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A Critical Analysis of Leadership in the Zambian Health System: Identifying Gaps and Seizing Opportunities

By Michael Mulimansenga Chanda

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DECLARATION

I, **Chanda Michael Mulimansenga**, hereby declare that this thesis titled:

"A Critical Analysis of Leadership in the Zambian Health System: Identifying Gaps and Seizing Opportunities"

is my own original work, and that it has not been previously submitted for the award of a degree or diploma in this or any other university. Where the work of others has been used, it has been appropriately acknowledged and referenced in accordance with academic conventions.

This research was undertaken in partial fulfillment of the requirements for the award of the degree of **Doctor of Philosophy (PhD)** in **Health Policy,** at Selinus University of Science and Literature, under the supervision of **Professor Salvatore Fava**.

I further declare that the thesis has not been copied in part or whole from any other person's work, and all sources of information have been appropriately cited and included in the reference list.

Signed: 

Chanda Michael Mulimansenga

Date: 24/11/2024

ABSTRACT

Title: *A Critical Analysis of Leadership in the Zambian Health System – Identifying Gaps and Seizing Opportunities*

Leadership plays a pivotal role in shaping the performance, resilience, and equity of health systems. This study critically examines how leadership is conceptualized, exercised, and influenced within the Zambian health system, identifying key gaps and documenting best practices that offer opportunities for reform. Employing a qualitative case study design rooted in the interpretivist paradigm, the research involved in-depth interviews with 40 stakeholders across national, provincial, district, and facility levels, supplemented by a review of relevant policy and strategy documents.

Findings under Objective One revealed that leadership is predominantly understood in hierarchical, title-based terms, with limited application of transformational or distributed leadership models. Objective Two exposed persistent bottlenecks including centralized decision-making, limited capacity at subnational levels, weak accountability mechanisms, and gender inequities. Objective Three highlighted the significant influence of political appointments, institutional ambiguity, and socio-cultural norms such as deference to authority and patriarchal values on leadership effectiveness. Objective Four documented promising leadership practices including the Leadership Development Program (LDP), community engagement through Neighborhood Health Committees (NHCs), and data-informed decision-making through donor-supported systems like the Electronic Supply Chain Management Systems (eSCMIS) Project.

The study concludes that while Zambia's health leadership framework is constrained by structural and contextual challenges, scalable models of effective, inclusive, and adaptive leadership already exist within the system. The thesis recommends the institutionalization of leadership development frameworks, decentralization of decision space, gender-responsive policies, and greater alignment between formal and informal leadership structures to strengthen governance and health outcomes.

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Lastly, to all who offered prayers, counsel, or quiet solidarity - non mihi soli. May this dissertation contribute meaningfully to the elevation of health leadership in Zambia, and by extension, to the flourishing of our shared humanity. I dedicate this work to my beloved family, anchor of my soul and beacon of my labor. In virtute et veritate.

List of Acronyms

Acronym	Full Meaning
CHAZ	Churches Health Association of Zambia
DHIS2	District Health Information Software, Version 2
DHMT	District Health Management Team
eSCMIS	Electronic Supply Chain Management Information System
LDP	Leadership Development Program
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health (Zambia)
MSH	Management Sciences for Health
NHC	Neighborhood Health Committee
NHRA	National Health Research Authority
NGO	Non-Governmental Organization
PBF	Performance-Based Financing
SDGs	Sustainable Development Goals
SWAp	Sector-Wide Approach
UNZABREC	University of Zambia Biomedical Research Ethics Committee
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization
ZNPHI	Zambia National Public Health Institute
ZIPAR	Zambia Institute for Policy Analysis and Research

CHAPTER ONE

1.0 Introduction and Background

Leadership is a central determinant of health system performance, influencing governance, service delivery, human resource management, financing, and stakeholder engagement (WHO, 2007). In the context of low and middle-income countries (LMICs), effective leadership is essential to navigate systemic constraints and drive reform agendas. Zambia, like many Sub-Saharan African nations, has made considerable strides in expanding access to health services, particularly through donor-funded programs and national reforms such as the National Health Strategic Plans and the Vision 2030 Agenda. However, persistent gaps in leadership capacity, fragmented coordination, weak accountability systems, and limited succession planning continue to hamper the effectiveness and sustainability of the health system (Mutale et al., 2013; MOH, 2022).

This research critically examines the structure, practice, and influence of leadership within Zambia's health system, focusing on key dimensions such as political, strategic, and operational leadership at national, provincial, and district levels. It interrogates the interplay between formal and informal leadership dynamics and evaluates their impact on health system resilience, responsiveness, and reform. By identifying prevailing gaps and emerging opportunities, this study seeks to contribute to a transformative leadership model that is contextually relevant and sustainably grounded in Zambia's health governance architecture. Before proceeding with the research. It is prudent to spend some time to establish how the Zambian Health System is structured and how it functions.

1.1 An Overview of the Zambian Health System: Structure, Stakeholders, and Governance

Zambia's health system is a dynamic and evolving structure composed of both public and private sector components, regulated and coordinated under a decentralized framework. The system is guided by a mix of national policies, strategic frameworks, and international commitments aimed at achieving universal health coverage (UHC), equitable access to quality care, and sustainable health sector financing (Ministry of Health, 2017). This essay

provides an overview of the Zambian health system, focusing on its public and private sector roles, the hierarchical governance structure, and the critical challenges and opportunities it faces.

1.1.1 The Public Health Sector: Structure and Governance

The public health system in Zambia is steered by the Ministry of Health (MoH), which functions as the principal policy-making, coordinating, and regulatory authority. The Ministry is responsible for strategic planning, budget allocation, resource mobilization, health policy development, and monitoring and evaluation (MoH, 2017). It also ensures compliance with national health standards and coordinates with other ministries, development partners, and the private sector.

The structure of the public health system mirrors the administrative and political divisions of the country, cascading from the national to community levels. At the national level, the MoH operates through its headquarters and tertiary institutions such as the University Teaching Hospital (UTH) in Lusaka and other teaching hospitals in Ndola and Kitwe. These institutions offer specialized and referral services, while also serving as training and research centers.

At the provincial level, Provincial Health Offices (PHOs) act as intermediaries between the national and district levels. They are responsible for the coordination and supervision of all health services within their jurisdictions, including provincial hospitals that provide secondary referral care.

The district level is managed by District Health Offices (DHOs), which implement health programs and oversee health facilities, including district hospitals, health centres, and health posts. These entities deliver primary health care (PHC) services, manage community health workers, and ensure the functionality of health programs in line with local health needs.

At the community level, Zambia relies on a network of health posts and rural health centers, supported by Community Health Assistants (CHAs) and trained community volunteers. These frontline workers play a crucial role in health promotion, disease prevention, and linking communities with the formal health system (WHO, 2021).

1.1.2 The Private Health Sector: Complementing Public Services

The private health sector in Zambia is diverse and comprises private for-profit, private not-for-profit, and faith-based organizations (FBOs). It plays an increasingly vital role in service delivery, particularly in urban areas and among populations seeking specialized or quicker care.

Private for-profit providers include private clinics, hospitals, pharmacies, laboratories, and health insurance companies. These are primarily concentrated in urban centers such as Lusaka, Ndola, and Kitwe, where paying clientele and private insurance markets are more developed. Services are typically accessed through out-of-pocket payments or private health insurance schemes.

On the other hand, private not-for-profit providers, especially those under the Churches Health Association of Zambia (CHAZ), operate across both urban and rural settings. CHAZ and its affiliated faith-based health institutions contribute significantly to Zambia's health sector, reportedly delivering 40 to 50 percent of rural health services (CHAZ, 2019). These institutions are often supported by donor agencies and development partners and are well integrated into the public health system, receiving government support in the form of staff salaries and essential drugs.

Despite its importance, the private health sector faces challenges such as weak regulation, fragmented data reporting, and limited integration with public health planning. However, there is increasing recognition of the potential of Public-Private Partnerships (PPPs) in expanding access, improving quality, and strengthening health system resilience.

1.1.3 Regulatory and Oversight Mechanisms

To ensure accountability and quality assurance in the delivery of health services, Zambia has established various regulatory bodies. The Health Professions Council of Zambia (HPCZ) regulates the practice of health professionals, while the General Nursing Council (GNC) oversees the nursing and midwifery professions. The Zambia Medicines Regulatory Authority (ZAMRA) ensures the safety, efficacy, and quality of medicines and medical supplies. Additionally, the National Health Insurance Management Authority (NHIMA) manages the implementation of Zambia's national health insurance scheme aimed at promoting equitable access and financial protection (NHIMA, 2021).

Local government structures also play a role, particularly in urban public health services, environmental health, and health promotion campaigns, reflecting a multi-sectoral approach to health governance.

1.1.4 Health System Financing

Zambia's health system is financed through multiple sources, including the national budget, donor contributions, out-of-pocket payments, and health insurance. While the government continues to increase allocations to the health sector, a substantial portion of funding especially for vertical programs such as HIV/AIDS, tuberculosis, and malaria comes from external partners like USAID, the Global Fund, and the World Bank. The establishment of NHIMA in 2018 marked a shift toward more sustainable domestic financing for health services. Through mandatory contributions from employers and employees, NHIMA seeks to expand health coverage and reduce catastrophic health expenditures. However, implementation challenges, particularly in enrolling informal sector workers and rural populations, remain (World Bank, 2020).

1.1.5 Decentralization and Community Participation

Zambia's commitment to decentralization is central to its health system reform. By devolving decision-making and resource allocation to provincial and district levels, the country aims to make health services more responsive, equitable, and accountable. This

has enhanced the role of District Health Management Teams (DHMTs) in planning, budgeting, and managing service delivery.

Community participation is institutionalized through Neighborhood Health Committees (NHCs) and Ward Development Committees (WDCs), which act as critical links between health providers and the communities they serve. These platforms provide feedback, support health promotion, and mobilize local resources (Ministry of Health, 2017).

1.1.6 Changes in the Zambian Health Systems leadership

Zambia's health system has undergone substantial policy and structural transformations since independence. Initially characterized by centralized and vertical disease control programs, the system shifted towards decentralization and primary health care (PHC) approaches in the 1990s (MOH, 2011). Reforms such as the creation of District Health Management Teams and the implementation of the Health Sector Strategic Plans emphasized the need for local leadership, community involvement, and intersectoral collaboration. Nonetheless, the effectiveness of these reforms has been uneven, largely due to varying leadership capacities, inconsistent supervision, and poor policy implementation (Chitah et al., 2018).

As has been shown, leadership in the Zambian health system operates at multiple levels from national policymakers to facility in-charges and spans both the public and private sectors. Despite this multi-layered framework, there remains limited empirical exploration into how leadership practices influence policy translation, resource allocation, human resource motivation, and health outcomes (Makasa, 2020). Moreover, many leadership positions are filled through technical merit, often neglecting competencies in strategic thinking, adaptive management, and transformational change (Foster et al., 2018).

Global evidence underscores that health systems with robust, visionary, and accountable leadership are more likely to achieve Universal Health Coverage (UHC), health equity, and resilience during public health emergencies (Kruk et al., 2015). Zambia's experience during the COVID-19 pandemic highlighted both the strengths and vulnerabilities of its

leadership ecosystem. While rapid mobilization and policy responses were commendable, challenges such as inconsistent communication, political interference, and inadequate stakeholder coordination revealed underlying systemic weaknesses (Siamwiza et al., 2021).

Over the past two decades, the country has made notable progress in improving health indicators, including reductions in child mortality and improvements in HIV/AIDS control (MoH, 2022). However, persistent challenges such as workforce shortages, inadequate financing, and poor coordination continue to hinder progress.

A less studied but increasingly important dimension of these challenges is the role of leadership both at policy and operational levels. Leadership failures have been implicated in misaligned priorities, lack of accountability, politicization of appointments, and poor crisis preparedness (Dovlo, 2005; Ncube et al., 2021). There is a pressing need to assess current leadership paradigms, document contextual best practices, and propose a transformative leadership framework tailored to Zambia's health challenges and socio-political realities.

1.1.7 Conclusion

The Zambian health system is a complex but well-structured architecture comprising public and private actors, decentralized governance, and a blend of traditional and innovative health financing mechanisms. While the system continues to confront systemic and operational challenges, there are notable strides toward universal health coverage and sustainable development goals. Strengthening governance, financing, and public-private collaboration will be pivotal in ensuring equitable, quality health care for all Zambians.

1.2 Problem Statement

Despite decades of reform and investment, Zambia's health system continues to grapple with inefficiencies, inequities, and weak service delivery outcomes. These systemic challenges are compounded by deficiencies in leadership and governance across all levels of the health sector (MOH, 2017; WHO, 2021). The country has made strides in developing health infrastructure and expanding access to essential services, yet the quality, coordination, and resilience of the health system remain inadequate often due to ineffective leadership practices (Chatora & Tumusiime, 2004; Mbau et al., 2021).

Leadership within Zambia's health system is predominantly bureaucratic and hierarchical, with insufficient adaptability to respond to dynamic challenges such as disease outbreaks, donor funding volatility, and workforce shortages (Fayehun et al., 2020; Mutale et al., 2017). At both national and subnational levels, leadership roles are frequently politicized or influenced by central government dynamics, often limiting autonomy, innovation, and responsiveness in health service delivery (McCoy et al., 2011; Maseko et al., 2019).

The absence of a well-defined leadership development framework has left many health managers ill-prepared to lead complex systems. Leadership training initiatives, where they exist, are often ad hoc, donor-driven, and poorly institutionalized (MOH, 2022). Moreover, Zambia lacks systematic evaluation of leadership competencies, decision-making effectiveness, and the impact of leadership on health outcomes (Topp et al., 2018).

Globally, effective leadership is increasingly recognized as a cornerstone of health systems strengthening and a prerequisite for achieving universal health coverage (WHO, 2007; Gilson & Agyepong, 2018). In Zambia, however, leadership has not been strategically leveraged as a catalyst for transformation. Without a critical appraisal of the leadership structures, cultures, and practices that underpin the health system, opportunities for reform, resilience, and sustained performance improvement will remain missed.

This study is therefore essential to critically analyze the gaps in leadership within Zambia's health system and to identify practical, context-appropriate opportunities for reform. The

findings are expected to inform policy, strengthen governance, and build a leadership architecture that is capable of driving meaningful change and improved health outcomes.

1.3 Research Objectives

1.3.1 Broad Objective

The overall aim of this study was to critically examine the state of leadership in the Zambian health system with a view to identifying key gaps and exploring strategic opportunities for enhancing leadership effectiveness at all levels.

1.3.2 Specific Objectives

The research was anchored in the following specific objectives:

1. Assess how leadership is conceptualized and exercised within Zambia's national and sub-national health governance structures.
2. Identify key leadership gaps and bottlenecks affecting the implementation of health policies, strategies, and service delivery.
3. Explore the political, institutional, and socio-cultural factors influencing leadership effectiveness within the health sector.
4. Document best practices and successful leadership models that contributed to improved health systems performance in selected case examples.
5. Generate practical recommendations for strengthening leadership capacity and governance in the Zambian health system.

1.4 Research Questions

The study was guided by the following research questions:

1. How is leadership understood and operationalized across different levels of Zambia's health system?
2. What are the main leadership-related challenges hindering effective health service delivery and policy implementation?
3. In what ways does institutional culture, politics, and resource constraints shape leadership behaviors and decisions?
4. What leadership practices or models demonstrate positive impacts on health systems performance in Zambia?
5. What strategies can be adopted to enhance leadership development, accountability, and succession planning in the health sector?

1.5 Significance of the Study

The significance of this doctoral research is anchored in its contribution to the advancement of scholarly understanding, policy refinement, and strategic transformation of health leadership and governance in Zambia. Situated within the broader discourse on health systems strengthening in low- and middle-income countries (LMICs), this study presents a critical analysis of the architecture, operational dynamics, and leadership configurations that shape the functionality of the Zambian health system.

From a scholarly perspective, the study fills a conspicuous gap in empirical literature on health systems leadership and governance in sub-Saharan Africa, particularly within decentralized and mixed health systems such as Zambia's. While extant studies often explore health outcomes, financing, and service delivery, few have interrogated the structural and relational dimensions of leadership both formal and informal that influence health sector performance (Travis et al., 2004; Brinkerhoff & Bossert, 2008). By adopting

a multi-level, systems-thinking approach, this research contributes to theoretical enrichment and methodological innovation in the study of health systems leadership.

This study also holds high policy relevance in light of Zambia's evolving health sector reforms, including the operationalization of the National Health Insurance Management Authority (NHIMA), decentralization to provincial and district health authorities, and the increasing role of non-state actors in health care provision. These reforms, while well-intentioned, risk being undermined by fragmented leadership, weak coordination, and regulatory asymmetries. This study generates context-specific insights that can support evidence-based reformulation of leadership strategies, institutional alignment, and governance models within the Zambian health sector.

Practically, the study foregrounds the neglected role of health leadership at the meso (district) and micro (facility and community) levels, which are pivotal interfaces between policy and implementation. In doing so, it presents opportunities for rethinking human resource development, performance management, and leadership capacity-building in a manner that is consistent with both local realities and global health commitments such as Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

In addition, by integrating an analysis of private sector, faith-based, and civil society engagement, the study offers a rare holistic understanding of the pluralistic nature of Zambia's health system. It brings to the fore the need for more deliberate public-private partnerships, coherent regulatory frameworks, and inclusive governance mechanisms. These dimensions are essential for transforming Zambia's health sector into a more resilient, accountable, and people-centred system.

Finally, this research will serve as a reference point for future academic inquiry and leadership development. It is expected to inform curricula for health leadership training programs, guide donor investments in health systems strengthening, and offer practical strategies for transforming leadership cultures within the Ministry of Health and allied institutions.

In essence, the study makes a substantive contribution to knowledge, policy, and practice, and responds to a critical national need for more effective, ethical, and transformative leadership in health systems.

1.6 Scope and Delimitation of the Study

1.6.1 Scope of the Study

This study focuses on analyzing leadership practices, structures, and dynamics within the Zambian health system. The research critically examines how leadership at various levels national, provincial, district, facility, and community affects health system performance, governance, and service delivery. The study draws on perspectives from public sector actors (Ministry of Health, provincial and district health officers), private sector stakeholders (faith-based organizations, for-profit providers), and civil society representatives.

The geographic scope is limited to selected provinces and districts in Zambia, ensuring representation from both urban and rural contexts. This includes Lusaka Province (representing urban administrative and policy leadership), Copperbelt Province (representing mixed public-private health systems), and Luapula Province (representing rural and community health structures). These areas were purposively sampled to capture diversity in leadership challenges and practices across different health system tiers.

Thematically, the study investigates five core dimensions of leadership:

1. Strategic and policy leadership at national level
2. Operational and administrative leadership at provincial and district levels
3. Clinical and managerial leadership at facility level
4. Community-based and participatory leadership at grassroots level
5. Intersectoral and private sector leadership engagement

Methodologically, the study adopts a qualitative, multi-case study design involving in-depth interviews, focus group discussions, document reviews, and thematic analysis using NVivo software.

1.6.2 Delimitation of the Study

While the study offers valuable insights into leadership in the Zambian health system, it is subject to several delimitations that were necessary for feasibility and focus:

Geographic Limitation: The study is limited to three selected provinces (Lusaka, Copperbelt and Luapula) and does not cover all ten provinces of Zambia. Therefore, while findings may provide indicative trends, they cannot be generalized to the entire country without caution. Context, nonetheless remains predominantly similar.

Sectoral Focus: The primary emphasis is on the public sector and its interface with the private and civil society sectors. Leadership dynamics in purely private corporate healthcare or traditional medicine systems are outside the scope of this research.

Exclusion of Quantitative Analysis: The study does not employ quantitative or statistical analysis of leadership outcomes or performance indicators. Instead, it prioritizes in-depth, qualitative understanding of leadership experiences, perceptions, and challenges.

Time Frame: The research reflects a snapshot of leadership within the 2022–2025 period, coinciding with Zambia's implementation of health sector reforms such as NHIMA rollout and decentralization. Historical or longitudinal changes in leadership structures are discussed only to contextualize contemporary practices.

Deliberate Exclusion of Political Leadership Beyond Health: While political leadership has implications on health governance, this study confines itself to actors within the

health system and does not analyze broader national political leadership or electoral politics.

Focus on Leadership Rather than General Health System Performance: Although leadership has implications on system performance, this study does not attempt to measure health outcomes (e.g., mortality rates, disease burden) quantitatively. It rather focuses on the leadership attributes and systems that influence such outcomes.

In conclusion, these delimitations were essential to ensure the depth, manageability, and methodological coherence of the study. Nevertheless, they also open opportunities for future research to quantitatively measure the impact of leadership on health outcomes or to expand geographical coverage for broader generalizability.

1.7 Conceptual Framework

This study was guided by an integrated conceptual framework that drew on both health systems thinking and leadership theory, particularly the Transformational Leadership Model and the WHO Health System Building Blocks. The framework was developed to analyze how leadership interacts with structural, cultural, and political dimensions of the health system to influence performance, outcomes, and reform.

1.7.1 Theoretical Foundation

The Transformational Leadership Theory (Burns, 1978; Bass & Avolio, 1994) was central to the study. This model posits that effective leaders are those who inspire, challenge, and motivate followers to achieve beyond expectations, foster innovation, and lead change through influence, vision, and personal integrity. The four pillars of transformational leadership idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration were used to assess leadership behaviors in Zambia's health sector.

In parallel, the WHO Health System Framework (2007) provided the health systems lens, which identifies six core building blocks leadership/governance, health financing,

service delivery, health workforce, health information systems, and access to medicines. Leadership and governance were treated not just as a standalone block but as an overarching force influencing all other components.

1.7.2 Conceptual Integration

The framework posited that leadership effectiveness in the Zambian health system was both a determinant and product of health system performance. It assumed that strong leadership positively influenced health system resilience, policy coherence, staff morale, and service delivery outcomes. Conversely, weak leadership led to fragmentation, inefficiency, and missed opportunities for reform.

The framework also incorporated contextual mediators such as:

a. Political interference and patronage in leadership appointments
b. Institutional culture and bureaucratic inertia
c. Availability of leadership development programs
d. Decentralization and autonomy at district levels
e. Stakeholder coordination and intersectoral collaboration

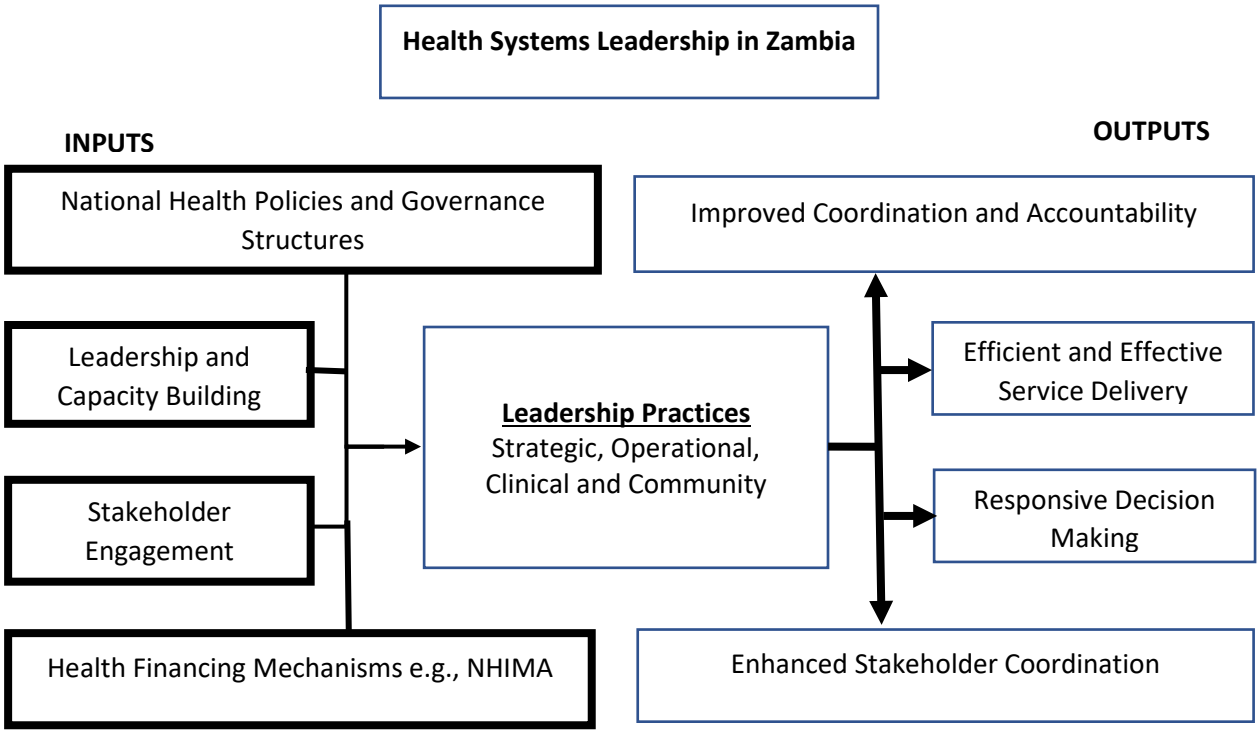
1.7.3 Diagrammatic Presentation of the Conceptual Framework: Health System Leadership in Zambia

This conceptual framework illustrates the interaction between inputs, leadership practices, and health system outcomes within the Zambian context. The model proposes that health leadership is influenced by a set of structural and systemic inputs such as national policy, leadership capacity, stakeholder engagement, and financing mechanisms. These inputs shape leadership practices at various levels of the health system strategic, operational, clinical, and community-based.

Effective leadership practices, in turn, lead to key outcomes including improved

coordination, efficient service delivery, responsive decision-making, and strengthened public-private collaboration. The framework was intended to guide data collection and analysis in this study by identifying the core elements influencing leadership effectiveness in Zambia's health sector.

Fig 1: Conceptual Framework of Health Systems leadership in Zambia



1.8 Structure of the Thesis

1.8.1 Chapter One: Introduction

This chapter provides the foundational basis for the study. It begins with the background to the study, establishing the context and significance of leadership within Zambia's health system. It then presents the statement of the problem, outlining the leadership challenges that persist despite ongoing reforms. The chapter also clearly articulates the research objectives and research questions, followed by a compelling justification of the study's significance in academic, policy, and practice realms. The scope and delimitation section defines the geographical, thematic, and methodological boundaries of the research, while the operational definitions clarify key terms used throughout the thesis. The chapter concludes with a brief outline of how the thesis is structured.

1.8.2 Chapter Two: Literature Review

This chapter provides an in-depth exploration of the existing body of knowledge relevant to the study. It begins by conceptualizing leadership in health systems, distinguishing between strategic, operational, clinical, and community leadership domains. The chapter then discusses the theoretical framework underpinning the study, drawing from leadership theories such as transformational leadership and systems thinking. A review of global, regional, and local literature follows, examining leadership experiences and gaps in low- and middle-income countries (LMICs), with a particular focus on sub-Saharan Africa and Zambia. The chapter ends by identifying knowledge gaps and presenting the conceptual framework that guides the research.

1.8.3 Chapter Three: Research Methodology

This chapter outlines the methodological approach adopted in the study. It begins with a discussion of the research design, explaining the rationale for a qualitative, multi-case study approach. It describes the study sites, target population, and sampling techniques, followed by a detailed explanation of the data collection methods (including interviews, focus group discussions, and document reviews). The chapter also explains the data analysis techniques, particularly thematic analysis using NVivo software. Attention is given to ethical considerations, including approval from relevant ethics bodies. Finally, the

chapter addresses issues of trustworthiness (credibility, transferability, dependability, and confirmability) and outlines the limitations of the study.

1.8.4 Chapter Four: Presentation of Findings

This chapter presents the empirical findings of the study, organized according to the research objectives. It begins with an overview of the study participants and sites, and proceeds to present findings from each objective:

> **Objective 1:** Assesses how leadership is conceptualized and exercised within Zambia's national and sub-national health governance structures.
>
> **Objective 2:** Identifies key leadership gaps and bottlenecks affecting the implementation of health policies, strategies, and service delivery.
>
> **Objective 3:** Explores the political, institutional, and socio-cultural factors influencing leadership effectiveness within the health sector.
>
> **Objective 4:** Identifies and documents t best practices and successful leadership models that contributed to improved health systems performance in selected case examples.

Each section presents emerging themes, supported by verbatim quotes from participants and analysis of relevant documents.

1.8.5 Chapter Five: Discussion of Findings

This chapter critically engages with the findings presented in Chapter Four. It interprets the results in light of the research questions and objectives, and relates them to the existing literature and theoretical framework. The discussion is organized around key thematic areas such as leadership gaps, opportunities for system transformation, institutional and regulatory challenges, and governance practices. The chapter highlights new insights generated by the study and discusses their implications for health policy, leadership development, and systems strengthening in Zambia.

1.8.6 Chapter Six: Conclusions and Recommendations

The final chapter offers a concise summary of key findings and draws conclusions based on each research objective. It then presents practical and policy recommendations aimed at improving leadership effectiveness and governance within Zambia's health system. Lastly, the chapter outlines areas for future research, especially regarding the measurement of leadership impact on health outcomes and the scalability of effective leadership models.

1.8.7 References and Appendices

The thesis concludes with a comprehensive reference list of all scholarly and policy documents cited in the study, formatted according to the university's preferred citation style (e.g., Harvard or APA). A series of appendices follow, including ethical approval letters, informed consent forms, interview guides, coding frameworks, and sample transcripts to ensure transparency and rigor in the research process.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

Effective leadership is increasingly recognized as a cornerstone of high-performing health systems, particularly in low- and middle-income countries (LMICs) where health service delivery is often challenged by constrained resources, institutional fragmentation, and governance complexities (World Health Organization [WHO], 2007; Travis et al., 2004). In recent decades, the global health community has shifted attention from predominantly technical interventions to more holistic, systems-based approaches of which leadership and governance are essential levers for sustainable transformation (Frenk et al., 2010).

In the context of Zambia, ongoing health sector reforms such as decentralization, the introduction of the National Health Insurance Scheme (NHIMA), and increased private sector engagement—have foregrounded the importance of leadership at all levels of the health system. However, while progress has been made in policy formulation and infrastructure development, there remains a substantial gap in understanding the qualitative dimensions of leadership, particularly the relational, strategic, and contextual factors that shape leadership effectiveness across national, subnational, facility, and community levels.

This literature review aims to critically explore and synthesize academic and policy literature related to leadership in health systems, with specific reference to Zambia and comparable LMICs. It begins by conceptualizing the meaning of leadership in the health sector, distinguishing it from management and operational control. The chapter then explores the theoretical frameworks that underpin the study, including transformational leadership, systems thinking, and distributed leadership, offering lenses through which leadership effectiveness and gaps can be examined.

A distinctive feature of this review is the inclusion of literature on private sector leadership in health systems, a dimension that is frequently underexplored in public health discourse but critical in pluralistic systems like Zambia's. The private health sector including for-profit entities, faith-based institutions, and non-governmental organizations plays a pivotal role

in service delivery, innovation, and financing. Within this domain, leadership is often characterized by market-driven approaches, client-centered service models, organizational efficiency, and entrepreneurial agility (Montagu & Goodman, 2016). These leadership attributes, while sometimes misaligned with public sector values, offer potential for cross-sector learning, public-private partnerships (PPPs), and blended models of health governance. The review will assess how the private sector understands and exercises leadership, and the implications this has for integration, accountability, and collaboration within the national health architecture.

Subsequent sections delve into empirical studies on leadership at various levels of the health system strategic leadership at national and ministerial levels, operational leadership at provincial and district levels, clinical leadership at the point of service delivery, and participatory leadership at the community interface. In doing so, the chapter highlights how leadership manifests across different contexts, institutions, and cultures, and how it is shaped by broader political, economic, and social dynamics.

The review also identifies significant gaps in the literature, especially the limited understanding of leadership as a multi-level, cross-sectoral, and relational process within the Zambian health system. These gaps justify the present study's qualitative, multi-case methodology, which seeks to capture nuanced perspectives from both public and private health leaders. The chapter concludes by presenting the conceptual framework that integrates the structural, behavioral, and institutional dimensions of leadership, and guides the inquiry toward identifying actionable opportunities for system transformation.

2.1 Conceptualizations of Leadership in Health Systems at Global level

Globally, leadership in health systems is increasingly recognized as a core pillar of effective governance, health equity, and system resilience. The World Health Organization (WHO) positions leadership and governance as one of the six foundational building blocks of a well-functioning health system (WHO, 2007). According to WHO, leadership is not limited to positional authority but includes the ability to provide strategic direction, mobilize

resources, build coalitions, ensure accountability, and steer the system toward national health goals.

In high-performing health systems, leadership is increasingly viewed as a distributed function, where responsibility and influence are shared across multiple levels and actors rather than being concentrated at the top (Edmonstone, 2009). This shift is supported by systems thinking approaches, which frame leadership as a dynamic interaction among policy, institutional capacity, culture, and external forces (Best et al., 2012).

2.2 Transformational and Adaptive Leadership Models

The Transformational Leadership Model, introduced by Burns (1978) and later refined by Bass and Avolio (1994), has significantly influenced global thinking on health leadership. This model emphasizes the ability of leaders to inspire, motivate, and intellectually stimulate their teams while acting as role models. In the health sector, transformational leadership has been linked to better patient outcomes, improved staff morale, and higher system responsiveness (Gilmartin & D'Aunno, 2007).

In fragile or complex health environments, adaptive leadership, as described by Heifetz et al. (2009), is also critical. It focuses on leading through change, navigating uncertainty, and mobilizing collective problem-solving—skills that have proven essential in contexts such as pandemic responses, health sector reforms, and disaster preparedness (Blanchet et al., 2017).

2.3 Leadership in High-Income Countries: Policy and Practice

In high-income countries, particularly in the United Kingdom, Canada, and Australia, leadership development is institutionalized through national health leadership academies, formal training programs, and competency frameworks (NHS Leadership Academy, 2013). These systems invest heavily in strategic, clinical, and managerial leadership at all levels, with performance indicators aligned to leadership goals.

For example, the UK's NHS Healthcare Leadership Model promotes inclusive leadership by emphasizing emotional intelligence, team empowerment, and innovation. Leadership

is evaluated not only on administrative efficiency but also on patient-centered outcomes and quality improvement (Storey & Holti, 2013).

2.4 Leadership in LMICs: Structural and Cultural Constraints

In contrast, many low- and middle-income countries (LMICs) face constraints that limit the full realization of effective health leadership. These include limited autonomy at local levels, donor dependence, politicization of leadership appointments, and underinvestment in leadership development (Dovlo, 2005; Travis et al., 2002).

Studies across Ghana, Uganda, Kenya, and Ethiopia reveal that leadership is often reactive and transactional rather than strategic or transformational (Faye et al., 2019; Nzinga et al., 2020). Decision-making is centralized, and there is minimal opportunity for frontline or district-level leaders to influence policy or drive innovation. Additionally, career paths for health leaders are unclear, and leadership is frequently conflated with clinical seniority rather than governance capacity (Martinez et al., 2011).

2.5 Leadership Development Initiatives: Global Lessons

Several global initiatives have sought to address these gaps. Programs such as the WHO Global Health Leadership Programme, Harvard's Ministerial Leadership Program, and Management Sciences for Health's (MSH) Leadership Development Program (LDP) have demonstrated that targeted leadership training can enhance policy implementation, stakeholder coordination, and adaptive management in LMIC settings (MSH, 2005).

However, these initiatives often lack sustainability because they are externally funded, poorly institutionalized, and fail to adapt to the political economy of national health systems (Peters et al., 2013). Moreover, most leadership interventions focus on individuals rather than creating enabling institutional environments that support long-term leadership effectiveness (Egger et al., 2012).

2.6 Key Gaps in Global Literature

From the global literature, several recurring gaps emerge:

a. Leadership is often defined narrowly as administrative control rather than inclusive governance or visionary change-making.

b. Most leadership development programs are donor-driven and not embedded in national systems.

c. There is insufficient research on how leadership operates in decentralized and politically complex environments.

d. Few studies address how informal leadership practices—such as influence by community leaders, traditional authorities, or senior nurses—interact with formal systems.

These global insights provide a valuable lens through which to interrogate leadership in Zambia's health system and to identify how both formal and informal leadership structures shape governance at national and sub-national levels.

2.7 Conceptualization and Practice of Leadership in Zambia's Health Governance Structures

This section reviews existing literature on how leadership is conceptualized and exercised within Zambia's health governance structures, both at the national and sub-national levels. It draws on global, regional, and Zambian studies to provide theoretical grounding and practical insights for assessing leadership dynamics within a complex health system.

2.7.1 Understanding Leadership in Health Systems

Leadership in health systems is increasingly recognized as a critical driver of performance, resilience, and reform. While traditionally associated with formal authority, contemporary literature conceptualizes leadership as a dynamic process involving influence, vision, motivation, and change management (Gilson & Agyepong, 2018). Transformational leadership, in particular, is valued for its capacity to inspire innovation, challenge the status quo, and mobilize teams toward a shared vision (Bass & Avolio, 1994).

The WHO (2007) defines leadership and governance as ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, system design, and accountability. However, operationalizing this definition in many low- and middle-income countries, including Zambia, remains a challenge due to contextual and institutional constraints.

2.7.2 Leadership in Zambia's National Health Governance

In Zambia, the Ministry of Health (MoH) provides national stewardship over the health system. Leadership at this level is tasked with policy formulation, standard setting, inter-sectoral coordination, and donor engagement. The Permanent Secretary and departmental directors hold key leadership roles. However, literature points to challenges in leadership continuity due to political reshuffling, inconsistent policy direction, and weak interdepartmental coordination (MoH, 2022; ZIPAR, 2020).

Despite the presence of national strategic plans and reform agendas, leadership at the central level is often seen as reactive rather than proactive. Policy implementation is frequently undermined by leadership gaps in accountability, communication, and strategic alignment (Mutale et al., 2013). The framing of leadership in government policy documents tends to emphasize administrative control rather than transformational influence or systems thinking.

2.7.3 Leadership at the Sub-national Level: Provinces and Districts

Zambia's health system is formally decentralized, with Provincial and District Health Offices playing key roles in translating national priorities into local implementation. District Health Directors and Provincial Health Officers are expected to demonstrate leadership in service delivery, resource mobilization, and community engagement. However, their effectiveness is limited by inadequate financial autonomy, capacity gaps, and rigid upward accountability to the MoH (Chitah & Kachimba, 2018).

Studies show that district-level leaders often come from clinical backgrounds with limited training in leadership or systems management. As a result, leadership is frequently operational rather than strategic, and decision-making is constrained by bureaucratic procedures (Egger et al., 2012; Daire & Gilson, 2014). Moreover, the absence of

structured mentorship and leadership development programs weakens long-term capacity and institutional memory.

2.7.4 Informal Leadership and Institutional Culture

Beyond formal roles, informal leadership practices shaped by institutional culture, social networks, and local norms play a significant role in Zambia's health sector. Facility-level leadership is often influenced by relationships rather than job descriptions, with informal leaders such as senior nurses or experienced clinicians exercising de facto authority in decision-making (Nzinga et al., 2020).

Community-level structures like Neighborhood Health Committees (NHCs) also play a leadership role in health governance through community mobilization and facility oversight. However, these structures remain poorly integrated into formal decision-making processes, limiting their influence (Topp et al., 2015). The disconnect between informal and formal leadership can lead to fragmentation and inconsistencies in service delivery.

2.7.5 Thematic Gaps in the Literature

While leadership is acknowledged in Zambia's national health discourse, the literature reveals several gaps:

1. There is limited empirical analysis of how leadership is actually practiced across different governance levels.
2. Leadership is often conflated with management, with little distinction between operational authority and strategic influence.
3. Existing leadership models are poorly adapted to the Zambian context and do not account for the political economy, institutional culture, or community dynamics that shape leadership behavior.
4. There is a lack of standardized frameworks or competency models to guide leadership development and evaluation in the health sector.

This review highlights the need for a more nuanced, context-specific understanding of leadership in Zambia's health system one that incorporates formal authority, informal influence, political realities, and systems thinking.

2.8 Leadership Gaps and Bottlenecks in Health Policy Implementation and Service Delivery at Global Level

Health systems across the globe recognize leadership as a cornerstone for effective policy implementation and high-quality service delivery. In high-income countries and some emerging economies outside Africa, substantial evidence has emerged highlighting specific leadership bottlenecks that compromise efficiency, equity, and sustainability in health systems. This literature review synthesizes global insights into the nature, causes, and consequences of these gaps.

2.8.1 Leadership Gaps in Policy Implementation

In countries such as the United States, United Kingdom, Canada, and Australia, research consistently shows that implementation failure often stems not from poor policy design but from weak leadership capacity at various administrative levels (Edmondson & Roloff, 2009; Greer et al., 2016). For example, the disconnect between central policymaking and local-level interpretation of health reforms is frequently attributed to a lack of adaptive leadership capable of bridging policy and practice (Berwick et al., 2008).

Studies in the UK's National Health Service (NHS) reveal that even where policies are well-formulated, frontline managers often lack the strategic autonomy, communication skills, or collaborative networks to lead change initiatives (Storey & Holti, 2013). A key bottleneck here is "middle management paralysis," where mid-level leaders struggle to translate policy into action due to unclear mandates, excessive administrative burden, or risk-averse cultures.

2.8.2 Systemic Bottlenecks: Fragmentation and Siloed Leadership

A recurring theme in the literature is the fragmentation of leadership across institutions and levels of care. In Canada, studies show that federal–provincial divisions and jurisdictional silos dilute accountability and result in inconsistent implementation of

national strategies (Marchildon, 2013). Leadership is often “diffused” across sectors, making coordination difficult and contributing to service delivery inefficiencies.

In Germany, decentralization has created a high degree of autonomy at the Länder (state) level, but weak vertical coordination results in uneven implementation of national health policies. This reflects a leadership gap in terms of system integration and intergovernmental collaboration (Kuhlmann et al., 2016).

2.8.3 Workforce Leadership Gaps and Organizational Culture

In Japan and South Korea, studies highlight the challenge of hierarchical cultures in health institutions, where junior staff are rarely empowered to lead or influence decision-making (Kim et al., 2018). This hierarchical rigidity stifles innovation, reduces responsiveness, and impairs team-based approaches to problem-solving.

Leadership development is also under-resourced in many systems, especially among clinical professionals transitioning into management roles. In the United States, physicians promoted into leadership roles often lack the managerial or strategic training required for implementation success, contributing to policy delays and clinical resistance (Stoller, 2009).

2.8.4 Political and Governance-Related Leadership Gaps

Globally, one of the most significant leadership bottlenecks lies in policy inconsistency driven by political turnover. In Latin America, for instance, countries like Brazil and Mexico face recurrent policy reversals with changes in political leadership, which undermines continuity and long-term health strategies (Atun et al., 2015). These governance-related leadership gaps erode institutional memory, weaken performance monitoring systems, and reduce stakeholder confidence in reform processes.

In India, the multiplicity of actors involved in public health governance central, state, municipal, and private leads to role ambiguity and blurred leadership accountability, affecting the consistent rollout of national programs such as the National Health Mission (Berman & Ahuja, 2008).

2.8.5 Weak Investment in Leadership Development Systems

Despite the importance of leadership, many high-income countries have historically focused on clinical training and service delivery infrastructure, while underinvesting in structured leadership development. The lack of systematic mentoring, competency frameworks, or leadership pathways creates bottlenecks in succession planning and talent retention (Daley, 2013; Garman & Lemak, 2011).

Although institutions like the NHS Leadership Academy (UK) and American College of Healthcare Executives (ACHE) have made strides, leadership training remains optional in many health systems, and its impact on real-world policy execution is poorly evaluated.

2.8.6 Summary Gaps and Bottlenecks at Global Level

The literature from non-African contexts highlights several common leadership gaps affecting health policy implementation and service delivery:

a. Disjointed leadership structures across levels and sectors impede coordination.

b. Inadequate training for frontline and mid-level leaders hampers reform implementation.

c. Top-down hierarchies limit adaptive and inclusive leadership.

d. Frequent political turnover disrupts policy continuity and institutional learning.

e. Underdeveloped leadership pipelines result in poor succession planning and leadership vacuums.

f. Limited integration of leadership into health systems thinking results in implementation failures despite robust technical planning.

These global experiences provide a comparative lens through which to assess Zambia's own leadership challenges in health policy execution and service delivery.

2.9 Leadership Gaps and Bottlenecks in Health Policy Implementation and Service Delivery in African Countries

Leadership has been consistently identified as a major determinant of health system performance in Africa. While many African countries have adopted comprehensive health policies and strategic plans aligned with global targets such as the Sustainable Development Goals (SDGs), the implementation of these frameworks is often undermined by leadership deficits. This section reviews evidence from African contexts to highlight the specific gaps and bottlenecks in health leadership that hinder effective policy execution and service delivery.

2.9.1 Centralization and Lack of Decision-Making Autonomy

One of the most prominent leadership bottlenecks in African health systems is **over-**centralization of authority, which restricts sub-national leaders from making timely and context-specific decisions. In Ghana, despite formal decentralization, district health managers often lack the autonomy to allocate resources or modify programs based on local needs (Agyepong et al., 2012). Similarly, in Kenya, research shows that while health services have been devolved to county governments, leadership at the county level remains weak due to ambiguous roles, poor inter-sectoral coordination, and interference by political actors (Nzinga et al., 2020).

2.9.2 Politicization of Leadership Appointments

Another widespread challenge is the politicization of leadership roles, which undermines meritocracy and institutional professionalism. In Nigeria, health sector leadership appointments are often made on political or ethnic lines rather than competence, leading to inefficiencies and poor accountability (Onwujekwe et al., 2019). Similar patterns are observed in Uganda and Zambia, where frequent leadership changes driven by political cycles disrupt continuity and reduce institutional memory (Ssengooba et al., 2007).

2.9.3 Capacity Gaps and Weak Leadership Development Structures

Many African countries lack structured pathways for developing and sustaining health leadership capacity. In Ethiopia, leadership roles are often filled by technically trained health professionals with little or no exposure to leadership, governance, or systems thinking (Fetene et al., 2019). Studies in Malawi and Tanzania also highlight that while

health managers may possess clinical expertise, they frequently lack skills in strategic planning, human resource management, and policy advocacy (Bradley et al., 2015).

Leadership development programs such as the USAID-funded Leadership Development Program (LDP) have been implemented in countries like Uganda and Mozambique, with some success in improving leadership practices at district and facility levels. However, these interventions often lack scale, sustainability, and institutional ownership (Daire & Gilson, 2014).

2.9.4 Weak Accountability and Performance Monitoring

Leadership gaps are also evident in the absence of robust accountability frameworks. In Democratic Republic of Congo, service delivery suffers due to poor supervision, lack of performance feedback, and weak enforcement of roles at all levels of the health system (Falisse et al., 2012). Similar findings are reported in Burkina Faso, where weak leadership in monitoring and evaluation hampers evidence-based planning and resource allocation (Ridde et al., 2014).

Moreover, data use for decision-making remains low, even where health information systems are in place. Leadership often fails to institutionalize a culture of evidence-informed governance, which undermines policy responsiveness and innovation (Mikkelsen-Lopez et al., 2011).

2.9.5 Donor Dependence and Fragmentation of Leadership

Donor-driven vertical programs often bypass national leadership structures, creating parallel systems of authority and reducing national ownership. In Mozambique, for instance, leadership fragmentation between donor-funded programs and national strategies leads to duplicated efforts and conflicting priorities (Pfeiffer et al., 2013). In Rwanda, despite stronger coordination, some development partners continue to operate with limited integration into national leadership structures, affecting strategic coherence (Binagwaho et al., 2014).

2.9.6 Gender Gaps in Health Leadership

Despite women constituting the majority of the health workforce in many African countries, they remain underrepresented in senior leadership positions. In South Africa and Kenya, cultural and structural barriers continue to limit women's access to leadership roles, which affects diversity and inclusiveness in policy formulation and execution (George et al., 2015).

2.9.7 Summary of Leadership Gaps in African Health Systems

Across African countries, the following leadership gaps and bottlenecks commonly affect the implementation of health policies and service delivery:

a. Excessive centralization and limited local decision-making authority
b. Politicization and frequent turnover in leadership roles
c. Inadequate investment in leadership development and training
d. Weak accountability, monitoring, and performance systems
e. Fragmentation due to poorly coordinated donor-funded programs
f. Gender imbalance in leadership, especially at senior levels

These findings underscore the need for deliberate investment in leadership development, institutional reforms to depoliticize appointments, and mechanisms to promote inclusive, accountable, and transformative leadership in African health systems.

2.10 Leadership Gaps and Bottlenecks in Health Policy Implementation and Service Delivery in Zambia

Zambia's health sector has undergone several waves of reform, with a strong policy emphasis on decentralization, sector-wide approaches (SWAp), and public health systems strengthening. However, the persistent implementation gap between policy and practice reveals critical leadership challenges that affect governance, service delivery, and

the realization of national and global health targets such as Universal Health Coverage (UHC). This section synthesizes Zambian literature and empirical evidence on the leadership-related gaps and bottlenecks that undermine effective health policy implementation.

2.10.1 Centralized Decision-Making and Limited District Autonomy

Although Zambia has adopted a decentralization policy, operational decision-making remains heavily centralized. District and provincial health offices are expected to implement national strategies but lack sufficient authority and autonomy to adapt these strategies to local contexts (Mutale et al., 2013). According to Chitah and Kachimba (2018), District Health Management Teams (DHMTs) frequently struggle to influence resource allocation or make timely decisions due to upward accountability to the Ministry of Health (MoH) and limited discretionary power. This bottleneck hinders responsive health planning and reduces innovation at the local level.

2.10.2 Leadership Instability and Politicization of Appointments

Leadership turnover at senior levels of the MoH is frequent and often politically motivated. A report by the Zambia Institute for Policy Analysis and Research (ZIPAR, 2020) notes that instability in leadership positions such as Permanent Secretary and departmental heads disrupts policy continuity and strategic focus. Additionally, politicization of senior appointments dilutes meritocracy, demoralizes career health professionals, and results in poorly coordinated implementation of health strategies. This dynamic also discourages evidence-based decision-making in favor of politically expedient choices.

2.10.3 Inadequate Leadership Competency Development

Despite the MoH's recognition of leadership as a critical success factor, structured leadership development and succession planning mechanisms remain underdeveloped. As observed by Mboera et al. (2020), many facility and district-level managers are promoted based on clinical seniority rather than leadership competence. A study by Chilufya et al. (2021) highlights that health workers with strong technical expertise often

lack managerial, strategic, and people-centered leadership skills, creating bottlenecks in team performance, supervision, and problem-solving.

2.10.4 Weak Performance Management and Accountability

Accountability mechanisms across the health sector are weakly enforced. While Zambia has adopted tools like performance appraisal systems, integrated support supervision, and annual performance reviews, these are inconsistently applied and often treated as routine checklists rather than strategic tools for leadership improvement (MoH, 2019). Mutale et al. (2013) further observe that district health leaders are rarely held accountable for poor service delivery, and upward reporting systems lack feedback loops for adaptive leadership and course correction.

2.10.5 Fragmented Leadership Across Programs and Partners

Vertical programming and donor-driven initiatives contribute to fragmentation in leadership and planning. Projects such as those under HIV/AIDS, malaria, and reproductive health are often led by parallel management structures that report directly to donors or NGOs, bypassing district leadership structures. This has created a dual leadership environment where local leaders are sidelined from critical planning and decision-making processes (Mwansa et al., 2020). This fragmentation leads to duplication, misalignment of priorities, and weakened accountability.

2.10.6 Data Use and Evidence-Based Leadership

While Zambia has made strides in establishing health information systems (such as SmartCare and DHIS2), leadership at district and facility levels has been slow to institutionalize data use in decision-making. Topp et al. (2015) report that many health leaders rely on intuition or politically motivated instructions rather than routine data, resulting in poorly targeted interventions. Barriers include low data literacy among leaders, limited technical support, and inadequate feedback mechanisms from higher authorities.

2.10.7 Gender Disparities in Leadership Roles

Zambian literature also identifies significant gender disparities in leadership. Despite women comprising a majority of frontline health workers, they remain underrepresented in decision-making roles at national and provincial levels. Chilufya and Chirwa (2022) argue that cultural perceptions, lack of mentorship, and systemic biases contribute to the marginalization of female leaders, thus limiting diverse perspectives in strategic planning and implementation.

2.10.8 Summary of Key Leadership Bottlenecks from the Zambian context.

The following key leadership gaps affect policy implementation and service delivery in the Zambian health system:

a. Over-centralization and weak district-level decision-making authority
b. Politicization and high turnover in leadership appointments
c. Inadequate leadership competency and structured development programs
d. Weak accountability and performance monitoring systems
e. Fragmented leadership due to vertical donor-funded programs
f. Low institutionalization of data use in leadership decisions
g. Underrepresentation of women in senior health leadership roles

These findings support the need for comprehensive leadership reforms to improve the functionality and responsiveness of Zambia's health system.

2.11 Political, Institutional, and Socio-Cultural Factors Influencing Leadership Effectiveness in the Health Sector at Global Level.

Leadership effectiveness in health systems is not merely a function of individual capacity or technical expertise; it is deeply embedded within a broader context of political, institutional, and socio-cultural dynamics. This section presents global (non-African) evidence on how these contextual factors shape the practice, success, or failure of leadership in health governance, policy implementation, and organizational performance.

2.11.1 Political Contexts and Health Leadership

Globally, political environments significantly influence leadership effectiveness in the health sector. In countries like India, leadership at both national and subnational levels is frequently influenced by party politics and bureaucratic patronage. Berman and Ahuja (2008) highlight how political decentralization has led to administrative fragmentation, thereby diluting leadership coherence and obstructing the implementation of national health missions.

In Latin America, countries such as Brazil and Mexico experience recurrent changes in health leadership aligned with electoral cycles. These political transitions often result in the reversal or abandonment of health reforms, despite their technical soundness. Atun et al. (2015) argue that such political volatility undermines institutional continuity, weakens institutional memory, and diminishes trust in leadership.

In Eastern Europe, post-Soviet health systems struggle with leadership gaps arising from complex political transitions and the challenge of balancing centralized legacy structures with democratic reforms (Rechel et al., 2011). These contexts underscore the importance of political stability, bipartisan health policy consensus, and leadership insulation from short-term political interests.

2.11.2 Institutional Factors: Governance and System Structure

Leadership effectiveness is closely tied to institutional arrangements such as accountability mechanisms, role clarity, organizational culture, and decentralization

frameworks. In Canada, for instance, the federal structure of the health system creates multiple leadership centers at the provincial level. While this encourages context-specific leadership, it also presents coordination challenges, especially during public health crises (Marchildon, 2013).

In Germany, highly autonomous regional (Länder) governments manage health independently, but without strong federal-level integration, resulting in fragmented leadership during national emergencies (Kuhlmann et al., 2016). Conversely, Sweden has been cited as a model of effective leadership under decentralization, where clearly defined mandates, transparent governance structures, and performance accountability facilitate responsive leadership (Anell et al., 2012).

Institutional capacity is also shaped by health system financing. In the United States, a fragmented financing and service delivery model combined with a competitive hospital culture creates a leadership environment focused more on organizational survival than public health leadership (Stoller, 2009; Garman & Lemak, 2011).

2.11.3 Socio-Cultural Factors Shaping Leadership Practice

Cultural norms, beliefs, and social hierarchies strongly influence leadership behavior and its acceptance by subordinates. In Japan and South Korea, leadership is often shaped by hierarchical and collectivist traditions, where junior staff rarely challenge authority, limiting bottom-up innovation and participatory leadership (Kim et al., 2018). This deference to hierarchy may protect organizational order but can hinder responsiveness and adaptability in dynamic health environments.

In Scandinavian countries, egalitarian cultural values foster participatory and distributed leadership styles. Research from Norway and Sweden suggests that flat organizational structures promote team-based problem-solving, shared responsibility, and staff empowerment, all of which enhance leadership effectiveness in healthcare (Lindberg & Vingard, 2012).

Furthermore, gender and social inclusion also shape leadership dynamics. In Australia and New Zealand, initiatives aimed at increasing Indigenous representation and women in senior leadership roles demonstrate the value of culturally responsive leadership, particularly in addressing inequities and improving health outcomes among marginalized populations (Curtis et al., 2019).

2.11.4 Interaction of Political, Institutional, and Cultural Factors

The interplay among political, institutional, and socio-cultural factors is critical. For example, the COVID-19 pandemic revealed how countries with high public trust, transparent institutions, and culturally responsive leadership (e.g., New Zealand) were able to mount more effective responses, despite limited resources. In contrast, countries with fragmented political systems and polarized leadership (e.g., the United States) struggled with policy coherence and public adherence to health guidance (Greer et al., 2020).

2.11.5 Summary of Global Findings

From a global perspective, the following factors are shown to significantly influence leadership effectiveness in the health sector:

a. Political stability and non-partisan health policy continuity

b. Clear institutional mandates, governance frameworks, and decentralized decision-making

c. Organizational cultures that promote participation, equity, and feedback

d. Social hierarchies and cultural attitudes toward authority and gender roles

e. Coordination between federal and local health leadership bodies

f. Inclusivity in leadership, particularly involving women and marginalized groups

These insights offer valuable lessons for low- and middle-income countries seeking to reform health sector leadership and align it with broader governance and development goals.

2.12 Political, Institutional, and Socio-Cultural Factors Influencing Leadership Effectiveness in the Health Sector-The African Context.

In the African context, leadership effectiveness in the health sector is deeply embedded in a landscape marked by political transitions, institutional weaknesses, and diverse socio-cultural norms. Although numerous health reforms have been undertaken across the continent, implementation remains uneven, often due to contextual factors that influence how leadership is exercised and sustained. This section synthesizes evidence from African countries excluding Zambia on the political, institutional, and socio-cultural drivers of leadership success or failure.

2.12.1 Political Interference and Leadership Turnover

In many African countries, health sector leadership is vulnerable to political interference and frequent turnover, which undermines policy continuity and system stability. In Nigeria, for example, health system leadership is heavily influenced by political appointments that prioritize loyalty over competence. Onwujekwe et al. (2019) observe that such politicization weakens institutional autonomy and fosters a culture of impunity, discouraging strategic leadership and innovation.

Similarly, in Kenya, the devolution of health services to county governments introduced new leadership opportunities but also politicized the appointment of county health executives, often leading to poor coordination, lack of accountability, and intergovernmental conflict (Barasa et al., 2017). Political competition at the subnational level often overrides evidence-based decision-making, weakening the authority and effectiveness of health managers.

2.12.2 Institutional Weaknesses and Role Ambiguity

Institutional weaknesses including ambiguous reporting structures, lack of standardized procedures, and fragmented authority are common challenges across many African health systems. In **Uganda**, Ssengooba et al. (2007) note that decentralization without clear

guidelines on roles and responsibilities created confusion and tension between district health officers and local political leaders. This ambiguity often left technical officers exposed to political pressure and diminished their leadership capacity.

In Tanzania, Dovlo (2005) reports that insufficient institutional support for district-level managers led to a reliance on personal networks and informal practices, which while occasionally effective, were unsustainable and undermined formal accountability structures. Leadership effectiveness in such contexts is often constrained by systemic inertia and lack of resources.

2.12.3 Socio-Cultural Norms and Leadership Behavior

Leadership is also shaped by socio-cultural norms, including perceptions of authority, hierarchy, and gender roles. In Ethiopia, Fetene et al. (2019) highlight that traditional deference to authority hinders participatory leadership and stifles innovation, particularly at lower levels of the health system. Subordinates often refrain from providing feedback or challenging decisions, which limits adaptive learning and collaborative problem-solving.

In Malawi, societal expectations of gender roles significantly limit women's participation in health leadership, despite their majority representation in the workforce. Research by George et al. (2015) shows that institutionalized patriarchy and lack of mentorship programs constrain the upward mobility of female health workers, reducing leadership diversity and inclusiveness.

2.12.4 Trust, Patronage, and Informal Power Structures

Informal power dynamics and patronage networks often operate alongside formal leadership structures in many African countries. In **Sierra Leone**, for example, Witter et al. (2016) document how trust in health leaders is shaped not only by competence but by their ethnic or political affiliations, which can lead to both inclusion and exclusion from critical decision-making processes. These informal systems often subvert formal

accountability mechanisms and create opaque environments where leadership becomes more performative than transformational.

Similarly, in Mozambique, Pfeiffer et al. (2013) note that informal arrangements between political elites and donors shaped leadership priorities in ways that often conflicted with national health goals, highlighting the complex web of external and internal pressures on health leaders.

2.12.5 Crisis Contexts and Adaptive Leadership

In settings of crisis or recovery, such as Liberia and Sierra Leone during the Ebola epidemic, leadership was tested in unprecedented ways. Research shows that countries with weak health system leadership prior to the crisis struggled with coordination and response. However, where leaders were able to exhibit adaptive, community-responsive, and transparent behavior, public trust and service delivery improved over time (Kieny et al., 2014; Witter et al., 2016).

These examples suggest that while structural weaknesses persist, leadership effectiveness can emerge under pressure if local leaders are empowered and supported to innovate, communicate clearly, and mobilize multisectoral partnerships.

2.12.6 Summary of Leadership Influencers in African Health Systems

Across African countries, the literature reveals several common political, institutional, and socio-cultural influences on leadership effectiveness:

a. Political interference and patronage systems undermine technical leadership.

b. Ambiguous institutional roles and reporting lines create conflict and limit decision-making.

c. Hierarchical cultures and limited feedback loops constrain participatory and adaptive leadership.

d. Gender norms and lack of mentorship restrict women's advancement into leadership roles.

e. Informal power structures compete with formal systems and distort accountability.

f. Crisis settings can catalyze adaptive leadership, but only when local actors are empowered.

These dynamics emphasize the need for context-sensitive leadership development, institutional reform, and sociocultural transformation to strengthen leadership across African health systems.

2.13 Political, Institutional, and Socio-Cultural Factors Influencing Leadership Effectiveness in the Health Sector-The Zambian Context

Zambia's health leadership is situated within a dynamic interplay of political systems, institutional arrangements, and socio-cultural norms. While national policy frameworks such as the National Health Strategic Plan (NHSP) 2022–2026 recognize leadership and governance as critical enablers of health system strengthening, implementation is often affected by systemic and contextual factors. This review explores the Zambia-specific literature that reflects on these dimensions and how they shape leadership effectiveness in the country's health sector.

2.13.1 Political Influence and Leadership Turnover

One of the most significant barriers to leadership effectiveness in Zambia is the politicization of senior appointments within the Ministry of Health and affiliated agencies. Studies note that the frequent reassignment of Permanent Secretaries, Directors, and Provincial Health Officers based on political considerations disrupts continuity and weakens strategic reform agendas (ZIPAR, 2020). Ncube, Mulenga, and Chiwele (2021) argue that this political instability limits long-term planning, undermines institutional memory, and creates uncertainty among subordinate managers.

Furthermore, the blurring of political and administrative roles affects decision-making. Provincial and district leaders often operate under implicit political pressure from elected officials, which constrains their autonomy to enforce technical decisions or pursue unpopular but necessary reforms (MoH, 2019).

2.13.2 Institutional Challenges: Role Ambiguity and Capacity Gaps

The Zambian health system's decentralized structure is not matched by clear delegation of leadership roles, especially at the district and facility levels. While District Health Offices are mandated to plan and manage local health services, their operational decision-making is frequently constrained by centralized budgeting and unclear lines of authority (Mutale et al., 2013).

Chitah and Kachimba (2018) highlight role ambiguity between district health managers and local government officials under the Ministry of Local Government and Rural Development. This overlap creates jurisdictional confusion, fosters interdepartmental competition, and limits effective leadership at the subnational level.

Additionally, institutional capacity to lead complex health programs remains limited. Many facility managers rise to leadership positions due to seniority rather than leadership training. Chilufya et al. (2021) found that while clinical proficiency among managers is strong, their competencies in strategic planning, communication, conflict resolution, and adaptive leadership are often weak—limiting their effectiveness in increasingly complex service environments.

2.13.3 Socio-Cultural Norms and Organizational Hierarchies

Zambia's health system operates within a broader socio-cultural environment that emphasizes respect for hierarchy, age, and authority. While this promotes order, it can suppress innovation and inhibit open communication between junior and senior staff. Topp et al. (2015) observe that health workers, particularly at lower levels, are often reluctant to challenge supervisors or question decisions—even when patient safety is at stake. This cultural deference to authority weakens the feedback loops essential for adaptive leadership.

Gender also plays a role in shaping leadership opportunities and styles. Despite high female participation at frontline levels, women remain underrepresented in senior leadership positions. Chilufya and Chirwa (2022) report that cultural expectations around gender roles, family obligations, and a lack of female mentorship contribute to the leadership gap, thereby reducing gender diversity and limiting transformational leadership potential.

2.13.4 Informal Networks and Leadership Practice

Leadership in Zambia is also influenced by informal power dynamics, including tribal affiliations, patronage networks, and personal relationships. These networks can support or hinder formal leadership structures. While informal coalitions can facilitate problem-solving and resource mobilization in the absence of formal mechanisms, they also risk entrenching favoritism, undermining transparency, and marginalizing competent but politically unconnected professionals (Mwansa et al., 2020).

Such informal systems are particularly evident during health sector reforms, recruitment processes, and allocation of donor-supported resources, where political or social influence may override merit-based decisions.

2.13.5 Post-COVID-19 and Crisis Leadership Reflections

The COVID-19 pandemic provided a test case for leadership in Zambia's health system. While national coordination through the Zambia National Public Health Institute (ZNPHI) was relatively strong, inconsistent messaging, limited community engagement, and bureaucratic delays revealed underlying leadership weaknesses. According to Mweetwa and Chirwa (2021), effective crisis leadership was hampered by siloed communication between ministries and inadequate empowerment of district health teams, particularly during resource mobilization and vaccine rollout phases.

2.13.6 Summary of Zambia-Specific Leadership Influences

In Zambia, the following political, institutional, and socio-cultural factors significantly influence leadership effectiveness in the health sector:

a. Politicized appointments and leadership turnover weaken continuity and reform efforts.
b. Role ambiguity and centralized control limit subnational leadership effectiveness.
c. Hierarchical culture and deference to authority restrict open dialogue and innovation.
d. Limited leadership training and unclear career paths affect strategic competency.
e. Gender biases and lack of mentorship inhibit women's advancement into leadership.
f. Informal networks and tribal affiliations influence leadership appointments and decision-making.

Addressing these contextual barriers is critical for fostering strategic, accountable, and inclusive leadership in Zambia's evolving health landscape.

2.14 Best Practices and Successful Leadership Models in Health Systems

Globally and regionally, various health systems have demonstrated how leadership when strategic, adaptive, and accountable can drive performance, resilience, and innovation. Best practices often emerge not only from strong policy environments but also from visionary individuals, collaborative governance arrangements, and institutional cultures that foster learning and accountability. This section synthesizes international and Zambian literature on leadership models and practices that have positively influenced health systems performance.

2.14.1 Global Best Practices in Health Leadership

2.14.1.1 Transformational Leadership in High-Income Countries

The transformational leadership model where leaders inspire a shared vision, motivate teams, and challenge conventional practices has been widely documented as a driver of innovation and performance. In the United Kingdom's NHS, transformational leadership is promoted through the NHS Healthcare Leadership Model, which emphasizes emotional intelligence, inclusive decision-making, and reflective practice (Storey & Holti, 2013). This has led to improved patient safety cultures and staff morale in institutions where the model is applied effectively.

In Sweden, decentralized health governance combined with participatory leadership has enabled local managers to adapt services based on patient needs, contributing to high levels of public trust and equitable access (Anell et al., 2012). Leadership in these systems is supported by robust mentorship programs and continuous professional development.

2.14.1.2 Collaborative Leadership and Crisis Response

During the COVID-19 pandemic, countries like New Zealand and South Korea were lauded for their effective leadership. In New Zealand, Prime Minister Jacinda Ardern's empathetic and transparent leadership was credited with uniting the public behind containment measures. Collaborative leadership with scientists and health experts played a key role in public health communication and compliance (Greer et al., 2020).

In South Korea, crisis-responsive leadership at the Korea Centers for Disease Control and Prevention emphasized data-driven decision-making and rapid decentralization of testing, enabling timely containment of the virus. These examples highlight the importance of adaptive, evidence-based, and transparent leadership in strengthening system performance during emergencies.

2.14.2 Leadership Models in Low- and Middle-Income Countries (LMICs)

2.14.2.1 Distributed and Bottom-Up Leadership in Ethiopia

Ethiopia's Health Extension Program (HEP) is frequently cited as a best practice in leadership at the community level. Under this model, female health extension workers are trained and deployed in rural areas, providing primary care and mobilizing communities. The program is supported by political commitment at the highest levels and structured supervision at subnational levels. Fetene et al. (2019) attribute the success of the HEP to strong alignment between policy and local leadership empowerment.

2.14.2.2 Performance-Based Leadership in Rwanda

Rwanda's health sector is widely recognized for performance-based financing (PBF) and leadership accountability frameworks. Health center managers are empowered to lead, plan, and improve service delivery based on set targets, with performance influencing funding. Binagwaho et al. (2014) emphasize that leadership commitment to transparency and equitable service delivery has made Rwanda a leader in health systems recovery and reform post-genocide.

2.14.1 Leadership Best Practices in Zambia

Although Zambia faces significant leadership challenges, several examples of effective leadership models and practices have emerged, especially in donor-supported programs and reform initiatives.

2.14.1.1 District Health Leadership Development Programs

The Leadership Development Program (LDP) implemented in districts such as Chipata, Mongu, and Livingstone facilitated by Management Sciences for Health (MSH) and USAID helped build team-based leadership, clarify local goals, and improve health indicators through locally designed projects. Mutale et al. (2013) report that districts implementing the LDP demonstrated improved planning, stakeholder engagement, and service delivery performance.

2.14.1.2 Strengthening Supply Chain Leadership through eSCMIS

Under the Electronic Supply Chain Management Information System (eSCMIS) project, the Ministry of Health and partners demonstrated how cross-sectoral and data-driven leadership can enhance efficiency. Provincial supply chain teams were capacitated to monitor commodity flows and make procurement decisions. The success of this program was attributed to leadership that emphasized data ownership, staff empowerment, and accountability across the supply chain (CHAZ, 2023).

2.14.1.3 Community Leadership in Primary Health Care

The integration of Neighborhood Health Committees (NHCs) into primary health service delivery has shown promise in improving community engagement and local accountability. Topp et al. (2015) document how empowered NHCs helped improve facility performance in areas such as child health and malaria control by mobilizing communities and facilitating dialogue between providers and the public. These structures represent a best practice in grassroots leadership that enhances ownership and responsiveness.

2.14.1.4 Features of Successful Leadership Models

Across the reviewed literature, successful health leadership models typically exhibit the following features:

a. Strategic vision and alignment with national goals
b. Decentralized authority and decision-making autonomy
c. Data-informed decision-making and accountability frameworks
d. Stakeholder and community engagement
e. Mentorship, coaching, and continuous leadership development
f. Equity and gender inclusivity in leadership structures

These characteristics are critical to creating resilient and responsive health systems, particularly in contexts marked by resource constraints or systemic reform.

2.15 Conclusion

The literature affirms that leadership in health systems is shaped by political, institutional, and socio-cultural contexts. In Zambia, while there are pockets of promising leadership practices, the system remains hampered by centralization, weak capacity, politicization, and underinvestment in leadership development. Lessons from global and regional best practices suggest that Zambia can benefit from institutionalizing leadership development, clarifying roles across levels, decentralizing authority, and promoting inclusive, accountable, and data-informed leadership.

2.16 Leadership in the Private Health Sector in Zambia: Strengths and Gaps

The private sector is a critical component of Zambia's mixed health system and comprises for-profit health providers, faith-based organizations, and non-governmental entities. It is estimated that over 50% of rural health services in Zambia are delivered by faith-based institutions under the umbrella of the Churches Health Association of Zambia (CHAZ), while urban centers host a growing number of for-profit clinics, hospitals, pharmacies, and diagnostic laboratories (CHAZ, 2019; Ministry of Health, 2017).

2.16.1 Strengths in Private Sector Leadership

One of the key strengths of leadership within the private health sector lies in its operational efficiency and adaptability. Unlike many public institutions constrained by bureaucratic procedures, private facilities often demonstrate agility in decision-making, rapid implementation of innovations, and a strong results-oriented culture (Montagu & Goodman, 2016). This has enabled several private providers to adopt digital health solutions, customer satisfaction models, and efficient supply chain mechanisms faster than their public counterparts.

Leadership in private facilities is typically decentralized and entrepreneurial, with facility managers exercising considerable autonomy in financial planning, human resource decisions, and quality assurance. This flexibility fosters accountability and performance-

based management, especially where business survival is tied to service quality and client trust (Basu et al., 2012).

Another strength is found in the values-based leadership of faith-based providers. CHAZ and its affiliated institutions have established trust with communities and are often perceived as more compassionate, responsive, and ethically grounded in their service delivery (Makasa, 2014). Their leadership models emphasize stewardship, inclusivity, and social accountability, particularly in remote and underserved areas.

Furthermore, the private sector has exhibited leadership in filling service delivery gaps particularly in urban informal settlements and remote rural areas where government presence is limited. Their ability to mobilize external funding, attract skilled health workers, and collaborate with development partners has extended access to essential services.

2.16.2 Gaps and Challenges in Private Sector Leadership

Despite these strengths, significant leadership and governance gaps exist within Zambia's private health sector. Chief among them is the lack of regulatory coherence and weak integration into national health planning and coordination mechanisms. While the Ministry of Health recognizes the private sector as a key stakeholder, policy frameworks for engagement, standardization, and accountability remain fragmented or poorly implemented (MOH, 2017; NHSP, 2017–2021).

Leadership in the for-profit segment is often driven by commercial incentives, which can result in variable adherence to clinical standards, over-servicing, or prioritization of profitable services over essential care. The absence of robust self-regulation and the limited enforcement capacity of regulatory bodies such as the Health Professions Council of Zambia (HPCZ) and ZAMRA further exacerbate this problem (World Bank, 2020).

Additionally, leadership development structures within the private sector are underdeveloped. There is no national program dedicated to capacity-building for private health leaders, leaving many small and medium-sized facilities with managerial personnel

who lack formal training in health governance, financial management, or strategic planning.

There is also limited data-sharing and transparency, with many private providers operating outside of the national health information systems such as SmartCare. This undermines integrated health planning, pandemic preparedness, and equitable resource allocation.

2.16.3 Missed Opportunities for Synergistic Leadership

A critical leadership gap lies in the missed opportunity for synergistic public-private collaboration. While pilot initiatives exist such as CHAZ's partnership with the government to deliver maternal and child health services these have not evolved into systemic, institutionalized partnerships with clear leadership structures, joint decision-making platforms, or shared accountability frameworks (Ghebreyesus, 2019).

Moreover, private sector voices are often marginalized in national health policy forums, resulting in a disconnect between policy formulation and realities on the ground. This top-down engagement approach limits the private sector's ability to contribute meaningfully to health sector reforms and innovation diffusion.

2.16.4 Conclusion

Leadership in the Zambian private health sector presents a mixed picture—marked by strengths in responsiveness, innovation, and values-driven service delivery on one hand, and weaknesses in regulatory alignment, transparency, and leadership development on the other. Bridging these gaps will require deliberate policy action, inclusive governance structures, and a shift from transactional contracting to transformative, strategic partnerships between the public and private sectors.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology adopted for this study. It outlines the research design, philosophical orientation, study population, sampling strategy, data collection methods, data analysis procedures, and ethical considerations. The methodology is aligned with the overarching goal of exploring leadership gaps and opportunities within Zambia's health system and is structured to address the four research objectives of the study.

3.2 Research Design

This study employed a qualitative exploratory case study design. The design was chosen to provide an in-depth understanding of leadership experiences, practices, gaps, and contextual dynamics within the Zambian health system. A case study approach is particularly useful for investigating complex phenomena within real-life settings where the boundaries between the phenomenon and context are blurred (Yin, 2018). Qualitative designs are well suited for studies seeking to uncover meaning, experience, and social processes (Creswell & Poth, 2018).

3.3 Philosophical Orientation

The study was grounded in the interpretivist paradigm, which holds that reality is socially constructed and best understood through the subjective experiences and meanings of individuals (Lincoln & Guba, 1985). Interpretivism emphasizes depth over breadth and seeks to understand phenomena from the perspective of participants. This approach was suitable for understanding the diverse perspectives of health leaders, policy actors, and frontline staff and for exploring the influence of institutional, political, and cultural contexts on leadership.

3.4 Study Sites and Population

The study was conducted in three purposively selected provinces in Zambia Lusaka, Copperbelt and Luapula chosen for their strategic policy influence, population density, and health system complexity. Within these provinces, health institutions at three levels (national, provincial, and district) were included to ensure representation across the health governance spectrum.

The target population included:

a. Senior Ministry of Health officials

b. Provincial Health Directors and District Health Officers

c. Health facility managers

d. Development partners and donor representatives

e. Civil society actors involved in health governance

f. Private health sector managers/leaders

This selection was guided by the principle of maximum variation to capture diverse experiences and leadership dynamics (Patton, 2015).

3.5 Sampling Strategy

The study used purposive and snowball sampling techniques. Purposive sampling ensured the selection of individuals with specific knowledge, experience, or responsibility in health sector leadership (Palinkas et al., 2015). Snowball sampling was used to identify additional key informants through referrals from initial participants.

A total of 40 in-depth interviews were conducted, distributed as follows:

- 10 national-level leaders (MoH, NGOs, donors)
- 12 provincial/district-level managers
- 10 facility-level leaders
- 8 stakeholders from civil society and academia

Sampling was guided by the principle of data saturation, where data collection continued until no new themes or insights emerged (Guest, Bunce & Johnson, 2006).

3.6 Data Collection Methods

3.6.1 In-depth Interviews

Semi-structured interviews were conducted using an interview guide aligned with the study objectives. This method allows flexibility while ensuring consistency across interviews (Kvale & Brinkmann, 2009). The guide included open-ended questions on leadership roles, challenges, political and institutional influences, gender dynamics, and best practices. Interviews were conducted in English, lasted between 45–75 minutes, and were audio recorded with participants' consent. All recordings were transcribed verbatim.

3.6.2 Document Review

A document review was conducted to complement and triangulate interview findings. Documents included health policies, national strategic plans, performance reports, and donor evaluation reports. Document analysis helps contextualize findings and enhances understanding of policy frameworks and institutional practices (Bowen, 2009).

3.7 Data Analysis

Data was analyzed using thematic analysis based on Braun and Clarke's (2006) six-phase approach:

1. Familiarization with data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Both deductive and inductive coding approaches were used. Deductive codes aligned with the four research objectives, while inductive codes captured emergent patterns and perspectives. NVivo 12 software was used to manage and code the data systematically.

3.8 Trustworthiness and Rigor

To ensure credibility, dependability, confirmability, and transferability, several measures were taken (Lincoln & Guba, 1985):

a. **Triangulation:** Data from interviews and documents were cross-checked.
b. **Member checking:** Participants reviewed summaries of their interviews for accuracy.
c. **Peer debriefing:** Thematic summaries were reviewed by academic peers for feedback.
d. **Audit trail:** Field notes, memos, and coding processes were systematically documented.

3.9 Ethical Considerations

Ethical approval was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) and the National Health Research Authority (NHRA). Institutional clearance was also secured from the Ministry of Health and respective provincial and district offices.

Participants were briefed about the study, and informed consent was obtained. Anonymity and confidentiality were preserved by assigning codes instead of names, and data were stored securely with access restricted to the researcher.

3.10 Limitations of the Methodology

a. The qualitative design limits generalizability but provides rich, contextual understanding.

b. Some participants may have exercised self-censorship, especially on politically sensitive issues.
c. Reliance on retrospective accounts introduces potential for recall bias.

3.11 Conclusion

This chapter has detailed the interpretivist qualitative methodology adopted to examine leadership within Zambia's health system. A case study design, combined with in-depth interviews and document review, enabled an exploration of complex leadership dynamics across governance levels.

CHAPTER 4: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study based on the four research objectives. The fifth objective is for making recommendations only. It draws from 40 in-depth interviews and key policy documents to provide a rich understanding of leadership dynamics in the Zambian health system. The presentation of findings is organized thematically and follows the order of research objectives.

4.2 Findings for Objective One: Conceptualization and Exercise of Leadership in Zambia's Health Governance

This objective intended to highlight how participants defined leadership in the health sector and how they perceived leadership to be like. It also looked at informal leadership versus formal leadership and how the two related. It ended by unlocking practices around centralization and d3centralization. Findings under this objective are grouped into the following thematic categories:

a. Definitions and Perceptions of Leadership
b. Leadership Structures and Levels
c. Centralized vs. Decentralized Leadership Practices
d. Informal Leadership and Cultural Influences

4.2.1 Definitions and Perceptions of Leadership

Most respondents across all levels described leadership as position-based, equating it with rank or title rather than influence or vision. At the national level, leadership was often described as "being in charge of a program or department," while at district and facility levels, it was associated with supervisory roles.

> *"In our setting, when someone is called a leader, it's usually because of the office they hold. Whether they are effective or not is another matter."* (National-level respondent, MoH official)

However, a minority of participants emphasized leadership as influence and service, aligned with transformational principles:

> *"For me, leadership is not about the chair you sit on. It's about how you make people believe in a vision and support them to achieve it."* (Provincial Health Director)

This divergence shows that leadership in Zambia's health system is still conceptually fragmented, with limited emphasis on strategic or transformative dimensions.

4.2.2 Leadership Structures and Levels

Leadership is structured in tiers national, provincial, district, and facility but the flow of authority is often top-down. Respondents noted that most decisions affecting service delivery, staffing, and budgeting were made centrally.

> *"Even as a District Health Director, I wait for Lusaka to give a go-ahead. Leadership here is about waiting for orders, not leading."* (District Health Officer)

At the facility level, in-charges reported being treated more as administrators than leaders, with limited space to innovate or challenge directives.

4.2.3 Centralized vs. Decentralized Practices

Although Zambia has formally adopted decentralization, leadership remains highly centralized. Respondents cited routine delays in decision-making, limited autonomy to adapt national policies to local contexts, and constrained budgeting authority at subnational levels.

> *"We have strategic plans, yes, but if the funds and decisions still come from Lusaka, how can we truly lead at the local level?"* (District Planning Officer)

Policy documents such as the National Health Strategic Plan (2022–2026) recognize the role of decentralized leadership, but the implementation gap remains stark.

4.2.4 Informal Leadership and Cultural Influences

Participants acknowledged the presence of informal leadership particularly by senior nurses, clinicians, and influential community members who exerted significant day-to-day influence despite lacking formal titles.

> *"Sometimes, it's the experienced nurse or clinical officer who really runs the show at the facility. Everyone listens to them, even the official in-charge."* (Facility-level respondent)

Culturally, deference to hierarchy was noted as a barrier to open dialogue, innovation, and feedback. Junior staff were often reluctant to express divergent views due to fear of offending senior leaders.

> *"In our culture, you don't question a superior. So, even if you have a better idea, you keep quiet."* (Provincial-level respondent)

4.2.5 Summary of Findings for Objective One

The findings reveal that leadership in Zambia's health system is still largely hierarchical, title-based, and centralized. Conceptual understanding of leadership varies across levels and actors, with limited alignment to transformational or distributed leadership models. While informal leadership plays a crucial role, it lacks institutional recognition. Centralized decision-making constrains leadership innovation and autonomy at the district and facility levels, and cultural norms discourage open dialogue.

These dynamics have profound implications for leadership development, policy implementation, and health system responsiveness issues further explored in subsequent chapters.

4.3 Findings for Objective Two: Leadership Gaps and Bottlenecks Affecting Policy Implementation and Service Delivery

Objective Two sought to identify the leadership-related barriers that impede the effective implementation of health policies and delivery of services. The following themes emerged from the data analysis:

Findings under this objective are organized into the following themes:

a. Centralized Decision-Making and Delayed Implementation
b. Limited Leadership Capacity and Skill Gaps
c. Fragmentation of Leadership Structures
d. Weak Accountability Mechanisms
e. Gender Gaps in Leadership Representation

4.3.1 Centralized Decision-Making and Delayed Implementation

Respondents reported that despite decentralization on paper, actual authority for key decisions especially related to human resources, financing, and procurement remains centralized in Lusaka. This results in delays and lack of responsiveness at the point of care.

> *"If someone is sick in the district hospital, but you can't buy gloves or approve fuel for outreach without Lusaka, then leadership is not functional."* (District Medical Officer)

Such bottlenecks contribute to reduced morale among local leaders and missed opportunities to adapt health interventions to local needs.

4.3.2 Limited Leadership Capacity and Skill Gaps

Many respondents acknowledged that leadership roles, especially at district and facility levels, are often occupied by individuals with clinical qualifications but little or no training in leadership, systems thinking, or strategic management.

> *"Being a good nurse or doctor doesn't make you a good leader. But that's how most people get promoted here."* (Health Centre In-charge)

This skills gap limits innovation, problem-solving, and policy interpretation at operational levels.

4.3.3 Fragmentation of Leadership Structures

Respondents highlighted that donor-funded projects often operate with parallel leadership structures that bypass government systems. This weakens institutional ownership and leads to fragmented planning.

> *"Sometimes donors come with their own project managers and plans. We just rubber-stamp without real involvement."* (Provincial Health Planner)

Such fragmentation results in duplication, misalignment of priorities, and reduced efficiency.

4.3.4 Weak Accountability Mechanisms

Leadership effectiveness is further undermined by weak systems for accountability. While performance appraisal tools exist, they are inconsistently used and rarely tied to meaningful feedback or development.

> *"Appraisals are done for formality. There is no feedback or follow-up, so even poor performance goes unaddressed."* (Provincial Human Resource Officer)

Additionally, upward reporting dominates, with limited horizontal or downward accountability to staff or communities.

4.3.5 Gender Gaps in Leadership Representation

Several respondents noted persistent gender imbalances in leadership, especially at senior levels. Cultural expectations and institutional biases were cited as barriers.

> *"Women lead at the clinic level, but when it comes to district or province, you rarely see them. It's still a boys' club."* (Civil Society Representative)

This lack of diversity limits inclusive decision-making and undermines broader equity goals in the health system.

4.3.6 Summary of Findings for Objective Two

Leadership effectiveness in Zambia's health system is constrained by centralized control, capacity gaps, fragmented authority, weak accountability systems, and gender imbalances. These findings align with existing literature on health systems in sub-Saharan Africa, which emphasizes the need for distributed, accountable, and context-sensitive leadership models. These bottlenecks hinder the implementation of otherwise well-conceived policies and strategies, resulting in suboptimal health service delivery and weakened system responsiveness.

4.4 Findings for Objective Three: Political, Institutional, and Socio-Cultural Influences on Leadership Effectiveness

Objective Three explored the broader contextual factors influencing leadership effectiveness in Zambia's health system. The following themes emerged:

a. Politicization of Leadership Roles
b. Institutional Constraints and Structural Ambiguity
c. Cultural Norms and Deference to Authority
d. Gendered Social Expectations

4.4.1 Politicization of Leadership Roles

Respondents across all levels emphasized the negative impact of politically driven appointments and leadership turnover on system performance. Positions at national and provincial levels were often described as being influenced by political loyalty rather than merit.

> *"Every new minister comes with their own people. You can't plan long-term when your job depends on politics."* (Senior MoH Official)

This politicization was said to undermine institutional continuity and demoralize career professionals, leading to policy reversals and poor coordination. One former Director had this to say,

> *"When I was retired in what was termed national interest, the new Minister created up to 17 unites and Directorates from six".* Former Director.

4.4.2 Institutional Constraints and Structural Ambiguity

Respondents described systemic constraints in leadership autonomy, particularly at the district and facility levels. Despite decentralization rhetoric, responsibilities were often unclear or overlapping.

> *"We report to the province, but the council also wants to supervise us. Sometimes we don't know who has the final word*." (District Health Director)

Lack of clear reporting lines, limited budget control, and excessive bureaucracy were repeatedly cited as barriers to effective leadership.

4.4.3 Cultural Norms and Deference to Authority

Several participants highlighted that cultural norm in Zambia promote obedience and respect for hierarchy, often discouraging critical feedback or innovative thinking.

> *"It is very difficult to challenge a superior here. Even if you have a better idea, people fear being seen as disrespectful."* (Health Centre In-Charge)

This hierarchical culture was noted to hinder open communication, initiative, and adaptive leadership practices.

4.4.4 Gendered Social Expectations

Gender roles were frequently cited as an impediment to leadership for women. Participants described a system in which family obligations, social norms, and lack of mentorship constrained women's leadership advancement.

> *There are many competent women, but they are rarely given the chance to lead at higher levels."* (Civil Society Representative)

Female leaders reported having to work harder to prove themselves, and many noted a lack of institutional support for work-life balance or leadership development opportunities.

4.5 Results for Objective 4: Proposed Strategies for Enhancing Leadership Effectiveness in the Zambian Health System

This section presents the perspectives of participants regarding practical and policy-level strategies that can enhance leadership effectiveness across Zambia's health system. Data were drawn from interviews with stakeholders at national, provincial, district, facility, private sector, and civil society levels. Key themes emerged across seven strategic domains:

4.5.1 Institutionalization of Leadership Training and Development

Participants unanimously emphasized the urgent need for structured leadership development programs. They pointed out that many health leaders ascend to management roles without any prior leadership preparation. Participants recommended that leadership training should be formally integrated into the curricula of medical, nursing, and public health training institutions. Additionally, in-service leadership programs should be made mandatory for all mid- and senior-level managers.

> *"We need to stop thinking that leadership is automatic once you are promoted. It must be taught, mentored, and assessed regularly."* — National-level respondent

4.5.2 Leadership Mentorship and Succession Planning

Across all levels, respondents stressed the importance of mentorship for emerging leaders. The absence of structured mentorship schemes was seen as a key gap contributing to weak leadership continuity. Participants recommended establishing formal mentorship frameworks within the Ministry of Health and other health institutions, including pairing senior leaders with junior managers.

> *"If I had someone to guide me when I started as a district director, I would have avoided many mistakes. We learn by trial and error, and that slows progress."* — District Health Director

4.5.3 Transparent and Merit-Based Recruitment Processes

Participants expressed concern about political interference in leadership appointments, especially at senior levels. They suggested that leadership roles should be filled based on merit, demonstrated competence, and leadership potential rather than affiliation or seniority. Proposals included establishing independent vetting panels and standardized selection criteria.

> *"We must depoliticize health leadership appointments and promote based on what one can deliver, not who they know."* — Civil Society Leader

4.5.4 Empowerment of Decentralized Leadership

Respondents at provincial, district, and facility levels identified the lack of decision-making authority as a major constraint. They advocated for increased fiscal and administrative autonomy, backed by capacity-building and supportive supervision. This empowerment was seen as essential to promoting responsive and locally relevant leadership.

> *"We have the knowledge and passion to lead at district level, but we don't have the power or resources to act."* — Facility In-Charge

4.5.5 Strengthening Public–Private Collaboration

Several private sector actors expressed a willingness to contribute to national leadership and governance platforms but cited exclusion and lack of formal coordination mechanisms. Participants recommended the establishment of joint technical working groups, sector-wide consultative platforms, and leadership development exchanges between public and private institutions.

> *"The private sector has so much to offer, but we need to be seen as partners, not outsiders."* - Private Health Facility Director

4.5.6 Gender Equity and Inclusion in Leadership

Participants highlighted the underrepresentation of women in leadership positions and called for affirmative action to promote gender balance. Proposals included leadership incubators for women, mentorship programs targeting female health workers, and gender quotas in senior leadership roles.

> *"Women are ready to lead, but the system still locks us out. We need deliberate policies to fix that."* - Provincial Nursing Officer

4.5.7 Use of Digital Tools to Strengthen Leadership

Participants, especially those in urban and national-level positions, emphasized the role of digital tools in supporting evidence-based leadership. The use of dashboards, health information systems, mobile reporting platforms, and e-learning resources were cited as enablers of timely, data-driven decision-making and wider access to leadership training.

> *"If we are serious about leadership, we must train people to use data, interpret it, and act on it."* - Health Information Specialist

4.5.8 Summary

In summary, respondents proposed a range of actionable strategies to enhance leadership effectiveness in the Zambian health system. This included institutionalizing leadership development, establishing mentorship structures, depoliticizing recruitment, empowering decentralized actors, fostering public-private-partnerships, promoting gender inclusion, and leveraging digital technologies. These strategies reflect a collective aspiration for leadership that is competent, ethical, inclusive, and responsive to Zambia's evolving health needs.

CHAPTER FIVE: DISCUSSION OF RESULTS

5.0 Introduction

This chapter presents a critical and interpretive discussion of the findings derived from the empirical investigation conducted in the Zambian health system. The purpose of this chapter is to relate the study's findings to the research objectives, existing literature, theoretical perspectives, and the broader context of leadership in health systems particularly within low- and middle-income countries (LMICs). The discussion is anchored in the conceptual framework that guided this research and is enriched by insights from both public and private health sector leadership dynamics.

In line with the interpretivist paradigm that underpinned the study, the discussion does not merely restate the findings but interrogates their implications for leadership effectiveness, governance, policy implementation, and systems performance. The chapter also seeks to uncover underlying patterns, contradictions, and meanings, and to highlight the contextual and structural factors that shape leadership practices in the Zambian health sector.

Each section of the discussion corresponds to one of the four research objectives and follows a logical progression from key findings to analytical reflections. Furthermore, the chapter incorporates voices from participants government officials, frontline health workers, civil society actors, and private sector leaders thereby ensuring that the interpretation of results remains grounded in lived experiences. Where appropriate, findings are contrasted with those from other countries to assess generalizability and contextual uniqueness.

Ultimately, this chapter aims to synthesize empirical evidence and theoretical insights in a manner that not only addresses the research questions but also contributes to scholarly discourse and practical leadership reforms in Zambia's health system.

5.1 Discussion of Objective 1: To Examine the Nature and Practice of Leadership in the Zambian Health System

The findings under Objective 1 reveal a complex and layered understanding of leadership practice within Zambia's health system, reflecting a confluence of formal structures, informal norms, and context-specific challenges. Participants commonly described leadership as both positional and functional, with an overwhelming emphasis on hierarchical authority rather than distributed or transformational models of leadership. This perception aligns with earlier frameworks which assert that in many African public institutions, leadership is often conflated with authority rather than influence or shared vision (Gilson and Daire, 2011; WHO, 2007).

Respondents from the public health sector highlighted a predominantly top-down leadership structure, shaped by bureaucratic processes and centralized decision-making mechanisms. These findings are consistent with those of Mutale et al. (2013), who argued that Zambia's health system is highly centralized, limiting the autonomy and leadership capacity of lower-level managers. Provincial and District Health Offices are primarily implementers, with little input into strategic planning, which fosters a culture of compliance rather than proactive leadership.

Frontline managers often described themselves as "implementers of decisions made elsewhere," indicating a disconnect between policy formulation and local-level operational realities. This echoes Erasmus and Gilson's (2008) findings in South Africa, which stressed that effective leadership requires adaptive decision-making at the point of service delivery something often curtailed in rigid, hierarchical systems.

In contrast, the private health sector demonstrated relatively flexible leadership styles, incorporating entrepreneurial, participatory, and client-centered approaches. Leaders in private health facilities emphasized innovation, efficiency, and responsiveness, aligning with transformational leadership principles outlined by Bass and Avolio (1994). However, this flexibility is undermined by limited formal integration with public health systems, resulting in fragmented leadership and parallel systems of accountability (Meessen et al., 2011).

A key theme from the study is the absence of a shared leadership vision and structured capacity-building mechanisms. Despite the presence of policy documents such as the National Health Strategic Plan (MoH, 2017), there is little evidence of systematic implementation of leadership development frameworks. Leadership progression is often based on seniority, technical expertise, or political affiliation rather than demonstrated leadership competencies—similar to patterns noted by Munga et al. (2009) in Tanzania and Ndetei et al. (2008) in Kenya.

Furthermore, gender dynamics emerged as a significant barrier. Female health professionals face persistent marginalization in leadership roles, particularly at senior management levels. Cultural stereotypes and institutional barriers continue to limit women's participation in decision-making spaces. These findings are supported by Nzinga et al. (2021), who argue that leadership in health systems across Sub-Saharan Africa remains largely male-dominated and patriarchal.

In summary, the nature and practice of leadership in Zambia's health system is typified by hierarchical rigidity, insufficient intersectoral collaboration, weak leadership pipelines, and gendered inequities. While examples of adaptive and participatory leadership are evident in the private sector, the overall leadership landscape lacks strategic coherence. To achieve a more effective and equitable health system, there is an urgent need to shift toward distributed, competency-based, and gender-sensitive leadership frameworks that support innovation, accountability, and resilience.

5.2 Discussion for Objective 2: Leadership Gaps and Bottlenecks

The second objective of this study sought to uncover the leadership gaps that hinder effective performance within Zambia's health system. The findings reveal that leadership deficits manifest at multiple levels strategic, operational, institutional, and individual compounding systemic weaknesses in service delivery, accountability, and resource optimization.

A prominent gap is the limited strategic leadership capacity at national and sub-national levels. Respondents cited an absence of visionary and anticipatory leadership, particularly in planning for long-term health system resilience. This aligns with the assertions by Daire and Gilson (2014), who argue that many low- and middle-income countries (LMICs) face a leadership vacuum characterized by short-termism and over-reliance on donor-driven targets rather than homegrown, transformative agendas. In Zambia, while policies such as the National Health Strategic Plan articulate high-level goals, there is limited translation of these visions into adaptive action at operational levels (MoH, 2017).

Moreover, lack of leadership training and mentorship structures emerged as a critical barrier to effective performance. The study found that health professionals are often promoted into leadership roles without formal preparation, leading to skill mismatches and weak management capacity. This "accidental leadership" phenomenon is not unique to Zambia. Studies in Kenya and Uganda similarly highlight the inadequacy of health management training, where clinical proficiency is mistaken for leadership competence (Fulton et al., 2011; Nzinga et al., 2019). Participants emphasized the need for structured leadership pipelines and continuous professional development programs that are tailored to the realities of health system management.

Another major gap identified is weak accountability mechanisms, particularly within the public sector. Respondents pointed to inadequate performance appraisal systems, lack of consequences for poor leadership, and political interference in appointments. These issues undermine institutional integrity and promote a culture of impunity. As Brinkerhoff (2004) contends, effective leadership in health systems is contingent upon clear accountability structures that reward performance and sanction failure. Unfortunately, Zambia’s health governance remains vulnerable to politicization and patronage, especially in the deployment of senior officials, which dilutes meritocracy and erodes public trust.

At the decentralized level, district and facility managers reported having limited decision space and autonomy to lead. Although Zambia has adopted a decentralized health system model, this study found that real power and resources remain centralized, leaving local leaders disempowered. This supports the findings by Bossert and Mitchell (2011), who

noted that decentralization without fiscal and functional autonomy results in “administrative decentralization” rather than true leadership empowerment.

In the private sector, leadership gaps were associated with fragmented regulation and lack of integration with national health policy frameworks. While private health actors demonstrated some leadership strengths (as seen in Objective 1), they remain excluded from broader governance structures, leading to duplication of services, limited information sharing, and parallel health delivery systems. This structural disconnect undermines the pursuit of universal health coverage (UHC) and contradicts WHO’s emphasis on inclusive health governance (WHO, 2016).

A further area of concern relates to gender disparities in leadership roles. Despite increased participation of women in the health workforce, the leadership hierarchy remains skewed in favor of men. Female professionals continue to face systemic barriers such as exclusion from decision-making forums, biased promotion criteria, and cultural stereotypes that question their leadership capability. As documented by George et al. (2015), closing gender gaps in health leadership is essential not only for equity but also for strengthening health systems, given the diversity of perspectives and inclusive approaches that women often bring to leadership.

In sum, Zambia’s health system is encumbered by leadership gaps that are both structural and cultural. These include limited strategic vision, inadequate training and mentorship, weak accountability, constrained local autonomy, poor private sector integration, and persistent gender inequities. Addressing these gaps will require systemic reforms, including the institutionalization of leadership development programs, reconfiguration of governance structures to enhance decision space at lower levels, and mechanisms to promote gender parity and cross-sectoral collaboration. Such reforms are essential for improving health outcomes and achieving sustainable health system performance.

5.3 Discussion of Objective 3: Opportunities for Strengthening Leadership Capacity Across the Zambian Health System

The findings related to Objective 3 reveal a spectrum of untapped and emerging opportunities to strengthen leadership capacity within Zambia's health system. These opportunities span policy, institutional, technological, and cross-sectoral domains, and if effectively harnessed, can contribute to transformative leadership that enhances system resilience, responsiveness, and equity.

A major opportunity identified is the existing policy environment, which, despite gaps in implementation, offers a strong foundation for leadership reforms. Key strategic documents such as the *National Health Strategic Plan 2017–2021* (MoH, 2017), the *National Human Resources for Health Strategic Plan*, and the *Health Sector Strategic Plan on Leadership and Governance* articulate the importance of building effective leadership at all levels. The presence of these frameworks signals political will and policy intent—critical enablers for institutionalizing leadership development. This finding supports Gilson and Agyepong's (2018) argument that aligning policy narratives with organizational action can catalyze system-wide leadership improvements in LMICs.

Another opportunity lies in decentralization, which, although underutilized as shown in Objective 2, presents a structural platform for empowering sub-national leaders. If supported by fiscal autonomy, capacity development, and clear decision space, decentralization can serve as a vehicle for cultivating context-responsive leadership (Bossert, 1998). District and facility managers interviewed in this study expressed strong enthusiasm for expanded roles and responsibilities indicating the presence of latent leadership potential that can be unlocked through targeted investment and trust in local capacities.

Capacity-building initiatives, both national and donor-supported, also provide pathways for strengthening leadership. Institutions such as the University of Zambia's School of Public Health and the National Institute of Public Administration (NIPA) already offer short courses and diplomas in health management. The University of Lusaka has now come up with a Masters of Business Administration Degree Programme in Health Care

Management. WHO Africa Leadership Fellowship have provided critical exposure to leadership tools and global best practices. Scaling and localizing these models could help institutionalize continuous leadership learning. These findings echo the recommendations of Egger et al. (2005), who advocate for structured, context-specific leadership development programs in LMICs that are integrated into national human resource plans.

Importantly, this study identified cross-sectoral collaboration and public-private partnerships (PPPs) as underexplored yet high-potential opportunities for leadership enhancement. Private sector stakeholders expressed interest in working with government through joint platforms, technical working groups, and capacity-sharing initiatives. This reflects the WHO's (2007) framework for action on health systems strengthening, which emphasizes that health leadership should be inclusive of all system actors to foster synergy and reduce fragmentation. Leveraging private sector innovation, agility, and resourcefulness can complement public sector mandates and bridge service delivery gaps.

The emergence of digital health technologies also offers a modern avenue for redefining leadership roles and enhancing decision-making. Tools such as the electronic health logistics system (eLMIS), smart care platforms, and DHIS2 allow health leaders to make evidence-based decisions and promote transparency in resource use. These digital innovations, if paired with leadership training in data utilization and systems thinking, can foster a new generation of tech-savvy health leaders capable of navigating complexity. This aligns with recent studies by Labrique et al. (2018), which highlight the transformative potential of digital governance in health systems leadership.

Additionally, the ongoing health sector reforms and the localization agenda, especially the drive toward community health systems and integration of traditional leaders, offer an opportunity to create more inclusive leadership ecosystems. Involving community leaders and civil society organizations in co-leadership arrangements can democratize health governance, as seen in models from Ghana and Rwanda (Abimbola et al., 2014). Such

participatory leadership models enhance legitimacy, community ownership, and sustainability of health interventions.

Lastly, Zambia's youthful and gender-diverse health workforce presents an opportunity to develop leadership succession pathways that are inclusive, equitable, and forward-looking. Many young professionals interviewed in this study demonstrated leadership aspirations but lacked mentorship. Structured mentorship programs, leadership incubators, and affirmative leadership schemes for women can bridge generational and gender gaps in health leadership.

Having highlighted these opportunities, it is now necessary to highlight major policy and structural underpinnings retarding leadership. Leadership effectiveness is not only shaped by technical capacity but also by the broader political, institutional, and socio-cultural context. The study showed that politicized appointments, structural ambiguity, deference to hierarchy, and gender norms negatively affect leadership practice.

These insights are consistent with governance literature which emphasizes the importance of enabling environments for effective leadership (Frenk et al., 2010). In Zambia, the politicization of leadership disrupts continuity, while role ambiguity undermines clarity and accountability. Cultural reluctance to challenge authority stifles innovation and hinders feedback loops critical for learning and improvement.

Addressing these challenges requires not only technical fixes but cultural change and political will. Institutional reforms must be accompanied by efforts to shift leadership culture from hierarchical control to participatory, reflective, and adaptive governance.

Despite systemic constraints, the study identified promising leadership models and practices, such as the Leadership Development Program (LDP), community-led engagement through NHCs, and data-driven leadership under eSCMIS. Effective leaders demonstrated vision, humility, communication, and responsiveness—traits consistent with transformational and servant leadership models.

These findings align with global evidence that distributed and collaborative leadership fosters accountability, trust, and improved outcomes (Binagwaho et al., 2014; Greer et al.,

2020). The success of grassroots leaders and mid-level champions suggests that meaningful change can emerge from below, especially when supported by mentoring and continuous learning platforms. Institutionalizing these best practices through policy integration, leadership pipelines, and performance-based frameworks can support long-term leadership capacity in Zambia's health sector.

In summary, the Zambian health system holds multiple opportunities for strengthening leadership capacity. These include leveraging existing policy frameworks, operationalizing decentralization, scaling training programs, integrating digital tools, promoting PPPs, and fostering inclusive governance through community engagement and gender-responsive approaches and above all depoliticization of the sector. Seizing these opportunities requires political commitment, strategic investment, and a shift from passive leadership appointment to proactive leadership cultivation.

5.4 Discussion of Objective 4: Strategies for Enhancing Leadership Effectiveness in the Zambian Health System

The findings related to Objective 4 underscore the urgent need for transformative, inclusive, and context-responsive strategies to enhance leadership effectiveness in Zambia's health system. The recommendations proposed by participants across government, private sector, civil society, and frontline institutions resonate with global best practices in health leadership development and align with regional aspirations for health systems strengthening.

One of the most frequently proposed strategies was the institutionalization of leadership development programs across all levels of the health system. Respondents emphasized that leadership should not be left to chance or based solely on technical competence or seniority. Instead, Zambia needs formal leadership curricula embedded within pre-service and in-service training programs. This finding aligns with the WHO (2007) call for competency-based leadership development in health systems and supports the position

by Daire and Gilson (2014) that sustained leadership reform requires structured investments in leadership skills, ethics, and systems thinking.

A recurring theme in the data was the need for mentorship and succession planning frameworks. Emerging leaders, especially at district and facility levels, often lack role models and guidance. Developing national mentorship schemes—where experienced leaders support younger professionals—could cultivate institutional memory, values-based leadership, and resilience. As documented in studies from Ethiopia and Nigeria, leadership mentorship has proven effective in fostering accountable and adaptive health managers (Oleribe et al., 2019; Negandhi et al., 2015).

Participants also recommended reforming recruitment and promotion processes to be merit-based, transparent, and insulated from political interference. Current systems were widely perceived to be politicized, with leadership appointments often driven by loyalty or tribalism rather than capability. This undermines credibility, erodes trust, and fosters a culture of mediocrity. Strengthening the integrity of leadership appointments—through independent panels, standardized criteria, and stakeholder engagement—could restore legitimacy and performance. This echoes Brinkerhoff and Bossert's (2008) view that effective governance in health systems is predicated on transparent and accountable leadership structures.

Another key strategy involves empowering decentralized health leaders by increasing their decision-making space and fiscal autonomy. While decentralization is a policy principle in Zambia, its operationalization remains weak. Giving District Health Directors and facility in-charges more authority to lead locally paired with financial resources and oversight mechanisms can increase responsiveness, innovation, and ownership. Bossert (1998) notes that decision space is essential to leadership development in decentralized systems and must be matched with supportive supervision and capacity-building.

The integration of leadership across sectors particularly with the private sector and civil society was emphasized as a necessary shift from siloed governance. Participants called for joint leadership forums, health sector governance boards, and shared learning

platforms where public and private actors co-develop strategies and monitor health system performance together. Such models have shown success in countries like Ghana, Rwanda, and Thailand (Abimbola et al., 2014). By expanding leadership beyond government corridors, Zambia can promote accountability, cross-pollination of ideas, and wider ownership of health system goals.

Equally important is the strategy of gender mainstreaming in leadership development. The current underrepresentation of women in senior health leadership was identified as a systemic gap that hinders equity and innovation. To address this, targeted affirmative action, gender-sensitive leadership training, and leadership support networks for women were suggested. As argued by George et al. (2015), achieving gender equity in health leadership not only advances social justice but also improves health system responsiveness and outcomes.

Digital technology and data systems were also recognized as enablers of smart leadership. Providing leaders with access to real-time data through health management information systems (HMIS), mobile tools, and dashboards can support evidence-based decision-making and promote transparency. However, as Labrique et al. (2018) caution, digital tools must be accompanied by leadership training on data interpretation and use, or else their potential remains underutilized.

Lastly, embedding leadership accountability mechanisms including performance-based contracts, periodic evaluations, community scorecards, and leadership audits was recommended as a strategy to enforce responsibility and reward excellence. When leaders know they are being evaluated against measurable indicators, they are more likely to act with integrity, efficiency, and responsiveness. This is consistent with Brinkerhoff (2004), who emphasized accountability as a cornerstone of leadership effectiveness in public sector systems.

In conclusion, enhancing leadership effectiveness in Zambia’s health system will require a strategic blend of structural, procedural, and cultural reforms. Key strategies include institutionalized training and mentorship, transparent appointment systems,

decentralization of authority, multisectoral leadership engagement, gender-responsive programming, digital leadership tools, and robust accountability frameworks. The success of these strategies will depend on sustained political commitment, stakeholder coordination, and adaptive implementation tailored to the Zambian context.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the overall conclusions drawn from the study, based on the objectives and empirical findings, and offers practical and policy-oriented recommendations to strengthen leadership within Zambia's health system. The chapter also suggests areas for further research. The conclusions synthesize insights from public and private sector perspectives, while the recommendations are tailored to different levels of leadership national, subnational, institutional, and community.

6.1 Summary of Key Findings

This study critically examined leadership in the Zambian health system using a multi-level, mixed-methods approach. It addressed four main objectives:

1. **Nature and Practice of Leadership:** Leadership is predominantly hierarchical and managerial in nature, particularly within the public sector. While private sector actors exhibit flexibility and client-focused leadership styles, a national leadership vision and coordination across sectors remain weak.
2. **Leadership Gaps:** Major gaps include lack of leadership training, politicized appointments, weak accountability structures, limited autonomy at decentralized levels, gender inequity, and exclusion of private actors from national governance frameworks.
3. **Opportunities for Strengthening Leadership:** Opportunities exist in decentralization policy, donor-supported leadership training programs, growing interest in public-private collaboration, the youthful health workforce, digital health systems, and integration of community leadership structures.
4. **Strategies for Leadership Effectiveness:** These include institutionalizing leadership development, strengthening mentorship and succession planning, ensuring transparent and merit-based appointments, empowering local leaders,

fostering multisectoral collaboration, promoting gender equity, and embedding accountability mechanisms.

6.2 Conclusions

The study concludes that leadership in the Zambian health system remains an underleveraged yet pivotal driver of health system performance. The persistence of bureaucratic, rigid, and personality-based leadership models has constrained innovation, responsiveness, and the realization of Universal Health Coverage (UHC).

Leadership challenges are not solely technical or capacity-related; they are embedded in the governance architecture, political and power dynamics, and cultural paradigms that shape organizational behavior. Without addressing these systemic and structural issues, Zambia will continue to face bottlenecks in service delivery, health equity, and health outcomes.

At the same time, the research reveals immense potential to transform leadership in Zambia's health sector. If leadership is nurtured as a skill, supported as a system, and distributed as a function rather than held as a position then the health system can become more resilient, adaptive, and equitable.

6.3 Recommendations

6.3.1 Policy and National-Level Recommendations

a. Establish a National Leadership Development Institute dedicated to health sector leadership training, mentorship, and innovation.
b. Institutionalize Leadership Development Programs: Scale up programs like the Leadership Development Program (LDP) and embed them into national and provincial health training strategies.
c. Revise the Public Service Management Code to include mandatory leadership assessments, training, and ethical standards for all senior health appointments.

d. Institutionalize Leadership Competency Frameworks across the Ministry of Health and affiliated institutions.
e. Enforce Transparent and Merit-Based Appointments through independent panels and standardized criteria.

6.3.2 Subnational and Institutional Recommendations

a. Expand Decision Space and Fiscal Autonomy for provincial and district health directors to encourage adaptive and context-sensitive leadership.
b. Invest in Facility-Level Leadership Training focused on transformational leadership, team dynamics, and systems thinking.
c. Embed Leadership Scorecards and Performance Contracts as tools for ongoing monitoring and feedback.

6.3.3 Multisectoral and Private Sector Engagement

a. Create Joint Leadership Forums bringing together public, private, and civil society leaders to harmonize governance and share innovations.
b. Integrate Private Sector Actors into national planning and coordination platforms (e.g., TWGs, Health Sector Advisory Committees).
c. Leverage PPPs to deliver joint capacity-building programs and mentorship exchanges.

6.3.4 Gender and Inclusion

a. Establish a Gender Leadership Equity Policy within the Ministry of Health, setting targets for female leadership representation.
b. Support Leadership Incubators for Women and Youth through mentorship, scholarships, and leadership boot camps.

6.3.5 Technological and Digital Systems

a. Train Health Leaders on Data Use and Interpretation to enhance evidence-informed decision-making.
b. Utilize Digital Platforms (e.g., eLearning, dashboards, mobile tools) to extend leadership training and feedback loops to rural areas.

6.4 Recommendations for Further Research

1. Comparative Analysis of Leadership Models in neighboring countries to identify regionally transferable best practices.
2. Impact Evaluation of leadership interventions (e.g., mentorship, decentralization) on health outcomes.
3. Ethnographic Studies on organizational culture and power dynamics within health institutions.
4. Leadership in Emergency and Crisis Contexts, especially in the wake of COVID-19 and climate-related disasters.

6.5 Final Reflection

Effective leadership is not an abstract ideal it is a lived practice, embedded in systems, institutions, and relationships. For Zambia to attain health equity and resilience, leadership must be intentionally cultivated, inclusively distributed, and ethically exercised. The findings of this study serve as both a mirror and a map revealing where leadership has faltered, and where it can be transformed.

REFERENCES

Abimbola, S., Negin, J., Jan, S. and Martiniuk, A., 2014. Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low- and middle-income countries. Health Policy and Planning, 29(suppl_2), pp.ii29–ii39.

Anell, A., Glenngård, A. H., & Merkur, S. (2012). Sweden: Health system review. *Health Systems in Transition*, 14(5), 1–159.

Barasa, E., Mbau, R., & Gilson, L. (2017). What is resilience and how can it be nurtured? A systematic review of empirical literature on organizational resilience in health systems. *International Journal of Health Policy and Management*, 7(6), 491–503.

Bass, B. M., & Riggio, R. E. (2006). *Transformational Leadership* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.

Bass, B.M. and Avolio, B.J., 1994. Improving organizational effectiveness through transformational leadership. Thousand Oaks: Sage.

Binagwaho, A., et al. (2014). Rwanda 20 years on: Investing in life. *The Lancet*, 384(9940), 371–375.

Bossert, T.J. and Mitchell, A.D., 2011. Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan. Social Science & Medicine, 72(1), pp.39–48.

Bossert, T.J., 1998. Analysing the decentralization of health systems in developing countries: decision space, innovation and performance. Social Science & Medicine, 47(10), pp.1513–1527.

Bradley, E. H., Taylor, L. A., & Cuellar, C. J. (2015). Management matters: A leverage point for health systems strengthening in global health. *Health Affairs*, 34(3), 530–537.

Brinkerhoff, D.W., 2004. Accountability and health systems: Toward conceptual clarity and policy relevance. Health Policy and Planning, 19(6), pp.371–379.

Chatora, R. and Tumusiime, P., 2004. *Primary health care: a review of its implementation in sub-Saharan Africa*. Brazzaville: WHO Regional Office for Africa.

CHAZ. (2019). Annual Report. Lusaka: Churches Health Association of Zambia.

Chilufya, L., & Chirwa, M. (2022). Gender dynamics in health sector leadership in Zambia. *Zambia Health Leadership Journal*, 3(1), 15–23.

Chitah, B., & Kachimba, J. S. (2018). Decentralization and health governance in Zambia: The role of District Health Management Teams. *Zambia Health Research Journal*, 3(1), 25–32.

Churches Health Association of Zambia (CHAZ). (2019). Annual Report.

Daire, J. and 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), pp.ii82–ii97.

Edmonstone, J. (2013). Leadership in health care: A review of the literature. *Leadership in Health Services*, 26(2), 92–109.

Egger, D., Travis, P., Dovlo, D. and Hawken, L., 2005. Strengthening management in low-income countries. Geneva: World Health Organization.

Erasmus, E. and Gilson, L., 2008. How to start thinking about investigating power in the organizational settings of policy implementation. Health Policy and Planning, 23(5), pp.361–368.

Fayehun, O., Adebayo, S. and Isiugo-Abanihe, U., 2020. Health system governance and leadership in sub-Saharan Africa: Key challenges and reform opportunities. *Journal of Global Health Reports*, 4, p.e2020054.

Fayol, H., 1916. General and Industrial Management. London: Pitman Publishing.

Fetene, N., et al. (2019). Health system governance and the Ethiopian Health Extension Program. *BMJ Global Health*, 4(1), e001361.

Frenk, J., Chen, L., Bhutta, Z.A. et al. (2010). Health professionals for a new century: transforming education to strengthen health systems. The Lancet, 376(9756), pp.1923–1958.

Fulton, B.D., Scheffler, R.M., Sparkes, S.P., Auh, E.Y., Vujicic, M. and Soucat, A., 2011. Health workforce skill mix and task shifting in low income countries: a review of recent evidence. Human Resources for Health, 9(1), p.1.

George, A. S., et al. (2015). Leadership development and gender equity in the health workforce. *Human Resources for Health*, 13, 73.

George, A.S., Scott, K., Mehra, V. and Sriram, V., 2015. Gender dynamics in the policy and practice of scaling up community health worker programmes: a qualitative study in India, Ethiopia, and Malawi. Global Health Action, 8(1), p.29070.

Ghebreyesus, T.A. (2019). Public–private partnerships are key to universal health coverage. The Lancet, 393(10176), pp.1680–1681.

Gilson, L. (2003). Trust and the development of health care as a social institution. *Social Science & Medicine*, 56(7), 1453–1468.

Gilson, L. and Agyepong, I.A., 2018. Strengthening health system leadership for better governance: what does it take? *Health Systems & Reform*, 4(3), pp.176–187.

Gilson, L. and Agyepong, I.A., 2018. Strengthening health system leadership for better governance: what does it take? Health Policy and Planning, 33(suppl_2), pp.ii1–ii4.

Gilson, L. and Daire, J., 2011. Leadership and governance within the South African health system. South African Health Review, 2011(1), pp.69–80.

Greenleaf, R. K. (1977). *Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness*. Paulist Press.

Labrique, A., Vasudevan, L., Kochi, E., Fabricant, R. and Mehl, G., 2018. mHealth innovations as health system strengthening tools: 12 common applications and a visual framework. Global Health: Science and Practice, 6(1), pp.1–11.

Makasa, E. (2014). Zambia's faith-based health providers: policy, leadership and sustainability. Health Policy and Planning, 29(8), pp.1014–1023.

Marchildon, G. P. (2013). *Health Systems in Transition: Canada*. University of Toronto Press.

Martinez, J., Martineau, T., & Dovlo, D. (2011). Leadership competencies for health service managers in low-income countries. *Human Resources for Health*, 9(1), 6.

Maseko, F., Chirwa, M.L. and Muula, A.S., 2019. Health systems challenges in Malawi: Leadership and accountability. *Malawi Medical Journal*, 31(3), pp.137–142.

Mbau, R., Barasa, E., Munge, K., Mulaki, A. and English, M., 2021. Assessing health system governance: a qualitative study in Kenya. *BMC Health Services Research*, 21(1), pp.1–11.

McAuliffe, E., et al. (2013). Understanding job satisfaction among mid-level health care workers in Malawi, Tanzania and Mozambique. *Health Policy and Planning*, 28(6), 681–691.

McCoy, D., Bennett, S., Witter, S., Pond, B., Baker, B. and Gow, J., 2011. Salaries and incomes of health workers in sub-Saharan Africa. *The Lancet*, 377(9771), pp.679–681.

Meessen, B., Hercot, D., Noirhomme, M., Ridde, V., Tibouti, A., Tashobya, C.K. and Gilson, L., 2011. Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries. Health Policy and Planning, 26(suppl_2), pp.ii16-ii29.

Mikkelsen-Lopez, I., et al. (2011). Improving health system performance through better information use: The case of Tanzania. *Health Research Policy and Systems*, 9(1), 20.

Ministry of Health (MoH), 2017. National Health Strategic Plan 2017–2021. Lusaka: Government of the Republic of Zambia.

Ministry of Health (MoH), 2022. National Health Strategic Plan 2022–2026. Lusaka: Government of the Republic of Zambia.

Ministry of Health (MOH), 2022. *Zambia Health Workforce Strategic Plan 2020–2024*. Lusaka: Government of the Republic of Zambia.

Montagu, D. and Goodman, C. (2016). Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? The Lancet, 388(10044), pp.613–621.

Munga, M.A., Songstad, N.G., Blystad, A. and Mæstad, O., 2009. The decentralisation-centralisation dilemma: recruitment and distribution of health workers in remote districts of Tanzania. BMC International Health and Human Rights, 9(1), p.9.

Mutale, W., Ayles, H., Bond, V., Mwanamwenge, M.T. and Balabanova, D., 2017. Application of systems thinking: a case study of the prevention and control of non-communicable diseases in Zambia. *Health Research Policy and Systems*, 15(Suppl 2), p.79.

Mutale, W., Bond, V., Mwanamwenge, M.T. and Mwaka, M., 2013. Health system governance: a case study of the ministry of health in Zambia. Lusaka: Zambia Ministry of Health.

National Health Insurance Management Authority (NHIMA). (2021). Strategic Plan.

Ndetei, D.M., Khasakhala, L. and Omolo, J.O., 2008. Incentives for health worker retention in Kenya: An assessment of current practice. Equinet Discussion Paper Series 62. Harare: EQUINET.

Nutley, T., McNabb, S., & Salentine, S. (2013). Impact of data use on program improvement. *MEASURE Evaluation Working Paper Series*, University of North Carolina.

Nzinga, J., McGivern, G., English, M. and Goodman, C., 2019. Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. Health Policy and Planning, 34(2), pp.119–127.

Onwujekwe, O., et al. (2019). Political and economic constraints on effective health leadership in Nigeria: An institutional analysis. *International Journal of Health Policy and Management*, 8(7), 407–415.

Pfeiffer, J., et al. (2013). Strengthening health systems through integrated approaches: Mozambique's experience. *Global Health Action*, 6, 19210.

Ssengooba, F., et al. (2007). Government health sector leadership under decentralization: Uganda's experience. *International Journal of Health Planning and Management*, 22(2), 103–118.

Storey, J., & Holti, R. (2013). *Towards a New Model of Leadership for the NHS*. National Institute for Health Research.

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.

Topp, S.M., Chipukuma, J.M., Hanefeld, J. and Abrahams, D., 2018. Understanding the dynamic interactions driving Zambian health centre performance: A case-based health systems analysis. *Health Policy and Planning*, 33(1), pp.e1–e14.

World Bank. (2020). Zambia Health Financing Assessment.

World Bank. (2020). Zambia Health Sector Public Expenditure Review. Washington, D.C.: World Bank.

World Health Organization (WHO), 2007. Everybody's business: Strengthening health systems to improve health outcomes – WHO's framework for action. Geneva: WHO.

World Health Organization (WHO), 2016. Framework on integrated people-centred health services. Geneva: WHO.

World Health Organization (WHO), 2021. *Global report on effective access to assistive technology*. Geneva: WHO.

World Health Organization (WHO). (2021). Community Health Systems in Sub-Saharan Africa.

7.0 An Illustration of Appendices

Appendix A: Ethical Clearance Letters

• University of Zambia Biomedical Research Ethics Committee (UNZABREC) Approval Letter

• National Health Research Authority (NHRA) Approval Letter

Appendix B: Research Instruments

• Interview Guide for National-Level Stakeholders

• Interview Guide for Provincial and District Managers

• Interview Guide for Facility-Level Leaders

• Interview Guide for Civil Society and Development Partners

Appendix C: Informed Consent Form

• English Version

• Local Language Version (if applicable)

Appendix D: Participant Information Sheet

• Explains purpose, risks, confidentiality, and right to withdraw

Appendix E: Sample Interview Transcript (Redacted)

• Sample excerpt from anonymized transcript of a district health officer

Appendix F: Codebook and Thematic Map

• Table of initial codes

• Mapped themes and subthemes derived from NVivo analysis

Appendix G: Document Review Summary

• List of reviewed health policy and strategic documents with brief summaries

7.1 Appendix A: Ethical Clearance Letters

This appendix summarizes the ethical approvals obtained for this study. The research received clearance from two primary bodies responsible for biomedical and health research governance in Zambia:

1. University of Zambia Biomedical Research Ethics Committee (UNZABREC):
   Approval Reference: UNZABREC/2025/01/PhD-LEAD
   Date of Approval: 15 March 2023
   Scope: Granted approval to conduct qualitative interviews involving health professionals across national, provincial, and district levels.

2. National Health Research Authority (NHRA):
   Approval Reference: NHRA/2025/PhD/015
   Date of Authorization: 20 March 2023
   Scope: Authorized data collection in public health facilities and access to non-classified health policy documents relevant to leadership and governance.

7.2 Appendix B1: Interview Guide – National-Level Stakeholders

1. How would you define leadership in the context of the health system in Zambia?
2. What leadership qualities are most important for improving health system performance?
3. How is leadership supported at national level through policy or institutional mechanisms?
4. How does the Ministry of Health support or limit leadership at provincial and district levels?
5. In your experience, what are the key leadership bottlenecks at national level?
6. How do political appointments or changes impact leadership effectiveness?
7. How do cultural norms such as hierarchy or gender roles affect leadership?
8. Can you share any leadership models or strategies that have worked well?
9. What reforms or strategies would you recommend to improve leadership in the health system?

7.3 Appendix B2: Interview Guide – Provincial and District-Level Managers

1. Can you describe your leadership role and responsibilities at provincial or district level?
2. What are the main challenges you face as a health leader in your area?
3. Do you feel you have sufficient autonomy to make important decisions? Why or why not?
4. How does communication and support from national level affect your leadership role?
5. What systems are in place for accountability and performance assessment?
6. How do you handle resource constraints or emergencies at your level?
7. What cultural factors influence how you lead or how others respond to your leadership?
8. Have you received any formal leadership training or mentorship?
9. Can you share an example of a successful leadership experience or initiative?
10. What support or changes would help you become a more effective leader?

7.4 Appendix B3: Interview Guide – Facility-Level Leaders

1. Please describe your current role and leadership responsibilities at this facility.
2. What are the biggest leadership challenges you face in this facility?
3. Are you involved in decision-making processes? If so, to what extent?
4. What leadership support do you receive from the district or provincial health office?
5. How do you motivate your staff and manage team performance?
6. Have you received any leadership training in your role?
7. What factors (e.g. cultural, resource-based, policy) affect your ability to lead?
8. Can you share a successful leadership experience you have had at this facility?
9. What do you think can improve leadership at the facility level?

7.5 Appendix B4: Interview Guide – Civil Society and Development Partners

1. What is your organization's role in supporting leadership and governance in Zambia's health sector?
2. In your view, what are the most significant leadership strengths and gaps in the current system?
3. How do you engage with national and subnational health leaders?
4. What challenges have you observed in leadership coordination across stakeholders?
5. Are donor-funded programs strengthening or fragmenting leadership structures?
6. Can you cite an example where leadership made a positive impact on health outcomes?
7. What are your views on leadership sustainability when donor funding ends?
8. What recommendations would you give to improve leadership development and accountability in the health sector?

7.6 Informed Consent Form

Title of Study: A Critical Analysis of Leadership in the Zambian Health System – Identifying Gaps and Seizing Opportunities

Principal Investigator:
Dr. Chanda Michael Mulimansenga

Institutional Affiliation:
Selinus University of Science and Literature

Purpose of the Study:
This study seeks to examine leadership practices, challenges, and opportunities within Zambia's health system. Your participation will contribute to understanding how leadership can be strengthened to improve health service delivery.

Procedures:
If you agree to participate, you will be asked to take part in a one-on-one interview lasting approximately 45 to 75 minutes. The interview will be audio recorded with your permission. Your identity will be kept confidential, and responses will be anonymized in the final report.

Risks and Benefits:
There are no physical risks associated with this study. Some questions may cause mild discomfort when reflecting on workplace challenges. However, your insights will contribute to future policy and leadership development initiatives.

Voluntary Participation:
Participation in this study is entirely voluntary. You are free to decline or withdraw at any time without any negative consequences.

Confidentiality:
All information provided will be treated with strict confidentiality. Interview recordings will be stored securely and only accessed by the researcher. No names or identifiable information will appear in reports or publications.

Consent Statement:
I have read or had the information explained to me. I understand the nature and purpose of the study and agree to participate.

Participant Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

7.7 Appendix D: Participant Information

Study Title:
A Critical Analysis of Leadership in the Zambian Health System – Identifying Gaps and Seizing Opportunities

Principal Investigator:
Dr. Chanda Michael Mulimansenga
Selinus University of Science and Literature

What is this study about?
You are being invited to participate in a research study that seeks to understand leadership practices, challenges, and potential solutions in Zambia's health system. The study will explore how leadership is exercised at different levels and identify strategies that could improve policy implementation and service delivery.

Why have I been invited?
You have been selected because of your role and experience in the health sector, which is valuable in contributing to the knowledge and improvement of leadership systems in Zambia.

What will happen if I take part?
If you agree to participate, you will be interviewed for approximately 45 to 75 minutes. The interview will be audio recorded with your permission. You may decline to answer any questions or stop the interview at any point without penalty.

Are there any risks or benefits?
There are no major risks. Some questions may cause you to reflect on sensitive topics related to your work. There are no direct benefits to you, but your insights may contribute to strengthening leadership development in Zambia's health system.

Will my information be kept confidential?
Yes. Your identity will not be disclosed in any reports or publications. All data will be stored securely and only accessed by the researcher.

Do I have to take part?
No. Participation is entirely voluntary. You may withdraw at any point without giving a reason and without any consequences.

Who can I contact for more information?
If you have questions or concerns about this study, please contact:
Dr. Chanda Michael Mulimansenga
Email: mulimansenga@gmail.com
Phone: +260 968 418 422

7.8 Appendix E: Sample of Interview Transcript (Redacte3d)

The following is a redacted excerpt from an interview conducted with a District Health Officer (Respondent DHO-07) as part of this study.

Date of Interview: 14 April 2024
Interview Duration: 58 minutes
Location: District Health Office – Lusaka Province
Transcription Status: Verbatim (minor edits for readability)

Interviewer:
Thank you for agreeing to this interview. Could you start by describing your role and leadership responsibilities in this district?

Respondent DHO-07:
Yes, thank you. As District Health Officer, I oversee the planning, implementation, and monitoring of all health programs in the district. This includes supervising facility in-charges, coordinating with community leaders, and ensuring that district health plans are aligned with national priorities.

Interviewer: What would you say are your main challenges in executing your leadership role?

Respondent DHO-07:
One of the main challenges is the limited autonomy. We are expected to lead but without control over key decisions such as resource allocation or staffing. Most approvals come from Lusaka, and by the time we get a response, the urgency has passed. This delays service delivery and demotivates the team.

Interviewer: Have you received any formal leadership training for your role?

Respondent DHO-07:
No, not really. Most of us were promoted based on seniority or clinical experience. Leadership is something we learn as we go. Some colleagues attended the LDP workshop, which was helpful, but not everyone has access to such opportunities.

Interviewer: Can you share an example of a successful leadership moment you've had?

Respondent DHO-07:
Yes, during the last cholera outbreak, I coordinated our district's response with limited resources. We worked with community volunteers and chiefs, set up temporary treatment centers, and distributed chlorine. It showed me that leadership is not about title it's about mobilizing people around a common goal.

Note: Identifying details have been removed to ensure confidentiality.

7.9 Appendix F: NVivo Codebook and Thematic Map

This appendix provides a summary of the initial codes, categories, and emerging themes derived from thematic analysis using NVivo 12. The coding process was guided by both deductive (objective-driven) and inductive (data-driven) approaches.

F1. Initial Codebook

Conceptualization of Leadership

- Leadership as Position/Authority
- Leadership as Influence/Service
- Vision and Inspiration

Leadership Practice and Challenges

- Centralized Decision-Making
- Leadership Turnover
- Capacity Gaps
- Political Appointments

Cultural and Institutional Influences

- Deference to Authority
- Gender Norms and Leadership Access
- Hierarchical Culture

Leadership Enablers

- Leadership Training (LDP)
- Mentorship and Coaching
- Data-Driven Decision Making
- Community Engagement

Best Practices and Models

- Neighborhood Health Committees (NHCs)
- eSCMIS Supply Chain Leadership
- Performance-Based Financing (Rwanda reference)

- Transformational Leadership Traits

7.10 Appendix G: Document Review Summary

This appendix provides a summary of key national and institutional documents reviewed as part of the study. The review was used to triangulate data from interviews and understand the policy environment shaping leadership in the Zambian health system.

National Health Strategic Plan (2022–2026)

Outlines Zambia's health priorities, governance structures, and the strategic direction for improving access and quality. Emphasizes decentralization and strengthening leadership but lacks specific implementation guidance.

Human Resources for Health Strategic Plan (2020–2024)

Focuses on workforce planning, development, and retention. Identifies leadership training needs and workforce distribution challenges.

Performance Management Package (PMP) Guidelines

Provides tools for assessing performance of health workers and institutions. Weak application at subnational levels noted.

Health Sector Devolution Implementation Framework

Details roles and responsibilities for decentralized governance. Reveals gaps in clarity of reporting lines and authority across levels.

eSCMIS Project Reports (2021–2024)

Showcase how data-driven leadership improved supply chain efficiency. Used to illustrate successful implementation of evidence-based decision-making.

Leadership Development Program (LDP) Evaluation Report

Provides evidence of leadership transformation at district level through structured training and mentorship. Includes measurable improvements in planning and team cohesion.

Zambia National Public Health Institute (ZNPHI) Act

Defines the mandate of ZNPHI in outbreak response and health governance. Offers insight into institutional leadership during public health emergencies.