The role of leadership in people-centred health systems: a sub-national study in The Gambia

Recently, in the emerging field of global health research, increasing attention has been given to behavioural and relational aspects of the people who both define and shape health systems, placing them at the core. A growing refrain – “people-centered health systems” includes the assertion that important decisions determining health system performance, including agenda setting, policy formulation and policy implementation, are made by and for people. Within this actor-oriented approach, good leadership has been identified as a key contributing factor in health systems strengthening (HSS). However, understanding the links between leadership, HSS and health outcomes remains a challenge, especially in resource-limited settings. Though leadership has been rigorously studied, traditionally within a positivist knowledge paradigm (Klenke 2008), it remains ill-defined and under-researched. Moreover, this positivist approach presupposes that leadership is an objective, measurable, and value-free phenomenon, and, in so doing, belies the multiplicity of meanings embedded within the concept (Klenke 2008). In contrast, we argue that leadership is an inter-subjective phenomenon that exists within a social, political and organizational reality and is shaped by particular, culturally determined ways of framing problems and solutions (Sheikh et al. 2011).

In this work we explore the concept and practice of healthcare leadership at sub-national level in a low-income country setting in sub-Saharan Africa. In June and July 2013, 15 in-depth interviews were conducted with key informants in formal healthcare leadership roles across urban, peri-urban and rural settings of The Gambia, West Africa. Participants included the entire spectrum of Regional Health Team (RHT) Directors and Chief Executive Officers of all government hospitals, as well as one clinical officer-in-charge in a secondary-
level major health center. This study, the first of its kind in The Gambia and, to our knowledge, across much of the African continent, provides a rich, albeit introductory, view of the conceptual understandings, practices and experiences of healthcare leadership from the perspectives of executives at the sub-national level, adding both relevance and rigour to the existing body of leadership research. The subnational level is an important unit of analysis within many countries, due to fiscal and/or administrative decentralization of healthcare (Gilson and Mills 1995).

Though our study participants were all based in formal leadership positions, most had little formal leadership training and thus we infer that the leadership styles they discussed are born out of contextual reality and practical problem solving. Many of the participants stated, implicitly and explicitly, that the different leadership styles that they employ overlap continually and must be leveraged flexibly depending on the demands of the moment or the task at hand. A salient feature, consistent across all the interviews, is that sub-national health leaders operate in a multi-polar network of stakeholders to whom they attend and are accountable. Both groups—RHT directors and hospital CEOs—have to manage and mediate between a multitude of interfaces within their professional networks. These interfaces thus constitute the ‘organizational ecology’ of the healthcare landscape in which they are placed. The key themes that emerged from the interviews reflect a number of the complexities and dynamics of this institutional architecture, particularly the politics of decentralization, stakeholder pluralism and resource constraints, and they also inflect the predominant leadership styles and ideas that the participants self-report.

In this study, the self-reporting of leadership styles was overwhelmingly biased towards the ‘democratic’ typology; this is unsurprising given that, despite a general lack of leadership training, all participants were familiar with some of the terminology associated with management jargon and they appeared to be aware of the normative categorizations of
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leadership styles. Clearly, the idea of being ‘democratic’ was seen to be ‘better’ than being ‘coercive’ even though it is known from experience that executives in hierarchical, resource constrained health systems are frequently ‘coercive’ in their approach. Collectively, participants indicated simultaneously attending to constituencies in national government, other programmatic arms of the MoHSW, DAPs, civil society, and to the populations they serve, and this may, in part, explain the special importance accorded to being (seen to be) ‘democratic’. Moreover, results highlighted several key aspects that are consistent with the empirical literature of leadership in high-income countries, including the importance of setting a clear vision (Porter 1996; Kotter 2012), engendering shared and distributed leadership (Hartley and Hinksman 2003; Avolio et al. 2009; Kitts 2013), and paying attention to human relations and emotional intelligence in management (Goleman 2000; Chemers 2001; Sellgren et al. 2006). Participants also stressed the need to win trust, elicit effort and galvanize followers around shared organizational goals. They used a moral vocabulary, or pace-setting leadership and strong visions to convey this point, charging that, even under challenging work conditions, they and their team members were ethically bound to alleviate suffering and attend to the health of the Gambian people.

Overall, this work places an important premium on the informants’ critical commentary of the health system and supports an increasingly repeated refrain (Goodwin 2000, 2010; Hartley and Hinksman 2003; Avolio 2007; Avolio et al. 2009) that research on leadership, ‘which has focused primarily on the leader–follower relationship, needs to change its focus from person–person to person–context’ (Goodwin 2000). The lessons learned from the current research have several important policy implications, particularly in view of the current focus on promoting people-centered health systems (Sheikh et al. 2014). We argue that the study of leadership aids in constructing a narrative of local agency—in the sense of being able to create change—and it relocates focus from thinking primarily about
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‘interventions’ and ‘innovations’ in health systems, towards that of people-centred health systems comprised of local actors and their sense of ownership, authority and power. In so doing, it offers an opportunity to add an extra dimension to the dominant paradigms in global health discourses. Moreover, by bridging academic disciplines, this work adds to the growing literature on dominant and marginal approaches to leadership research across different cultural and institutional settings. There is a need to further research and develop healthcare leadership across all levels, within various political, socio economic and cultural contexts, in order to better work with a range of health actors and to engage them in identifying and acting upon opportunities for strengthening health systems and improving health outcomes.