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

Simukai Chigudu,[1,2] Momodou Jasseh,[3] Umberto d'Alessandro,[3,4] Tumani Corrah,[3] Adama Demba[5] and Julie Balen[1,6,*]

[1]Centre for Health Policy, Institute of Global Health Innovation, Imperial College London, London, UK, [2]African Studies Centre, University of Oxford, Oxford, UK, [3]Disease Control and Elimination, Medical Research Council The Gambia Unit, Serrekunda, The Gambia, [4]Institute of Tropical Medicine, Antwerp, Belgium, [5]Ministry of Health and Social Welfare, The Gambia and [6]School of Health and Related Research, The University of Sheffield, Sheffield, UK

*Corresponding author. School of Health and Related Research, The University of Sheffield, Sheffield, UK. E-mail: j.balen@sheffield.ac.uk

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Recently, 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 includes the assertion that important decisions determining health system performance, including agenda setting, policy formulation and policy implementation, are made by people. Within this actor-oriented approach, good leadership has been identified as a key contributing factor in health systems strengthening. However, leadership remains ill-defined and under-researched, especially in resource-limited settings, and understanding the links between leadership and health outcomes remains a challenge. We explore the concept and practice of healthcare leadership at sub-national level in a low-income country setting, using a people-centric research methodology. 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 centre. We found reference to several important aspects of, and approaches to, leadership, including (i) setting a clear vision; (ii) engendering shared leadership; and (iii) paying attention to human relations in management. Participants described attending to constituencies in government, international development agencies and civil society, as well as to the populations they serve. By illuminating the multi-polar networks within which these leaders are embedded, and through which they operate, we provide insight into the complex 'organizational ecology' of the Gambian health system. 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 health systems strengthening.

Keywords Context, health systems, leadership, people, The Gambia

KEY MESSAGES

- 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.

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- The study of leadership in health systems of low- and middle-income countries aids in constructing a narrative of local agency and advances a perspective from which public health challenges, organizational weaknesses and global–national–local power configurations can be viewed as complex, dynamic and interacting entities.
- This study has identified a fundamental lack in institutionalized leadership training in the health system, which is in urgent need to be addressed to build the human resource capacity of the system, to engender a culture of shared leadership across all professional ranks, and to prepare future generations of leaders with the competence to manage the technical, managerial and political challenges that the health system presents.
- There is a need to research and develop healthcare leadership across all levels, within specific political, socio-economic and cultural contexts, in order to better work with a range of health system actors and to engage them in identifying and acting on opportunities for health systems strengthening.

Introduction

The post-millennial era ushered in an unprecedented level of attention to the role of health systems in improving global health (Sheikh *et al*. 2011). Frequently conceptualized as complex adaptive systems (Holland 1992; Plsek 2001; Plsek and Greenhalgh 2001; Lansing 2003; Zimmerman and Dooley 2003; Tan *et al*. 2005; Lindstrom 2013), health systems encompass many constituent elements that exist in various interrelationships but function, as holistic entities, toward a common purpose. More recently, the global health community has become attuned to the behavioural and relational aspects of the actors embedded within 'people-centred' health systems (Porter and Venkatapuram 2012; Sheikh *et al*. 2014). Porter and Venkatapuram (2012), for example, propose that the 'health' in health systems emerges through the actions and inter-actions of all individuals within them. It is along these lines that the World Health Organization has emphasized leadership and governance—beyond formal legislation and prescribed policies—as pre-eminent factors that drive progressive change in health systems (WHO 2007; Gostin and Mok 2009; Lussier and Achua 2010; Subhi and Duke 2011). Notably however, while efforts to clarify the role of governance in health systems have increased in recent years (Brinkerhoff 2004; Siddiqi *et al*. 2009; Smith *et al*. 2012), the role of leadership in this context remains considerably more contested and ambiguous (Goodwin 2000). In sub-Saharan Africa, the region that most urgently needs to bolster its health systems capacity, there is a conspicuous lack of systematic academic inquiry into leadership in the continent's diverse health systems and the notion of healthcare leadership remains ill defined and poorly understood (Eckert and Rweyongoza 2010). As such, this study set out to make an initial contribution to the nascent work on leadership in health policy and systems research (HPSR) through a case study in The Gambia, West Africa.

As a point of departure, we begin by outlining our key assumptions about a scholarly approach to leadership and how these have been deployed in the current research. First, we submit that in the study of leadership, it is important to delineate the differences between the person, the position and the collective process (Goodwin 2000; Hartley and Hinksman 2003). Research on the 'person as leader' includes a vast body of literature on the abilities, personality and behaviours of individual leaders, stemming principally from organizational and business research in high-income settings (Kotter 1990; Goleman 1998; Chemers 2001; Yukl 2006; Goffee and Jones 2006; Bennis and Nanus 2007). While yielding valuable insights, this approach does not sufficiently account for the often complex, inter-related roles of 'followers', organizational factors and the external environment, and their impact on leaders and leadership. The second approach views leadership as a designated 'leading position' of authority and responsibility within organizations. Similarly, while this is informative, it is not wholly encompassing, since formal positions may confer authority but fail to translate into effective or meaningful acts of leadership. Moreover, leadership may be actualized through informal channels of influence rather than direct control (Heifetz 1998). The third perspective frames 'leadership as a process'—a set of dynamic activities and interactions occurring among, and between, individuals, groups and organizations (Hartley and Hinksman 2003). In this paradigm, leadership, and the manner in which it is practised, emerges through the local interactions of the constituent elements of the system, which reshape and renew the system as a whole (Hartley and Hinksman 2003), rather than being simply a set of traits and abilities that inhere within one individual.

This exploratory study draws upon elements of the latter two approaches to the study of leadership outlined above. In terms of 'leading positions', we focus our scope of interrogation on the social imaginaries and praxis of individuals in formal executive positions at sub-national level in The Gambian health system. As such, the study rests on heuristic and normative typologies of individual leadership styles based on the work of Goleman (2000), which is arguably the most widely cited, influential and intuitive on the academic study of leadership in this regard (Thinkers50 2011). Goleman characterizes six unique, but not mutually exclusive, leadership styles, namely: (i) coercive; (ii) authoritative; (iii) affiliative; (iv) democratic; (v) pace-setting; and (vi) coaching (Goleman 2000) (Table 1). However, as stand-alone observations, individual leadership styles will tell us little about how to improve healthcare leadership and health systems without more thorough-going contextualization. As Goodwin (2000) has argued, leadership in complex organizations is best understood as a close dialectic between 'person' and context'. As such, we couch the styles proffered by our study informants within their experiences of leadership in the specific context of The Gambian health system and thus we place heavy emphasis on leadership as a contingent and negotiated process. Having given a brief indication of our assumptions about studying leadership, we now introduce the setting of the research project.

The Gambia is the smallest country on mainland Africa. A predominantly agrarian economy, the gross domestic product

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Table 1 Summary of the six leadership styles

	Coercive	Authoritative	Affiliative	Democratic	Pace-setting	Coaching
Modus operandi	Demands immediate compliance	Mobilizes people toward a vision	Creates harmony; Builds emotional bonds	Forges consensus through participation	Sets high standards for performance	Develops people for the future
Underlying emotional intelligence components	Drive to achieve; Initiative; Self-control	Self-confidence; Empathy; Change catalysts	Empathy; Builds relationships	Collaborates; Team leadership; Consults	Conscientious; Drive to achieve; Initiative	Develops others; Empathy; Self-aware
The style in a phrase	'Do what I tell you'	'Come with me'	'People come first'	'What do you think?'	'Do as I do, now'	'Try this'

Adapted from Goleman (2000).

(GDP) per capita in 2012 was $579 (UNdata 2012). Total expenditure on health was 5.7% of GDP in 2010 (World Bank 2012). According to the Multidimensional Poverty Index, 60.4% of The Gambian population suffers multiple deprivations (in education, health and standard of living) while an additional 17.6% are vulnerable to multiple deprivations (UNDP 2012). In terms of human and social development, The Gambia's Human Development Index (HDI) value was cited as 0.448 – in the low human development category – positioning the country at 165 out of 186 countries and territories in 2012 (UNDP 2012). The HDI of sub-Saharan Africa as a region increased from 0.366 in 1980 to 0.475 in 2012, placing The Gambia below the regional average (UNDP 2012). Despite this, the health status of Gambian citizens has improved significantly over the past decades and, according to the latest Millennium Development Goals (MDG) Report Card, The Gambia is among the top four African countries having accomplished progress vis-à-vis the MDGs (Steer & Geddes 2010). However, many pressing public health issues persist in the population (Palmer *et al*. 2009). Limited capacity in human and technical resources is a major systemic constraint in the Gambian health sector (Toure *et al*. 2009). Moreover, the stewardship of the health system, the strategies used to bolster its capacity and the public health policies and programmes are determined as much by population needs as by political interests and economic constraints (Palmer *et al*. 2009). Very little published work from The Gambia, and indeed across West Africa, is available in the field of HPSR, although its importance is evident and rising.

Research on leadership in health systems in low-income countries is, as such, both timely and relevant to the global public health agenda and to the expanding academic fields of leadership studies and HPSR. Here, we explore the concept and practice of healthcare leadership in The Gambia in order to form a contextual understanding of the definition and concept of leadership and to determine the predominant leadership styles in praxis.

Methodology

Ethics statement

Ethical clearance for this study was obtained from Imperial College Research Ethics Committee and from The Gambian Government/Medical Research Council (MRC) Unit, The Gambia, Joint Ethics Committee, headed by the Director of Health Services in the Ministry of Health and Social Welfare (MoHSW). The aims and objectives of the study were explained to each participant and written informed consent was obtained before beginning each interview. All personal identifiers of the study notes and tapes were kept confidential and destroyed once the study was completed.

Study area and sampling population

A total of 15 key informant interviews were conducted across urban, peri-urban and rural settings of The Gambia in June and July 2013, representing the full complement of senior executives in the sub-national 'horizontal' health programmes of the Directorate of Health Services (DoHS) (Figure 1). These include the four major tertiary-level government hospitals and the

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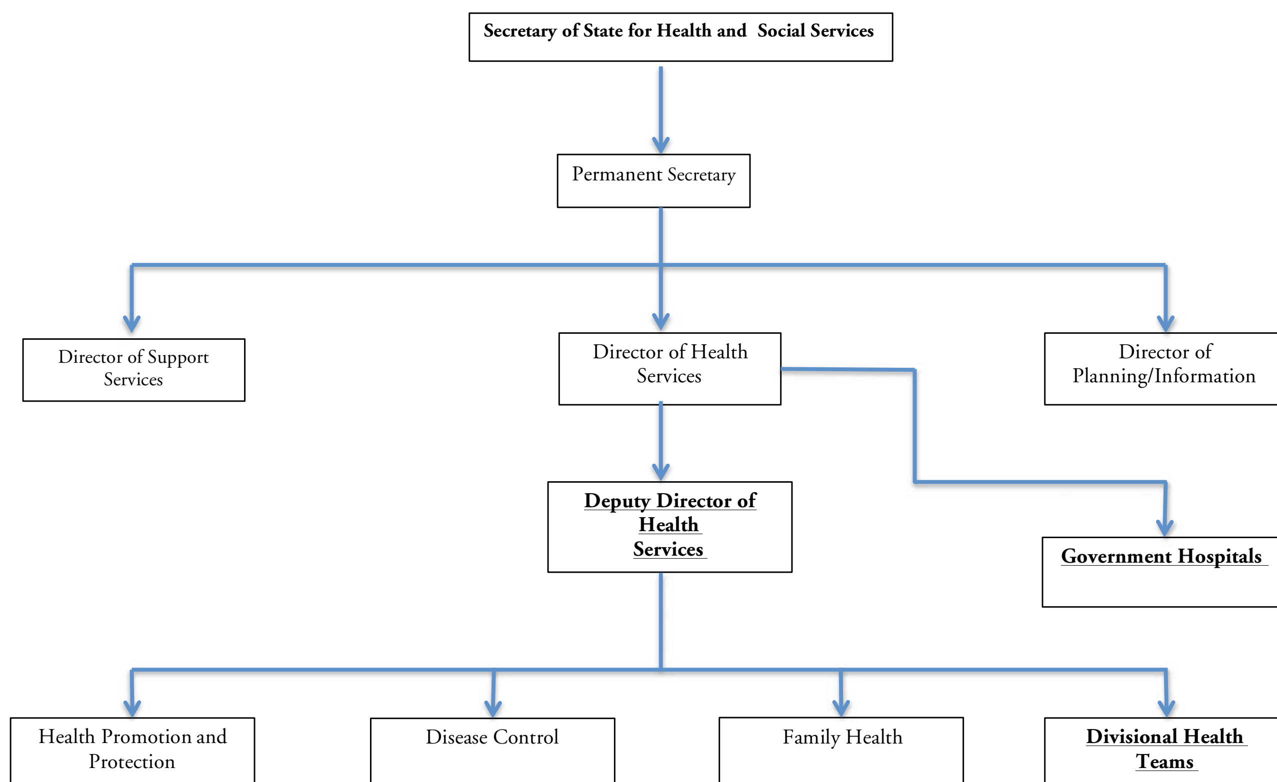

Figure 1 Simplified institutional architecture of The Gambian health system, highlighting 'horizontal' health programmes focussed on in this study (red).

Figure 2 Map of The Gambia, highlighting administrative regions including Western Region (WR, subdivided into WR1 and WR2), North Bank West (NBW), North Bank East (NBE), Western Region (WR), Lower River Region (LRR), Central River Region (CRR) and Upper River Region (URR) and four tertiary hospitals.

seven Regional Health Teams (RHTs), the latter of which are organized administratively by geographic region (Figure 2). The study focused specifically on the 'horizontal' programmes as these form the primary strategic sites of health policy implementation in The Gambian health system.

The selection of study participants was purposeful: each individual invited to participate had direct experience of the phenomenon in question and was thus well placed to offer insights specific to the research question (Patton 2002). We sought to formally interview each Director of the RHTs, the Chief Executive Officers (CEOs) of each of the government hospitals, a current or former member of the DoHS, and the clinical officer-in-charge in a secondary-level major health centre in a region without a government hospital. Primary-level community health leaders were not included as their sphere of influence is confined mostly to the micro-level, and also for practical reason relating to the short time-span available for fieldwork. All individuals invited to interview agreed to participate in the study. Interviews took place in a range of settings depending on the location of the participant, including private offices and meeting rooms, and domestic residences.

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Table 2 Thematic outline of interview guide

Construct	Questions based around
Leadership structures	Roles and responsibilities; Everyday acts of leadership
Health system performance	Organizational values and ideas; Institutional challenges; Future planning
Leadership relationships	Goals and aspirations in current position; Change management; Setting a vision
Leadership operations	Conflict resolution; Problem-solving; Individual and organizational learning
Personal leadership	Reflections on meaning of leadership; Self-assessment; Preferred leadership styles

This work is situated within a long-term, on-going research collaboration between Imperial College London, The University of Sheffield, the MRC Gambia and the Directorate of Health Services in The Gambian Government and as such, the research team has a strong familiarity with The Gambian health system as well as pre-existing partnerships with many of the interview participants.

In-depth interviews

Interviews were conducted in English, in-person and on a one-to-one basis with each participant, lasting between 45 and 90 min each. With the consent of participants, interviews were recorded using an audio device and were then professionally transcribed by an off-site international transcription company (Way With Words Ltd., UK) and reviewed by members of the research team to verify accuracy. Notes were not taken during the interviews, but a detailed reflective field diary was kept and updated within an hour of each interview.

Interviews were semi-structured according to an interview guide developed by the research team following an extensive and critical review of the academic literature on leadership (Table 2). The guide adapted and elaborated several questions from a study by Curry *et al*. (2012), that explores experiences of healthcare leadership in sub-Saharan Africa (Curry *et al*. 2012), and drew on recommendations put forward by Klenke (2008) in her book, *Qualitative Research in the Study of Leadership*. The guide aimed to draw out a contextually specific discussion about being a leader in The Gambian health system and to elicit more general ideas about leadership, which we then compared with our a priori understanding of the characteristics of successful leaders and leadership. For example, all interview participants were asked to describe their own leadership styles without being directed to specific typologies. The interviewer then matched the descriptions offered to a distinct leadership style using Goleman's classification. For quality control, this was corroborated by another senior member of the research team. The interview guide was pre-tested and validated by interviewing staff at the MRC Clinical Services Department, in order to optimize quality and rigour.

Data analysis

We began the analysis with self-immersion in the raw data by listening to the audio recordings of the interviews, reading and re-reading the transcripts, and studying the records and reflections in the field diary. This initial process was guided by principles of grounded theory (Glaser and Strauss 1967). The data were analysed iteratively throughout the study using the constant comparison method, whereby verbatim quotes from the interview transcripts were catalogued into essential concepts (or codes) that were then compared with each new transcript, or section of text, to determine whether the same code is apparent (Klenke 2008; Curry *et al.* 2012). The qualitative data analysis software programme, NVivo (QSR International Pty Ltd. Version 10, 2012), was used to facilitate data organization and retrieval. By examining the findings from the data with a priori issues from the extant literature on leadership and questions derived from the study objectives, we were then able to create a detailed thematic index of the data (Pope *et al.* 2000). The process of mapping and interpretation of results was influenced both by our research objectives and by the emergent themes in the data. Exemplary quotations from the data were selected to illustrate all key themes.

Results

Participant characteristics

Participants ($n = 15$) all held sub-national leadership roles within the government health system and collectively they covered all of The Gambia's administrative regions. All participants were male Gambian nationals. The majority of participants had been in their present position for between 2 and 5 years, though one had been appointed in the 3 months prior to the interview. Several participants had been working in The Gambian health sector for nearly 30 years (Table 3).

Predominant leadership styles and ideas

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. Presented here are the *predominant* styles based on discursive frequency and the subjective value given to each style by the participants.

Democratic

The democratic style of leadership was reflected across almost all the interviews and was the most frequently put forward as the normative standard for healthcare leadership.

> *Participant 12: ''I also conduct meetings because I understand, or I believe, if you want to effectively manage staff you need to encourage meetings. Frequently call your staff and have a discussion, basically they will show you ways how to manage a facility. So I capitalise on what they say because I may not know exactly what is happening or may not know all, but sometimes their ideas are very good, I take them.''*

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Table 3 Key characteristics of informants interviewed in this study

Characteristic	Total ($n = 15$)
Occupational role	
Directorate of Health Services	1
District Health Team Director	9
Hospital Chief Executive Officer	4
Major Health Centre Officer in Charge	1
Gender	
Male	15
Professional background/training	
Doctor	2
Nurse/midwife	10
Public health officer	2
Other	1

Participant 13: ''I think I would describe myself as democratic because I don't want to be authoritative. I never want to take just a unilateral decision, taking decisions on my own. I have the qualities to listen to people. Not to accept anything anyway but I have to listen to people before I make my final decision.''

Pace-setting (or moral-charismatic)

Several respondents framed their leadership as a moral drive to achieve change, often in 'impossible' circumstances, and made appeals to their personal charisma or to religious calling as an aspirational standard for their followers.

Participant 12: ''Myself I use the religious aspect, whatever we do to help others no one can pay you, and the payment will come after death. This is how mainly I encourage people to strive. Because we believe whatever we do money cannot pay for, whatever money we get we think of life after death, so this thought is pushing many people.''

Authoritative

Authoritative leadership styles were most manifest as setting a vision for the organization, steering the team through change and challenges and instilling a sense of discipline and institutional pride among the staff. The leaders stressed the need to have context-sensitive visions that are aligned with their constituencies' real needs and which promote active civic engagement and teamwork to achieve collective goals. Participants generally avoided specific use of the term 'authoritative' noting its negative, 'autocratic' connotations.

Participant 13: ''As a leader what is important is the mission and the vision of your institution. You have to guide the team to that mission and vision.''

Participant 15: ''So it is context specific, I should think, that a leader must always have a particular vision and wants that vision to be embraced by those around them so that we get to that goal.''

Career progression and leadership development

The vast majority of participants started their careers in nursing and midwifery ($n = 10$) before taking public health roles and progressing through the organizational ranks over time. Among the remaining five, two were doctors, two were public health officers and one was an administrator by background. Opportunities for formal leadership development in The Gambian health system are limited and many of the participants had gained qualifications abroad in areas such as International Health, Public Health and Management of Health Services. While these sabbatical periods offered some element of leadership development, they were not geared towards iterative development and most participants explained that they learnt to be leaders experientially.

Participant 13: ''The only training I have is just what I read, I read about it, I haven't got a formal training. I don't have any formal training, I just have my professional training as a registered nurse.''

Participant 9: ''I don't think I have that formal training, just based on my personal experience and learning best practices from people and reading books.''

In this way, the dominant leadership styles presented above – democratic, pace-setting and authoritative—emerged 'organically' and are more contingent on the beliefs, experiences, personalities and circumstances of the leaders than on adherence to formal instruction on leadership. Indeed, there was actually a strong demand for such formal training to be instituted as part of continuing professional development across all cadres of staff. The leaders suggested that such training would bolster the collective capacity to influence a wider range of stakeholders, manage scarce resources, enhance teamwork and effectiveness and nurture a new generation of future leaders in the health system. What follows below are the contextual factors that played the greatest role in shaping the ideas and practice of leadership based on the participant narratives.

Complex organizational structure and multi-polar networks

A salient feature, consistent across all the interviews, is that sub-national health leaders operate in a multi-polar[1] 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.

The politics of decentralization

Participants described administrative decentralization as the major, and often the only, strength in the organizational design of the health system citing the geographic demarcation of responsibilities as an efficient means of service delivery and implementing public health programmes.

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Participant 8: ''Well, we are small, the country is small, and we don't have very difficult—as compared to other countries—an access to healthcare. We have structures, very good structures, which, if nurtured, [could become] one of the best health systems in the southern region.''

The hospital CEOs described having greater financial and administrative autonomy to lead their institutions than do their RHT counterparts. As such, they have greater freedom to put in place a diverse range of innovations to bolster the capacity and expand the reach of the hospitals. Examples include use of information and communication technology for hospital records, solar energy to supplement the limited electricity supply from the national grid, smallholder farms to provide hospital food and bilateral partnerships with overseas institutions for mutual staff training and clinical research.

Participant 11: ''we have a goat milk farm... You know, goat milk is the second best dairy in the world. We are breeding goats and we are milking them, and we are using this milk for malnourished children... Then we have a farm, a patient's farm to subsidise food for the patients.''

Participant 5: ''to start with this maternal improvement project is one of the strengths, we are doing very, very well, because since it started we have been able to have two cohorts of training staff of 20 who have been training for one month [in Taiwan].''

This narrative, however, was strongly outweighed by the view that administrative decentralization was not adequately supported by financial, political or resource-based decentralization more broadly. The implications for policy implementation and management of services by sub-national leaders were far-reaching. RHT directors, in particular, were compelled to spend much of their time lobbying national government for additional resources.

Participant 5: ''The other strategy we use to overcome some of these supplies is that any time we meet in forums or in meetings we express our concern, we also write, keep writing and making telephone calls. So that they [Government] realise that the problem is not only Ministry of Health but it's also down to Ministry of Finance... And for them [Government] to be able to send us adequate supplies on a monthly basis the money has to be paid adequately from Finance to Health.''

The overwhelming majority of the study participants noted that tight fiscal control over the healthcare budget at national level, coupled with a lack of political agency at regional levels were among the most important limitations in addressing public health challenges and in exercising local stewardship over their health regions.

Participant 13: ''Yes resources, exactly, and when you decentralise at this level of the region this, the director of the region should be able to appoint all staff for promotion and perhaps have financial influence on the activities that they are doing. I think those things are really important... But at this moment at the level of the region, we don't have that financial control over anything. Everything has to come direct from the Ministry of Health at a central level... We don't even have an account for the regional office so that means there are problems.''

Participant 4: ''But in the case of The Gambia, decentralised, so those structures are there, but the budget, we don't have our own budget to be free to do whatever you want or to improve services within your region. That's the big challenge... when you come to resources, budget, that one is centralised.''

The relationship between sub-national leaders and national government was further strained by perceived political interference and bureaucratic inertia at the central level. One participant derided national governmental action at regional level as lacking 'rationality' and responsible for 'confusion' through the issuance of ambiguous and ill-conceived policy directives. Political interference in the regional health system was most commonly noted with respect to irregular and unpredictable deployment and re-designation of sub-national level staff while excluding them from health policy-making within their jurisdictions. These problems were seen to diffuse through every level of the health system; thus, political directives and strict financial control were seen as a means of retaining power at the central level.

Participant 5: ''there is sometimes too much political influence and interference in our service provision... and it makes it very difficult for us.''

When discussing the politics and weaknesses of the national health system further, one-third of the participants emphasized the weak institutional memory, owing to high staff turnover, in the MoHSW as an especially salient factor limiting progress in the health system as a whole.

Participant 5: ''I felt that at the central level here there is no institutional memory simply because there is this frequent changing of senior management here. One minister comes, another one goes, one PS [Permanent Secretary] comes, another one goes, one director comes another one goes. And anyone who comes doesn't want to know why Mr X was removed from the position. And sometimes when they come in, I don't know what information they normally get, so when they come they do their own things.''

The limited scope for RHT directors to meet in a formal arena and take collective action for resource mobilization, joint learning, influencing policy or reporting concerns to national government was a widely cited systemic weakness. While all directors mentioned that such a forum used to exist and they acknowledged its political and educational value, there was much less consensus as to why the forum had become 'dormant'. The various factors that were identified as inhibitory to forming a coalition included time pressures, a shortage of resources and finances, and inter-regional or inter-hospital competition for recognition as the 'best' in the country. One participant speculated that these factors belie high-level political resistance to coalition building within the regions as these meetings might expose fundamental weaknesses in the health system to the general public, thereby undermining public confidence in the Government.

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Participant 14: ''They will, eh, to me personally, they [the Government] don't want us to meet. They can reactivate it here at central level but they will not, those are salient issues that are being discussed at that meeting, which are always pointing at them.''

Stakeholder pluralism

There are a multitude of actors and agencies, outside of the national health system, working at regional level in The Gambia. Sub-national leaders described the necessity of building strategic alliances with diverse stakeholders including programmatic arms of the MoHSW (for example, the National Malaria Programme), other RHT directors or hospital CEOs, different actors across the public sector and development assistance partners (DAPs), such as multilateral agencies, philanthropic institutions and non-governmental organizations. These alliances were seen as crucial to resource mobilization, garnering material support and expanding healthcare access and community outreach as well as compensating for capacity constraints within the RHTs.

Participant 9: ''I know as leader in this region on public health I am dealing with a lot of inter-sectoral collaboration.''

The interpenetration of research, particularly through the MRC, into the operations of the health system was also put forward as a major strength—one that is facilitated by leadership at the regional level:

Participant 3: ''...apart from the global topics or subjects the MRC is interested in, they're also interested in locally, local disease epidemiology and problems. So this is where we create a platform of engaging them and working very closely with them, and I've got very good examples of where MRC research findings have been translated into policies and strategies in this country. For example, the insecticide treated mosquito net, which I mentioned earlier, not only for The Gambia but also it informed global malaria prevention policy and strategy.''

Most of the regional health directors reported that community engagement and primary care represent a crucial strength in the health system. The leaders describe having oversight for the delivery of routine primary care and for supporting community health workers. They receive both material and ideological impetus for this work from global health initiatives and global policy declarations; for instance, a number of participants commented on the importance of the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria as well as the Alma Ata Declaration on Primary Care (1978) in driving their community work forward. As such, the leaders co-ordinate a range of community outreach programmes—in both health promotion and protection—for maternal and child health, major infectious diseases and training in health literacy.

Participant 9: ''And then the community participation in public health is increasing because for example we have a high rate of immunisation programmes. And then you cannot achieve this in the absence of public participation. These are some of the strengths.''

As noted, the presence of many external entities in the health sector allows sub-national leaders to access substantial material and technical support to their regions; however, the plurality of actors also presents challenges and threats to the leadership and authority of sub-national directors. Participants highlighted two principal problems arising from this dynamic: poor harmonization of a myriad of public health activities and programmes, and unequal power relationships between foreign actors and domestic leaders.

Participant 13: ''the problem is we need to organise all these programmes... these programmes need to sit with the regional offices and then when you prepare your activity plan or your strategic plan, you put into consideration these activities, so there are not things like conflicts when it comes to implementation of activities, this makes people lose focus. To ensure that things are well co-ordinated in that way.''

Participant 8: ''Well, anyhow you look at it, it's an association of un-equals, even though the Global Fund is saying that, for example, they support country programmes, but they are too prescriptive at times. They want to bring in a system of one-size fits all, but that's not useful. Different countries have different systems and challenges.''

A similar power dynamic between foreign actors and local interests was cited with respect to stewardship of medical research in the health system. As already noted, sub-national leaders often provide a platform for facilitating internationally funded research within The Gambia. However, one of the participants, with extensive experience collaborating with global research institutions over the last three decades, expressed concern that their research agenda does not always benefit the country's people. He thus asserts that there is a need for greater collaboration in setting research agendas to meet the interests of both parties.

Participant 3: ''there are concerns, what could be the contributing factors, you remember the old English saying, ''the one who pays the piper dictates the tune.'' So if you have money to do molecular something, surely you'll go that pathway. So this is where, now, countries should find ways and means of either contributing or influencing global research agendas. Those who fund the research must take cognisance of the realities at the ground level.''

Resource constraints

The most frequently and most consistently cited constraint, across all interviews, was a profound lack of human resources in the national health system. The vast majority of participants described a critical want in numbers of staff and skilled personnel needed to deliver health services. This shortage came to bear on decision-making and handling of social and professional workplace relationships by the participants and is thus pertinent to the practice of healthcare leadership.

Participant 5: ''Actually one of the biggest challenges that we are faced within the health service provision is inadequate human resources. That's a very big problem because as we speak now the health facilities are grossly inadequately supplied with staff... So

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that is one of the biggest problems that is affecting not only my region but the entire country. Staffing is a very big problem.''

Most participants reported that the above problem was compounded by the 'deplorable' living and working conditions—such as housing, salaries and the state of the health facilities—for healthcare workers, which were cardinal factors in discouraging individuals from entering the healthcare profession and in driving attrition of staff from the health system. These structural conditions have ramifications for staff motivation, quality of service delivery and livelihood poverty of healthcare workers. Crucially, while these challenges are spread throughout the country, the rural areas are disproportionately affected.

Participant 12: ''So housing is a very big challenge in [this] health centre, there is not even enough and most of them are not even in good condition. Remuneration, as I say, is not also very good.... So those are challenges that we are facing. And then people are trying to save and find a better place, have a better life. So this affects service delivery and the quality of service delivery, actually.''

Participant 3: ''And more challenging was really trying to get this critical limited mass [of health workers] out where their services are needed most, and that's in the rural areas. For various reasons, you know, distance from a family setting in the urban areas and some challenges at the family level, you know, schooling for the kids or housing. So both in terms of numbers and also in terms of the range of skills – skill mix required at that point in time.''

After discussing the human resource challenges, many of the participants proceeded to detail a lack of material and technical resources as the next major challenge in running their health facilities or regions.

Participant 5: 'The second concern is in the area of equipment, drugs, and medical supplies. A lot of equipment is no longer working in the health facilities... Things like oxygen concentrators are not working and so many other things.'

Discussion

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. The sub-national level is an important unit of analysis within many countries, due to fiscal and/or administrative decentralization of healthcare (Gilson and Mills 1995). Results highlighted several key aspects that are consistent with the empirical literature on 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; Best 2013), and paying attention to human relations and emotional intelligence in management (Goleman 2000; Chemers 2001; Sellgren *et al*. 2006). 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).

Leadership has traditionally been studied within a positivist knowledge paradigm (Klenke 2008). However, this 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 and political reality and is shaped by particular, culturally determined ways of framing problems and solutions (Sheikh *et al*. 2011). Many of our study participants 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. This observation places an important premium on the informants' critical commentary of the health system and supports an increasingly repeated refrain (Goodwin 2000; Goodwin 2010 Unpublished data; 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).

This work illustrates some of the ways in which public sector executives must be sensitive to their context, particularly in contending with 'ambiguous accountability [to] a multitude of constituencies' in their multi-polar networks (Walt *et al*. 1999; Goodwin 2000; Biesma *et al*. 2009). 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 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'. 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. This stated conviction seemed to be the unifying theme of much of the discussion, including how to manage ambiguous political relationships and balance the use of resources. The appeal of a moral framing of leadership is self-evident. However, deeper ethnographic study would be required to explore how these ideas manifest in practice and what impact they have on different cadres of healthcare staff.

In terms of leadership development, and a distinct lack thereof, a repeated demand for more formal training among all participants points to a systemic failing to develop staff professionally. While a scarcity of resources was popularly cited as the major barrier to implementing continuing-professional-development programmes, many of the participants

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believed that such training would ultimately augment the efficiency and effectiveness of the health system, thereby easing the pressure from material constraints. It is plausible that other, likely political, factors may be acting as barriers to institutionalizing leadership development, especially in the context of a central authority whose edicts and appointments have been inimical to staff continuity and the formation of institutional memory in the health system.

Indeed, one of the most salient finding from this study concerns the relationship between sub-national leaders and the national government. Participants described a complicated power tussle, which is most evident in the pervasive discussions about how the centralized budgetary control limits their managerial capacity and their decision-making capabilities. This contestation is further highlighted by the claims made by several participants that governmental officials at national level were interfering with programmatic and policy work at regional and local levels. The only explanation offered as to why this might be the case was that the national government was making its presence felt in rural areas potentially to canvass further political support. It was very challenging to elicit more specific details about why this may be the case—a question beyond the scope of this work. Nevertheless, this power dynamic highlights the tension between being 'authoritative' and being 'autocratic'. In the context of power tussles and the need to steer the organization forward, the leaders attempted to tread the fine line of presenting an authoritative vision for their followers while not reflecting the perceived autocratic tendencies of the national government.

The lack of financial autonomy accorded to sub-national leaders (especially the RHT directors), and their taut relationship with more senior officials, forced many participants to draw upon 'institutional entrepreneurship' skills—in this case, forging personal relationships with actors in international development organizations to leverage new resources and bring about organizational change (Maguire *et al*. 2004). At the same time, however, several participants expressed frustration at the complex organizational arrangements introduced by DAPs, as some international agencies would only work through the national government while others were prepared to engage with sub-national teams directly. In part, the prospect of forging strategic alliances was determined by individual personalities more than official mandates. Furthermore, one participant, when commenting on whose public health priorities are advanced furthest in his jurisdiction, noted that DAPs yield greater power to set health policies and determine programmes based on their financial and technical resources as well as their political backing from the international community.

This study was subject to several limitations. First, its limited scope, short time frame and exploratory design preclude generalization across other settings. The Gambia is, however, strongly suited to a study of this nature; given the size of the country and organization of its health system, we were able to identify and interview all individuals in formal, or designated, leadership positions of interest. As such, selection of the participants achieved strong representation in terms of geographic scope, adding to the validity of the results. All 15 informants were male however, and while this reflects the makeup of sub-national leadership at the time of the data collection, it limits the diversity of experiences and opinions expressed. Moreover, the gendered nature of the RHTs reflects the societal bias towards men in the professional classes both as frontline staff and in progressing through the organization.

Secondly, though this study demonstrates that 'leadership' is an analytically useful lens to examine how sub-national executives in The Gambian health system manage a complex set of interrelationships between different actors along a 'global–national–local' axis, the concept of leadership itself is highly protean and endowed with a range of normative ascriptions. To uncover the ways in which it manifests in social relations through an organization, therefore demands more substantive and long-term research engaging with leaders across all levels, from the front-line of service delivery to the top echelons of Government, as well as international partners involved in health and development. Methodologically, research strategies such as ethnography and quantitative modelling of health system performance against conceptually distinct 'leadership factors' would capture a much richer understanding of leadership.

Thirdly, qualitative research, by its nature, is subject to a number of biases and informants' reluctance to talk about sensitive issues. The depth and openness of the interviews helped to overcome both recall and social desirability bias. Nevertheless, interpretation of the study results must certainly be approached with caution given the sensitivity of some of the information that emerged in the interviews. While most of the participants offered frank accounts of their leadership experiences and views of the health system, they were much more circumspect when specific sensitive issues, events and practices were raised. Informal discussions with a range of individuals revealed that staff could easily be removed or transferred from their posts at short notice. This may elucidate the ambivalence of many of the participants towards officialdom expressed through contradictory statements such as describing their relationship with Government as 'cordial' and then decrying the political interference at regional level, the high staff turnover both centrally and peripherally, and the limited scope to hold Government to account for its policies and directives.

All interviews were conducted by one of the researchers who is professionally trained in the field of medicine, of black African descent, male and affiliated with both Imperial College London and the MRC. Being a qualified doctor seemed to confer a degree of 'credibility' in the eyes of the participants who appeared to view the interviews as a formal exchange between healthcare professionals with a mutual interest in health system performance. This was reflected in the positive responses given by many of the participants to the revelation that the interviewer was a doctor. Perhaps even more notable was the researcher's identity as a black African. Several respondents made affirmative statements of solidarity in this respect, while others expected that the interviewer would easily understand and empathize with their narratives; for example, after discussing several difficulties in the health system, a participant then added: 'you might know, by the way, you are an African'. In a patriarchal society and interviewing an entire male contingent of high-level professionals, being male also

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served as an advantage in terms of having 'buy-in' with the participants. Conversely, while these identity attributes may have facilitated free-flowing interviews, they may also have influenced social desirability bias (Sudman *et al*. 2010). To counter this possibility, the interviewer encouraged the participants to share personal experiences in detail and highlighting both positive and negative aspects of their experience; the candour of the interviews suggests that social desirability bias was minimal. Lastly, while the institutional affiliations of the interviewer assured the participants that the project was ethical and legitimate, we believed that they exerted only minimal influence on the content or conduct of the interviews. Overall, these aspects of the interviewer's positionality played a crucial role in the research process.

In summary, this study has provided an important, though preliminary, understanding of the dynamics of leadership at sub-national level in The Gambian health system. Overall, 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 'interventions' and 'innovations' in health systems strengthening, 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. We found that while there is a demand for healthcare leadership development, which will certainly improve the managerial, administrative and teamwork capacities of the health system at a micro-level, it is the specific political, economic and cultural dynamics of The Gambia that ultimately delimit how much sub-national leaders can contribute towards strengthening the health system and improving health outcomes. This work has contributed to a nascent research agenda in HPSR in The Gambia and we believe it serves well as a foundation for future research in this area.

Drawing upon insights from this work, we propose recommendations in three key areas:

- *Leadership and health system outcomes*—to harness the full potential of leadership in strengthening the health system, it is important to foster a politically enabling environment for sub-national healthcare leadership including greater financial and administrative decentralization as well as sub-national level control over issues of human resource management. Additionally, increasing consolidation, co-ordination and communication within and across the multi-polar network of stakeholders would help counter significant capacity constraints. As such we recommend re-instituting a formal and regular platform for joint working between RHT directors and hospital CEOs would facilitate shared learning, vertical and horizontal accountability, and advocacy for increased resource mobilization.
- *Understanding the definition and praxis of leadership*—this exploratory study has laid the groundwork for future inter-disciplinary research on leadership, which will be crucial in determining and clarifying the organizational demands and strategic directions necessary to strengthen the health system including how country ownership of healthcare can be further supported materially and ideologically.
- *Career progression and leadership development*—this study has identified a fundamental lack in institutionalized leadership development in The Gambian health system. This area must be urgently addressed to build the human resource capacity of the system, to engender a culture of shared leadership across all professional ranks, and to prepare future generations of leaders with the competence to manage the technical, managerial and political challenges that the health system presents. Moreover, issues of gender imbalance in the healthcare profession, especially in senior executive positions, need addressing.

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Endnote

[1] A pole is an actor, or group of actors, whose influence extends beyond its immediate sphere of action.

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