions. *BMC Health Services Research*, *10*(1), 65. https://doi.org/10.1186/1472-6963-10-65

Kruk, M. E., Chukwuma, A., Mbaruku, G., & Leslie, H. H. (2017). Variation in quality of primary-care services in Kenya, Malawi, Namibia, Rwanda, Senegal, Uganda and the United

Republic of Tanzania. *Bulletin of the World Health Organization*, *95*(6), 408–418. https://doi.org/10.2471/BLT.16.175869

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., … Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. *The Lancet Global Health*, *6*(11), e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

Kruk, M. E., Myers, M., Varpilah, S. T., & Dahn, B. T. (2015). What is a resilient health system? Lessons from Ebola. *The Lancet*, *385*(9980), 1910–1912. https://doi.org/10.1016/S0140-6736(15)60755-3

Kutengule, M., Kampanje, R., Chiweza, A. and Chunga, D. (2014). Review of the National Decentralisation Programme II. Joint Review. Lilongwe: Ministry of Local Government and Ministry of Rural Development.

Kutzin, J., & Sparkes, S. P. (2016). Health systems strengthening, universal health coverage, health security and resilience. *Bulletin of the World Health Organization*, *94*(1), 2–2. https://doi.org/10.2471/BLT.15.165050

Kwamie, A. (2015). Balancing Management and Leadership in Complex Health Systems Comment on 'Management Matters: A Leverage Point for Health Systems Strengthening in Global Health'. *International Journal of Health Policy and Management*, *4*(12), 849–851. https://doi.org/10.15171/ijhpm.2015.152

Kwamie, A., Agyepong, I. A., & van Dijk, H. (2015). What Governs District Manager Decision Making? A Case Study of Complex Leadership in Dangme West District, Ghana. *Health Systems & Reform*, *1*(2), 167–177. https://doi.org/10.1080/23288604.2015.1032475

Kwamie, A., van Dijk, H., & Agyepong, I. A. (2014). Advancing the application of systems thinking in health: Realist evaluation of the Leadership Development Programme for district manager decision-making in Ghana. *Health Research Policy and Systems*, *12*(1), 1–12.

Kwamie, A., van Dijk, H., Ansah, E. K., & Agyepong, I. A. (2016). The path dependence of district manager decision-space in Ghana. *Health Policy and Planning*, *31*(3), 356–366. https://doi.org/10.1093/heapol/czv069

Laaser, U., & Brand, H. (2014). Global health in the 21st century. *Global Health Action*, *7*(1), 23694.

Landes, M., Pfaff, C., Zerihun, M., Wondimagegn, D., Sodhi, S., Rouleau, K., & Kidd, M. R. (2019). Calling non-governmental organisations to strengthen primary health care: Lessons following Alma-Ata. *African Journal of Primary Health Care & Family Medicine*, *11*(1). https://doi.org/10.4102/phcfm.v11i1.1945

Langlois, E. V., McKenzie, A., Schneider, H., & Mecaskey, J. W. (2020). Measures to strengthen primary health-care systems in low- and middle-income countries. *Bulletin of the World Health Organization*, *98*(11), 781–791. https://doi.org/10.2471/BLT.20.252742

Lassi, Z. S., Musavi, N. B., Maliqi, B., Mansoor, N., de Francisco, A., Toure, K., & Bhutta, Z. A. (2016). Systematic review on human resources for health interventions to improve maternal health outcomes: Evidence from low- and middle-income countries. *Human Resources for Health*, *14*(1), 10. https://doi.org/10.1186/s12960-016-0106-y

Laws, K., & McLeod, R. (2004). Case study and grounded theory: Sharing some alternative qualitative research methodologies with systems professionals. *Proceedings of the 22nd International Conference of the Systems Dynamics Society*, *78*, 1–25.

Lehmann, U., & Gilson, L. (2015). Action learning for health system governance: The reward and challenge of co-production. *Health Policy and Planning*, *30*(8), 957–963. https://doi.org/10.1093/heapol/czu097

Lehmann, U., Twum-Danso, N. A. Y., & Nyoni, J. (2019). Towards universal health coverage: What are the system requirements for effective large-scale community health worker programmes? *BMJ Global Health*, *4*(Suppl 9), e001046. https://doi.org/10.1136/bmjgh-2018-001046

Leslie, H. H., Gage, A., Nsona, H., Hirschhorn, L. R., & Kruk, M. E. (2016). Training and supervision did not meaningfully improve quality of care for pregnant women or sick children in sub-Saharan Africa. *Health Affairs*, *35*(9), 1716–1724.

Lim, M. Y. H., & Lin, V. (2021). Governance in health workforce: How do we improve on the concept? A network-based, stakeholder-driven approach. *Human Resources for Health*, *19*(1), 1. https://doi.org/10.1186/s12960-020-00545-0

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. sage.

Liu, J. X., Goryakin, Y., Maeda, A., Bruckner, T., & Scheffler, R. (2017). Global Health Workforce Labor Market Projections for 2030. *Human Resources for Health*, *15*(1), 11. https://doi.org/10.1186/s12960-017-0187-2

Liwanag, H. J., & Wyss, K. (2018). What conditions enable decentralization to improve the health system? Qualitative analysis of perspectives on decision space after 25 years of devolution in the Philippines. *PLOS ONE*, *13*(11), e0206809. https://doi.org/10.1371/journal.pone.0206809

Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. E. W. (2017). Health provider responsiveness to social accountability initiatives in low- and middle-income countries: A realist review. *Health Policy and Planning*, *32*(1), 125–140. https://doi.org/10.1093/heapol/czw089

Lodenstein, E., Molenaar, J. M., Ingemann, C., Botha, K., Mkandawire, J. J., Liem, L., Broerse, J. E. W., & Dieleman, M. (2019). "We come as friends": Approaches to social accountability by health committees in Northern Malawi. *BMC Health Services Research*, *19*(1), 279. https://doi.org/10.1186/s12913-019-4069-2

Loffreda, G., Bello, K., Kiendrébéogo, J. A., Selenou, I., Ahmed, M. A. A., Dossou, J. P., ... & Bertone, M. P. (2021). Political economy analysis of universal health coverage and health financing reforms in low-and middle-income countries: the role of stakeholder engagement in the research process. *Health Research Policy and Systems*, *19*(1), 1-19.

Lohmann, J., Houlfort, N., & De Allegri, M. (2016). Crowding out or no crowding out? A Self-Determination Theory approach to health worker motivation in performance-based financing. *Social Science & Medicine*, *169*, 1–8. https://doi.org/10.1016/j.socscimed.2016.09.006

Lohmann, J. (2019). The effects of Performance-Based Financing on health worker motivation: A mixed methods study in Malawi and Burkina Faso.

Lord, R. G., & Hall, R. J. (2005). Identity, deep structure and the development of leadership skill. *The Leadership Quarterly*, *16*(4), 591–615. https://doi.org/10.1016/j.leaqua.2005.06.003

Lowe, K. B., Kroeck, K. G., & Sivasubramaniam, N. (1996). Effectiveness correlates of transformational and transactional leadership: A meta-analytic review of the MLQ literature. *The Leadership Quarterly*, *7*(3), 385–425.

Luck, L., Jackson, D., & Usher, K. (2006). Case study: A bridge across the paradigms. *Nursing Inquiry*, *13*(2), 103–109.

Macarayan, E. K., Ratcliffe, H. L., Otupiri, E., Hirschhorn, L. R., Miller, K., Lipsitz, S. R., Gawande, A. A., & Bitton, A. (2019). Facility management associated with improved primary health care outcomes in Ghana. *PLOS ONE*, *14*(7), e0218662. https://doi.org/10.1371/journal.pone.0218662

MacPherson, E. E., Reynolds, J., Sanudi, E., Nkaombe, A., Phiri, C., Mankhomwa, J., ... & Chandler, C. I. (2021). Understanding antimicrobial resistance through the lens of antibiotic vulnerabilities in primary health care in rural Malawi. *Global Public Health*, 1-17.

Madede, T., Sidat, M., McAuliffe, E., Patricio, S. R., Uduma, O., Galligan, M., Bradley, S., & Cambe, I. (2017). The impact of a supportive supervision intervention on health workers in Niassa, Mozambique: A cluster-controlled trial. *Human Resources for Health*, *15*(1), 58. https://doi.org/10.1186/s12960-017-0213-4

Majamanda, M. D., Joshua Gondwe, M., O'Byrne, T., Makwero, M., Chalira, A., Lufesi, N., ... & Desmond, N. (2022). Capacity Building for Health Care Workers and Support Staff in Pediatric Emergency Triage Assessment and Treatment (ETAT) at Primary Health Care

Level in Resource Limited Settings: Experiences from Malawi. Comprehensive Child and Adolescent Nursing, 45(2), 201-216.

Makuta, I., & O'Hare, B. (2015). Quality of governance, public spending on health and health status in Sub Saharan Africa: A panel data regression analysis. *BMC Public Health*, *15*(1), 932. https://doi.org/10.1186/s12889-015-2287-z

Makwero, M. T. (2018). Delivery of primary health care in Malawi. *African Journal of Primary Health Care and Family Medicine*, *10*(1), 1-3.

Mandeville, K. L., Lagarde, M., Hanson, K., & Mills, A. (2016). Human resources for health: Time to move out of crisis mode. *The Lancet*, *388*(10041), 220–222. https://doi.org/10.1016/S0140-6736(16)30952-7

Mannion, R., & Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ*, k4907. https://doi.org/10.1136/bmj.k4907

Mansour, M., Mansour, J. B., & El Swesy, A. H. (2010). Scaling up proven public health interventions through a locally owned and sustained leadership development programme in rural Upper Egypt. *Human Resources for Health*, *8*(1), 1–6.

Manthalu, G., Yi, D., Farrar, S., & Nkhoma, D. (2016). The effect of user fee exemption on the utilization of maternal health care at mission health facilities in Malawi. *Health policy and planning*, *31*(9), 1184-1192

Marchal, B., Cavalli, A., & Kegels, G. (2009). Global Health Actors Claim To Support Health System Strengthening—Is This Reality or Rhetoric? *PLoS Medicine*, *6*(4), e1000059. https://doi.org/10.1371/journal.pmed.1000059

Martin, C. M., & Félix-Bortolotti, M. (2010). W (h) ither complexity? The emperor's new toolkit? Or elucidating the evolution of health systems knowledge? *Journal of Evaluation in Clinical Practice*, *16*(3), 415–420.

Martin, W., Pauly, B., MacDonald, M., & 1 College of Nursing, University of Saskatchewan, Saskatoon, SK, Canada. (2016). Situational Analysis for Complex Systems: Methodological Development in Public Health Research. *AIMS Public Health*, *3*(1), 94–109. https://doi.org/10.3934/publichealth.2016.1.94

Martineau, T., Raven, J., Aikins, M., Alonso-Garbayo, A., Baine, S., Huss, R., Maluka, S., & Wyss, K. (2018). Strengthening health district management competencies in Ghana, Tanzania and Uganda: Lessons from using action research to improve health workforce performance. *BMJ Global Health*, *3*(2), e000619. https://doi.org/10.1136/bmjgh-2017-000619

Masefield, S. C., Msosa, A., & Grugel, J. (2020). Challenges to effective governance in a low income healthcare system: A qualitative study of stakeholder perceptions in Malawi. *BMC Health Services Research*, *20*(1), 1142. https://doi.org/10.1186/s12913-020-06002-x

Mash, B., Ray, S., Essuman, A., & Burgueño, E. (2019). Community-orientated primary care: A scoping review of different models, and their effectiveness and feasibility in sub-Saharan Africa. *BMJ Global Health*, *4*(Suppl 8), e001489. https://doi.org/10.1136/bmjgh-2019-001489

Masiano, S., Dunga, S., Tembo, T., Pfaff, C., Cox, C., Robert, B., ... & Kim, M. (2020). Implementing remote supervision to improve HIV service delivery in rural Malawi. *Journal of Global Health Reports*, *4*, e2020081.

Mason, J. (2017). *Qualitative researching*. sage.

Mathauer, I., & Imhoff, I. (2006). Health worker motivation in Africa: The role of non-financial incentives and human resource management tools. *Human Resources for Health*, *4*(1), 24. https://doi.org/10.1186/1478-4491-4-24

Mathole, T., Lembani, M., Jackson, D., Zarowsky, C., Bijlmakers, L., & Sanders, D. (2018). Leadership and the functioning of maternal health services in two rural district hospitals in South Africa. *Health Policy and Planning*, *33*(suppl_2), ii5–ii15. https://doi.org/10.1093/heapol/czx174

Mbau, R., & Gilson, L. (2018). Influence of organisational culture on the implementation of health sector reforms in low- and middle-income countries: A qualitative interpretive review. *Global Health Action*, *11*(1), 1462579. https://doi.org/10.1080/16549716.2018.1462579

McCollum, R., Theobald, S., Otiso, L., Martineau, T., Karuga, R., Barasa, E., Molyneux, S., & Taegtmeyer, M. (2018). Priority setting for health in the context of devolution in Kenya:

Implications for health equity and community-based primary care. *Health Policy and Planning*, *33*(6), 729–742. https://doi.org/10.1093/heapol/czy043

McCoy, D. C., Hall, J. A., & Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low-and middle-income countries. *Health policy and planning*, *27*(6), 449-466

McDonald, R. (2014). Leadership and leadership development in healthcare settings – a simplistic solution to complex problems? *International Journal of Health Policy and Management*, *3*(5), 227–229. https://doi.org/10.15171/ijhpm.2014.101

McPake, B., & Mills, A. (2000). What can we learn from international comparisons of health systems and health system reform? *Bulletin of the World Health Organization*, 10.

Meadows, D. H. (1999). *Leverage points: Places to intervene in a system*.

Meessen, B., Malanda, B., & for the Community of Practice "Health Service Delivery". (2014). No universal health coverage without strong local health systems. *Bulletin of the World Health Organization*, *92*(2), 78-78A. https://doi.org/10.2471/BLT.14.135228

Merriel, A., Hussein, J., Coomarasamy, A., & Larkin, M. (2018). Learning from the experience of maternity healthcare workers in Malawi: a qualitative study leading to ten low-cost recommendations to improve working lives and quality of care. *BMC pregnancy and childbirth*, *18*(1), 1-11.

Merriam, S. B., Johnson-Bailey, J., Lee, M.-Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education*, *20*(5), 405–416.

Mianda, S., & Voce, A. (2018). Developing and evaluating clinical leadership interventions for frontline healthcare providers: A review of the literature. *BMC Health Services Research*, *18*(1), 1–15.

Micah, A. E., Zlavog, B. S., Chen, C. S., Chapin, A., & Dieleman, J. L. (2018). Donor financing of human resources for health, 1990–2016: An examination of trends, sources of funds, and recipients. *Globalization and Health*, *14*(1), 98. https://doi.org/10.1186/s12992-018-0416-z

Michel, J., Evans, D., Tediosi, F., deSavigny, D., Egger, M., Bärnighausen, T., McIntyre, D., & Rispel, L. (2018). Lest we forget, primary health care in Sub-Saharan Africa is nurse led. Is this reflected in the current health systems strengthening undertakings and initiatives? *Journal of Global Health Reports*, *2*, e2018009. https://doi.org/10.29392/joghr.2.e2018009

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. sage.

Mills, A. (1994). Decentralization and accountability in the health sector from an international perspective: What are the choices? *Public Administration and Development*, *14*(3), 281–292.

Mills, J., Bonner, A., & Francis, K. (2006). The Development of Constructivist Grounded Theory. *International Journal of Qualitative Methods*, *5*(1), 25–35. https://doi.org/10.1177/160940690600500103

Ministry of Health (2014). *Performance Management Policy and Procedures Handbook for Malawi Civil Service and the Public Service Training Guidelines and Procedures*

Ministry of Health (2016) *Human Resource Management Standard Operating Procedures*

Ministry of Health (2017). *National Community Health Strategy 2017—2022*. Ministry of Health Malawi.

Ministry of Health (2017). *Health Sector Strategic Plan II:2017-2022*. Lilongwe, Ministry of Health Malawi

Ministry of Health (2017) *Quality Management Policy for the Health Sector,* Lilongwe, Ministry of Health Malawi

Ministry of Health (2018) *Guidelines for District Health Planning* 2018-2022, Lilongwe, Ministry of Health Malawi

Ministry of Health (2018b). *Human Resources for Health Strategic Plan, 2018-2022*. Ministry of Health Malawi

Ministry of Health (2019) *Malawi health facility accreditation programme annual report*. Lilongwe,

Ministry of Health (2020*) Joint annual review 2017/2018: community health services.* Lilongwe

Ministry of Health (2020) *Health sector resource mapping report*, round 6. Lilongwe

Ministry of Health (2020) *National Digital Health Strategy 2020-2025*

Mirzoev, T., & Kane, S. (2017). What is health systems responsiveness? Review of existing knowledge and proposed conceptual framework. BMJ Global Health, 2(4), e000486. https://doi.org/10.1136/bmjgh-2017-000486

Mitroff, I. I., & Linstone, H. A. (1995). The unbounded mind: Breaking the chains of traditional business thinking. Oxford University Press.

Molyneux, S., Atela, M., Angwenyi, V., & Goodman, C. (2012). Community accountability at peripheral health facilities: A review of the empirical literature and development of a conceptual framework. *Health Policy and Planning*, *27*(7), 541–554. https://doi.org/10.1093/heapol/czr083

Molyneux, S., & Marsh, V. (2019). Commentary 1: Sharing and Responding to Day-to-Day Ethics Challenges in Health Research. *Journal of Empirical Research on Human Research Ethics*, *14*(5), 513–515. https://doi.org/10.1177/1556264619835709a

Monk, A., & Howard, S. (1998). Methods & tools: The rich picture: a tool for reasoning about work context. *Interactions*, *5*(2), 21–30.

Moodie, R. (2016). Learning about self: Leadership skills for public health. *Journal of Public Health Research*, *5*(1). https://doi.org/10.4081/jphr.2016.679

Mounier-Jack, S., Griffiths, U. K., Closser, S., Burchett, H., & Marchal, B. (2014). Measuring the health systems impact of disease control programmes: A critical reflection on the WHO building blocks framework. *BMC Public Health*, *14*(1), 278. https://doi.org/10.1186/1471-2458-14-278

Mshelia, C., Huss, R., Mirzoev, T., Elsey, H., Baine, S. O., Aikins, M., Kamuzora, P., Bosch-Capblanch, X., Raven, J., Wyss, K., Green, A., & Martineau, T. (2013). Can action research strengthen district health management and improve health workforce performance? A research protocol. *BMJ Open*, *3*(8), e003625. https://doi.org/10.1136/bmjopen-2013-003625

Munar, W., Snilstveit, B., Aranda, L. E., Biswas, N., Baffour, T., & Stevenson, J. (2019). Evidence gap map of performance measurement and management in primary healthcare systems in low-income and middle-income countries. *BMJ Global Health*, *4*(Suppl 8), e001451. https://doi.org/10.1136/bmjgh-2019-001451

Munga, M. A., & Mæstad, O. (2009). Measuring inequalities in the distribution of health workers: The case of Tanzania. *Human Resources for Health*, *7*(1), 4. https://doi.org/10.1186/1478-4491-7-4

Muñoz, D. C., Amador, P. M., Llamas, L. M., Hernandez, D. M., & Sancho, J. M. S. (2017). Decentralization of health systems in low and middle income countries: A systematic review. *International Journal of Public Health*, *62*(2), 219–229.

Munyewende, P. O., Levin, J., & Rispel, L. C. (2016). An evaluation of the competencies of primary health care clinic nursing managers in two South African provinces. *Global Health Action*, *9*(1), 32486. https://doi.org/10.3402/gha.v9.32486

Murray, C. J. L., & Frenk, J. (2000). A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*, 15.

Musinguzi, C., Namale, L., Rutebemberwa, E., Dahal, A., Nahirya-Ntege, P., & Kekitiinwa, A. (2018). The relationship between leadership style and health worker motivation, job satisfaction and teamwork in Uganda. *Journal of Healthcare Leadership*, *Volume 10*, 21–32. https://doi.org/10.2147/JHL.S147885

Mutale, W., Balabanova, D., Chintu, N., Mwanamwenge, M. T., & Ayles, H. (2016). Application of system thinking concepts in health system strengthening in low-income settings: A proposed conceptual framework for the evaluation of a complex health system intervention: the case of the BHOMA intervention in Z ambia. *Journal of Evaluation in Clinical Practice*, *22*(1), 112–121. https://doi.org/10.1111/jep.12160

Mutale, W., Vardoy-Mutale, A.-T., Kachemba, A., Mukendi, R., Clarke, K., & Mulenga, D. (2017). Leadership and management training as a catalyst to health system strengthening in low-income settings: Evidence from implementation of the Zambia Management and Leadership course for district health managers in Zambia. *PLOS ONE*, *12*(7), e0174536. https://doi.org/10.1371/journal.pone.0174536

Muthuri, R. N. D. K., Senkubuge, F., & Hongoro, C. (2020). Determinants of Motivation among Healthcare Workers in the East African Community between 2009–2019: A Systematic Review. *Healthcare*, *8*(2), 164. https://doi.org/10.3390/healthcare8020164

Mwenyekonde, E., & Makoka, M. (2015) CHAM: *General Report of the Health Workforce Productivity Assessment and Early Progress on Implementation of improvement interventions*

Mwisongo, A., & Nabyonga-Orem, J. (2016). Global health initiatives in Africa – governance, priorities, harmonisation and alignment. *BMC Health Services Research*, *16*(S4), 212. https://doi.org/10.1186/s12913-016-1448-9

Nagesh, S., & Chakraborty, S. (2020). Saving the frontline health workforce amidst the COVID-19 crisis: Challenges and recommendations. *Journal of Global Health*, *10*(1).

Naghavi, M., Abajobir, A. A., Abbafati, C., Abbas, K. M., Abd-Allah, F., Abera, S. F., Aboyans, V., Adetokunboh, O., Afshin, A., & Agrawal, A. (2017). Global, regional, and national age-sex specific mortality for 264 causes of death, 1980–2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet*, *390*(10100), 1151–1210.

National Academies of Sciences & Medicine. (2018). *Crossing the global quality chasm: Improving health care worldwide*.

National Statistical Office. (2017). *Malawi demographic and health survey 2015-2016.* Zomba: national Statistical Office.

Newman, A., Donohue, R., & Eva, N. (2017). Psychological safety: A systematic review of the literature. *Human resource management review*, *27*(3), 521-535.

Nguyen, M. P., Mirzoev, T., & Le, T. M. (2016). Contribution of health workforce to health outcomes: Empirical evidence from Vietnam. *Human Resources for Health*, *14*(1), 1–11.

Nkomazana, O., Mash, R., Wojczewski, S., Kutalek, R., & Phaladze, N. (2016). How to create more supportive supervision for primary healthcare: Lessons from Ngamiland district of Botswana: co-operative inquiry group. *Global Health Action*, *9*(1), 31263.

Nxumalo, N., Gilson, L., Goudge, J., Tsofa, B., Cleary, S., Barasa, E., & Molyneux, S. (2018). Accountability mechanisms and the value of relationships: Experiences of front-line managers at subnational level in Kenya and South Africa. *BMJ Global Health*, *3*(4), e000842. https://doi.org/10.1136/bmjgh-2018-000842

Nyikuri, M. M., Tsofa, B., Okoth, P., Barasa, E. W., & Molyneux, S. (2017). "We are toothless and hanging, but optimistic": Sub county managers' experiences of rapid devolution in coastal Kenya. *International Journal for Equity in Health*, *16*(1), 113. https://doi.org/10.1186/s12939-017-0607-x

Nyikuri, M., Tsofa, B., Barasa, E., Okoth, P., & Molyneux, S. (2015). Crises and Resilience at the Frontline—Public Health Facility Managers under Devolution in a Sub-County on the Kenyan Coast. *PLOS ONE*, *10*(12), e0144768. https://doi.org/10.1371/journal.pone.0144768

Nyirenda, L., Kumar, M. B., Theobald, S., Sarker, M., Simwinga, M., Kumwenda, M., Johnson, C., Hatzold, K., Corbett, E. L., Sibanda, E., & Taegtmeyer, M. (2020). Using research networks to generate trustworthy qualitative public health research findings from multiple contexts. *BMC Medical Research Methodology*, *20*(1), 13. https://doi.org/10.1186/s12874-019-0895-5

Nyondo-Mipando, A. L., Woo Kinshella, M. L., Bohne, C., Suwedi-Kapesa, L. C., Salimu, S., Banda, M., ... & Mijovic, H. (2020). Barriers and enablers of implementing bubble Continuous Positive Airway Pressure (CPAP): Perspectives of health professionals in Malawi. *PLoS One*, *15*(2), e0228915.

Nzinga, J., Boga, M., Kagwanja, N., Waithaka, D., Barasa, E., Tsofa, B., Gilson, L., & Molyneux, S. (2021). An innovative leadership development initiative to support building everyday resilience in health systems. *Health Policy and Planning*, *36*(7), 1023–1035. https://doi.org/10.1093/heapol/czab056

Nzinga, J., McGivern, G., & English, M. (2018). Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. *Health Policy and Planning*, *33*(suppl_2), ii27–ii34. https://doi.org/10.1093/heapol/czx167

O'Donovan, R., & Mcauliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. *International journal for quality in health care*, *32*(4), 240-250.

OECD, & Analysis, I. I. for A. S. (2020). *Systems Thinking for Policy Making*. OECD. https://doi.org/10.1787/f71e4f2b-en

OECD & International Institute for Applied Systems Analysis. (2020). *Systemic Thinking for Policy Making: The Potential of Systems Analysis for Addressing Global Policy Challenges in the 21st Century* (W. Hynes, M. Lees, & J. M. Müller, Eds.). OECD. https://doi.org/10.1787/879c4f7a-en

Okech, T. C., & Lelegwe, S. L. (2015). Analysis of Universal Health Coverage and Equity on Health Care in Kenya. *Global Journal of Health Science*, *8*(7), 218. https://doi.org/10.5539/gjhs.v8n7p218

Okello, D. R. O., & Gilson, L. (2015). Exploring the influence of trust relationships on motivation in the health sector: A systematic review. *Human Resources for Health*, *13*(1), 16. https://doi.org/10.1186/s12960-015-0007-5

Okura, M., Uza, M., Izumi, H., Ohno, M., Arai, H., & Saeki, K. (2013). Factors that affect the process of professional identity formation in public health nurses. *Open Journal of Nursing*, *03*(01), 8–15. https://doi.org/10.4236/ojn.2013.31002

Olaniran, A., Madaj, B., Bar-Zev, S., & van den Broek, N. (2019). The roles of community health workers who provide maternal and newborn health services: Case studies from Africa and Asia. *BMJ Global Health*, *4*(4), e001388. https://doi.org/10.1136/bmjgh-2019-001388

Olivier, J., Whyle, E., & Gilson, L. (2017). *Embedded health policy and systems research: A rapid scoping review*. Geneva. Available at: https://apps. who. int/iris/bitstream/handle/10665 ….

Olmen, J. V., Criel, B., Bhojani, U., Marchal, B., Belle, S. V., Chenge, M. F., Hoerée, T., Pirard, M., Damme, W. V., & Kegels, G. (2012). The Health System Dynamics Framework: The introduction of an analytical model for health system analysis and its application to two case-studies. *Health, Culture and Society*, *2*(1), 1–21. https://doi.org/10.5195/HCS.2012.71

Omaswa, F., & Crisp, N. (2014). *African health leaders: Making change and claiming the future*. OUP Oxford.

O'Meara, W. P., Tsofa, B., Molyneux, S., Goodman, C., & McKenzie, F. E. (2011). Community and facility-level engagement in planning and budgeting for the government health sector – A district perspective from Kenya. *Health Policy*, *99*(3), 234–243. https://doi.org/10.1016/j.healthpol.2010.08.027

O'Neil, T., Cammack, D., Kanyongolo, E., Mkandawire, M. W., Mwalyambwire, T., Welham, B. and Wild, L. (2014) 'Fragmented governance and local service delivery in Malawi', *London: Overseas Development Institute*.

Onuka, O., Madukwe, O., Chukwueme, N., Gidado, M., Emperor, U., Agbaiyero, K., & Adeleke, O. (2015). Use of smartphone for supportive supervision in Nigeria. *IBusiness*, *7*(02), 75.

OPTIONS (2015) Health Sector Efficiency Report, Lilongwe

OPTIONS (2018) Malawi Health Sector Programme Progress Report Health Centre Improvement Grants, Lilongwe

Organisation mondiale de la Santé. (2021). *Gestion des personnels de santé et politique à leur égard dans le contexte de la riposte à la pandémie de COVID-19: Orientations provisoires, 3 décembre 2020*. Organisation mondiale de la Santé. https://apps.who.int/iris/handle/10665/341555

Østergaard, L. R. (2015). Trust matters: A narrative literature review of the role of trust in health care systems in sub-Saharan Africa. *Global Public Health*, *10*(9), 1046–1059. https://doi.org/10.1080/17441692.2015.1019538

Ostrom, E. (1990). *Governing the commons: The evolution of institutions for collective action*. Cambridge university press.

Paina, L., & Peters, D. H. (2012). Understanding pathways for scaling up health services through the lens of complex adaptive systems. *Health Policy and Planning*, *27*(5), 365–373. https://doi.org/10.1093/heapol/czr054

Palk, L., Okano, J. T., Dullie, L., & Blower, S. (2020). Travel time to health-care facilities, mode of transportation, and HIV elimination in Malawi: a geospatial modelling analysis. *The Lancet Global Health*, *8*(12), e1555-e1564.

Panda, B., Thakur, H. P., & Zodpey, S. P. (2016). Does decentralization influence efficiency of health units? A study of opinion and perception of health workers in Odisha. *BMC Health Services Research*, *16*(S6), 550. https://doi.org/10.1186/s12913-016-1786-7

Pandey, K. R. (2018). From health for all to universal health coverage: Alma Ata is still relevant. *Globalization and Health*, *14*(1), 62. https://doi.org/10.1186/s12992-018-0381-6

Patton, M. (1999). *Enhancing the Quality and Credibility of Qualitative Analysis*.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. SAGE Publications, inc.

Pearce, C. L. (2004). The future of leadership: Combining vertical and shared leadership to transform knowledge work. *Academy of Management Perspectives*, *18*(1), 47-57.

Peters, D. H. (2014). The application of systems thinking in health: Why use systems thinking? *Health Research Policy and Systems*, *12*(1), 51. https://doi.org/10.1186/1478-4505-12-51

Peters, D. H., Adam, T., Alonge, O., Agyepong, I. A., & Tran, N. (2014). Republished research: Implementation research: what it is and how to do it: Implementation research is a growing but not well understood field of health research that can contribute to more effective public health and clinical policies and programmes. This article provides a broad definition of implementation research and outlines key principles for how to do it. *British Journal of Sports Medicine*, *48*(8), 731–736. https://doi.org/10.1136/bmj.f6753

Petricca, K., Bekele, A., Berta, W., Gibson, J., & Pain, C. (2018). Advancing methods for health priority setting practice through the contribution of systems theory: Lessons from a case study in Ethiopia. *Social Science & Medicine*, *198*, 165–174. https://doi.org/10.1016/j.socscimed.2017.12.009

Petross, C., McMahon, S., Lohmann, J., Chase, R. P., Muula, A. S., & De Allegri, M. (2020). Intended and unintended effects: Community perspectives on a performance-based financing programme in Malawi. *BMJ Global Health*, *5*(4), e001894. https://doi.org/10.1136/bmjgh-2019-001894

Pfadenhauer, L. M., Gerhardus, A., Mozygemba, K., Lysdahl, K. B., Booth, A., Hofmann, B., Wahlster, P., Polus, S., Burns, J., Brereton, L., & Rehfuess, E. (2017). Making sense of complexity in context and implementation: The Context and Implementation of Complex Interventions (CICI) framework. *Implementation Science*, *12*(1), 21. https://doi.org/10.1186/s13012-017-0552-5

Pinder, C. C. (2008). *Work motivation in organizational behavior*.

Pinder, C. C. (2014). *Work motivation in organizational behavior*. psychology press.

Plsek, P. E., & Wilson, T. (2001). Complexity science: Complexity, leadership, and management in healthcare organisations. *BMJ*, *323*(7315), 746–749. https://doi.org/10.1136/bmj.323.7315.746

Pope, C., & Mays, N. (2006). *Qualitative Research in Health Care*.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *BMJ: British Medical Journal*, *320*(7227), 114.

Pozo-Martin, F., Nove, A., Lopes, S. C., Campbell, J., Buchan, J., Dussault, G., Kunjumen, T., Cometto, G., & Siyam, A. (2017). Health workforce metrics pre-and post-2015: A stimulus to public policy and planning. *Human Resources for Health*, *15*(1), 1–16.

Prashanth, N. S., Marchal, B., Devadasan, N., Kegels, G., & Criel, B. (2014). Advancing the application of systems thinking in health: A realist evaluation of a capacity building

programme for district managers in Tumkur, India. *Health Research Policy and Systems*, *12*(1), 42. https://doi.org/10.1186/1478-4505-12-42

Prior, L. (2008). Repositioning documents in social research. *Sociology*, *42*(5), 821–836.

Prytherch, H., Kagoné, M., Aninanya, G. A., Williams, J. E., Kakoko, D. C., Leshabari, M. T., Yé, M., Marx, M., & Sauerborn, R. (2013). Motivation and incentives of rural maternal and neonatal health care providers: A comparison of qualitative findings from Burkina Faso, Ghana and Tanzania. *BMC Health Services Research*, *13*(1), 149. https://doi.org/10.1186/1472-6963-13-149

Purity, M., Eilish, M., Ogenna, U., Honorati, M., & Henry, M. (2017). The Impact of Supportive Supervision on the Implementation of HRM processes; A Mixed-Methods study in Tanzania. *Health Systems and Policy Research*, *04*(01). https://doi.org/10.21767/2254-9137.100066

Rajbhandari R, McMahon DE, Rhatigan JJ, Farmer PE.(2020) The Neglected Hospital — The District Hospital's Central Role in Global Health Care Delivery. N Engl J Med

Rao, M., & Pilot, E. (2014). The missing link – the role of primary care in global health. *Global Health Action*, *7*(1), 23693. https://doi.org/10.3402/gha.v7.23693

Raven, J., Akweongo, P., Baba, A., Baine, S. O., Sall, M. G., Buzuzi, S., & Martineau, T. (2015). Using a human resource management approach to support community health workers: Experiences from five African countries. *Human Resources for Health*, *13*(1), 45. https://doi.org/10.1186/s12960-015-0034-2

Raven, J. H., Tolhurst, R. J., Tang, S., & Van Den Broek, N. (2012). What is quality in maternal and neonatal health care? *Midwifery*, *28*(5), e676–e683.

Reich, M. R., Javadi, D., & Ghaffar, A. (2016a). Introduction to the special issue on "effective leadership for health systems". In *Health Systems & Reform* (Vol. 2, Issue 3, pp. 171–175). Taylor & Francis.

Reich, M. R., Javadi, D., & Ghaffar, A. (2016b). Introduction to the Special Issue on "Effective Leadership for Health Systems". *Health Systems & Reform*, *2*(3), 171–175. https://doi.org/10.1080/23288604.2016.1223978

Rifkin, S. B. (2018). Alma Ata after 40 years: Primary Health Care and Health for All—from consensus to complexity. *BMJ Global Health*, *3*(Suppl 3), e001188. https://doi.org/10.1136/bmjgh-2018-001188

Rispel, L. C., Blaauw, D., Ditlopo, P., & White, J. (2018). Human resources for health and universal health coverage: Progress, complexities and contestations. *South African Health Review*, *2018*(1), 13–21.

Rispel, L. C., de Jager, P., & Fonn, S. (2016). Exploring corruption in the South African health sector. *Health Policy and Planning*, *31*(2), 239–249. https://doi.org/10.1093/heapol/czv047

Ritchie, J., Lewis, J., & Elam, R. G. (2013). Selecting samples. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, *111*.

Rizvi, S. S., Douglas, R., Williams, O. D., & Hill, P. S. (2020). The political economy of universal health coverage: A systematic narrative review. *Health Policy and Planning*, *35*(3), 364–372. https://doi.org/10.1093/heapol/czz171

Roberton, T., Applegate, J., Lefevre, A. E., Mosha, I., Cooper, C. M., Silverman, M., Feldhaus, I., Chebet, J. J., Mpembeni, R., & Semu, H. (2015). Initial experiences and innovations in supervising community health workers for maternal, newborn, and child health in Morogoro region, Tanzania. *Human Resources for Health*, *13*(1), 1–12.

Roberts, M., Hsiao, W., Berman, P., & Reich, M. (2003). *Getting health reform right: A guide to improving performance and equity*. Oxford university press.

Rockers, P. C., & Bärnighausen, T. (2013). Interventions for hiring, retaining and training district health systems managers in low- and middle-income countries. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD009035.pub2

Rogers, L., De Brún, A., & McAuliffe, E. (2020). Defining and assessing context in healthcare implementation studies: A systematic review. *BMC Health Services Research*, *20*(1), 1–24.

Roman, T. E., Cleary, S., & McIntyre, D. (2017). Exploring the Functioning of Decision Space: A Review of the Available Health Systems Literature. *International Journal of Health Policy and Management*, *6*(7), 365–376. https://doi.org/10.15171/ijhpm.2017.26

Roncarolo, F., Boivin, A., Denis, J.-L., Hébert, R., & Lehoux, P. (2017). What do we know about the needs and challenges of health systems? A scoping review of the international literature. *BMC Health Services Research*, *17*(1), 636. https://doi.org/10.1186/s12913-017-2585-5

Rowe, A. K., Rowe, S. Y., Peters, D. H., Holloway, K. A., & Ross-Degnan, D. (2021). The effectiveness of training strategies to improve healthcare provider practices in low-income and middle-income countries. *BMJ Global Health*, *6*(1), e003229. https://doi.org/10.1136/bmjgh-2020-003229

Rusoja, E., Haynie, D., Sievers, J., Mustafee, N., Nelson, F., Reynolds, M., Sarriot, E., Swanson, R. C., & Williams, B. (2018). Thinking about complexity in health: A systematic review of the key systems thinking and complexity ideas in health. *Journal of Evaluation in Clinical Practice*, *24*(3), 600–606. https://doi.org/10.1111/jep.12856

Russell, R. F., & Stone, A. G. (2002). A review of servant leadership attributes: Developing a practical model. *Leadership & Organization Development Journal*.

Rwabukwisi, F. C., Bawah, A. A., Gimbel, S., Phillips, J. F., Mutale, W., & Drobac, P. (2017). Health system strengthening: a qualitative evaluation of implementation experience and lessons learned across five African countries. *BMC health services research*, *17*(3), 77-89.

Ryan-Nicholls, K., & Will, C. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher*, *16*(3).

Sacks, E., Morrow, M., Story, W. T., Shelley, K. D., Shanklin, D., Rahimtoola, M., Rosales, A., Ibe, O., & Sarriot, E. (2019). Beyond the building blocks: Integrating community roles into health systems frameworks to achieve health for all. *BMJ Global Health*, *3*(Suppl 3), e001384. https://doi.org/10.1136/bmjgh-2018-001384

Sambo, L. G., & Jackson, M. C. (2021). Empowering health systems research to engage with technical, organizational, social and economic forces: Lessons from the 2014 Ebola epidemic. *Systems Research and Behavioral Science*, *38*(3), 307–320.

Sammut, S. M., & Ngoye, B. (2019). Perspectives on Developing Healthcare Managers in Africa: The Strathmore Business School's Healthcare Management Programme. *Frontiers in Public Health*, *7*, 44. https://doi.org/10.3389/fpubh.2019.00044

Samuels, F., Amaya, A. B., & Balabanova, D. (2017). Drivers of health system strengthening: Learning from implementation of maternal and child health programmes in Mozambique, Nepal and Rwanda. *Health Policy and Planning*, *32*(7), 1015–1031. https://doi.org/10.1093/heapol/czx037

Scheffler, R. M., Mahoney, C. B., Fulton, B. D., Dal Poz, M. R., & Preker, A. S. (2009). Estimates Of Health Care Professional Shortages In Sub-Saharan Africa By 2015. *Health Affairs*. https://doi.org/10.1377/hlthaff.28.5.w849

Scheil-Adlung, X. (2015). *Global Evidence on inequities in rural health protection. New data on rural deficits in health coverage for 174 countries*. https://reliefweb.int/sites/reliefweb.int/files/resources/RessourcePDF.pdf

Schriver, M., Cubaka, V. K., Nyirazinyoye, L., Itangishaka, S., & Kallestrup, P. (2017). The relationship between primary healthcare providers and their external supervisors in Rwanda. *African Journal of Primary Health Care & Family Medicine*, *9*(1), 1–11.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. *Handbook of Qualitative Research*, *1*(1994), 118–137.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, *114*, 11–25.

Scott, V. (2014). *Operational health service management- Understanding the role of information in decision-making*. SAHR.

Scott, V., Crawford-Browne, S., & Sanders, D. (2016). Critiquing the response to the Ebola epidemic through a Primary Health Care Approach. *BMC Public Health*, *16*(1), 410. https://doi.org/10.1186/s12889-016-3071-4

Seims, L. R. K., Alegre, J. C., Murei, L., Bragar, J., Thatte, N., Kibunga, P., & Cheburet, S. (2012). Strengthening management and leadership practices to increase health-service delivery in Kenya: An evidence-based approach. *Human Resources for Health*, *10*(1), 25. https://doi.org/10.1186/1478-4491-10-25

Senge, P. M. (1990). *The art and practice of the learning organization*. New York: Doubleday.

Shakarishvili, G., Atun, R., Berman, P., Hsiao, W., Burgess, C., & Lansang, M. A. (2010). Converging health systems frameworks: Towards a concepts-to-actions roadmap for health systems strengthening in low and middle income countries. *Global Health Governance*, *3*(2).

Sharma, V., Kerr, S. H., Kawar, Z., & Kerr, D. J. (2011). Challenges of cancer control in developing countries: Current status and future perspective. *Future Oncology*, *7*(10), 1213–1222.

Sheikh, K., George, A., & Gilson, L. (2014). People-centred science: Strengthening the practice of health policy and systems research. *Health Research Policy and Systems*, *12*(1), 19. https://doi.org/10.1186/1478-4505-12-19

Sheikh, K., Gilson, L., Agyepong, I. A., Hanson, K., Ssengooba, F., & Bennett, S. (2011). Building the Field of Health Policy and Systems Research: Framing the Questions. *PLoS Medicine*, *8*(8), e1001073. https://doi.org/10.1371/journal.pmed.1001073

Shung-King, M., Gilson, L., Mbachu, C., Molyneux, S., Muraya, K. W., Uguru, N., & Govender, V. (2018). Leadership experiences and practices of South African health managers: What is the influence of gender? -a qualitative, exploratory study. *International Journal for Equity in Health*, *17*(1), 148. https://doi.org/10.1186/s12939-018-0859-0

Silverman, D. (2015). *Interpreting qualitative data*. Sage.

Soeters, R., Habineza, C., & Peerenboom, P. B. (2006). Performance-based financing and changing the district health system: Experience from Rwanda. *Bulletin of the World Health Organization*, 6.

Speybroeck, N., Kinfu, Y., Poz, M. R. D., & Evans, D. B. (2006). *Reassessing the relationship between human resources for health, intervention coverage and health outcomes* WHO,. 15.

Stake, R. E. (1995). *The art of case study research*. sage.

Stevenson, A. (2010). *Oxford dictionary of English*. Oxford University Press, USA.

Straus, A. L., & Glaser, B. G. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publications Company.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Citeseer.

Sudhinaraset, M., Ingram, M., Lofthouse, H. K., & Montagu, D. (2013). What Is the Role of Informal Healthcare Providers in Developing Countries? A Systematic Review. *PLoS ONE*, *8*(2), e54978. https://doi.org/10.1371/journal.pone.0054978

Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An International Journal for Critical Geographies*, *6*(3), 374–385.

Swanson, R., Atun, R., Best, A., Betigeri, A., de Campos, F., Chunharas, S., Collins, T., Currie, G., Jan, S., McCoy, D., Omaswa, F., Sanders, D., Sundararaman, T., & Van Damme, W. (2015). Strengthening health systems in low-income countries by enhancing organizational capacities and improving institutions. *Globalization and Health*, *11*(1), 5. https://doi.org/10.1186/s12992-015-0090-3

Szlezák, N. A., Bloom, B. R., Jamison, D. T., Keusch, G. T., Michaud, C. M., Moon, S., & Clark, W. C. (2010). The Global Health System: Actors, Norms, and Expectations in Transition. *PLoS Medicine*, *7*(1), e1000183. https://doi.org/10.1371/journal.pmed.1000183

Tetui, M., Coe, A.-B., Hurtig, A.-K., Bennett, S., Kiwanuka, S. N., George, A., & Kiracho, E. E. (2017). A participatory action research approach to strengthening health managers' capacity at district level in Eastern Uganda. *Health Research Policy and Systems*, *15*(S2), 110. https://doi.org/10.1186/s12961-017-0273-x

Tetui, M., Hurtig, A.-K., Ekirpa-Kiracho, E., Kiwanuka, S. N., & Coe, A.-B. (2016). Building a competent health manager at district level: A grounded theory study from Eastern Uganda. *BMC Health Services Research*, *16*(1), 665. https://doi.org/10.1186/s12913-016-1918-0

Tetui, M., Zulu, J. M., Hurtig, A.-K., Ekirapa-Kiracho, E., Kiwanuka, S. N., & Coe, A.-B. (2018). Elements for harnessing participatory action research to strengthen health managers' capacity: A critical interpretative synthesis. *Health Research Policy and Systems*, *16*(1), 33. https://doi.org/10.1186/s12961-018-0306-0

The Lancet. (2018). Putting quality and people at the centre of health systems. *The Lancet*, *392*(10150), 795. https://doi.org/10.1016/S0140-6736(18)32064-6

RESYST/DIAHLS learning site team. (2020). Learning sites for health system governance in Kenya and South Africa: Reflecting on our experience. *Health Research Policy and Systems*, *18*(1), 44. https://doi.org/10.1186/s12961-020-00552-6

Thiadens, T., Regev, G., Beard, J. W., & Fors, A. C. (2012). Growing Wings on the Way: Systems Thinking for Messy Situations. *International Journal of Sociotechnology and Knowledge Development (IJSKD)*, *4*(3), 56–63.

Thompson, D. S., Fazio, X., Kustra, E., Patrick, L., & Stanley, D. (2016). Scoping review of complexity theory in health services research. *BMC Health Services Research*, *16*(1), 87. https://doi.org/10.1186/s12913-016-1343-4

Thompson, R., & Garry, S. (2019). The political economy of NCDs, and the limits of global health. *The Lancet*, *393*(10177), 1186–1187. https://doi.org/10.1016/S0140-6736(19)30432-5

Thornberg, R., & Dunne, C. (2019). Literature review in grounded theory. *The Sage Handbook of Current Developments in Grounded Theory*, 206–221.

Timonen, V., Foley, G., & Conlon, C. (2018). Challenges when using grounded theory: A pragmatic introduction to doing GT research. *International Journal of Qualitative Methods*, *17*(1), 1609406918758086.

Tostensen, A. (2017). Malawi: A political economy analysis.

Topp, S. M., Chipukuma, J. M., & Hanefeld, J. (2015). Understanding the dynamic interactions driving Zambian health centre performance: a case-based health systems analysis. *Health policy and planning*, *30*(4), 485-499

Truth, A. U. (2013). No Health without a workforce. *World Health Organisation (WHO) Report*, 1–104.

Tsofa, B., Goodman, C., Gilson, L., & Molyneux, S. (2017). Devolution and its effects on health workforce and commodities management – early implementation experiences in Kilifi County, Kenya. *International Journal for Equity in Health*, *16*(1), 169. https://doi.org/10.1186/s12939-017-0663-2

Tsofa, B., Molyneux, S., Gilson, L., & Goodman, C. (2017). How does decentralisation affect health sector planning and financial management? A case study of early effects of devolution in Kilifi County, Kenya. *International Journal for Equity in Health*, *16*(1), 151. https://doi.org/10.1186/s12939-017-0649-0

Tudor Car, L., & Atun, R. (2017). eLearning for health system leadership and management capacity building: A protocol for a systematic review. *BMJ Open*, *7*(8), e017050. https://doi.org/10.1136/bmjopen-2017-017050

Tumusiime, P., Karamagi, H., Titi-Ofei, R., Amri, M., Seydi, A. B. W., Kipruto, H., Droti, B., Zombre, S., Yoti, Z., & Zawaira, F. (2020). Building health system resilience in the context of primary health care revitalization for attainment of UHC: Proceedings from the Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region. *BMC Proceedings*, *14*(19), 1–8.

Tumusiime, P., Nabyonga-Orem, J., Karamagi, H., Lehmann, U., Elongo, T., Nikiema, J.-B., Kabaniha, G., & Okeibunor, J. (2019). Resilient health systems for attaining universal health coverage. *BMJ Global Health*, *4*(Suppl 9), e002006. https://doi.org/10.1136/bmjgh-2019-002006

Tunçalp, Ö., Were, W., MacLennan, C., Oladapo, O., Gülmezoglu, A., Bahl, R., Daelmans, B., Mathai, M., Say, L., Kristensen, F., Temmerman, M., & Bustreo, F. (2015). Quality of care for pregnant women and newborns—The WHO vision. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(8), 1045–1049. https://doi.org/10.1111/1471-0528.13451

Turenne, C. P., Gautier, L., Degroote, S., Guillard, E., Chabrol, F., & Ridde, V. (2019). Conceptual analysis of health systems resilience: a scoping review. *Social Science & Medicine*, *232*, 168-180.

UHC2030. (2018). *Healthy Systems for Universal Health Coverage: A Joint Vision for Healthy Lives*. Geneva: World Health Organization and the World Bank. https://doi.org/10.1596/978-92-4-151252-7

Uhl-Bien, M. (2006). Relational leadership theory: Exploring the social processes of leadership and organizing. *The Leadership Quarterly*, *17*(6), 654–676.

UNICEF. (2016a). *The Unicef Health Systems Strengthening Approach*. https://www.unicef.org/media/60296/file

UNICEF. (2016b). *The UNICEF Health Systems Strengthening Approach*.

UNICEF (2021) 2019/2020 Health Budget Brief, UNICEF, Malawi

United Nations Economic Commission for Africa (2020) *African Development Bank: African Gender Index Report 2019*

UNIGME (2018) *Levels and Trends in Child Mortality Report*. UNICEF

Vall Castelló, B. (2016). Bridging constructivism and social constructionism: The journey from narrative to dialogical approaches and towards synchrony. *Journal of Psychotherapy Integration*, *26*(2), 129.

Vallières, F., Kok, M., Mahmud, I., Sarker, M., Jeacocke, P., Karuga, R., Limato, L., Kea, A. Z., Chikaphupha, K., Sidat, M., Gilmore, B., & Taegtmeyer, M. (2020). Measuring motivation among close-to-community health workers: Developing the CTC Provider Motivational Indicator Scale across six countries. *Human Resources for Health*, *18*(1), 54. https://doi.org/10.1186/s12960-020-00495-7

Van der Veken, K., Belaid, L., Delvaux, T., & De Brouwere, V. (2017). Research capacity building through North–South–South networking: Towards true partnership? An exploratory study of a network for scientific support in the field of sexual and reproductive health. *Health Research Policy and Systems*, *15*(1), 39. https://doi.org/10.1186/s12961-017-0202-z

van Olmen, J., Marchal, B., Ricarte, B., Van Damme, W., & Van Belle, S. (2019). The Need for a Dynamic Approach to Health SystemCentered Innovations Comment on 'What Health System Challenges Should Responsible Innovation in Health Address? Insights From an International Scoping Review'. *International Journal of Health Policy and Management*, *8*(7), 444–446. https://doi.org/10.15171/ijhpm.2019.25

VanderZanden, A., Langlois, E. V., Ghaffar, A., Bitton, A., Fifield, J., & Hirschhorn, L. R. (2019). It takes a community: A landscape analysis of global health research consortia. *BMJ Global Health*, *4*(Suppl 8), e001450. https://doi.org/10.1136/bmjgh-2019-001450

Varela, C., Young, S., Mkandawire, N., Groen, R. S., Banza, L., & Viste, A. (2019). Transportation barriers to access health care for surgical conditions in Malawi a cross sectional nationwide household survey. *BMC public health*, *19*(1), 1-8.

Vecchio, R. P. (Ed.). (2007). *Leadership: Understanding the Dynamics of Power and Influence in Organizations, Second Edition*. University of Notre Dame Press. https://doi.org/10.2307/j.ctvpg85tk

VON BERTALANFFY, L. (1976). Cultures as systems: Toward a critique of historical reason. *The Bucknell Review*, *22*(1), 151.

Vygotsky, L. S., & Cole, M. (1978). *Mind in society: Development of higher psychological processes*. Harvard university press.

Walsh, C. M., Mwase, T., & De Allegri, M. (2020). How actors, processes, context and evidence influenced the development of Malawi's Health Sector Strategic Plan II. *The International Journal of Health Planning and Management*, *35*(6), 1571–1592.

Warren, A. E., Wyss, K., Shakarishvili, G., Atun, R., & de Savigny, D. (2013). Global health initiative investments and health systems strengthening: A content analysis of global fund investments. *Globalization and Health*, *9*(1), 30. https://doi.org/10.1186/1744-8603-9-30

Washburn, R., Friese, C., & Clarke, A. (n.d.). *Situational Analysis in Practice*. 348.

Waters, M. C. (2018). Black Identities: West Indian Immigrant Dreams and American Realities. In *The Inequality Reader* (pp. 250–253). Routledge.

Watkins, D. A., Yamey, G., Schäferhoff, M., Adeyi, O., Alleyne, G., Alwan, A., Berkley, S., Feachem, R., Frenk, J., Ghosh, G., Goldie, S. J., Guo, Y., Gupta, S., Knaul, F., Kruk, M., Nugent, R., Ogbuoji, O., Qi, J., Reddy, S., … Summers, L. H. (2018). Alma-Ata at 40

years: Reflections from the Lancet Commission on Investing in Health. *The Lancet*, *392*(10156), 1434–1460. https://doi.org/10.1016/S0140-6736(18)32389-4

White, L., Currie, G., & Lockett, A. (2016). Pluralized leadership in complex organizations: Exploring the cross network effects between formal and informal leadership relations. *The Leadership Quarterly*,*27*(2), 280–297.

WHO, (2000). *The world health report 2000: Health systems: improving performance*. World Health Organization.

WHO, (2005). *Strengthening Management in Low-Income Countries*. World Health Organization.

WHO, (2006). *The world health report 2006: Working together for health*. World Health Organization.

WHO, (2007). *Towards better leadership and management in health: Report of an international consultation on strengthening leadership and management in low-income countries, 29 January-1 February, Accra, Ghana*. World Health Organization.

WHO, (2007a). *Everybody's Business, Strengthening Health Systems to Improve health Outcomes* (pp. 756–763). World Health Organization. https://apps.who.int/iris/handle/10665/272168

WHO, (2007b). *Managing the Health Millennium Development Goals—The challenge of management strengthening*. World Health Organization.

WHO, (2007c). *Managing the Health Millennium Development Goals—The Challenge of Management Strengthening: Lessons from Three Countries*.

WHO, (2007e). *Towards better leadership and management in health: Report of an international consultation on strengthening leadership and management in low-income countries, 29 January-1 February, Accra, Ghana*. World Health Organization.

WHO, (2011). *World Health Organization Health Systems Strengthening Glossary*.

WHO, (2012). *Strategy on health policy and systems research: Changing the mindset*. World Health Organization.

WHO, (2015). *WHO-2015-Global-strategy-on-integrated-people-centred-health-services*

WHO, (2016). *Global strategy on human resources for health: Workforce 2030*.

WHO, (2017). *Leave no one behind: Strengthening health systems for UHC and the SDGs in Africa*.

WHO, (2017) *Tracking Universal Health Coverage, Global Monitoring Report*

WHO, (2020). *Annual report 2019: Alliance for health policy and systems research*. World Health Organization.

WHO, (2018a). A vision for primary health care in the 21st Century

WHO, (2018b). *Country Cooperation Strategy at a Glance* [Data set]. https://doi.org/10.1787/20758480-table1

WHO, (2018c). *Delivering Quality Health Services: A Global Imperative*. OECD Publishing.

WHO, A. U. (2013). No Health without a workforce. *World Health Organisation (WHO) Report*, 1–104.

WHO, Policy, A. for H., & Research, S. (2020). *Annual report 2019: Alliance for health policy and systems research*. World Health Organization.

Whyle, E. B., & Olivier, J. (2021). Towards an explanation of the social value of health systems: An interpretive synthesis. *International Journal of Health Policy and Management*, *10*(7), 414–429.

Whyle, E., & Olivier, J. (2020). Social values and health systems in health policy and systems research: A mixed-method systematic review and evidence map. *Health Policy and Planning*, *35*(6), 735–751.

WEMOS, (2018) Country Report Malawi: *Mind the funding gap - Who is paying the health workers?*

Whaites, A. (2017). The beginner's guide to political economy analysis (PEA). *National School of Government International (NSGI)*, *13*.

Wilkinson, J., Goff, M., Rusoja, E., Hanson, C., & Swanson, R. C. (2018). The application of systems thinking concepts, methods, and tools to global health practices: An analysis of case studies. *Journal of Evaluation in Clinical Practice*, *24*(3), 607–618. https://doi.org/10.1111/jep.12842

Willcox, M. L., Peersman, W., Daou, P., Diakité, C., Bajunirwe, F., Mubangizi, V., Mahmoud, E. H., Moosa, S., Phaladze, N., Nkomazana, O., Khogali, M., Diallo, D., De Maeseneer, J., & Mant, D. (2015). Human resources for primary health care in sub-Saharan Africa: Progress or stagnation? *Human Resources for Health*, *13*(1), 76. https://doi.org/10.1186/s12960-015-0073-8

Willis, C. D., Best, A., Riley, B., Herbert, C. P., Millar, J., & Howland, D. (2014). Systems thinking for transformational change in health. *Evidence & Policy: A Journal of Research, Debate and Practice*, *10*(1), 113–126. https://doi.org/10.1332/174426413X662815

Willis, C. D., Riley, B. L., Stockton, L., Abramowicz, A., Zummach, D., Wong, G., Robinson, K. L., & Best, A. (2016). Scaling up complex interventions: Insights from a realist synthesis. *Health Research Policy and Systems*, *14*(1), 88. https://doi.org/10.1186/s12961-016-0158-4

Willis-Shattuck, M., Bidwell, P., Thomas, S., Wyness, L., Blaauw, D., & Ditlopo, P. (2008). Motivation and retention of health workers in developing countries: a systematic review. *BMC health services research*, *8*(1), 1-8.

Witter, S., Palmer, N., Balabanova, D., Mounier-Jack, S., Martineau, T., Klicpera, A., Jensen, C., Garcia, M. P., & Gilson, L. (2019). *Evidence review of what works for health systems strengthening, where and when?* 99.

Witter, S., Palmer, N., Balabanova, D., Mounier-Jack, S., Martineau, T., Klicpera, A., Jensen, C., Pugliese-Garcia, M., & Gilson, L. (2019). Health system strengthening—Reflections on its meaning, assessment, and our state of knowledge. *The International Journal of Health Planning and Management*, *34*(4). https://doi.org/10.1002/hpm.2882

Woodward, A., Sondorp, E., Witter, S., & Martineau, T. (2016). Health systems research in fragile and conflict-affected states: A research agenda-setting exercise. *Health Research Policy and Systems*, *14*(1), 51. https://doi.org/10.1186/s12961-016-0124-1

World Bank. (2020). *The World Bank in Malawi* [Text/HTML]. World Bank. https://www.worldbank.org/en/country/malawi/overview

World Health Organization. (2012). *The WHO strategy on research for health*. World Health Organization. https://apps.who.int/iris/handle/10665/77935

World Health Organization. (2016a). *Global strategy on human resources for health: Workforce 2030*. World Health Organization. https://apps.who.int/iris/handle/10665/250368

World Health Organization. (2016b). *Open mindsets: Participatory leadership for health*. World Health Organization. https://apps.who.int/iris/handle/10665/251458

World Health Organization, International Labour Organization, & Organisation for Economic Co-operation and Development. (2021). *Working for health: A review of the relevance and effectiveness of the five-year action plan for health employment and inclusive economic growth (2017-2021) and ILO-OECD-WHO Working for Health programme*. World Health Organization. https://apps.who.int/iris/handle/10665/340716

World Health Organization. Regional Office for South-East Asia. (2006). *Regional Health Forum, Vol. 10, No. 2*. WHO Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/205774

World Health Organization. Regional Office for the Eastern Mediterranean. (2020). Eastern Mediterranean Health Journal. *Eastern Mediterranean Health Journal*, *26*(8), 870–989.

Yeager, V. A., & Bertrand, J. (2015). Putting Management Capacity Building at the Forefront of Health Systems Strengthening Comment on 'Management Matters: A Leverage Point for Health Systems Strengthening in Global Health'. *International Journal of Health Policy and Management*, *5*(2), 129–131. https://doi.org/10.15171/ijhpm.2015.195

Yin, R. K. (1994). Discovering the future of the case study. Method in evaluation research. *Evaluation Practice*, *15*(3), 283–290.

Yin, R. K. (2003). Designing case studies. *Qualitative Research Methods*, *5*, 359–386.

Yin, R. K. (2009). *Case study research: Design and methods* (Vol. 5). sage.

Yip, W., & Hafez, R. (2015). *IMPROVING HEALTH SYSTEM EFFICIENCY* (p. 35). WHO.

Yukl, G. A. (2013). *Leadership in organizations* (8th ed). Pearson.

Zulu, J. M., Kinsman, J., Michelo, C., & Hurtig, A.-K. (2014). Integrating national community-based health worker programmes into health systems: A systematic review identifying

lessons learned from low-and middle-income countries. *BMC Public Health*, *14*(1), 987. https://doi.org/10.1186/1471-2458-14-987

Appendix 1: Letter of Support from REACH Trust

REACH Trust
Research for Equity And Community Health,
Box 1597,
Lilongwe, Malawi.

Phone: +265 1 753 260
+265 1 753 261
Email: info@reachtrust.org

8th November, 2018

The Chairperson,
NHSRC,
Ministry of Health,
P. O. Box 30377
Lilongwe 3

Dear Dr. Chilima,

RE: 'TOWARDS A THEORY OF HUMAN RESOURCES FOR HEALTH PROGRAMMES TO IMPROVE HEALTH WORKFORCE PERFORMANCE: A CASE STUDY APPROACH IN MALAWI

I am writing to confirm the support of REACH Trust for the PhD study entitled **"Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi"**. This study will be hosted here at REACH Trust in collaboration with Trinity College in Ireland. This study is relevant to our study **PERFORM2Scale – Strengthening Management at District Level to support the achievement of Universal Health Coverage** (PROTOCOL NO.P.12/17/232). The project aims to contribute to the current dearth of evidence in support of using management strengthening interventions at the level of District Health Management Teams in order to achieve positive and proximal outcomes at the level of district hospitals and primary health centres.

This project fits well within the wider aim of REACH Trust to improve equitable access to and delivery of health care services in Malawi.

Your assistance with this study is, as always, greatly appreciated.

Yours sincerely,

Lifah Sanudi
Acting Director, REACH Trust

Our Vision: To be an internationally recognised leading institution in health equity research in Malawi working to break the cycle of poverty and ill-health.

Appendix 2: Letter of Approval from MLW Trust

Malawi-Liverpool-Wellcome Trust

Clinical Research Programme

P.O Box 30096, Chichiri, Blantyre 3, Malawi.

Tel. +265 1 876444 Fax +265 1 875774

23rd October, 2018.

Thomasena O'Byrne
Malawi Liverpool Wellcome Trust
P.O Box 30096
Chichiri
Blantyre 3.

Dear Thomasena,

RE: RSG FEEDBACK LOI LOI473: TOWARDS A THEORY OF HUMAN RESOURCES FOR HEALTH
PROGRAMMES TO IMPROVE HEALTH WORKFORCE PERFORMANCE: A CASE STUDY
APPROACH IN MALAWI

Thank you for submitting the above LOI. The Research Strategy Group (RSG) reviewed your proposal at its meeting on 23rd October, 2018 which was noted to be supervised within the Policy Unit. In line with other studies led by units in MLW, we also ask that you have an affiliation with a Research Group and we suggest Behaviour and Health.

The RSG approved part A of the proposal and requests you to liaise with the Head of Behaviour and Health as you prepare to submit part B for RSG consideration.

Please note that the implementation of the study may not commence until full approval has been granted.

Yours Sincerely,

Stephen Gordon
MLW Program Director

Appendix 3: Tool for Desk Review

Desk Review & Ongoing Documentary Review

Preparation
-Malawi's constitution, health policies and strategies from GoM, academic political economy literature, national studies, documents on HSS, leadership/management/ quality improvement/HRH development, Legislation and administrative legislation initiative procedures (SOPs), grey literature (programme evaluations/reports etc)/media sources -Reading documents, web search, field/organisation visits, conversations, attend disseminations
Things to consider during reviews: -Similarities/differences across documents/topic areas (consider different levels for the system as well as international/national -Completeness of document. Draft? How credible is it? -What does the evidence say? -Target audience/purpose of document -Who created the document -Comparison between my own data collections sources -Consider visual information -Relate back to research aim and objectives

Research Objective	Questions to address the objective	Source	Key Points	Follow-Up/Actions
Include research objective here	Consider the following as a starting point: -Intervention info -Priorities identified -Influences -Decision-making -Health system related -Stakeholders involved -Socio/cultural -Political Economic situation -Donor influence -Challenges identified	Information on the source (e.g. academic/grey literature/policy/website/media etc)	Extract key messages aligned to objective	Note other sources to follow up on/questions to ask

Appendix 4: Interview Guide

Interview Topic Guide

Participant ID:
Gender:
Professional Title:
Length of time working in health:

Introduction

Thank you for agreeing to participate in this interview. During the next hour or so, I will ask you questions regarding your experiences with working in healthcare/health systems/Human Resources for Health programmes and interventions. As you are aware, your name will not appear on the findings of the study and if any quotes are used, you will be given a pseudonym.

Do you have any questions? Are you happy for the audio recorder to now be switched on?

(The structure and questions of the interviews may vary from one participant to the other depending on the job role/experience. The topic guide should ideally evolve over time. Possible topic areas therefore include the following)

Background and contextual understanding of health systems

- o Can you tell me a bit about your background and how you have come to be in your current role? Describe job role
- o Tell me about the health system here and how it works. (Explore each tier)
- o Relationships between the health system and others (Government/Community/stakeholders). Role of the DHMT/links between the different levels of the system

Health System and Decentralisation

- o What broader factors which may influence the health system in this context that you are aware of?

- o Explore the political economy and hierarchal structures in relation to decision making and health systems.
- o Who makes decisions at each level of the health system? What do you know about decentralisation? Can you describe any changes for health workers under decentralisation?

HRH

- o Tell me about the health workforce in Malawi.
- o How would you describe the dynamics between the different cadres? How do people work together? Teamwork?
- o What factors influence and/ impact on the health workforce being able to do their job well? What motivates health workers in this setting?
- o How are conflicts resolved in work?
- o Tell me about support available for HRH across the system

Interview Topic Guide

Health Systems Strengthening

- o What do you understand about health systems strengthening?
- o What are your experiences with interventions for HSS/HRH strengthening (in Malawi and beyond)

Leadership and Management

- o How would define leadership and management? What does it mean to you within this context and within the health system? Tell me about the management structures here.
- o Provide examples of what you consider to be effective/ineffective leadership/management
- o What is your experience in leadership/management roles? Preparation for role? Interactions with others?

Leadership and Management Development

- o Tell me about you experience of interventions designed to improve management and leadership capacity in Malawi
- o How do you understand these interventions to work? Probe on theory and practice
- o Can you talk about some of the benefits and challenges of these programmes/interventions?
- o In what ways can approaches to developing leadership and management in Malawi be improved?

Who else might you recommend that I talk to?

Are there any other areas you would like to discuss today?

Appendix 5: Examples from Coding Process

|	B	C	D	
			Stage 2	
	Stage 1			
	Memo		Memo	
	Absence of neutrality		Absence of a safe space	
			Absence of neutrality	
	Accountability		Accountability	
			Acculturation within the system	
			Challenges of speaking up or standing out from the crowd	
	Acculturation		Consequences of performing well	
			Appreciation, recognition, pride, value	
			Acknowledging	
			More than just monetary incentives	
	Acknowledging		It's the small things that can make all the difference	
			Assumptions	
			Expectations	
			Theory of Change	
			Perceptions	
			Reconciling thoughts, assumptions, beliefs	
			Blame , fault-finding, judgement	
			Blame culture	
	Appreciation, recognition & value			
			Bringing people together	
			Establishing trust	
			Teams	
	Assumptions		Working together/action learning	
			Change	
			Decentralisation	
			Critical mass of change agents	
	Background			

Nodes | **Memos 1** | Memos 2 | +
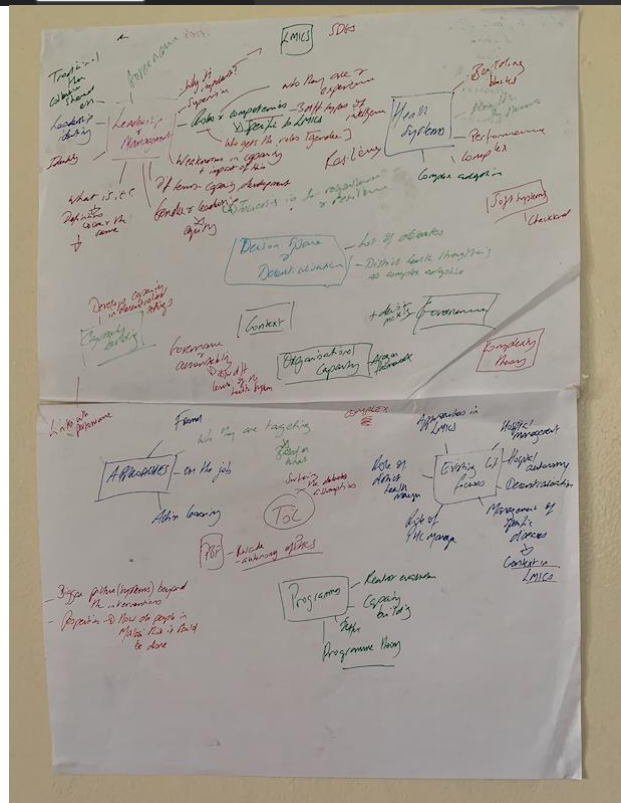
Health workforce challenges in Malawi	HRH	Leadership	Management Strengthening	Malawian Health System	Nursing Staff
Maldistribution	Different types of interventions/programs	Different styles	Benefits of it	Different tiers and how they work	Maternal health
Rural vs urban	Research in Malawi	Collective leadership	Teamwork	Hierarchal structure	Facility based vs communit
Accessability	International research	Need for self-assessment of skills	Theories	Leadership	Attitudes towards colleagu
Staffing	Focused at district level	Decision making	Lessons from other contexts	Decision-making	Attitudes towards
Resources	Within the community	Communication	Need for more in clinical medicine and publinc hea	Systems/structures not it place	Lack of opportunity
Lack of trust between colleagues	Addressing challenges	Dealing with people	Learn to be more funtional	Delineation	No opportunity to manage
Lack of trust between management and staff	Incentivising	Super users'	Increase safety	Changes that have occurred	Not respected by those less
Lack of motivation	With national level stakeholders	Leaders embezzling	Scaling up groups as well as individuals	Health workers (by cadre) per 1000	
Individuals using work resources for personal use	Task shifting	Need to share leadership across a team	Examples of MSIs working	Negatives perceptions	
Self-centredness and individualism	Providing staff housing	Collective intelligence of a team	Lack of evidence	Frustrations	
Lack of teamwork	Training	Move away from individual	Promotes control over issues in work	Overall performance	
Will only work for incentives because of poor salary	Need to share resources	Need for insight into own weaknesses	Need for longetvity and follow up	Large funding from ngos	
Lack of compassion			Need for training of trainers	Proactive individuals in ministry	
Job satisfaction			Need to co-design	Need for integration	
Distance from families			Taking responsibility for own learning	Plenty of policies, lack of implementation	
Gender roles unequal			Requires external funding	Political Economy	
Often not trained			Need to engage significantly		
Management skills			Support from MoH but not funders		
Poor infrastucture			Word of mouth		
Per diems			People should volunteer than be forced		
Constant fire-fighting			Need for inter-professionalism		
Unfair expectations			Learning from other sectors		
Attrition levels			Understanding strengths and weaknesses		
Lack of therapeutics			Skill, quantity, quality and consistency needed		
Fear of expressing vulnerabilities			Needs to be bottom up		
Lack of preparation and support			Motivation		
Fear of losing job if opinionated			Through technology and social media		
Favouitism			Previous lack of enthusiasm/not proactive		
Punishment			Ability of facility managers to solve their own problems		
Favouritism			Giving agency to proble solve		
Checklist culture			Avoid threatening other tiers		
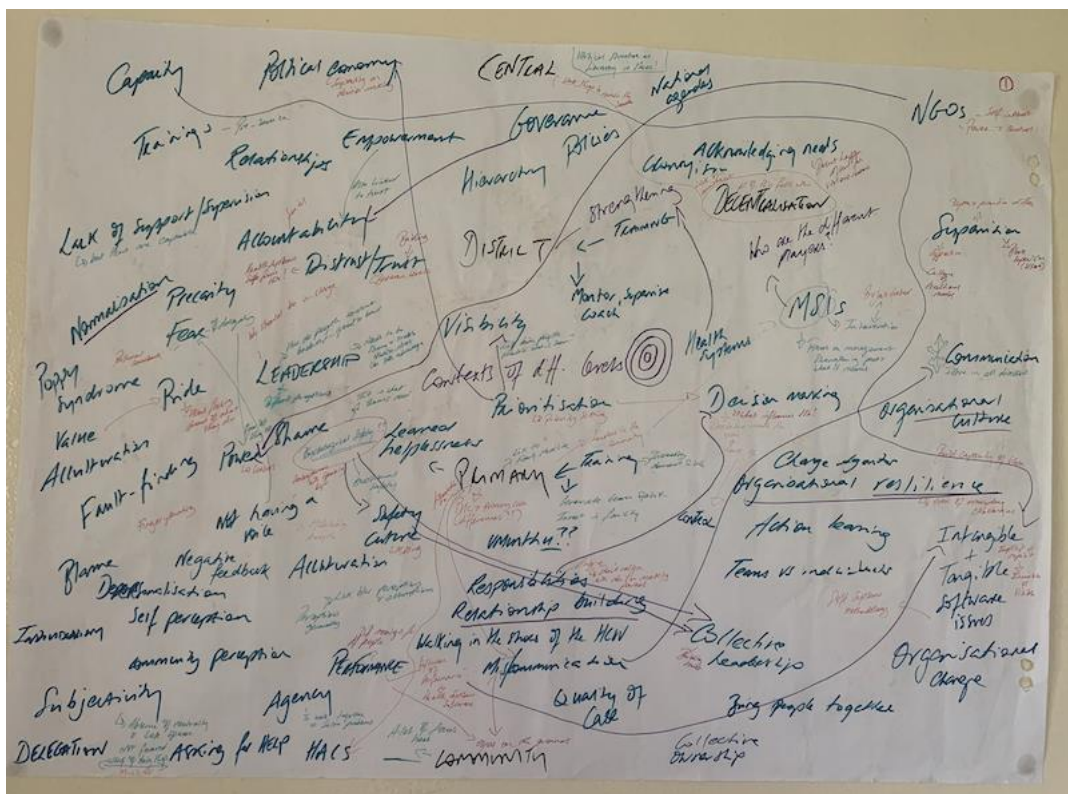
Appendix 6: Participant Information Leaflets

Participant Information Leaflet

Study Title: Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

Name of Principal Investigator: Thomasena O'Byrne
Name of Supervisors: Dr Frédérique Vallières & Dr Linda Nyondo-Mipando

Research purpose and procedures: The aim of this research is to develop a theoretical model demonstrating how Human Resources for Health interventions at district management level can impact on factors at primary level health care in Malawi. This involves understanding how professionals involved in Human Resources for Health programmes think that management strengthening interventions at the level of the District Health Management Team may work to improve health worker performance.

You are being invited to take part in this research as a professional with knowledge and/or experience of Human Resources for Health programmes aimed at improving health worker performance.

The research will take place over a period of two years, during which professionals involved in Human Resources for Health programmes will be invited to contribute to the initial stages of the project via an interview. Interviews will last for approximately one hour to 90 minutes. The primary researcher will discuss your knowledge and experience of Human Resources for Health programmes that are designed to improve health worker performance.

Please read this information sheet in order to make an informed decision about participating in the study. If you are willing to take part in the study, a suitable date, time and location will be arranged and you will be asked to sign an Informed Consent Form prior to the interview taking place.

1. **Risks and discomforts:** The investigator does not foresee any risks or discomforts to you taking part in this study.

2. **Potential benefits:** The benefits of participating in this research project is that participants will contribute to the generation of a theoretical model that will inform how Human Resources for Health interventions at the level of District Health Management Teams can impact on improving health worker performance. This in turn will contribute to the limited evidence base on intervening at this level to achieve positive and proximal outcomes across health systems. That said, this research will not directly change practice nor will it increase resourcing.

3. **Provisions for confidentiality:** If you decide to participate in an interview your contributions will be recorded. Interview transcripts will be marked with a special study number only, and not your name. All

1

information obtained during the course of this study will be held securely, and stored on paper and computer files. The investigator will take responsibility for keeping your personal information confidential. We would also like to seek your permission to use quotations from your interview or additional discussions. We will ensure that anything we use will be carefully selected so that you cannot be identified.

4. **Data Controller and Data Protection Officer:** Data collected will be controlled and processed by the investigator (Thomasena O'Byrne). Participants must consent to the processing of their data which will be facilitated through the provision of an Informed Consent Form prior to interview. The Data Protection Officer at Trinity College Dublin, Ireland is Jennifer Ryan and can be contacted on dataprotection@tcd.ie. Participants have a right to lodge a complaint with the Data Protection Commissioner at any time.

5. **Data Protection:**
   a) Personal data will be processed by the investigator for purposes of this study as outlined in the introduction and under the General Data Protection Regulations. If data is to be processed further, it will be for academic purposes.
   b) **Voluntary participation and the right to discontinue participation without penalty:** The investigator is asking you to participate voluntarily in this study and there is no obligation at all to do so. We would appreciate your contributions and opinions and it will be useful for us to hear your views but if you don't wish to participate please tell the investigator at any stage and you will not be asked to give a reason nor will there be any penalty or loss of benefits. Your refusal will not affect your right to participate in other discussions at another time. Any significant new findings developed during the course of this research which may relate to your willingness to continue, will be communicated to you.
   c) **Data storage:** Electronic data including the written transcripts and correspondence emails will be encrypted where possible and maintained on a password guarded computer with access limited to the PI and research supervisor. Anonymised data will be retained in a secure locked cabinet for the period as recommended by the Trinity College Dublin research best practice guidelines and the National health Sciences Research Committee (NHSRC). The participant identification key will be stored separately from the main data. Raw data of the interviews will be maintained for future reference, for a minimum time as final thesis has been assessed and results disseminated. Hardcopies will be maintained in a secure location with limited access for 5 years. Anonymised data will be retained as recommended by NHSRC and Trinity College Dublin research best practice guidelines. After the recommended timeframe has passed, data will be destroyed following the procedures set by the Data Protection Commissioner Ireland.
   d) **Access to transcripts:** Copies of interview transcripts will be made available to you if you chose to participate in a recorded interview and there will be an opportunity of deleting any wording that you feel may identify you.
   e) Participants have a right to have their personal data deleted. They also have a right data portability which it to receive the personal data concerning them, in a structured, commonly used and machine-readable format and have a right to transmit those data to another controller without hindrance.
   f) Participants have a right to object to automated processing including profiling if they wish. Profiling is any form of automated processing of personal data consisting of the use of personal data to evaluate certain personal aspects relating to the participant, to analyse or predict aspects of their performance at work, health or behaviour.

6. **Termination of participation by the investigator:** The investigator does not anticipate any circumstances under which your involvement may be terminated, but if a situation arises that leads the investigator to believe that you are no longer required to take part in the study, you will be informed of this decision.

2

7. **Permissions:** The investigator has obtained permission to conduct the study from REACH Trust, Malawi and the Centre for Global Health, Trinity College, Dublin. The study has also obtained ethical approval from the HPM-CGH Research Ethics Committee at Trinity College Dublin and the Malawi National Heath Science and Research Committee.

8. **Contacts for additional information:** If you have any questions about this research or your rights as a study participant, please feel free to ask. If you think of any questions at a later stage, you can contact the following number and ask to speak to the Principal Investigator Ms Thomasena O'Byrne on +265 (0) 996846736. Alternatively, please email obyrneth@tcd.ie.

Additionally, you can contact the Research Supervisors on +353 (0)1 896 4394/fvallier@tcd.ie or +265 1874 628/lindalinane@gmail.com.

Contact details for NHSRC are as follows: Tel: +265 1 726 422/418
Email: mohdoccentre@gmail.com

Tsamba lauthenga waotenga nawo mbali

Mutu wakafukufuku: Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

Dzina laofufuza wamkulu: Thomasena O'Byrne
Dzina laoyang'anira: Dr Frédérique Vallières & Dr Linda Nyondo-Mipando

Cholinga chakafukufuku ndi ndondomeko: Cholinga chakafukufukuyu ndikufuna kuyambitsa njira zamaganizidwe zomwe zisonyeze momwe zolowelerapo zaumoyo muntchito zachipatala pamlingo wa timu ya District Health Management angakhudzire zinthu zochitika muzipatala zing'onozing'ono m'Malawi. Izi zikukhudza kumvetsetsa momwe antchito okhudziwa mundondomkeo yogwira ntchito zaumoyo amaganizira momwe kulimbikitsa kulowerelapo pamlingo wa timu ya District Health Management kungagwilire ntchito potukula kagwiridwe ntchito ka anthuogwira ntchito zaumoyo.

Mukuyitanidwa kutenga nawo mbali mukafukufukuyi ngati ogwira ntchito yemwe ali ndi nzeru kapena zokumana nazo ndi pulogalamu ya anthu ogwira ntchito a zaumoyo chomwe cholinga chake ndikutukula magwiridwe ntchito a anthu ogwira ntchito zaumoyo

Kafukufuku achitika kwa nthawi yochuluka zaka ziwiri, mkatikati mwake ogwira ntchito yokhuzidwa ndi pulogalamu yantchito yazaumoyo adzayitanidwa kuti athandizire gawo loyambilira lantchitoli kudzera mukufunsidwa mafunso. Ndondomeko yofunsidwa mafunso idzatenga pafupifupi pakati pa ola limodzi ndi mphindi 90. Wakafukufuku adzakambilana nanu nzeru ndi zomwe mumakumana nazo mu pulogalamu ya ntchito yazaumoyio zomwe zinapangidwa ndicholinga chofuna kutukula magwiridwe ntchito aanthu ogwira ntchito zaumoyo

Chonde werengani tsamba lauthenga ndicholinga choti mupange chisankho choyenelera chotenga now mbali mukafukufukuyu. Ngati mukufuna kutenga nawo mbali mukafukufukuyu, tsiku lokuyenerani, nthawi ndi malo zizakonzedwa ndipo mudzapemphedwa kusayinira tsamba lopereka chilorezo chanu ndondomeko yokufunsani mafunso isanachitike.

1. **Zipsinjo ndi zosowetsa mtendere:** Ofufuza sakuonapo zoopsa ndi zosowetsa mtendera zomwe mungakumane nazo potenga mbali mukafukufukuyu.
2. **Zomwe mungapindule:** Zomwe mungapindule potenga nawo mbali mukafukufukuyu ndizoti otenga nawo mbali athandizira kubweretsa njira zamaganizidwe zomwe zisonyeze momwe zolowelerapo zaumoyo muntchito zachipatala pamlingo wa timu ya District Health Management angathandizire potukula kagwiridwe ntchito ka anthu ogwira ntchito zaumoyo. Motsatira, izi zizathandizira umboni ochepa omwe ulipo polowelerapo pa mlingo uwu ndicholinga chofuna kukwanilitsa zotsatira zabwino mundondomeko

zaumoyo zones. Kafukufukuyu sasintha pompopompo kagwiridwe ntchito kapena kuchulukitsa thandizo lazipangizo zogwiritsa ntchito .

3. **Masungidwe a chinsinsi:** Ngati mupange chiganizo chotenga nawo mbali zomwe mutigayire zizajambulidwa pamakina aojambulira mawu. Zolembedwa kuchokera mundondomeko yofunsidwa mafunso zizasonyezedwa ndi nambala yapadera yamukafukufuku, osati dzina lanu. Uthenga onse omwe uzapezedwe munthawi yakafukufukuyu udzasungidwa motetezeka papepala ndi mumafailo amakina a computer.Ofufuza azatenga udindo osunga uthenga wanu mwachinsinsi. Tikufunanso kupempha chilorezo chanu kuti tigwiritse ntchito zonenedwa zanu mundondomeko yokufunsani mafunso kapena zokambilana zowonjezera. Tionetsetsa kuti chilichonse chomwe titagwiritse ntchito chidzasungidwa mosamala ndicholinga chokuti musazindikilidwe.

4. **Osamala uthenga wa wakafukufuku::** Uthenga omwe utoleredwe udzatetezedwa ndi kukonzedwa mwa dongosolo lina ndi ofufuza (Thomasena O'Byrne). Otenga nawo mbali akuyenera kupereka chilorezo kuti uthenga wawo ukonzedwe mwadongosolo lina zomwe zizayendetsedwe popereka tsamba lachilorezo ndondomeko yofunsa mafunso isanachitike. Oteteza uthenga ku Trinity College Dublin, Ireland ndi Jennifer Ryan ndipo mutha kulumikizana naye pa <u>dataprotection@tcd.ie</u>. Otenga anwo mbali ali ndi ufulu opereka chidandaulo ndi wamkulu oteteza uthenga ntahwi inailiyonse

5. **Kasamalidwe ka uthenga wakafukufuku:**
   a) Uthengawu udzagwiritsidwa ntchito ndi wamkulu wa kafukufukuyu molingana ndi momwe zanenedwera pachiyambi komanso mu Ndondomeko zakatetezedwe kauthenga. Ngati uthenga udzapitilire kugwiritsidwa ntchito pena, chidzakhala cholinga choti ugwiritsidwe ntchito pamaphunziro.
   b) **Kutenga nawo mbali modzipereka mwaulere komanso ufulu osiya kutenga nawo mbali popanda kulandira chilango:** Ofufuza akukupemphani kuti mutenge nawo mbali modzipereka komanso mwaulere mukafukufukuyu ndipo popanda chipangano chilichonse chokuwumilizani kutero. Tikhala oyamika pachithandizo ndi maganizo anu ndipo zikhala zothandiza kwa ife kuti timve maganizo anu, koma ngati simukufuna kutenga nawo mbali, muwuzeni ofufuza pagawo lililonse ndipo simudzapemphedwa kuti mupereke chifukwa chake komanso sipadzakhala chilango, kapena kuluza zopindula zilizonse. Kukana kwanu sikukhudza ufulu wanu odzatenga nawo mbali muzokambilana zina nthawi ina. Zopezeka zilizonse zatsopano zomwe zizapezeke mkatikati mwakafukufukuyu zomwe zidzagwirizane ndi chifuniro chanu kupitiliza, zidzalumikizidwa kwa inu
   c) **Kasungidwe ka uthenga:** Uthenga wamu computer kuphatikizapo zolembedwa zochokera mundondomeko yokufunsani mafunso ndi makeyala a makalata ogwirizana nazo zizasungidwa motetezeka ndi nambala yachinsinsi pofunikira kutero, ndikusungidwa pamakina acomputer otetezedwa ndi nambala yachinsinsi ndipo chilorezo chidzapelekedwa kwa ofufuza wamkulu ndi oyang'anira kafukufuku. Uthenga opanda mayina udzasungidwa mukabati yokiyidwa kwanthawi yochuluka yovomelezeka ndi Trinity College Dublin research best practice guidelines ndi National Health Sciences Research Committee (NHSRC). Nambala yomuzindikilitsa otenga nawo mbali idzasungidwa mosiyana ndi uthenga weniweni. Uthenga ochokera mundondomeko yofunsa mafunso udzasungidwa kuti udzagwiritsidwe ntchito mtsogolo, kwanthawi yochepa pamene nkhani yolembedwa komaliza yaonedwa ndipo zotsatira zaulutsidwa. Mapepala ogwirika adzasungidwa m'malo otetezeka oloredwa kwa anthu ochepa kwa zaka zisanu. Uthenga opanda mayina udzasungidwa molingana ndi chikonzero cha Trinity College Dublin research best practice guidelines ndi NHSRC. Pamene nthawiyi yadutsa, uthenga udzaonongedwa potsatira ndondomeko zokhazikitsidwa ndi Data Protection Commissioner Ireland.

d) **Kupezeka kwa zolembedwa zochokera mundondomeko yofunsa mafunso:** Zolembedwa zochokera mundondomeko yakafukufuku zizapezeka kwa inu ngati mutasankhe kutenga nawo mbali mukafukufu okujambulani mawu ndipo padzakhala mwayi ofufuta mawu alionse omwe mukuona kuti atha kuzakuzindikilitsani

e) Otenga nawo mbali ali ndi ufulu ofufuta uthenga wawo. Komanso ali ndi mwayi olandira uthenga omwe ukuwakhudza, munjira yadongosolo, yogwiritsidwa ntchito ndi yowerengeka pamakina ndipo ali ndi ufulu otumiza uthengawo kwa oteteza wina popanda chotchinga chilichonse

f) Otenga nawo mbali ali ndi ufulu kukana njira yokonza mudongosolo lina mosavuta kuphatikizapo njira yofokotozeratu ngati akufuna. Njira yofotokozeratu ndi mtundu ulionse okonza mosavuta dongosolo lokonza munjira ina uthenga wamunthu kuphatikizapo kugwiritsa ntchito uthenga wamunthu pofuna kuwunguza mbali zina zamunthu zokhudzana ndi otenga nawo mbali, pofuna kuwunikira kapena kulosera mbali yakagwiridwe kawo kantchito, umoyo ndi khalidwe.

6. **Kuthetsedwa kotenga nawo mbali ndi ofufuza:** Ofufuza sakuyembekezera zochitika zinazilizonse zomwe zingapangitse kuti kukhudziwa kwanu mukafukufuku kuthetsedwe, koma ngati papezeka chochitika chomwe chitha kupangitsa kuti ofufuza akhulupilire kuti simukuyeneranso kutenga nawo mbali mukafukufuku, muzadziwitsidwa zaganizo limeneli.

7. **Zilorezo:** Ofufuza watenga chilorezo kuchita kafukufuku kuchokera ku REACH Trust, Malawi and Centre for Global Health, Trinity College, Dublin. Kafukufukuyu watenganso chilorezo kuchokera ku HPM-CGH Research Ethics Committee ku Trinity College Dublin ndi ku Bungwe la kafukufuku la Malawi National Heath Science and Research Committee

8. **Omwe mungalumikizane nawo kuti mupeze uthenga owonjezera:** Ngati muli ndi mafunso alionse okhudzana ndikafukufukuyu kapena ufulu wanu ngati otenga nawo mbali mukafukufuku, khalani omasuka kufunsa. Ngati mungaganizire mafunso alionse pagawo lililonse, mutha kulumikizana pamanambala otsatirawa ndikupempha kuti muyankhule ndi ofufuza wamkulu Ms Thomasena O'Byrne pa +265 (0) 996846736. Mwanjira ina, chonde lembani email obyrneth@tcd.ie.

Mongowonjezera, mutha kulumikizana ndi oyang'anira kafukufuku pa +353 (0)1 896 4394/fvallier@tcd.ie kapena +265 1874 628/lindalinane@gmail.com.

 Tsatane tsatane wamomwe mungalumikizanilane ndi NHSRC ali motere: Tel: +265 1 726 422/418 Email: mohdoccentre@gmail.com

Appendix 7: Informed Consent Forms

Informed Consent Form

Study Title: Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

Contacts
Principal Investigator: Thomasena O'Byrne
Tel: +265 99 684 6736 or Email: obyrneth@tcd.ie
NHSRC: Tel: +265 1 726 422/418 or Email: mohdoccentre@gmail.com

Introduction and Purpose

You are being invited to take part in this research as a professional with knowledge and/or experience of Human Resources for Health programmes aimed at improving health worker performance.

The aim of this research is to develop a theoretical model demonstrating how Human Resources for Health interventions at district management level can impact on factors at primary level health care in Malawi. This involves understanding how professionals involved in Human Resources for Health programmes think that management strengthening interventions at the level of the District Health Management Team may work to improve health worker performance.

Procedure

By agreeing to participate in this study, you will be asked to contribute to the process in the following way:

o Participation in a **face-to-face interview, Skype interview or telephone interview** with the Principal Investigator lasting approximately 60-90 minutes

If you agree to take part in an interview this will be digitally recorded. All information gathered through this process will remain confidential and a transcript of audio recordings will be provided at your request. You will have the opportunity to delete any words that may identify you. You have the right to leave the study at any time or you can refuse to answer any questions you do not want to answer throughout the process. There will be no penalties for withdrawing after consenting to participate.

Before starting the interview please confirm the following:

Checklist

☐ I have been informed about the research project Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

376

- I have been informed about the purpose of my participation in the interview.
- My decision to participate in this research is voluntary. I understand that there is no credit or penalty for my participation.
- I agree to the interview being audio recorded and transcribed. I understand that, following transcription of the discussion, I have the right to get a copy of my transcript and may correct any inaccuracies or delete any information.
- I have been made aware that all identifying information will be removed from the interview transcripts and that all information will be kept confidential at all times. I have been informed that only a participant number will be used in the analysis process and the file which matches number with the identity will be kept in a password-protected computer, accessible only to the researcher.
- I have been informed that the audio recording will be kept confidential at all times in a password-protected computer and encrypted terminals and only the researcher will have access to it.
- I agree that quotes from the interview, in which I participate, may be used for dissemination purposes and I am assured that these will be strictly anonymized, with no identifying information accompanying any quotes used. I further agree to that the information obtained from my interview being analysed and used in the writing of the principal investigator's doctoral thesis. I agree to the publication and dissemination of this study in the future. I further agree to my data, once anonymized, being used in research studies in the future.
- I am aware that, should I be affected by any of these issues that arise in the course of this research, I can ask the researcher for help.
- I have had the opportunity to ask questions and get answers about my participation in this research.
- I agree to participate in the key informant interview.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement. I consent to the processing of my data.

PARTICIPANT'S NAME: ………………………………………………………….

CONTACT DETAILS: ………………………………………………………….

PARTICIPANT'S SIGNATURE: ………………………………………………….

Date:…………………………….

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:……………………………………………….. Date:…………………….

Tsamba Iopempha Chilorezo

Study Title: Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

Momwe mungalumikizirane
Ofufuza wamkulu: Thomasena O'Byrne
Tel: +265 99 684 6736 or Email: obyrneth@tcd.ie
NHSRC: Tel: +265 1 726 422/418 or Email: mohdoccentre@gmail.com

Chiyambi ndi cholinga

Mukuyitanidwa kutenga nawo mbali mukafukufukuyi ngati ogwira ntchito yemwe ali ndi nzeru kapena zokumana nazo ndi pulogalamu ya anthu ogwira ntchito a zaumoyo chomwe cholinga chake ndikutukula magwiridwe ntchito a anthu ogwira ntchito zaumoyo.

Cholinga chakafukufukuyu ndikufuna kuyambitsa njira zamaganizidwe zomwe zisonyeze momwe zolowelerapo zaumoyo muntchito zachipatala pamlingo wa timu ya District Health Management angakhudzire zinthu zochitika muzipatala zing'onozing'ono m'Malawi. Izi zikukhudza kumvetsetsa momwe antchito okhudzidwa mundondomkeo yogwira ntchito zaumoyo amaganizira momwe kulimbikitsa kulowerelapo kwa oyang'anira pamlingo wa timu ya District Health Management kungagwilire ntchito potukula kagwiridwe ntchito ka anthu ogwira ntchito zaumoyo.

Ndondomeko

Povomera kutenga nawo mbali mukafukufukuyu, mudzapemphedwa kuthandizira kudongosolori munjira iyi:

o Kutenga nawo mbali **mundondomeko yofunsana mafunso pamaso, skype kapena kuyimbilidwa lamya** ndi ofufuza wamkulu ndipo izi zizatenga pafupifupi mpindi 60-90.

Ngati mukuvomereza kutenga nawo mbali mukafukufuku, izi zizajambulidwa pamakina ojambulira mau. Uthenga onse otoleredwa mudongosolo limeneli udzakhala wachinsinsi ndipo zolembedwa zonse kuchokera mumawu ojambulidwa zizaperekedwa kwa inu mukadzapempha. Mudzakhala ndi mwayi ofufuta mawu alionse omwe mukuona kuti angakuzindikilitseni . Muli ndi ufulu kusiya kutenga nawo mbali mukafukufukuyu nthawi iliyonse, kapena kukana kuyankha mafunso ena omwe simukufuna kuyankha mudongosolo limeneli. Palibe zilango zilizonse posiya kutenga nawo mbali mutapeleka kale chilorezo kuti mutenga mbali.

Musanayambe kafukufuku chonde tsimikizani zotsatirazi:

Mdandanda

☐ Ndauzidwa zokhudzana ndikafukufuku wa ntchito ya **Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi**

☐ Ndauzidwa zacholinga chakutenga nawo mbali kwanga mundondomeko yofunsidwa mafunso.

☐ Chiganizo changa kutenga nawo mbali mukafukufukuyu ndikozipereka mwaulere, Ndamvetsetsa kuti palibe mphoto kapena chilango pakutenga mbali kwanga.

☐ Ndavomera kuti mundondomeko yofunsidwa mafunso, mawu anga adzajambulidwa pamakina ojambulira mawu ndikulembedwa. Ndikumvetsetsa kuti kutsatira ndondomeko yofunsa mafunso ndi zokambirana, ndili ndi ufulu kupeza tsamba lina yazolembedwa ndikukonza zolakwika zonse kapena kufufuta uthenga uliwonse

☐ Ndadziwitsidwa kuti uthenga onse ondizindikilitsa mu ndondomeko yofunsidwa mafunso komanso zolembedwa zochokera mumawu ojambulidwa zizachotsedwa ndipo uthenga onse udzasungidwa mwachinsinsi nthawi zonse. Ndauzidwa kuti nambala yaotenga nawo mbali yokha idzagwiritsidwa ntchito mudongosolo lowunika uthenga ndipo mafailo omwe adzagwilizane ndi nambala yachizindikiro adzasungidwa motetezedwa mumakina a computer otetezedwa ndi nambala yachinsinsi, ndipo adzakhala opezeka kwa ofufuza yekha

☐ Ndauzidwa kuti mawu ojambulidwa adzasungidwa mwachinsinsi nthawi zonse ndipo adzakhala otetezeka ndi nambala yachinsinsi ndipo zidzakhala zopezeka kwa ofufuza okha.

☐ Ndikuvomera kuti mawu oyankhulidwa anga kuchokera kundondomeko yofunsidwa mafunso, yomwe nditatenge mbali atha kudzagwiritsidwa ntchito ndi cholinga chofalitsa uthenga ndipo ndatsimikizilidwa kuti zizakhala zosadziwika, zopanda chizindikiro chilichonse kutsatira mawu anga oyankhulidwa. Ndikuvomerezanso kuti uthenga omwe utapezedwe kuchokera mundondomeko yofunsidwa mafunso uzaunikilidwa muzolemba zaofufuza wamkulu. Ndikuvomeleza kutsindikizidwa kwa zofalitsidwazi mtsogolo. Ndikuvomeranso kuti uthenga wanga, ngati uli osadzindikilika, utha kudzagwiritsidwa ntchito mukafukufuku wamtsogolo

☐ Ndikudziwa kuti, ngati ndingakhudziwe ndinkhani zilizonse zomwe zingabwere mkatikati mwakutenga nawo mbali kwanga, nditha kumufunsa ofufuza kuti andithandize..

☐ Ndinali ndi mwayi ofunsa mafunso ndikupeza mayankho pakutenga nawo mbali kwanga mukafukufuku.

☐ Ndavomera kutenga anawo mbali mundondomeko yofunsidwa mwafunso

☐

KUVOMEREZA:

Ndawerenga kapena andiwerengera tsamba lauthenga lakafukufukuyu ndipo ndamvetsa zamkati mwake. Ndinali ndi mwayi ofunsa mafunso ndipo mafunso onse ayankhidwa mwakukhutira kwanga. Ndikuvomereza momasuka komanso modzipereka mwaulere kutenga nawo mbali mukafukufukuyu, ngakhale popanda tsankho lililonse kuufulu wanga ndi malamulo. Ndikumvetsa kuti nditha kusiya kutenga nawo mbali mukafukufukuyu nthawi iliyonse ndipo ndapatsidwa tsamba lina lamgwirizanowu. Ndikupereka chilorezo kuti uthenga wanga utha kukagwiritsidwa ntchito mukafukufukuyu.

DZINA LA OTENGA MBALI: ……………………………………………………..

MOMWE MUNGALUMIKIZANIRANE: ……………………………………………………………….

SIGINETCHALA YAOTENGA MBALI : ………………………………………………………

Date:…………………………..

Chiganizo cha udindo wa ofufuza: Ndafotokoza mtundu komanso cholinga chakafukufukuyu, ndondomeko zomwe zitengedwe ndiponso ziopsezo zomwe zingakhudzidwe. Ndadzipereka kuyankha mafunso aliwonse ndipo ndayankha mafunso amenewo mwathunthu. Ndili ndi chikhulupiliro kuti otenga nawo mbali wamva zofotokoza zanga ndipo wapereka chilorezo momasuka.

SIGINETCHALA YAOFUFUZA:……………………………………………………. TSIKU:…………………..

Appendix 8: Ethical Approval Letters

Telephone: + 265 789 400
Facsimile: + 265 789 431

All Communications should be
addressed to:

The Secretary for Health and Population

In reply please quote No.
....

MINISTRY OF HEALTH AND POPULATION
P.O. BOX 30377
LILONGWE 3
MALAWI

16ᵗʰ February, 2019
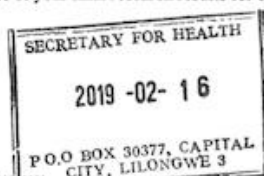
Thomasena O'Byrne
Trinity College London

Dear Sir/Madam,

Re: Protocol # 18/11/2171: Towards a Theory of Human Resources for Health Programmes to Improve Health Workforce Performance: A Case Study Approach in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : 2171
- The above details should be used on all correspondences, consent forms and documents as appropriate.
- **APPROVAL DATE** : 16/02/2019
- **EXPIRATION DATE**
  This approval expires on **15/02/2020**. After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC Secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the NHSRC within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS:** Prior NHSRC approval using forms obtainable from the NHSRC Secretariat is required before implementing any changes in the protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS:** Please contact the NHSRC on phone number *+265 994 063 425* or by email on mohdoccentre@gmail.com.
- **OTHER:** Please be reminded to send in copies of your final research results for our records (Health Research Database).

Kind regards from the NHSRC Secretariat.

SECRETARY FOR HEALTH

2019 -02- 1 6

P.O.O BOX 30377, CAPITAL
CITY, LILONGWE 3

For: **CHAIRPERSON, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE**
Promoting Ethical Conduct of Research[1]

_____

Executive Committee: *Dr B. Chilima (Chairperson), Dr B. Ngwira (Vice-Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRBIRB
Number IRB00003905 FWA00005976

Thomasena O'Byrne
36a Balally Park
Dundrum
Dublin 16

16 October 2018

Re: Towards a Theory of Human Resources for Health Programmes to Improve Health
Workforce Performance: A Case Study Approach in Malawi

Application 07E/2018/06

Dear Thomasena,

Thank you for your submission of the above proposal to the HPM/CGH REC.

The REC has given ethical approval to the proposed study.

Yours sincerely,

Prof Charles Normand
Chair of the HPM/CGH REC