DIGITAL ACCESS TO SCHOLARSHIP AT HARVARD
DASH.HARVARD.EDU

HARVARD LIBRARY
Office for Scholarly Communication

# The Influence of 'Context' and 'Nature of Challenges' on Leadership and Leadership Development: Perspectives From Senior Health Systems Leaders in Sub-Saharan Africa

**Citation**
Rusibamayila, Asinath Osmond. 2020. The Influence of 'Context' and 'Nature of Challenges' on Leadership and Leadership Development: Perspectives From Senior Health Systems Leaders in Sub-Saharan Africa. Doctoral dissertation, Harvard T.H. Chan School of Public Health.

**Permanent link**
https://nrs.harvard.edu/URN-3:HUL.INSTREPOS:37365686

**Terms of Use**
This article was downloaded from Harvard University's DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA

## Share Your Story

The Harvard community has made this article openly available.
Please share how this access benefits you. Submit a story .

Accessibility

# THE INFLUENCE OF 'CONTEXT' AND 'NATURE OF CHALLENGES' ON LEADERSHIP AND LEADERSHIP DEVELOPMENT: PERSPECTIVES FROM SENIOR HEALTH SYSTEMS LEADERS IN SUB-SAHARAN AFRICA

ASINATH OSMOND RUSIBAMAYILA

A Doctoral Thesis Submitted to the Faculty of

The Harvard T.H. Chan School of Public Health

in Partial Fulfillment of the Requirements

for the Degree of *Doctor of Public Health*

Harvard University

Boston, Massachusetts

*November 2020*

Thesis Advisor: Prof. Ana Langer Asinath Rusibamayila

**The Influence of 'Context' and 'Nature of Challenges' on Leadership and Leadership Development: Perspectives from Senior Health Systems Leaders in Sub-Saharan Africa**

## Abstract

There has been a growing recognition to make Africa an equal player in the global health community and to strengthen leadership capacity building for health systems in the region. Leadership is widely acknowledged as vital to effective health systems functioning as well as positive population health outcomes. However, there is little empirical research on health leadership and leadership development in sub-Saharan Africa. Additionally, most of the research has focused on identifying individual competence characteristics of influential leaders, and while these are vital, they are not sufficient without consideration of context. From the perspectives of senior health system leaders in sub-Saharan Africa, this research analyzes how 'context' and 'nature of challenges' influence leadership and leadership development in the region.

A qualitative study was conducted using interviews with strategic African leaders (n=15) who had in-depth knowledge and experience working to transform healthcare systems in sub-Saharan Africa. Purposive sampling was used to ensure a diversity of perspectives. Male and female leaders, originally from 13 different African countries and working from around the globe at national or international levels, were interviewed. The interviews were conducted virtually and were audiotaped and transcribed. For data analysis, thematic analysis was used, applying both inductive and deductive approaches and facilitated by Nvivo. A case study of leadership lessons in a health crisis was also conducted to identify key leadership behaviors and actions that can be applied to the current Covid-19 pandemic.

Research findings show that senior health systems leaders in Africa have a similar conceptualization of leadership as leaders in the West. However, 'humility' was identified as a representative leadership value amongst African leaders. Secondly, there were several social, economic, political as well as organizational contextual factors that influence leaders' abilities to cope the nature of challenges strategic -level leaders face. Thirdly, societal constructs of leadership were more connected to women's opportunities for leadership positions rather than their abilities as leaders.

This research provides evidence of the contextual factors influencing individual leadership within health systems in sub-Saharan Africa. The findings will inform leadership development for senior health leaders in the region.

# Table of Contents

# List of Figures

# List of Acronyms

| | |
|---|---|
| **AFRO** | Africa Regional Office |
| **DELTA** | Doctoral Engagement in Leadership and Translation for Africa |
| **DrPH** | Doctor of Public Health |
| **EJS** | Ellen Johnson Sirleaf |
| **HMLP** | Harvard Ministerial Leadership Program |
| **IRB** | Institutional Review Board |
| **MDG** | Millennium Development Goals |
| **MoH** | Minister of |
| **SDG** | Sustainable Development Goals |
| **SOP** | Standard Operating Procedures |
| **WHO** | World Health Organization |
| **UN** | United Nations |

# Acknowledgements

*This dissertation is in honor and appreciation of my beloved, late mama, Anna Fanuel Rusibamayila, who started this doctoral journey with me when I was admitted to the Harvard DrPH program in 2016 but unfortunately passed away April 20th, 2018.*

*Mama, thank you for living sacrificially for me and my siblings Mwize, Ndoli, and Fasha, to ensure that we get the best education and opportunities life has to offer.*
*I owe who I am and where I am to your love, sweat, and prayers.*

There is an African proverb that says if you want to go fast, go alone, but if you want to go far, go together. I have many people to thank who supported, advised, encouraged and challenged me in this ambitious educational endeavor. I am very grateful for my doctoral committee members Professors Ana Langer, Kimberlyn Leary, and Peter Berman, for believing in me and continually challenging me to do good work and setting high expectations for me. I am thankful to the DrPH leadership and management at Harvard, including Rick Siegrist, Gary Williams, Aria Xuemei, and Jocelyn Chu, for being open and responsive to student needs. Many thanks as well to the Harvard-wide faculty such as Emma Louise Aveling and Susan Madden, who immensely helped me in the qualitative research and also revisions the work. Prof. Wafaie Fawzi, who does a lot in Tanzania and has also been a great mentor to me since I arrived on campus. I would also like to thank my host organization, the Harvard Ministerial Leadership program, for the unique opportunity to work with the Ellen Johnson Foundation. I am as well very grateful to President Ellen Johnson Sirleaf for the humbling occasion to work with her; I have learned much about leadership from observing her lead in the times I spent with her in Liberia. Many thanks to Lucia Yallah, from the EJS Foundation as well who, spoilt me every time I was in Liberia and helped make Liberia a third home for me. I appreciate all the senior African leaders who took their valuable time to speak to me and answer, very thoughtfully, my questionnaire.

I am grateful for my colleagues, the DrPH cohorts, most especially cohort III. This journey wouldn't have been the same without the people I encountered here on campus. I have learned a lot from many of them and developed lifelong collogues and friendships. I am most grateful for my peer coach, Renzo Guinto, who I have enjoyed exchanging ideas with about my research and overall life goals. I am also thankful to the 'Kenyan Queens'-Jazmine Delgadillo, Jun Nakagawa, and Abril Campos, who I traveled with to Kenya for the winter-immersion program. We have maintained a strong peer network for professional support that I am confident goes beyond the Harvard walls.

I have a long list of friends and mentors that I am most grateful for their support. I am indebted to some of my closest friends Temitope Ojo and Saranya Ramakrishnan, who spent countless hours helping me prepare for my oral dissertation defense. I am also grateful to my public health sisterhood and brag squad Joy Chebbet and Ivy Mushamiri, who have been invaluable accountability partners. We have been meeting once a week, every week, for about 5 months to all work on our doctoral dissertations. Their encouragement and support were instrumental in the writing stage of the dissertation. I thank my young sisters Rita Orare and Ivonne Muganyizi, for creating a conducive supportive environment for me to work and be productive while working from home. A huge thank you as well to my friend and colleague Kudzai Makomva for connecting me to some of the former Ministers of Health from her network. I also cherish many of my longtime friends for being there for me at different stages of my life. I would like to thank Dr. Elizabeth Amuli, Sarah Salewi, Anneth Tumbo, Nacky Sinda, Nura-Lisa Karamagi, Lillian Rutaihwa, Nicholaus and Elizabeth Mollel, Annaneza Behista, and many more I could not possibly mention all.

Thankful for my extended family, the Rusibamayila's, and Solomons for their continued support. I am indebted to my beloved siblings Mwize, Ndoli, and Fasha, along with my sister-in-law (Anna) and nieces (Adora and Amora). Their love and encouragement keep me motivated to do my best in whatever I do. I thank my late parents Osmond and Anna Rusibamayila, for valuing education and making sure I get the best opportunities life has to offer. Last but certainly not least, I am most grateful for my fiancé, Joseph Chacha Mukohi, for being a very supportive and patient partner. His love and support mean the world to me. As a person of faith, I would like to end by thanking God for this remarkable opportunity to pursue my doctoral studies at Harvard University. It has been an incredible journey of learning, reflection and personal growth.

## AFRICAN PROVERBS ON LEADERSHIP

**On Purpose:**
Without a leader, black ants are confused
~ Ugandan proverb

**On Followership:**
He who thinks he is leading and has no one following him is only taking a walk.
~ Malawian proverb

**On Teamwork:**
If you want to go quickly, go alone. If you want to go far, go together
~ African proverb

**On Influence and Strategy:**
If the cockroach wants to rule over the chicken, then it must hire the fox as a bodyguard.
~ Sierra Leone proverb

**On Humility:**
Do not forget what it is to be a sailor because of being a captain yourself.
~ Tanzanian proverb

**On Authority:**
A large chair does not make a king.
~ Sudanese proverb

**On Resourcefulness:**
A good chief is like a forest: everyone can go there and get something.
~the Democratic Republic of the Congo Proverb

# Section I: Introduction

**Background**

In 2017, the World Health Organization (WHO) elected its first-ever Director-General from Africa in its 70-year history (The Washington Post 2017). In 2019, Denis Mukwege was awarded the Nobel Peace Prize and was the first Black African health professional to get the award (The guardian 2018). Within the global health community, there has recently been more emphasis on of making Africa an equal player because current models for global health partnerships, implementation and research are not sustainable and do not build capacity for the health systems in the region. There have also been global calls to cultivate national leadership in public health through the Accra Agenda for Action of 2008, where developing countries committed to taking control of their future (Sridhar 2009). And also the African leadership forum, which grew out of the need for capacity building and the need to improve the competence of African leaders in tackling development challenges in the continent (Curry, Taylor, Chen, et al. 2012). Currently more financial investments along with research is being devoted to building strategic health leadership and public health governance globally and in low-income countries. For instance, with the support of the Rockefeller foundation, five African universities have partnered to design and create the first Pan-Africa Doctor of Public Health program hosted in Africa with collaboration with some US universities (Agyepong et al. 2018)

African healthcare systems are besieged with a triple burden of disease: existing communicable infections, escalating chronic illnesses, and high incidences of injuries and accidents. Health systems in several Africa countries have been rendered "weak" or "fragile" because of the inability to cope with this burden or to deal with shocks such as the Ebola

outbreak. Current research shows that poor leadership plays a significant role in hindering health system development and ensuring positive population health outcomes (Chunharas and Davies 2016). However, there is a dearth of research on strategies to strengthen leadership training in developing countries (Doherty, Gilson, and Shung-King 2018). Current debates have now focused on ways to foster high-level leadership that can steer African health systems in the 21st century (Pan African DrPH Consortium 2014).

While some leadership frameworks focus on the individual and changing behavior, others recognize that in the health sector, leadership happens with many actors at various levels through policy initiation, implementation, and operations (Chunharas & Davies, 2016). Others conceptualize leadership in terms of organizational positions or roles (Hartley and Benington 2010). For example, in many health systems in Africa, Ministers of Health (MoH), Chief Medical officers, or District Medical Officers all lead and manage at different levels of the health system because of their positions. However, being in a particular top leadership position does not necessarily equate to being a good leader, and similarly, not being in a formal leadership role does not mean one cannot lead.

Ronald Heifetz (1994), a renowned Harvard University professor and expert on adaptive leadership, distinguishes between formal and informal authority in his seminal work, *Leadership Without Easy Answers*. Formal authority is the power and legitimacy to rule or lead given to a leader by their position in an organization. In contrast, informal authority is afforded to the leader by their followers.

Consideration of historical, political and sociocultural context is essential to the conceptualization of African leadership (Curry, Taylor, Guey, et al. 2012). There are various

theories of leadership and approaches to leadership capacity building, though many have been developed in the context of high-income countries (Curry, Taylor, Guey, et al. 2012). There has not been much exploration of what models or competencies are most pertinent for training leaders in the African context or in establishing whether the needs are the same as those in high-income settings. Ever since the 1978 Alma Alta Declaration that called for a leadership capacity building strengthening in sub-Saharan Africa, the priority has been primarily on training public health professionals at the operational and district levels. A significant focus of this was investments of training through Master of Public Health Training (MPH) programs. Many public health professionals have received MPH training in their home countries or have had the opportunity to go abroad and pursue public health training either in other African countries or Europe and the United States.

While MPH programs have catered to the training of mid-level managers, a report on a needs assessment for a Pan-African DrPH shows a gap for specialized training on strategic leadership and management that meets the demands of highly complex and unpredictable health systems (Pan African DrPH Consortium, 2014). There have been many other forms of short-term leadership training opportunities, including leadership fellowships, and executive education programs that have helped to mint public health leaders. Adair (2010) categorizes leadership into three levels: team, operational, and strategic levels. The team leader manages a small group of people for a specified task, and the operational level oversees several team leaders and groups. The strategic level involves leadership of entire organizations or major unit of an organization with a number of operational leaders under ones direction (Agyepong et al. 2018).

Strategic leadership has roots in the military because the word strategy or strategic in Greek means the art of being a commander-in-chief (Adair 2010). The prefix of the root 'Stratos' means an army spread out, and the second part -egy stems from a Greek verb to lead. The focus of this research is looking at leadership from the perspective of senior leaders at the strategic levels.

Most leadership training programs find it challenging to support trainees once they finish and re-enter complex work environments and have to deal with the unpredictability of the health system. There is usually a demand but a lack of opportunity to support workplace learning in a reliable manner (Doherty, Gilson, and Shung-King 2018). Additionally, the lack of a community of practice exists because not enough people in the health system are trained in leadership. Doherty et al (2018), explains that the lack of a "critical mass" of trained leaders limits the opportunity to drive a shift of the organizational culture of a health system. This reality in most health systems in sub-Saharan Africa points to the crucial need to introduce more highly trained leaders in the health system.

## Literature Review

### Concept of Leadership in Health Systems

In the 2000 World Health Report, the World Health Organization (WHO) introduced the concept of 'stewardship,' which is defined as encompassing "the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information." The report goes on to state that at the global level, the role of stewardship is to influence global research and production to meet health goals. It also entails providing an evidence base to guide countries' efforts to improve the performance of their health systems

(WHO 2000). A few years later, stewardship was redefined as "leadership and governance," and WHO identified it as one of six building blocks of the health system (WHO, 2007). According to the report, leadership and governance entail ensuring strategic policy frameworks exist and are followed with effective oversight, coalition building, regulation, attention to system design, and accountability. However, in the current governance debates the topic of leadership is not emphasized enough; more attention is given to understanding institutions, rules, and accountability mechanisms (Gilson and Agyepong 2018).

Omaswa and Crisp (2014) state that leadership is one of the essential drivers in strengthening health systems because of its impact on all the other building blocks of the health system, but it is also considered to be the most complex and the most ignored. Many complex health systems face the hurdle of nurturing leaders who can provide strategic vision, technical know-how, political acumen, and ethical orientation necessary for building and strengthening these health systems (Frenk 2010). Julio Frenk (2010) insists that without good leaders, even the best-designed systems will fail. Broadly, health systems are defined as actors, resources, and institutions involved in the financing, regulation, and provision of health actions (Murray and Frenk 2000). Health actions are any set of activities in which the intrinsic value of the activity is to improve or maintain health.

With an increasingly global and more connected world faced with a plethora of health crises, there is a global impetus to zoom in on the 'leadership' lens to understand new effective forms and requisite competencies for effective leadership. Health systems across the globe are evolving rapidly to keep up with societal, epidemiological, and demographic shifts (Figueroa et al. 2019). For instance, epidemiologically, while there has been an increased prevalence and

mortality from chronic diseases, there has also been a disruptive rise of unexpected health crises, including COVID-19, Ebola, and Zika. These outbreaks, or shocks to the health systems, are laying bare some of the damaging consequences of weak leadership across the health sector and the ramifications to the whole health system (WHO 2016). Additionally, technological advancements and global realities like climate change and divisive international politics have made it imperative for health leaders to acquire the leadership capabilities needed to overcome some of these complex challenges. According to Figuera et al. (2019), these challenges, coupled with the global movement towards universal health coverage and the Sustainable Development Goals, compel non-health actors to work together with health stakeholders in what is now termed "collaborative governance."

The discourse around "leadership" and its definition varies significantly by industry, individual, or cultural experiences. Gill (2006) among others, has argued that "there is no one correct definition of leadership or any single set of personal qualities or competencies that characterize leaders." In an early 1950's example of leadership and organization literature, Stogdill (1950) defines leadership as "the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement." There are three elements to this definition; first, leadership isn't a static concept that revolves around one individual but rather a process of influence (Hartley & Benington, 2010). So, in essence, it is less preoccupied with formal authority but instead on the ability to influence, which can occur internally at the team and organizational level, or externally at the societal level. Secondly, leadership is a relational process of influence between the leader and their followers. A leader is not a "free agent" because they have to cater to the needs of the group (Stogdill 1950). They must take into account the social

values of the members and the society, as well. If they ignore the needs of the members, they can lose their following, and if the leaders are not mindful of external stakeholders' welfare, they can cause challenges for the team. Lastly, leadership is connected to vision or purpose through goal setting. According to Hartley & Benington (2010), a leader sometimes has to uncover or frame the purpose and not just communicate or operationalize already agreed-upon goals or vision.

The terms health leadership and public health leadership have been vaguely applied and are closely linked to the general definition of leadership, although there is more of a system-wide focus. Health leadership can be understood as "the ability to identify priorities, provide strategic direction to multiple actors within the health system, and create commitment across the health sector to address those priorities for improved health services" (Figueroa et al. 2019). There are commonalities between the general definition of leadership as well as its definition within the health sector. In both cases, there is a group phenomenon of leaders and followers as well as a process where leaders motivate, influence, and shape the vision for the followers (Agyepong et al. 2018).

In the leadership scholarship, some have conflated the definitions of leadership and management; however, although these two terms are complementary, they are distinct (Gilson and Agyepong 2018). While leaders mobilize others and provide a vision for others to follow, managers work on practical implementation to plan and execute (Galer, Vriesendorp, and Ellis 2005). Kotterman (2006) differentiates the two: leaders shape culture, and managers work within it. So, leaders are perceived to be "charismatic" and are often admired or esteemed as role

models by others (Kotterman 2006). Managers, on the other hand, are taskmasters, whose primary mandate is to operationalize and get things done.

The understanding of the definition of leadership is vital for leadership development policies (Hartley & Benington, 2010). If leadership is defined around a heroic figure with unique traits or talents, then the emphasis is on cherry-picking these individuals for leadership positions or developing such characteristics. On the other hand, if the focus of leadership is on a particular formal position within an organization, then it means only people in these positions are privy for leadership capacity building. When the definition centers around a social process, the emphasis is on working in groups and teams. The scope of this research focuses on understanding leadership in relation to 'context.'

Relevant to this discussion, as well, is to understand the goals or outcomes that leadership is aiming to achieve, and what the 'nature of challenges' of leadership are. Leadership models from Heifetz (1994) and Grint (2005) postulate that the types of challenges that leadership is trying to solve affect leadership strategies, styles, and behaviors. For example, Heifetz differentiates between technical and adaptive challenges while Grint groups them into tame, wicked, and critical problems. Technical or tame problems are those problems whose solution is clear or direct and can be dealt with technical leadership or management strategies, as Grint suggests. Adaptative challenges or wicked problems are more complex, with no agreed-upon diagnosis or clear solution. Therefore, in adaptive challenges, the leader is compelled to persuade 'followers' to be involved in solving the problem and being part of the solution. Grint's third typology on critical challenge occurs when immediate and urgent action is needed. In such crises,

people are more willing to comply with a command and control style of leadership than in other situations (Hartley and Benington 2010).

**A Focus on Sub-Sharan Africa**

Since the institutionalization of the Sustainable Development Goals (SDGs) in 2015, sub-Saharan Africa has made positive strides in health improvements. The mandate of SDG 3 is to ensure healthy lives and promote well-being for all at all ages. Improved health is not only a fundamental goal of the health system but is also instrumental for the developmental process because good health is a measure of human capital (Makuta and O'Hare 2015). The SDG 3 was essential to continue to push countries to make progress in some of the lagging millennium development goals like decreasing maternal mortality rates.

Healthcare systems in Africa have been struggling with complex problems that range from deficiencies in institutions and human resources, as well as financial, technical, and political hurdles (Oleribe et al. 2019). Research from interviewing African health researchers and program officers on the key challenges facing Africa cited inadequate human resources, insufficient resource allocation to health, poor maintenance of healthcare system infrastructure, and weak political will (Oleribe et al. 2019). High disease burden with escalating rates of infectious diseases, non-communicable diseases/conditions and injuries are also a huge problem. Organized into the WHO six building blocks of the health system, the leading challenges in Africa are leadership and governance, health workforce, and health service delivery. These findings are similar to research that has looked at global health system challenges and found that health service delivery, human resources, leadership, and governance are the most frequently cited problems (Roncarolo et al. 2017). Roncarolo et al. (2017) concludes that countries with a very high Human Development

Index (HDI) face more health delivery challenges, while those in the low HDI category struggle more with human resources challenges.

WHO illuminates that the most considerable health human resource shortages are in Africa (WHO 2017). The human resource challenges in sub-Saharan Africa center around low numbers of health workers and poor competence, mix, and distribution. For example, data from 2015 shows that there were, on average, 1.30 health workers per 1000 population in Africa, which is significantly lower than the 4.5 per 1000 set by SDG (WHO 2017). This problem is driven by the brain drain of health workers to countries like America, Europe, and Asia for better work conditions, pay, and professional development (WHO 2017). There is also the problem of poor reliability and availability of health workers because of health worker strikes, having appointments in private practice rather than public hospitals, and rural-urban migration. The other challenge of poor resource allocation on health is that most African member countries have not been able to meet the 2001 Abuja Declaration target set by African heads of state to allocate 15% of government budgets to heath (WHO 2013). Also, out-of-pocket expenditures constitute more than 40% of the total health expenditures for most individuals in a significant number of African countries (WHO 2013). This is the most regressive means of health expenditure and can lead to catastrophic spending.

Leadership and poor management are a huge problem in Africa, although there is very little documentation on this subject. Several studies in the region have assessed the individual pillars of health systems such as financing, and human resources. However, there is very little empirical data on leadership and governance for health development in the continent (Gomes Sambo and Muthuri Kirigia 2014). Globally, some of the issues cited for poor health system

leadership and governance include ineffectual strategic policy planning and implementation, lack of horizontal cooperation, inadequate accountability systems, and little patient and community engagement (Roncarolo et al. 2017). For example, coordination of the health sector with the non-health actors and the private sector is considered a horizontal cooperation problem.

**Women and Health System Leadership**

Working towards better gender parity is part of effective governance for both health system strengthening and also meeting the gender and health-related SDG's (Dhatt et al. 2017). According to Dhatt et al. (2017), the SDGs have spurred a stronger global impetus around gender parity, including in leadership through SDG 5. The SDG 5 states that 'Achieve gender equality and empower all women and girls' has a specific focus on leadership: '5.5: Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life'.

The field of global health is criticized for not being gender responsive when it comes to women's representation in leadership positions (Shannon et al. 2019). According to Global Health 50/50 (2018) although women comprise 75% of the health workforce, there are substantial gender disparities at the senior leadership levels. A recent study found that only 20% of global health institutions and only two UN agencies working on health issues had gender parity in their governing boards, while only about a quarter of ministers of health are women Shannon et al. (2019). A recent report from Global Health 50/50 (2020) found that gender disparities in leadership positions are also with representation from developing countries. The report investigated 200 global health organizations and found that seventy (70%) of leaders in their sample are men, more than eighty (80%) are nationals of high-income countries and more than

ninety (90%) were educated in high-income countries. So, only about 5% of leaders were women from low- and middle-income countries. Although lack of gender parity in top leadership position exist in many other fields, such as business, law, politics, and technology, this gender gap in global health leadership is striking because of the importance of women's health in this field (Dhatt et al. 2017). Gender and leadership intersect when it comes to the challenges of women's leadership growth and development, which is further complicated by child-rearing expectations, sexism, and discrimination based on identity (Shung-King et al. 2018). The lack of gender-sensitive policies 'that enable women to integrate their social, biological, and occupational roles impede women's ability to live their full potential (Langer et al., 2015).

Global Health 50/50 defines gender as 'socially constructed norms that impose and determine roles, relationships, and positional power for all people across their lifetime.' This definition elucidates three critical elements that influence its interpretation. Shung-King et al., (2018) summarizes the three points as …' the first is that gender is relational and is shaped by access to and distribution of resources and power between men and women. Second, gender norms and roles are dependent on context and vary across time. Third, differences in gender relations are also shaped by the intersections of gender with other social constructs (i.e., race, class, ethnicity)'. Gender is different from sex, which is the biological and physical characteristics that define women, men, and those with intersex identities (Global Health 50/50, 2018).

In the 1995 Beijing conference, which was a landmark convention on the status of women, gender equality was the term proposed to be used to refer to aspirations for more equal gender considerations. Gender equality is defined as “the equal rights, responsibilities, and opportunities of women and men and girls and boys” which does not denote that the two genders are the same

but that the interests, needs, and priorities of both are given equal consideration in decision making and planning (OSAGI, 2001). Equality is different from equity, which applies to the interpretation of social justice and is often based on tradition, custom, religion, or culture.

Shannon et al. (2019) mention that achieving gender equality is essential in global health, science, and medicine because it has the potential to improve health, social and economic gains. For example, in medicine, there is evidence that patients may prefer providers of a particular gender and having a more diverse workforce equates to greater equity of access. Shannon continues to explain that research from business and management fields shows that organizations with a more varied workforce report more productivity, innovation, decision-making, and employee satisfaction. One randomized control study in India showed that women in government leadership positions are more likely than their male counterparts to implement policies that support the well-being of women and children (Downs et al. 2014). In 1993, India adopted a constitutional amendment that gave rural villages the freedom to choose whether or not to be led by female leaders. After adjusting for confounders, a look at the outcomes of this study showed that women invested more in public works closely linked to women's concerns, such as clean drinking water (Downs et al., 2014). On the other hand, men invested in initiatives more aligned with their gender, like irrigation systems for farming. Interestingly, ten years after the implementation of these random leadership assignments, adolescent girls in the communities with female leaders received significantly more education, acquired higher job aspirations, and were less likely to be subjected to domestic chores than the girls in the other arm of the study. Examples, like these, illuminate the theory that gender influences leadership decisions and the likely impact of women in their community.

Recently, there has been more recognition in developed nations of the need to have more women participate in global health leadership (E. Liu et al. 2019). This awareness has created a convenient window in these countries to evaluate institutional policies, ensure gender-parity in panels, and have more gender-responsive programming and guidelines. Unfortunately, most of these efforts have not trickled into low- and middle-income countries (LMIC), which is problematic given the social and political challenges that impede women's career advancement in these countries. However, new ideas of promoting women's leadership in LMICs and giving voice to this movement have sprung up. For example, in November 2019, a Women Leaders in Global Health Conference was held in Kigali, Rwanda, which opened up the platform to discuss gender equality in health leadership in different contexts. There have also been calls for crowdsourcing funds for women leaders from Africa or for leadership opportunities (E. Liu et al. 2019). However, there is still very little research on the influence of gender on health leadership in LMICs, most notably in sub-Saharan Africa.

Studies that have looked at the intersection of gender and leadership in Africa have shown that women often have to compromise on their career aspirations for the sake of their husband or children (Shung-King et al. 2018). Research of senior health managers in South Africa showed that many women managers and leaders had been pioneers in several professional positions, meaning they were the first to hold such posts (Shung-King et al. 2018). The challenge with this was that, usually, women lacked professional mentors and advisors in their organizations. This may be interlinked with the particular history of the country. South Africa got independence around two decades ago, and so for the first time, women occupied positions previously reserved for white males, or only people with medical backgrounds. Both in Africa and elsewhere, there

is evidence to show that women leaders who are considered 'positive deviances,' meaning that they can overcome challenges and rise to top positions of health leadership, are often supported by either family members or mentors (Dhatt et al. 2017).

Given the strong patriarchal nature of many African societies, it is important to investigate contextual elements from the region that can lead to heightened challenges of gender disparities in leadership.

**Leadership Development in Sub-Saharan Africa**

It is widely regarded that effective leadership is central to strengthening health systems to improve quality of care and assure better health outcomes (Curry et al. 2012) . With this acknowledgment, there has recently been more investment in leadership development programs for health systems leaders. However, most of the research around leadership capacity-building has focused primarily in the context of high-income countries. It is argued that consideration of the historical, political, and socio-cultural context is crucial to understanding African leadership. However, there is very little research done on leadership development in sub-Saharan Africa and, in particular, in the topic of health (Curry et al. 2012). Hartley & Benington (2010) describe leadership development as the activities and experiences that are used to enhance the quality of leadership and leadership potential in individuals, groups, teams, organizations, and networks.

Hartley & Benington, (2010) assert that the challenge with leadership is development is that they are often implemented with the implicit belief that it is a 'good thing' to do without much evidence on what works for the specific audience and context. Usually, there is a lack of precise planning to ensure that the models of leadership used are supporting relevant skills and values and that they have realistic expectations in terms of resources required. Effective

leadership development contributes to both individual leadership growth but also organizational change and improvement. There is often the view that there is a universal approach to leadership development; however, several researchers point to the need for contextualized learning because different stakeholders may value and require unique aspects of leadership scholarship (Hartley & Benington, 2010).

Though also true in the developed world, in limited-resource settings leadership training programs find it particularly challenging to support and sustain the learning for participants once they return to their complex workplaces (Doherty, Gilson, and Shung-King 2018). New leadership training programs are experimenting with online or a blended approach, ensuring they can provide mentoring and support to trainees once they have completed a residential leadership training. The value of this is less time spent away from work. However, it can also dilute the relationship building and networking opportunities of residential programs. Additionally, modeling of appropriate behaviors and emphasizing teamwork have become critical elements of newer techniques for leadership training, both of which are challenging to achieve in a remote learning environment. Contributing to a culture shift requires that a 'critical mass' of well-trained leaders are injected into the health system; however, limited resources make this problematic in LMICs (Doherty, Gilson, and Shung-King 2018).

## Section II: Analytical Platform

### Objectives

The primary goal of this research is to explore how 'context' and the 'nature of challenges' influence health leadership and leadership development in sub-Saharan Africa.

- **Objective I:** To investigate key leadership 'capabilities' or 'competencies' strategic health leaders in sub-Saharan Africa demonstrate in the 'context' and 'nature' of challenges they work in
    - **Special Case Study:** To focus on a particular kind of 'context' and 'challenge' and identify lessons leadership in a crisis using the example of the 2014 Ebola outbreak in Liberia.
- **Objective II:** To analyze how 'context' and the 'nature' of challenges intersect with gender in sub-Saharan Africa

**Research Focus**

Leadership and leadership development can happen at many levels, but the focus of this research is looking at leadership at the strategic level and leadership development at the individual level.

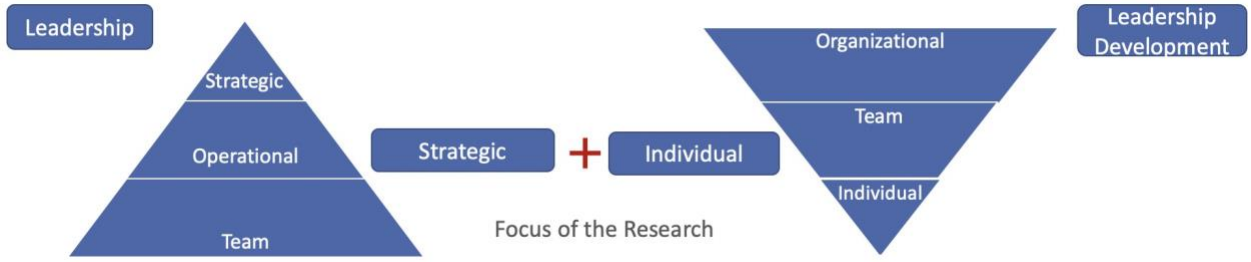


Figure 1: Levels of Leadership and Leadership Development

**Conceptual Framework**

Hartley & Benington (2010) critique the vast literature and frameworks on leadership as not being grounded on theory or context. Leadership frameworks, including health or public health leadership frameworks, are often a laundry list of prescriptive or aspirational behaviors, skills, and competencies exhibited by effective leaders. This 'heroic' narrative of leadership is primarily focused on the individual characteristics of the leader. It is divorced from the nature of

the context as well as the other players in the process. The challenge with this approach is that it becomes difficult to analyze leadership as 'a dynamic and contested process within a complex adaptive whole system' (Hartley and Benington 2010).


Figure 2: The Warwick Six C Leadership Framework (Hartley and Benington 2010)

The Warwick Six C analytical framework above, adapted from Hartley & Benington (2010), is used in this research to analyze the different aspects of strategic health leadership in sub-Saharan Africa. The framework has six pillars around it, with leadership and leadership development being at the core.

- ***Concepts:*** Various concepts that senior African health leaders use to define leadership are examined, including identifying which aspects of leadership they emphasize, and which ones they downplay, and how does this compare to the Western conceptualization of leadership? The definition of leadership influences the ways in which leadership behaviors, processes, and outcomes are interpreted and what is deemed acceptable or effectual.

- ***Characteristics:*** It is essential to recognize that there is no 'one best' or ‘universal’ approach to leadership. Even in healthcare, opportunities to influence depend on the roles and the resources (e.g., authority, information, legitimacy, and expertise) of the individual and their organizations and networks. For example, the type of direct influence a Minister of Health, who is also a politician in many African countries, can exert is sometimes quite different from a WHO Country Representative whose mandate is to provide indirect leadership through supporting governments.
- ***Context:*** Context is critical to understanding the processes and consequences of leadership (Hartley and Benington 2010). One fundamental prerequisite for effective leadership is the ability to understand the contexts in which leadership is exercised and to frame and articulate it to others. Health systems around the globe are complex and dynamic due to political, economic, and social influences from within the system and from the broader society. Health leaders must be aware of the challenges and opportunities of the geographical location, history, structure, culture, skills, resources, and reputations of the organizations they are operating. Leadership rarely operates on an empty canvas, and leaders have to work within the history and culture of their organizations as well as within a specific locale (Hartley and Benington 2010).
- ***Challenges:*** This research explores the nature of the challenges senior health system leaders face. The kind of challenge a leader faces can dictate the leadership style or approach. The section also broadly highlights some of the similarities and differences of challenges articulated by African health leaders versus Western healthcare executives.

- ***Capabilities:*** Given the 'context' and 'nature of challenges,' this section explores the competencies or qualities (traits, skills, attitudes, mindsets, and behaviors) of senior health system leaders needed to bring about transformative change in the African healthcare system.
- ***Consequence:*** Perceptions of leadership effectiveness and leadership impact are shaped by attributions, which explain how people interpret cause and effect. The interpretations may not be accurate but are often firmly held. Taking a gender lens, this section explores how gender interfaces with leadership in sub-Saharan Africa.
- ***Leadership Development:*** This arm explores some of the gaps, challenges, and opportunities for leadership development of senior health system leaders in Africa. The analysis of the six pillars of leadership—concept, context, characteristics, challenges, capabilities and consequence or gender—all influence leadership development.

**Host Organization: The Harvard Ministerial Program**

The Harvard Ministerial Leadership Program (HMLP) is designed to stimulate transformative vision, enhance leadership effectiveness and political acumen, and develop planning and execution capacity among government ministers. The Ministerial program has three main tracks of leadership training focused on training Ministers of Health, Education, and Financing. The Program combines ministerial-level support with customized technical facilitation and capacity development tailored to the specific needs and priorities of participating countries.

I was hired by the HMLP at end of 2018 as a Senior Research Fellow and had a unique opportunity to work with a former Noble Peace Laureate and first democratically elected female

head of state in Africa, Ellen Johnson Sirleaf (EJS), in supporting her to write a personal memoir. The focus of the book is to look at leadership lessons learned during her tenure as President of Liberia (2006-2017).

While the final deliverable for this role is very exciting because it plans to cement her legacy in leadership, I primarily act as an agent to President Sirleaf. She has the final say and copyrights of the book. Therefore, for this doctoral thesis, I use only the 2014 Ebola response in Liberia as a case study of 'Leadership in a Crisis.' The case study examines how Madame Sirleaf led the response for the Ebola outbreak, the leadership lessons learned and those that can be applied to the response for the current Covid-19 pandemic. This chapter is particularly relevant now that the world is looking for answers on 'best practices' for leadership in a health crisis.

The primary focus of the doctoral thesis is the set of qualitative interviews I conducted with various African senior health system leaders to understand different aspects of health leadership in Africa. Some of the research participants are alumni of HMLP, and their names were proposed to me through the HMLP Program Directors.

**Methodology Process of Interviewing 'Elites' or' Strategic' Leaders**

X. Liu (2018) explains that in qualitative research, interviewing *elite* leaders poses some unique methodological challenges, especially for novice or less experienced researchers because of imbalances of power between the interviewer and interviewee. A review of the research methodology literature shows that social scientists are less likely to use elites as study respondents and, rather, opt to use participants who have less power than them (Nudzor 2013). Although there is a lack of empirical studies that explore why elites are less preferred as research

interviewees, much of the qualitative research provides practical reasons and explanations on some of the challenges of using these stakeholders. Firstly, the definition of elites is ambiguous and varies with the context. Elites can be defined as individuals who have "the ability to exert influence" through "social networks, social capital, and strategic position within social structures" (X. Liu 2018). In this research, elites are considered as strategic leaders who have or have had high-level positions in the health system and have deep experience and knowledge in health field of the research. In this research I will refer to elites as strategic leaders or senior health leaders. These senior leaders have influence and decision-making power in their organizations because of their formal authority through their posts, or informal authority afforded through experience and technical know-how. Other legitimate reasons for less frequently preferring elites in research is the challenge of accessing them, either because of their busy schedules or the difficulty of getting past gatekeepers and personal assistants (Nudzor 2013).

Getting responses from elites can also be very challenging. For example, some of the senior health leaders that were approached to participate in this research never responded to emails. Others only responded after some nudging from other more senior persons. In this case, one of my doctoral committee professors helped me to follow up on a few of the respondents. One senior leader had initially said yes during a face-to-face interaction, but later changed their mind and said they were not interested. This may be due to the fact that some elites prefer to maintain social distance and are very selective of the kinds of research engagements they are part of, and they can protect themselves from intrusion through their positions and authority (Nudzor 2013; X. Liu 2018).

### 1. Preparation for the Interviews

Strategic leaders are busy individuals whose time and sometimes attention span for the interview is often limited. Therefore, the first part to successful interviewing is have a well-designed questionnaire (X. Liu 2018). The semi-structured questionnaire used in this research was adapted from Curry et al., (2012), a paper that looks at the leadership experiences of African health leaders. For this research, I first started with general questions on how these senior leaders define leadership. This was followed with questions to give more concrete examples of what attributes they look for when hiring someone for leadership positions in their team. I continued to ask broad-based questions on the nature of challenges African leaders face in working to transform health systems. I then moved on to more specific questions about a particular challenge or opportunity that required them to apply their leadership skills.

Research shows that the way questions are designed and asked can influence the kind of response one gets (X. Liu 2018). Therefore, the suggestion for the interviewer is to be flexible with the flow of questions. The questionnaire for this research had four main sections, but I made the order flexible. For example, several of the respondents brought up issues of gender and leadership earlier on in the conversations, so I would follow up on the questions of gender then even though it was a topic further in my questionnaire.

There can sometimes be a heightened challenge of time constraints and limited attention span when interviewing senior leaders because of their busy schedules and having other high priority items on their agenda. To aid with the prioritization of questions, the researcher needs to spend time creating an intention list and setting out the purpose or the 'why' behind each question. This can help in figuring how well-suited

the articulation of the question is to the intent. It also helps to reduce redundancy within the interview guide and ensure that key issues are adequately covered. Therefore, for each question, I made sure to document why it is being asked, and what it is I was getting at, as well as how it related to the primary research objectives. This helped me to be able to quickly rephrase the questions when the respondent was straying from the question or could not understand what I was asking them.

The final step of preparation for the interviews was to conduct pilot interviews to measure how the framing of the questions lands and also to calibrate timing. I did two pilot interviews with colleagues and got feedback on specific questions and flow. I also shared the interview guide with my dissertation committee and a study group of other doctoral student researchers and received feedback on whether or not the questions are aligning with the overall objectives of my research. For example, one feedback was to frame the questions in the context of sub-Saharan Africa because that is the focus of the research. Reading extensively on the informant's background is an important element of preparing to interview senior leaders, and so before the interviews, I researched the interviewees' professional experiences. Where relevant, I was able to bring up, during the interview, a respondent's remarkable achievement or work, and this helped to establish rapport and build trust.

**2. Access to the Interviewees**

Using senior leaders as respondents for qualitative research can be a challenging and time-consuming process that affects accessibility and sample size. Qualitative research that deploys purposive sampling selects individuals based on the virtue of their

capacity to provide richly textured information, relevant to the research subject under investigation (Vasileiou et al. 2018). For this reason, samples in qualitative research tend to be small so that in-depth case-oriented analysis can be conducted. I sent out emails of invitation for an interview with about 25 African senior leaders. The HMLP provided suggestions of names and emails of five former HMLP alumnae who were health leaders. There was little to no response from the first round of emails sent out to these contacts. Some responded after a second email was sent, but this was also not sufficient. From my experience of working with the Ministry of Health in Tanzania, one tactic that may be unique to accessing senior government leaders in sub-Saharan Africa, like Ministers of Health, is to reach them through telephone rather than email. Therefore, for the current or former Ministers of Health, I was able to find their telephone numbers of their offices online or through the HMLP and speak to their secretaries. In the call, I would introduce myself and call to attention the emails I had sent them and ask if the leaders are willing for me to interview them.

I would then follow up with the secretary and health leader through email with occasional call reminders about scheduling an interview time that works. It was essential to build a relationship with these gatekeepers and gain legitimacy with them first. One leader communicated through her secretary that she declined to participate. One minister had agreed to participate, but the secretary was not able to commit a time that would work for him because of the Minister's busy travel schedule.

The other contacts that I was able to get in touch with were through my networks. I spoke to colleagues who had worked in the continent for a long time and had potential connections with prominent leaders in sub-Saharan Africa. I also reached out to my doctoral committee advisors to assist me in connecting. I was able to reach out to some leaders directly if I had their contacts. While reaching out to senior leaders, it is helpful to think about what is of interest to these leaders or what did they have to gain. I had an email template that I adapted to each leader. Still, I made sure to mention that the goal of the research is to inform capacity-building initiatives for future health leaders in Africa. Liu (2018) says that a researcher's profile can be an influencing factor in committing to an interview. In the email, I mentioned my affiliation with Harvard University, as a doctoral student and a senior fellow with the HMLP. I also built credibility and legitimacy by mentioning my work with President Sirleaf and a few of the other 'respected names' of leaders who had agreed to interview with me.

**3. Interview Strategies**

To ensure interviewees adequately expressed their opinions and were authentic about their reflections, I took a few approaches. Firstly, recognizing what I represented as a Harvard doctoral student, I was careful to mention, for particular questions, that I was not looking for a textbook or scholarly definition. For instance, for the first question on ‘what is your definition of leadership?’ I asked senior leaders to respond from their own experiences and journeys of leadership.

Managing time was crucial for interviewing senior leaders. However, I was pleasantly surprised that most of my respondents were happy to speak for longer than

the allotted time of 45 minutes that I had requested. For questions for which I wasn't looking for lengthy responses, I asked for a brief answer. I also was careful to mention at the beginning that I thanked them for their time. Midway into the call or before the last 15 minutes, I would communicate that I was mindful of the time and so would move the conversation further along if I still had some important questions that I had not asked.

It was essential to ask some questions more than once to get more in-depth reflections from the leaders. One example was with the question of the 'nature of the challenges of leadership in Africa'. I asked this question at the beginning of the interview and also close to the end once. Repetition of the question allowed respondents time to reflect again about the question and offer a different or a more in-depth perspective. The questions on gender were challenging to get clear and reflective answers, especially from male leaders. It was my inclination that the questions on gender made the male African leaders slightly uncomfortable or that they were cautious about making politically incorrect statements about the topic. So, many times while interviewing male leaders on the topic of gender, I had to rephrase the questions a number of times and provide more examples or contextual emphasis to the questions.

A qualitative study using in-depth interviews was conducted with 15 African health system leaders. Purposeful sampling was used for the identification and selection of high-level, strategic health leaders. The HMLP Program proposed some of the participant's names; however, to minimize selection bias, it was essential to make sure that not all the participants were alumnae of the Ministerial Program. About five of the leaders, mostly who had been Ministers of Health in their countries, were alumnae of

HMLP. Both male and female participants with varying national and international health experiences were selected. The leaders interviewed come from 13 different African nations, including Ghana, Liberia, Naimbia, Cameroon, Sierra Leone, Liberia, Nigeria, Swaziland, Botswana, Tanzania, and Rwanda. Some had worked in the health sector either at the national or global level, while several had both national and global experience.

Interviews were conducted in English via zoom and were audiotaped and transcribed. Participants were emailed consent forms before the start of interviews. Given the high profile of the targeted participants, all participants were asked for verbal consent for their names, titles, and job descriptions to be identifiable as per the IRB approval. Participants were told that if they were not comfortable giving their names to be released or if there is sensitive information that is divulged, the names won't be identified. Generic roles and titles would be used for those that don't want to be identified. For example, if one of the participant's titles or positions is a Director at UNICEF, then her role will be coded as a high-level leader at a multinational organization. On average, each interview was about 60 minutes long. The shortest interview was about 35 minutes long and the longest around 1.35 hours. All interviews were transcribed using an automated software transcription program called Otter- ai. ®

**Table 1: Profiles of Respondents-Senior African Health Leaders**

| NAME | GENDER | NATIONALITY | TTILE | ORGANIZATION |
|---|---|---|---|---|
| Dr. Sibongile Ndlela-Simelane | F | Kingdom of Swaziland | Minister | Ministry of Health |
| Dr. Richard Nchabi Kamwi | M | Namibia | Minister | Ministry of Health |
| Dr. Awa Marie Coll-Seck | F | Senegal | Minister | Ministry of Health |
| Dr. Bernice Dhan | F | Liberia | Minister | Ministry of Health |
| Dr. Muhammad Ali Pate | M | Nigeria | Global Director | World Bank |
| Joyce Msuya | F | Tanzania | Deputy Director | UN Environment Program (UNEP) |
| Dr Matshidiso Rebecca Moeti | F | Botswana | Regional Director | World Health organization (WHO) |
| Dr. Paulin Basinga | M | Rwanda | Nigeria Country Director | Gates Foundation |
| Dr. Nana A. Y. Twum-Danso | F | Ghana | Director | Rockefeller Foundation |
| Magnus Conteh | M | Sierra Leone | Executive Director | Community Health Academy/Last Mile Health |

**Table 1 (Continued): Profiles of Respondents-Senior African Health Leaders**

| | | | | |
|---|---|---|---|---|
| Dr. Sodzi Sodzi-Tettey | M | Ghana | Africa Director | Institute for Health Improvement (IHI) |
| Myriam Sidibe | F | Mali | Social Mission Director | Unilever Africa |
| Dr. Irene Akua Agyepong | F | Ghana | Public Health Physician | Research and Development, Ghana and Health Service |
| Dr. Angela Nyamura Gichaga | F | Kenya | CEO | Financing Alliance for Health |
| Dr. Moka Lantum | F | Cameroon | CEO | Sagitarix Limited |

**Analysis**

After the transcription a bespoke software for qualitative analysis, Nvivio-v10, was used for the analysis; I used both inductive and deductive approaches to developing codes and themes. Thematic analysis as described by (Braun and Clarke 2006) is a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes the data set in (rich) detail but also interprets various aspects of the research topic.

I adopted the process of thematic content analysis coding described by Seale (2018), starting with open coding, to develop categories and then to form themes. The first step was to apply systematic, inductive procedures to generate insights grounded in the views expressed by study participants. Then, I applied the Warwick Six C Leadership Framework (Hartley and

Benington 2010) to develop categories using a 'theoretical' or 'deductive' approach to organize and structure the analysis. Finally, I applied the process of thematic coding using both inductive and deductive approaches, building themes based on existing leadership literature and concepts. In the following section, I discuss the results of the qualitative analysis.

## Section III: Results

**Objective I: To investigate key leadership 'capabilities' or 'competencies' strategic health leaders in sub-Saharan Africa demonstrate in the 'context' and 'nature' of challenges they work in**

The Warwick Six C Leadership Framework is used as the analytical framework to structure the major themes in the findings.

**Part I: How do senior health system Leaders in sub-Saharan Africa conceptualize Leadership?**

Senior African Health leaders have a conceptualization of leadership that is very similar to that of Stogdill (1950), which centers around the three elements of leadership: process of influence, relational, and goal oriented.

> I think leadership is identifying a vision of success. And then clearly or attempting to chart the way for the people or the teams that are trying to transform this vision into reality then. So, there has to be an element of vision, and then there's an element of charting the way and being there for them. So, to me, that's what leadership is. A good leader is someone who has clarity on the vision, and then tries to chart the way on how to get to the vision so that people feel inspired and equipped to be able to carry out the vision.
>
> - Dr. Myriam Sidibe Director Social Mission Unilever

The majority of respondents described a leader's ability to influence using words such as 'inspire' and 'empower.' Inspire was qualified by participants as creating an environment in which people are willing to give their best. Some health leaders went on to emphasize that a leader's ability to inspire others is critical in sub-Saharan Africa because the conditions of the health system in these settings can often be demoralizing due to challenges including low wages and lack of career development opportunities. This is particularly true in the public sector in sub-Saharan Africa, where institutions are weak.

> Leadership is the ability or capacity to inspire others. It is able to motivate others to work towards an agreed common objective or goal. And so, it includes very much including others, giving them the sense that they belong to the common purpose the common enterprise.
>
> - Dr. Matshidiso Moeti_Regional Director WHO Africa

Almost all the leaders defined leadership around having a vision or a purpose. Most saw leaders as custodians of the vision but mentioned that leaders need to consult with their followers and build ownership around a shared vision. Purpose as well was defined around a collectivistic notion as "doing something bigger than oneself to serve others."

> I think it also very much involves defining what common purpose is. So, having a vision, where are we going? What are we working towards? And communicating that to those, you're going to be leading and then being able to hear their views on it, being able to hopefully incorporate them if they have the right relevant experience, a relevant point of view so that it is a shared vision. But doing the work of envisioning, defining where we're going, what are we trying to achieve? What is our common vision?
>
> -Dr.Matshidiso Moeti_Regional Director WHO Africa

Reflecting on their leadership purpose, participants in this research shared similar sentiments to the Curry et al. (2012) findings where African health systems' leaders articulated an aspirational, value-based vision for the future of their countries. The leaders' purposes invoked a strong sense of country ownership or commitment to contribute to the 'Africa rising' movement and also giving back and serving the communities and people they are from.

> But this is what keeps me coming to the office every day; I'm very clear that the continent has so much potential. Huge, and we need to do whatever we can to exploit it, to leverage it, and to make this continent a success.
>
> -Dr.Matshidiso Moeti_Regional Director WHO Africa

African senior leaders also highlighted the relational nature of leadership. Leadership is a process and a journey where one leads, and others follow. However, even though the leader is the 'captain,' a good leader has to listen to others, give them the sense that they belong to the common purpose or joint enterprise, and recognize their value. Connected to this as well, was a strong sentiment by several of the leaders towards "collective success," i.e., that a leader is nothing without the team, and a leader's responsibility is to cultivate this mindset of collective work and success within the group. Moreover, as one of the leaders pointed, leaders need to earn their following. This notion of earning their following is connected to attributes of being a role model, which were emphasized by a number of the respondents.

> And it's my view, ultimately the leader is who is followed with that sort of merit to be followed, even whether or not he has got the authority, but at least he exemplifies the attributes, the values, the inspiration, that will make people follow him to get things done. So, I subscribe to the view that leadership is something that you do, and you take responsibility for moving an agenda, hopefully in a good direction, and that makes you a leader.
>
> -Dr. Muhammad Ali Pate_Global Director World Bank

Not many leaders made a clear distinction between management and leadership, although none wrongly defined leadership as management. One leader made the comment that leadership is much more complex than management.

> Leadership is dynamic; it is not like management where you have 12345678. Leadership is complex, dynamic, human interaction, organization interaction that helps to move agendas to a state of improved performance or delivery of an organizational goal.
>
> -Magnus Conteh_Executive Director Last Mile Health

Though many of the values associated with leadership for African leaders were similar to those cited in western leadership literature—such as integrity, ethics, and trust—one particular dimension that was unique or more apparent in this context was being 'humble.' Humbleness was cited as a positive virtue or value for authentic leadership by respondents. Humbleness is often used synonymously with humility. More recent theories of leadership cite that humility is a crucial feature of effective leadership. A landmark business book "Good to Great" by Jim Collins (2001) was referenced by one of the respondents as her inspiration for leadership style. Collins' book talks about servant leadership or how leaders who are humble but driven are the ones who drive companies that leap from good to great.

As a caveat to this idea, some scholars feel that it is crucial to avoid importing concepts developed in the West into other cultural contexts and expecting that they would be defined or interpreted similarly because different cultural milieus shape attributions, values, and what is deemed acceptable behaviors (Riordan 1994). Empirical studies of humility in leadership are scarce. However, one study showed that there are differences in the conceptualization of leadership humility between the Western and Eastern cultures (Oc et al. 2015). For example, in the Oc study of Western culture, humility in leadership is more associated with the attributes of being self-aware and honest about one's weaknesses, recognizing strengths and achievements

of followers, treating others with respect, and modeling the behavior of not always being right. On the other hand, the Asian conceptualization of humility was more similar to the respondents' comments on humility in leadership. The study shows that the dimensions of humble leadership in Asia (Singapore) include leading by example, working together for the collective good, showing modesty (meaning doesn't have to be in the limelight all the time), and mentoring and coaching. The respondents of this study had a similar conceptualization of humility as in the Asian context.

> If you are a leader, you cannot just be there to look at people working. You need to work for yourself and be part of the solution. But also, to be able to create a team around you *because a leader is nothing without the people around. And if you can have these minimum things you can try to be a leader, but if you are not working yourself, you have no team with you, you are not trying to help people grow all this part for me or the leadership style. And create a team, create a spirit of working in a team, building a lot of solidarity between people. Helping each other and not saying I am the leader; I will not help to push some chairs or things. You need to be able to do things without saying no, I cannot because I am the boss, or I am the leader."*
>
> -Dr. Awa-Marie Coll-Seck_former Minister of Health Senegal

More research is needed to understand the cultural aspects of the Asian and African contexts that influence this similar conceptualization of leadership humility. However, it has been hypothesized that humility has a unique importance in collectivistic or high-power cultures, which are characterize communities in Asia and sub-Saharan Africa (Oc et al. 2015). For example, in Asia, Taoism and Confucianism are central philosophies to leadership that explicitly mention the role of humility in leadership. For instance, in Chinese Taoism, the founding philosopher writes, "…the reason why seas can be lords over a hundred mountain streams is that they know how to keep below them". Similarly, in sub-Saharan Africa, community is widely recognized as a characteristic feature, and its meaning in the region is used to signify an ideal governing of how members of a group relate and interact (Adewale 2020). At the individual level, this notion of community calls for acting in solidarity towards the 'common good' or 'Ubuntu,' an African

philosophy that means 'I am because we are.' Secondly, African societies, like those in Asia, are also quite hierarchical with high power distance. Most times, followers are unable to interact directly with their leaders for fear of being termed 'disrespectful' or rude, and so to minimize this power distance, leaders need to practice humility without necessarily losing their power or prestige (Adewale 2020).

**Part II: Characteristics of Leadership in Health Systems**

There is no universal process of influencing others (Hartley and Benington, 2010). However, senior African health system leaders reflected on some of the key characteristics or qualities of leadership pertinent for effective leadership in the context of health systems in Africa.

**Technical Skills**

Most of the leaders indicated that technical competence or expertise, though not sufficient, was necessary when looking to hire people for leadership positions in their field. Technical skill is a requisite for technical roles. However, even for leadership or managerial positions, it was important for leaders to meet the minimum technical proficiency for the purpose. Technical skills were highlighted as necessary for non-technical leadership roles to ensure that leaders have sufficient confidence and authority in their roles. Some leaders in the public sector, for example, in the Ministry of Health in Ghana, lamented that hiring was very centralized and so they usually have little say on who joins their teams. There is a central hiring body in the government that is responsible for recruiting for various positions in the MoH, and they often focus primarily on technical eligibility. So, participants have little control and say on who joins their teams, which becomes challenging when people are given positional authority

but lack relevant 'soft' skills to lead. One participant mentioned that they often observe hired people over time and tailor responsibility, depending on a person's perceived strengths and weaknesses. Apart from the subject matter of technical expertise, some of the mentioned relevant skills included excellent writing skills. One leader highlighted that most of the work in the health system is funded through donors, and it is vital to have people in the team who have strong writing abilities. Another leader mentioned that they look for 'complementary' technical skills to theirs or the teams when hiring.

> You know, in the health sector in Ghana, the power of hiring and firing is very centralized. What we do have power over is that the people sent to you do have some discretion as to who you put in charge of what. Normally for those decisions, I would watch people over time, you know, watch you for innovativeness. For creativity for being proactive for being interested and enthusiastic about what you're doing, for having a vision and also for having people skill, you know, patience, kindness, those kinds of people skills, and then also integrity, honesty, truthfulness, and those are kind of things that sometimes rarely meet and then the ability to operate under stress. You certainly need to observe people over time. So, where I do have the power over that, I take time to actually put people. Sometimes in the public sector, you meet people they've been put there already, they are a leader by virtue of their position in a box in the bureaucracy, in which case you kind of read them and tailor the responsibility you give to them to the ability.
>
> -Dr.Irene Agyepong_Public Health Physician Ghana Health Services

**Soft skills**

One of the top key characteristics of leadership that participants valued was people skills. Almost all the leaders commented that because a majority of the work in health systems involves working with diverse stakeholders, they appreciated people who were able to deal with the inherent challenge of leading and convincing others, as well as those who contribute to team building and can cultivate the mindset of collective success. Connected to this was also the

importance of good communication skills, meaning people who are culturally sensitive and respect others.

Other soft skills mentioned included those who were agile, meaning flexible. The political, social, and economic currents of health systems are constantly shifting, and to deal with these complex systems requires leaders who are adaptive and creative.

> I look for somebody who is innovative, someone who finds solutions to challenging problems. Somebody someone who respects diversity. I also look specifically for someone who has good writing skills. Because there's a lot of writing involved from the level from which I work and especially for us to be mobilizing resources from all over. Someone who is able to work with other people and respect them and respects the opinion.
>
> -Dr.Bernice Dahn_former Minister of Health Liberia

**Part III: Contextual factors that can influence health system leadership in Sub-Saharan Africa**

According to Hartley and Benington (2010), it is vital to capture how leaders 'read' and 'interpret' the context in which their leadership operates. Equally important is their ability to articulate and make sense of the context for their following. Health leadership does not occur in a vacuum nor only in the confines of the medical or public health field; understanding the social, political, economic, and institutional contexts can help to unveil some of the challenges and opportunities that can influence leadership for senior health system leaders in sub-Saharan Africa. Participants in this research had extensive and diverse work experience, some working nationally for Ministries of Health in their country's other implementation organizations, and others regionally and internationally for entities such as WHO or the Rockefeller Foundation. The

nature of the context working at different institutions at the national, regional, and international levels can also influence the leadership style.

**Organizational and Institutional Context**

In global health, there are different kinds of organizations with varying degrees of responsibility and interest. The role, priorities, and pressures of Dr. Moeti as the Head of WHO Afro can be very different from that of a Minister of Health, for example, of Swaziland. While in the public sector, health leaders worked more directly with the people or beneficiaries, the way leaders at WHO influence and communicate can be very different, since they tend to lead indirectly through governments, helping them shape priorities and strategize.

> One of the key things we do is lead a little bit from behind the government, and that can be very delicate to navigate. So, we want we would like governments to be in charge of control, but we would like to support them to make the work with the different partners, inclusive but also effective, efficient. So, part of the role is to be a kind of co-leader, if you like support on the leadership or what we sometimes call the stewardship role of the government among a group of stakeholders to the table very different… so one of the biggest challenges is also to provide this advice in such a way that this is acceptable, but it does influence, and that creates an environment and in which the contributions of many players make a difference for the health people. In the context of it, they're needing to build relationships with government and with the many players in health and being able to operate on several dimensions on the technical level, and that is the role of WHO also in terms of our role in providing data in monitoring progress. You know, we need to be able to lead in giving evidence of progress and not progress in ways that are accepted by both governments and the partners. It is our responsibility to show when things are not going well when strategies need to be adjusted, or priorities need to be rethought. So, it's a very sort of multi-dimensional leadership role and all the time to show that, you know, we have this responsibility as WHO and as the leaders who are privileged to be in our position to have access to decision-makers."
>
> -Dr.Matshidiso Moeti_Regional Director WHO Africa

Many institutions in Africa are weak because they are marred by poor leadership and governance structures. In some countries the position of Minister of Health is a political one, and once an individual's term is over, there is often little leadership transition. The lack of continuity is quite problematic in terms of creating long-term sustainable programs.

> Increasingly, civil servants are drawn into the political dynamic of national politics. Therefore, their appointment, their ability to do their work, is not influenced so much by their professional parameters but sometimes influenced by the political dynamic in the country because of their political affiliations. Which is why usually after elections, there's a new political party in power, and you now see a change in not only the ministerial appointments, but you also see a change sometimes even in the top leadership in the civil services. And that happens with ministers of health as well. What that does is it takes away all institutional memory and learning. Because to those who are involved in health in this type of health worker capacity in an NGO world, they invest a lot of time and money and resources in building the capacity of Ministry of Health officials over the years and when there is political change these people are removed from their positions. And new people come in who do not necessarily have the right skills, right competencies, or that institutional memory and learning that you have invested over the years. That impacts on continuity and the kind of continuous improvement and progress that has been put in.
>
> - Magnus Conteh_Executive Director Last Mile Health

**Social Context**

Some participants, especially those in the public sector working for the Ministry of Health, commented on how, as senior government leaders operating within the social and cultural fabric of society in Africa, the social burden can be high. Many times, as top leaders in the government, society looks up to them to engage with different communities and they are often invited out of respect not only to government work-related events but also to social events. It becomes quite tricky to balance the time for work and social commitments. However, they cannot completely disengage from the society because they will be perceived as lacking empathy or respect for the community, and it is also one of the ways for leaders to build legitimacy with their people.

> Maybe Africa is a continent, and Africa has different cultures, different religions, different ways to do things, and I prefer just to speak on what I have seen in my country, where the social burden is very important. You have to be involved in a lot of things which are sometimes putting you out of your way, for example, in Senegal, you have too many social events. It's important for us in can be religious, cultural community and everywhere you need to go to give money to be praised them for being there people are saying you are the best person, but at the end of the day, if you are not careful, I have taken my distance to do what I have to do the minimum because you cannot be out of your society, but I don't want the society also to be always taking me out of my work, of what I want to do, but it is very is a very a real burden, and you have to navigate between these things without deciding I don't go anywhere No, I think we are in a society. We need to be part of society, but let's choose our priorities. If you have to go, you may go to the nearest events, and you don't go to all the events. You do what you have. That is, you choose your way to be part but not to be completely absorbed by society.
>
> -Dr.Awa-Marie Coll-Seck_former Minister of Health Senegal

Africa, being a continent with diverse countries, possesses complex layers of cultures and subcultures. For example, deeply embedded tribalism in nations such as Kenya and Ethiopia sometimes influence the way different people interact and can affect team building. One non-Kenyan leader working in that country hypothesized that 'generalized' tribalistic undertones sometimes influence the hiring of people from certain tribes for particular positions in the global health industry. When working in these types of contexts, leaders need to be aware of the tribalistic dynamics in order to make sure that they are not driving any team decisions or actions.

> I think it's sort of known in the industry, even the global health industry that if you're looking for a certain profile, there are certain tribes that that may deliver that profile, so you tend to see a lot of the persons from Western Kenya, doing the driver jobs or a lot of these program officer roles in the NGO space. I don't know if it's a coincidence, but almost systemically, that is what seems to be happening. I think there is a sub-narrative in the global health community that they are obedient…..so you see those dynamics happening…..if I can name 10 Chiefs of parties in Kenya, I don't think there's any Chief of Party who is Kikuyu who I know, almost all of them are from Western Kenya. Maybe because they tend to compete and like that space there better? I don't know? but there is a narrative that they are more obedient, ……. very less oppositional to the white supremacy that happens in global health organizations.
>
> -Dr.Moka Lantum_CEO Sagitarix

Although consultative forms of leadership and-decision making processes do occur in sub-Saharan Africa, hierarchical authority appears to be dominant in reaching final decisions (Wanasika et al. 2011). One leader, for example, indicated that in her country of origin, Ghana, there are strong chiefdom systems still operating. A chiefdom is defined as "a form of hierarchical political organization in non-industrial societies usually based on kinship, and in which formal leadership is monopolized by the legitimate senior members of select families or 'houses'." These hierarchical styles of leadership that are deeply ingrained in the social-cultural fabric of society, at times, influence what leadership means and what style of leadership is deemed acceptable or effective.

> I think the fact that many African societies today came out of the chiefdom, we have kings, we have queens, we have monarchies. And many people who are participating in democracies still have strong ties to their villages and the chiefs. And I think that that's the type of society where you have a chief and, and his or her subjects- it creates a certain type of leadership that the society thinks is the norm. So if you come in with a different style, maybe more of a servant leader type, or you're trying to teach servant leadership in an environment that does chieftaincy, it might not work, because a lot of chiefs are, you know, unfortunately extractive and dictatorial and tyrannical. Of course, there are some chiefs who really do work on democratic principles and make sure there is community participation and decision making but we know there are many examples on our continent, where chiefs have abused their people and taxed their people but haven't used the taxes to build anything useful for their settings. So, we need to think about what leadership means in different contexts. This is why we need to be very close to the people that we say we're trying to help
>
> Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

In many societies in sub-Saharan Africa the various gatekeepers of society such as religious leaders and also chiefs and traditional leaders have a lot of influence as well as formal

and informal authority in the community. It is paramount when working in such contexts to acknowledge and accept that authority in order to bring transformational change.

> So whatever programs we develop, make sure that the custodian's religion, the custodians of culture have got a buy-in on it. If you introduce a new program like family planning, some religions will say no God says we can have as many children as we want but it's the priest you take first and capacitate the priest. To say this is the message what are the negative what's bad about this practice? How would it affect them as individuals as this practice it shouldn't be said by us as health workers, but it should be shared by the priest? It's very important in our health programming. In public health even if come up with good and the best innovations but without taking the recipients into considerations and also the social life of that area- what are the type of people there? what is their religion? and what practices are they doing in that area? And so, as a public health worker it's very important. That's why you should make sure in whatever you bring in the community for change the leaders of different social groups should be the ones that have the buy in of your innovation and make sure you have them on board and make sure you use a dialogue approach not to talk down to them.
>
> -Dr.Sibongile Simelane_former Minister of Health Swaziland

Culture influences the way people interact in social settings, and many times this also crosses into professional environments. Social ties comprise a fundamental means of forming connections and establishing trust. As one of the leaders pointed out, people in many African settings appreciate making personal, tangible connections, possibly as a means of building trust before engaging professionally.

> So, when you work in global environments and then also you have your cultural identity in places like Africa. And it's not just in Ghana, and it's been Ethiopia, South Africa, Malawi, Nigeria, all over the place there's a deep understanding of the cultural differences. In the global environment, I would say 80% of the work done globally can be virtual. You can try to interview somebody in one of the ministries (in Africa), and it may never really go through. They want to see you face to face. So that difference of work where people want to see you or they want to spend the first 30 minutes asking about your husband, and how are your children and how many children you are going you have. All those questions that may not be necessary. People want to do that kind of relationship building, and then

> you do the work. So, there is a lot of our work here that is all face to face being there, being tangible.
>
> -Dr. Sodzi Sodzi-Tettey_Head of, Africa Region IHI

**Economic Context**

Several of the participants brought up the challenge of limited financial resources in the health sector, particularly in the public sector. Many Ministries of Health in sub-Saharan Africa are functioning under limited financial resources, making it difficult for senior health systems leaders to deploy the right teams and resources. Having sound support systems would allow them to focus on strategic visioning and planning rather than routine implementation. Ministries of Health often have a plethora of agendas, with priorities being pulled in different directions by different stakeholders. If senior leaders don't have the right teams and resources around them, they tend to focus their time and energy on daily operations and 'putting out fires' instead of focusing on strategic planning. This differs from the West, where leaders can also be busy, but because they have access to more financial resources, they can afford to employ more people with diverse skill sets that allow leaders to focus on the 'big picture' when needed.

> The more senior you get, the harder it is to get your hands into the data and know exactly what's going on everywhere in the organization. So, you need good people in different parts of your organization who are thinking strategically, who are thinking analytically who can bring you the information that you need to reflect on. ……And then, of course, good people cost money, good information systems costs money…. (but if).. you don't have the basic financial resources to make your organization function well then, your hand strap. So, I think a lot of the leaders in public sector institutions in African countries are actually quite hand strapped. They are working with essentially one arm tied behind your back. It is hard at first of all, they have been asked to participate in too many meetings….I think in the West, we have so many more people. And we have a lot of

> redundancy in skill sets. Because organizations are richer, they can afford to have a bunch of analysts, and managers. In a lot of government sectors, there might be people sitting there, but they may not have the skills. So, managers are doing everything. They're running around doing the managing, and they're trying to do the leading, and they're taking phone calls to sort out logistics. Something got stuck somewhere, and it's just not a good use of a leader's time. So, we need to, first of all, protect that time, make sure they have good people working for them, and then the financial resources to support the overall work. I think they would be more successful as leaders.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

Connected to this problem of limited financial resources, you also find that in both the public and private sectors, there is a pervasive culture of 'side hustling.' Low salaries and lower compensation have forced many health system workers and leaders to be involved inside projects, and consultancies, that are outside of their core work in order to increase their earnings. Sometimes these side hustles are also part of the system. For example, within Ministries of Health, because many of the partner meetings pay workers per-diems to attend meetings, conferences, or training, you would find that people fill up their schedules with such events, even then they are redundant, to be able to earn extra cash to supplement their salaries. This again removes leaders from the time needed to spend on their core roles and responsibilities. One participant hypothesized that side hustling is more prevalent amongst male health system workers.

> I think it's more of a reflection of the socio-economic undercurrents, whereby the average person in a low wage market is always looking for a side hustle. And I think men are not good spenders. Then they are always trying to look for something they could do on the side. Either because of family obligations or something like that. …You find the nurse is trying to do some other local jobs. So, there's always a side hustle, but women seem to have it less. I've had one or two bad cases of women who have too many side hustles. So, they were coming just as an addition to their upkeep. But then very quickly, they are always complaining about, oh, well, there's too much work or I don't have enough time because they're comparing the work at hand with the other side hustle. So that's a big

> thing in the market. A very big concern in the market. Once I interviewed four persons for CFO, and all of them had major side projects. So, I didn't make the offer to any of them.
>
> -Dr.Moka Lantum_CEO Sagitarix

To combat some of these financial constraints, a majority of sub-Saharan African governments rely heavily on foreign aid for financing their health systems, and, often, these dependencies come with set global agendas. Senior health system leaders sometimes find it challenging to balance the globally driven priorities versus serving the needs of those beneficiaries.

> I think it's just politics of global health, and whose voices and agendas carry weight and the asymmetry in legitimacy that is embedded within it. Important well-intentioned agendas but set by leaders that may not have as much legitimacy in terms of the people who get impacted by it. And the leader is sort of the filter in there. So that imbalance, in a way, puts the leader in an awkward position because you depend on people to give you money too. So, imagine if you have a system where 50% of your financing for the sector comes from external sources. So, what do you have in terms of the agenda? So, whether or not it's your priority, you follow along, as opposed to if you're financing. But governments are not putting as much money, so they are on the receiving end.
>
> - Dr. Muhammad Ali Pate_Global Director World Bank

**Political Context**

The environment in which health systems operate can be very politically charged due to the many stakeholders with different functions and expectations. Ministers of Health are often under a lot of pressure to be results-focused because, as a function of government, they need to show quick results to please voter constituents. Additionally, they are funded by the Ministry of Finance, and in order to convince this body about the need for more money and resources, they can be pressured to go for quick wins and make short-sighted decisions. Multinational

institutions like WHO tend to be more process-oriented because the nature of their work allows it to act as an indirect support system of the government.

> So, I think in health, in particular, the challenges that we face is that progress that you make is invisible and takes a long time. And many of us come from a health background, so as clinicians, you tend almost to want immediate gratification. But a leader in health is very different from if you're constructing or minister of road or minister of mining or something like that where things change fairly rapidly. And you can see here you have to be patient. Recently, I was looking at 10-year-old data DHS (Demographic Health Survey) in the country. And so, it took three DHS to tell the story of the things that have occurred. So, if you're looking for delayed gratification, then you can be all over you can make decisions very short term. Versus thinking about the longer term and make the hard decisions where the payouts politically or otherwise might not be immediate, but at the end of the day, that's where health systems need to go and respond to the needs of their people.
>
> -Dr. Muhammad Ali Pate_Global Director World Bank

**Part IV: The Nature of Challenges for African Health System Leaders**

The nature of challenges can also influence leadership because different kinds of problems call for a different form of leadership. Leach (2000) and Leach and Wilson (2002) have a framework on the nature of challenges for local political leaders that can be adapted for strategic leaders. The context points out four main problems of political leaders, which include developing strategic policy, maintaining political cohesion, exercising external influence, and ensuring task accomplishment. I have adapted this framework slightly to the public health setting to explore the nature of challenges senior health system leaders in Africa face.

**Developing Strategic Policies**

One of the principle responsibilities for senior leaders is to allocate time to develop and shape strategy. Before they can develop policy, however, they have to do strategic visioning to

figure out the gaps and possible solutions to various problems (Hartley and Benington 2010). Participants spoke about the fact that leadership strategy planning is one of their crucial responsibilities and raised concerns about needing to protect their time to be able to do this.

> But let me just break down why I focus on this time as I've gotten more senior and got more experience, I realized that time is our most precious asset as human beings. We can never get it back. We can lose money, and then within a week or a month, you can make that money. But we can never get back and as a leader, if you're not busy doing management giving instructions here and there. As a leader, your most important value to the organization is thinking, strategizing. Are we doing things that we shouldn't be doing anymore? Are we learning from what we're doing, taking a step back, and making decisions about should we continue this, or should we stop doing this? So, I think what we need to do a better job as leaders and people who work with leaders is help protect their time.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

**Maintaining Political Cohesion or "Ensuring Legitimacy"**

In the political field, this task involves building and consolidating a robust support system for the policy. However, to translate this into global leadership or a public health setting, this requires building legitimacy for the vision and actions a leader has to take with the authorizing group. The authorizing group can be internally the people you are leading, or donors or even the direct beneficiaries of the work and policy. As participants pointed out, before a leader can lead and influence, they have to garner trust from the authorizing body and convince them of the planned vision and course of action.

> I say that the psychological dimension of leadership meaning convincing people to believe you that the direction you want to take is worth taking and they should stick with it even when they don't see the payout is key. How do you do that as a leader, so when you come to say, let's improve primary health care in a way where people have failed repeatedly in

> the past. Why should they believe you and stick with you along the way, and why shouldn't they be skeptical? So, as a leader, how do you signal that? For instance, when there was a huge series of challenges, but then you come and say, oh, we'll finish it. So, who will believe you because they've seen many efforts in the past that have failed?
>
> -Dr. Muhammad Ali Pate - Global Director World Bank

**Exercising External Influence (Inter-organizational)**

Exercising influence through partnerships and networks is an integral part of leading and is becoming even more important in different types of organizations and sectors. In global health, within both the public and private sectors, there are diverse types of stakeholders and partners that leaders and organizations have to work with to either make policy or operationalize the work.

> First of all, in my position, in the role that WHO plays in being a key partner to the government but working with others is the fact that there are many others involved in health. Many organizations of different types, bilateral, technical, academic, civil society that are all working in each country to help the government essentially to improve the health of the population. So, one of the big challenges is being able to work with these multiple stakeholders, while being a key primary stakeholder within the government and also helping them work effectively with the stakeholders. In the context of our region, where financial resources are very much in short supply, sometimes those who come with money have a very heavy influence and voice because the countries need additional support. And sometimes their contribution needs to be guided by the government in terms of its priorities.
>
> -Dr.Matshidiso Moeti_Regional Director WHO Africa

## Ensuring Task Accomplishment

Task accomplishment involves operationalizing the vision and getting things done. As Hartley and Benington (2010) wrote, strategic leaders have to make sure that they can get things done through working with others rather than micro-managing. Participants pointed out that:

> So, in each region, we had just one pilot center or health post, which we have to change into a mini health clinic…. From that, we started one with key partners because, as a minister, sometimes to fund the research, we don't have money for that as government. So, I talked with WHO, and we tried to talk with other partners like USAID to support the pilot and us. I made sure that I put a team led by our Deputy Director clinical to work with the chief nursing officer and work with matrons so that they should identify one or two workers to work there and also work with the community people because the community they know that this structure is a neighborhood care point which has been neglected for so long. Now we are turning into a mini clinic, they need to be involved so that they will be responsible.
>
> -Dr.Sibongile Simelane_former Minister of Health Swaziland

**Part V: Leadership Capabilities of Senior Health System Leaders**

This section explores leadership 'competencies' or 'capabilities' for effective health leadership in sub-Saharan Africa. Thus, this is an analysis of crucial leadership attributes (traits, skills, abilities, mindsets, and behaviors) that participants demonstrated in the context of leading various challenges in sub-Saharan Africa.

**Personal skills**

This includes attributes such as self-awareness, confidence, and reliability that participants demonstrated in how they approached problems or opportunities and also how they described their strengths and weaknesses. Some of the attributes that senior African leaders mentioned were:

- **Self-awareness:** Many of the leaders were very aware of themselves and also their environment. They talked about their strengths and several mentioned situations when they admitted their limitations. For example, a few participants requested more support and resources because they knew they couldn't do the required task on their own. This sort of self-awareness and attitude was also connected with a willingness to learn.

> I think, also self-awareness, and willingness to learn willingness to read, willingness to talk to people not being afraid of reaching out to people to be your mentors, or coaches. But I think you have to be self-aware to reach out otherwise you're going to be head down, doing your best and you might be off you might be way off, but you don't know because you're not talking to anybody. You're not getting any feedback… But we need to be self-aware we cannot be swimming in our own Kool Aid and thinking that we're credible.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

- **Opportunistic Mindset:** Many of the leaders had a 'positive' or 'opportunistic' sort of mindset when faced with challenges. Several participants talked about how, when faced with a problem, they viewed it as an 'opportunity' to turn the challenge into a program, or an occasion to ask for more resources. This type of mindset empowered them to act.

> It's also about being opportunistic, you know, in seizing the moments. They tell you that in politics, it's all about the moment. Timing is everything. So, recognizing that perhaps the stars are aligned in terms of the relationship that one has with the Gates officer being able to describe in clarity what the opportunity is. Also been able to portray the issue to show how it benefits everybody in it, how it benefits us as an organization or benefits the health system, how it benefits the Gates Foundation, you know, and set the global good. So being able to be strategic in the way you position so that he can get there the resources. It's also about integrity, that if you've demonstrated integrity over the last seven years, and showed that you can apply resources correctly and you are not corrupt, then there

isn't that much of a fear when you make a request for additional resources, because you've demonstrated, you know, competence on the ground.

-Dr. Sodzi Sodzi-Tettey_Head of Africa Region IHI

- **Adaptable:** The leaders talked about the importance of being flexible in your approaches and in your leadership styles. They also spoke about scanning their environment and the people they work with before deciding to act. For example, one female leader spoke of how they preferred to have a more consultative approach to leadership but in certain cases felt it necessary to adopt a transactional form of leadership to gain respect and authority. This is particularly important in the context of a hierarchal and patriarchal society in sub-Saharan Africa where people who use authoritative leadership are seen to have more power.

> Normally, I have a very consultative approach to working with people because sometimes my staff complained, I'm too consultative, I should just make some snap decisions. And I told them my experience is that if it's not an emergency, sometimes snap decisions create problem. Sometimes I'm being slow because I'm really trying to scan the environment. But in this case, I thought, okay, now I am going to be very authoritarian. So, I went back, and I said, Oh, yes, the matter you raised I am changing the DHMT meetings time we'll have it on Wednesday morning. I will always chair the meeting, if I am not there, there will be no meeting. I am the chair and I refuse to delegate. I've used this example because, you know, in principle delegation is a good thing. But in this particular circumstance, I actually needed to back off from a consultative, delegating style to take control of the district and be able to move forward. And I was right in my assessment. I needed that recognition and the initial stage that if you don't pick up this challenge and pick it up properly, you're going to be undermined, you're not going to be able to do anything in this district.
>
> -Dr.Irene Agyepong_Public Health Physician Ghana Health Services

## Social skills

These included interpersonal skills such as the ability to empathize with others, and to convince, form networks, and partnerships. Building relationships was an essential skill desired and practiced by the leaders.

- **Resourcefulness:** Most of the senior leaders were quite 'resourceful,' meaning they could pull in resources from different sources and convince various stakeholders to provide support. In African settings where resources are limited, the leaders' ability to seize opportunity and form partnerships to advocate and garner support and resources for programs but also to empower their teams and fill gaps is key.

> I sat with the UK, and European Union ambassadors as well and shared with them this challenge and I didn't t just leave it to them. No. I went to the private sector. I went to the anthropologist. I engage even people like Bill Gates. You know, I engaged the WH0, which is the technical agent for the UN to assist developing countries. We had a WHO representative (WR) so I said to my team, we every week we had a steering committee where we sat down and shared what do. Then I said to them we must engage this person (WR) to work with us very closely. I brought them on board WHO, UNICEF, UNAIDS on our side." Then get back to my own team capacities and empowerment. I looked as I said to the outside. The private sector, I gave an example, (we used) Mckinsey Consulting to train (my team on) leadership. Well, I had team building. You know, when you go outside, with my team under the leadership of the Permanent Secretary.
>
> -Dr.Richard Nchabi Kamwi_former Ministerof Health Namibia

- **Building Ownership:** Many of the leaders demonstrated a unique ability to build ownership of the work and vision not only with their teams but also with different partners and stakeholders. Participants talked about being able to do this by showing humility, sharing the job, and also opening themselves up to the others. Two Ministers of Health gave examples where they were able to get buy-in from Ministers of Finance in

their countries by asking their Presidents to nominate Ministers of Finance to temporarily run health ministry's when they were away from the office.

> We don't have Deputy Ministers in Swaziland. When you are out of the country you would ask one of your colleagues to act for you. When you I was for a Minister of Health and I am away let's say attending a meeting in Geneva. So, I was making sure that when I leave sometimes, <I would make> the Minister of Finance to act on my behalf so that he feels the pinch. Because whatever we are doing, we are doing on behalf of the people. So that was one of the things that I did to make sure he understands my portfolio. It shouldn't be just me among 20 something ministers just always saying support me support me, but they fill the pinch when they act on my behalf.
>
> -Dr.Sibongile Simelane_former Minister of Health Swaziland

- **Building Coalitions through partnerships and networks:** Building strong partnerships and networks is a critical skill in health leadership in Africa because of all the different actors working in the system with different responsibilities and interests. Some of the leaders described themselves as good 'networkers'. Many were able to build these networks and collaborations through persuasion strategies, for example knowing when to compromise and when to stick to their agenda.

> It's also about interpersonal relationship building. I spent a lot of time building relationships in all of these other organizations that I worked with, and I was able to draw on that to do some interpersonal relationship building within the consortium that also helped me in my negotiations and navigation in the networks that I have built, because I consider myself a very good networker. I'm able to form relationships and building networks when I go to a conference or when I go to meetings even when I travel, and I come across people and I interact with people. You know, those interactions have led to long term relationships which I have continue to benefit from. One other thing I would add is I am somebody who is who doesn't hesitate to ask for help. Oh, if I'm not clear about something, I don't understand something that I'm dealing or a challenging situation, I will reach out

to a colleague or a friend or somebody that I know probably has experienced in that area or has the answer. I have that kind of approach and that has helped me improve my leadership capabilities.

-Magnus Conteh_Executive Director Last Mile Health

- **Effective Communication:** Being able to communicate well is an essential skill for any leadership role. Some participants, for example, those from French-speaking African countries, spoke about language barriers and needed to train on communication skills so as to participate effectively in international fora. But communication was also about knowing how to frame things for others in a way that is 'palatable' and 'agreeable' in order to be able to influence them.

> When you are Francophone, or all what I've said is more difficult for you because when you go at the international, you need to be fluent in English. And when you come from our countries like Senegal and others where it is very Francophone, you cannot go into the international and speak at the level you are. I have an example. I have worked on HIV AIDS and was selected to go and be part of a group working to evaluate its HIV AIDS at WHO. And I was the only one Francophone. For my English, as you see is broken, but I try now to work on it and try to speak. But in the beginning of my leadership where I knew the story, I knew what to do, I knew how to deal with HIV AIDS in my country and my community but to explain it in English was a big problem for me and I went to the first meetings the first day saying who I am, that I was a Marie-ColleSeck but all day I was not able to speak because people were speaking in between themselves quickly and I was not able to do something and I was so disappointed and discouraged…The day after I go to see the chair and I say to the chair I know that you have seen my view and you know that I am not here because people just wanted me to be here but they know that I can contribute. But do you realize that yesterday I have not spoken. I said First, I would like you to give me the opportunity to say what is my position on what we have said yesterday
>
> -Dr.Awa-Marie Coll-Seck_former Minister of Health Senegal

**Conceptual skills**

These include skills such as analytical ability and creativity (Hartley and Benington, 2010).

- **Strategic approach:** Many of the leaders were quite strategic in their problem-solving. They were able to really focus on building a vision as a necessary step in developing allies and coalitions to achieve their goals and that of the team.

> So, you know, as a leader sometime, you can say this is my own decision. I can just take the decision and then work to make sure that the people accept that this isn't right. So I took the different route to say, let's bring the 12 people who are willing to be working with this person <a new hire> to work together to make the decision collectively etc…..So now it's really paying off because now there's no question about transferring the decision power to that person or transferring the management of money because you know they knew the person, they were part of the decision to bring the person and it's making my life now life much better and easier. So, it's kind of like how as a leader, how you think about the final product would you want to achieve and then the process to get there. Sometimes you need to make some sacrifices to really make that happen.
>
> **-**Dr.Paulin Basinga_Gates Nigeria Country Director Gates Foundation

- **Long-term vision and short-term details:** The leaders demonstrated the ability to have a long-term vision and focus on the "bigger" picture while not losing site of the short-term details. This was particularly important in the public sector where the environment was very politized, leaders were pushed in many directions, and the institutions were weaker. Leaders spoke about needing to make difficult decisions that have long-term payouts to create sustainable systems.

> Health workers were afraid; community members were afraid to seek health care. So, with that, we had to find a way to revive the routine in healthcare services whilst we're responding to the emergency and that is because there were also more persons dying from the routine healthcare services at a time, then the Ebola outbreak itself. So, at that time, because the of the outbreak, the entire country,

> including from the president's office, shifted that to the emergency and it was difficult, no one was actually listening to routine health care services. So, I was like the lone voice in trying to push that we need to pay attention to routine healthcare services.
>
> -Dr. Bernice Dahn_former Minister of Health Liberia

- **Data and Evidence-Driven Policy:** Leaders spoke about using data and translating science to be able to advocate for policies and convince various stakeholders to push for policy.

> Because I was Minister of Health and I had figures. I have figures, and I have pictures of people who have been smoking and have cancer of their mouth, radios also to show how lungs. I have photos where you have a lot of damage and showing and women who are smoking also with prematurity. So I have a lot of figures coming particularly from WHO and our own doctors in Senegal, and this is what I have used, and also we did studies to shows the economic impact of smoking and economic harm in the family because of the individual family when you are sick, etc. It was very scientific but scientific at the level of people I was working with, and I was speaking with, and finally the population everybody was happy and was saying it is true we need to do this law it's not normal people are smoking and disturbing us. We stop not just for today but for tomorrow and our children. People were convinced from these photos, and now in the cigarettes, we have put there the cancer of mouth cancer in the packet.
>
> -Dr.Awa-Marie Coll-Seck_former Minister of Health Senegal

**Part VI: Leadership Development**

It was important to understand from the participants what sort of leadership development opportunities such as education, training, experiences or mentorship they had explored in their professional journey.

All the participants used for this research were highly educated. More than half of the participants were medical doctors, which is not surprising because many of those who go into

public health in sub-Saharan Africa usually often have a developed interest in health from their medical training. Almost all participants had at least a master's degree either in either Public Health (MPH) or Business (MBA) or both, and a few of the participants had a doctoral degree.

**Education**

Several of the leaders spoke about the importance of having a strong educational or technical background as a good foundation for leadership. This is especially true for women leaders; having a strong educational background is a means not only to gain confidence but also to establish legitimacy.

> First of all, with my background I have been respected, because the respect is important. I have done a training everybody agree that it was a very high-level training and they respect me already because of that.
>
> -Dr. Awa-Marie Coll-Seck_former Minister of Health Senegal

**Training**

Apart from strong academic backgrounds, some of the leaders also spoke about investing in their leadership growth through reading of leadership books and also participating in a variety of fellowships and leadership training programs. These are opportunities valued less for being academic than because they provide an opportunity to meet with other leaders where they challenge one another and establish new networks.

> I've done a lot of leadership development programs. And I talk about leadership development programs and a very good one is the tutu fellowship, that truly focuses on developing the leader as a leader. I value academics but I have also understood that at a

> certain point in your career, it's the fellowships that help. It's not this, oh, we're going to publish no, no, these are real life situations. You're in the same room with people who are facing similar real-life situations. You're challenging each other. It's iron, sharpening iron. You are making progress. You are challenged, you are asked, networks are built. You are skilled up, you are coached, you are mentored, you are pushed. That has been helpful. And so, I actively search for practical opportunities to build my leadership. So, I wouldn't go to a university and like, oh, teach me about leadership. No, I mean, you learn leadership by leading. Because all the Steve Covey books and all this is the theory and when you are looking at a team member that you need to fire, I assure you, all those theories go to the door. Leadership is difficult decision making, figuring out how to actually do it. Yes, the books have a value in giving you the theory and the basis, but you actually learn leadership by leading, and trial and error and reflecting and improving and doing it over and over again.
>
> -Dr. Angela Gichaga_CEO Financing Alliance for Health

However, as a few leaders indicated, especially those in more entrepreneurial kinds of work, sometimes the leadership models taught don't match the reality on the ground. Therefore, the programs end being like 'a good thing to do' but have little practicality.

> So most leadership models and frameworks assume a steady state. That you have the money in the bank. You have the staff on board, you have got your local customer base, you have a clear product. There are so many assumptions that go into the models of leadership that are that are marketed out there. Whereas my reality today is basically what do I need to do to keep the doors open for tomorrow. …So, I would say that I personally cannot talk about one leadership training or stuff. Obviously, you go to this training, you will feel inspired. You know, you are not alone. You pick up some language and some terminology. You pick up some frame of thinking, but then you quickly realize that is short lived. The end of the day, those things have very low stickability. They don't stick to that environment.
>
> -Dr.Moka Lantum_CEO Sagitarix

Leadership training has to be contextualized for all the reasons cited above. Therefore, as one leader emphasized, leadership training needs to be in-situ so that it is more translatable to people's realities, cultures, values and expectations of leadership means.

> And this is why I think the leadership building should happen inside in situ. It should not be too far away because it then becomes too academic. Can we find opportunities in the countries that were supporting for young people, early career, mid-career people to have designed leadership experience with support that fits in with their culture with the norms of the culture but still serves the people. So, if a culture is hierarchical and tyrannical, I don't know if we want to support that type of leadership but if there are people who want to get away from that tyrannical type of leadership and want to do something else, can we support them and translate some of these leadership principles into context, while helping them with the books that they need to read and whatever they need to do. it's really complex is not easy. It's not like teaching someone anatomy or biochemistry or epidemiology.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

Many of the leaders, especially those working in international organizations, spoke about getting on-the-job leadership training through programs that were organized by their organizations. In the public sector, one Minister spoke about hiring McKinsey & Company management consultants for a leadership training. All the leaders greatly valued these trainings and mentioned how they have continued to apply those lessons even once they left those organizations.

> The World Bank Group invested heavily in educating me as a leader. In the bank, if you become a manager, you are sent to management training. If you become a director, you are sent to higher level training. I mean, I had done for example, one of my best training was mindful leadership, you know, to really think about the potential impact of your actions and words on others from a bias perspective. So this mindfulness leadership was really handy. And the books that I went back to were actually the binders from some of these training that I did. How do you stay calm at a time of crisis? How do you not lose sight of the long term when you're going through a short-term crisis? How do you prioritize? So, part of me went back to the training that I had received over the years, mostly from the World Bank Group.
>
> -Joyce Msuya_Deputy Director UNEP

**Experience**

Most of the leaders cited the value of experience in leadership growth and development. Those working in the continent, with deep knowledge of the context, felt that the proximity to the work gave them authority over the issues specific to Africa compared to those working at the global level. In contrast, those working at the global level greatly valued varied exposure and working in different countries and organizations. They felt that the diversity of exposure gave them broad thinking and framing of problems and solutions that can be missed by those working in the field. Both opinions illuminate the complexity of the relationships and differences in perspective between those working in local and global contexts. Mr. Magnus Conteh, in the quote below, points out that being aware of these dynamics and being able to adjust is what can bring leadership success.

*Deep local context*

> Coming from Africa, you may think you are at a disadvantage, but you are actually at an advantage. And the work that you do, the proximity that you have to the results and the deep understanding you have to the health system gives you a certain authority over the subject that people who are at a very high level working globally as so on and so forth you don't have. In fact, they wish they did. This is the reason why people would come and do a two-week rotation in Africa and become experts on Africa one night in Boston. But you have to value the fact that if you are the district, if you are at the frontline, if you're in Africa it is an advantage. You have an experience that is unique and that you have to bring forth something to the table. So, it is not a disadvantage at all. But then, when you engage sometimes you come with authenticity as a leader, a certain strength. And you may find that people may be shaken a little bit by that by that aura, you know, that you represent and so on and so forth.
>
> -Dr. Sodzi Sodzi-Tettey_Head of Africa Region IHI

*Global context*

> I have about 25 years of senior leadership experience across different countries. I mean, having worked in Sierra leone as Head of Department and I was Deputy Regional Manager and then worked in the UK in leadership and also in Ireland in leadership positions. And I am now in the USA and so I have had good exposure in all these leadership roles…..When you go to Africa, you are being from the diaspora, though you are African, but you have been in the diaspora for a number of years. Your perspective, your knowledge, your exposure, give you a certain flare, oh thinking. It gives you a certain perspective which sometimes doesn't quite align with the context, even if it's the continent where you come from or even a country. Like I go to Sierra Leone, and sometimes I say certain things or I make certain solutions and people are looking at me like where is this guy coming from .So sometimes you need to be aware of that to be able to adjust and it is that adjustment of being cognizant of that dynamic and being able to accommodate that. I think that mix or that's the recipe from my perspective for leadership success.
>
> -Magnus Conteh_Executive Director, Academy Last Mile Health

**Mentoring, Peer Networks and Coaching**

Almost all the leaders spoke about the importance of mentoring and coaching. Many said that they found mentors or coaches through their work. Mentorship relationships were built organically through work relationships with their bosses and managers, and many times extended beyond the timeline of their jobs. Others found mentors outside their jobs through various networks, either through schools they had attended or by meeting someone at a conference. Coaching was also mentioned. One leader mentioned requesting that his organization hire a professional coach for him, which he has found to be invaluable. One important value of mentors and coaches is that leaders can reach out to them to bounce off ideas, especially when making difficult decisions.

> I would say more coaching, right coaching and mentorship. Having good mentors, I think that has really helped me a lot. You know, I've had the chance to have very good mentors

> and who have advised and helped me throughout. You know I am just very lucky to have very good bosses who I would I look up to and learn from them. And then as I started moving up in my career, I was you requesting mentorship from my work especially at the Gate's foundation. Even now I have a coach now from a private company. I did ask at the foundation to say, look can I have a professional coach who will teach me leadership. It is more conversation to discuss, you know, bounce ideas, etc.
>
> -Dr. Basinga_Gates Nigeria Country Director

For those in the public sector there can be limited resources for hiring private coaching. Some leaders spoke about the invaluable nature of partnerships with organizations such as WHO where they can get coaching and mentorship as well as technical assistance.

> WHO country representative, it's like your partners because they are there to support the whole system of your ministry. So, I think WHO also played a great role to make sure that they mentor us, they take us through and if there is a barrier that we encounter they are there as our pillars who we refer it to them. Even if I just have a task to go in and look at the strategies of how to overcome. Then they will come back and take you through what strategies as they discussed. Then when you go out to the media or community it will be like you the minister of health who is going to do it. She is going to do it like this. In fact, causes of the political arena it looks like it's you as a leader, but not you but it's your team. That's why your team members should be really your partners in leadership to support you where you face challenges
>
> -Dr.Sibongile Simelane_former Minister of Health Swaziland

A few leaders also spoke about tapping into their peer mentors and how this has also been invaluable in their leadership growth.

> She's been around for six years. And being new I said to her spontaneously, I think it would be really good, if we could have lunch once a month. Would you mind being like my buddy. I think being in a leadership position in a new organization, I have a lot to learn. And it would be nice to have a buddy. She is also at my level, so she's my peer in the organization from the title and scope perspective. I said, you know, I maybe I need a buddy. I think this is complex. And I would love to have a chance to have lunch with you

> once a month just to chat about nothing, or if there's an issue, I can bring it up and get your perspective. So, she said sure let's do it. And I never done that before. You would think 20 years in the workplace, I would have figured out how to get buddies and mentors. I think I know how to do mentors and coaches, but I've never done this buddy experience. But I think it's key. And so, some of it is self-awareness that you don't know enough. You have a learning curve you need to reach out and even if you're an introvert. So, I happen to be an extrovert so a little easier for me to like talk to people I don't know well and find ways to connect. But I think even if you're not an extrovert and this is an important part of professional development or understanding an organization or being successful in an organization, you have to find a way to reach out to people.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

Very few leaders spoke about providing mentoring themselves, but some leaders did imply that they mentor others. One leader commented that when mentoring others, it is key to share with them more than just your personal experiences but also some of the leadership theories behind what you do.

> Now when I'm in a situation I can call on some of those theories and concepts and say, okay, take a deep breath, this is what this is what you're in. let's see what skills I can bring to bear which theories can I bring to bear. Whereas perhaps 15 years ago, I did it instinctively and figured it out as I went along. I think I'm now more disciplined. When I see a situation that is challenging and I look back at my past and say, okay, have been in this situation before and this and you have a reference point and then you can also teach it because once you have mended instinctively, you've also understood it from a theoretical perspective. If you have younger people working under you or more junior people working under you, you want to teach them, or you want to give them feedback. I can call on more than just my own experience because if you rely on your own experience only, then your feedback ends up being too personal. Oh, look at me, I'm perfect, here's what I did, or here's what I would have done. It's bigger than that. You need to go beyond your experiences to say okay, this is the leadership principle behind that or the management theory behind that. Go read this book, if you have time and let's talk about it. So, it becomes less personal and it shows that leadership can be taught, it's not that you are just born with it.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

**Objective II:** How does 'Context' and the 'Nature of Challenges' associated with Gender influence Leadership in sub-Saharan Africa?

**Part VII: Leadership and Gender**

The ongoing debate on whether women and men have different leadership capabilities and styles has existed for a very long time (Hartley and Benington 2010). The primary basis of some of these discussions is whether one gender makes a better or worse leader than the other. For example, in the current Covid-19 crisis, the media has been plastered with articles on the comparison between men and women leaders and many have made the assertion that women can be better crisis leaders (Wittenberg-Cox 2020; Taub 2020). One article wrote that countries with women in leadership have suffered six times fewer confirmed deaths from Covid-19 than countries with governments led by men (Chamorro-Premuzic and Wittenberg-Cox 2020). However, the challenge of low sample size of women in these powerful political positions makes it difficult to make these comparisons with any confidence. Some articles have refuted these claims citing weak evidence and potential issues of 'confirmation bias' (Bastian 2020). But, as one researcher postulates, the lack of women in executive leadership positions is better explained by how society perceives and defines leadership rather than individual qualities of women as leaders (Sinclair 2005). The chapter focuses on exploring how gender dynamics influence leadership amongst senior health leaders in sub-Saharan Africa.

**How does 'Context' and the 'Nature of Challenges' associated with Gender influence Leadership?**

**Positive Influences**

More institutions and leaders are now promoting policies that endorse gender parity which have helped to increase the opportunities for women to uptake leadership roles. As the Deputy Director of UNEP noted, these policies are not just about favoring women but creating pathways for qualified women leaders to have equal chances with men to pursue and get into leadership positions.

> I think if you look at the current Secretary General policy, he has a policy that he wants 50% of his senior leadership team to be women. And if you look at the trends actually, he has done more than 50%. But he emphasized not just women but 'qualified' women. So, in that regard, because of this policy, there was an environment that actually allowed people like me and others to be considered. So, one is the policy. So, in that regard I would say it has worked well. So, if I competed with a white male or male assuming that everything is equal because of his policy I had the opportunity to serve. It's been great. And I would say the same thing when I was at the World Bank Group with different presidents who were promoting, for example Sub Saharan Africa, but I emphasize qualified because I think it's very important. I think there is still work to be done outside of these types of organizations with the right policies.
>
> -Joyce Msuya_Deputy Director UNEP

Several women leaders viewed their gender identity as a positive influence in their leadership. Given women's 'nurturing' roles as mothers and caretakers, they felt that their gender gave them particular 'sensibilities' that were connected to effective leadership attributes. For example, they mentioned that their ability to listen, to multitask, and to be inclusive and consultative comes 'naturally' for women.

> I also think gender sometimes works quite well for women as leaders. For example, women by nature we take care of people, we listened more. We tend to multitask. We tend to be decisive. And this has seen culturally whether it's in China, Korea, Africa, across I mean, who decide what to eat, usually, what children should will usually it's the mum. Of course, the power of the purse may come from the men. But so, I think we have the natural skills that come from us as women which in reality help us in leadership. We often tend to be integrators. I mean, we tend to look after our mothers, our children, our husbands, our grandparents. And when you become a leader, it's really about taking care of people. So, I have seen even in my group of 16, directors who report to me, generally speaking, women tend to be better leaders because of those integrating skills, the listening skills. I think, we a lot of times women shortchange ourselves because we do not speak up.
>
> -Joyce Msuya_Deputy Director UNEP

Some men leaders, as well, recognized this 'nurturing' leadership style from their female counterparts and appreciated this type of leadership that they saw more associated with women. For example, one male leader, mentioned how he views women's ability to nurture others as a positive leadership trait that contributed to creating a sense of belonging within the organizations, as well as a welcoming environment for their clients.

> Right now, all my direct reports are female except one. For this, there is always food in the office. There's always some candy floating around. There's always something being passed around, always, and it's not me. I've never bought candy for nobody. I just want you to do your work. The nurturing environment is quite dominant, and I think you'd have even be more dominant if you had a female lead in my position. So, when you walk into one of our clinics, it's the soft side comes around, It's not just hard things, you know…. Let us have Soft things in the office that make people feel like we miss this environment. We love working here, our customers or clients when they come, feel warm. It's not just that cold clinic you go to and it's just about the prescription pad and some medical literature on the wall. And then people would come naturally because <when> we go there we feel like we belong. We feel like it's our place. We don't feel anxious. From a gender perspective and not from a sexist perspective introducing that level of softness into our operations, where things are documented carefully, notes are well taken, and communicated to customers in a very sensitive way is really key. It needs to be a key part of our product experience. It's not just a nice to do it is like an imperative for the leadership to bring to on board that kind of experience for the customer.

-Dr.Moka Lantum_CEO Sagitarix

**Negative Influences**

Most of the participants mentioned that they have witnessed or experienced 'unconscious gender biases' in many settings, and not just in sub-Saharan Africa. However, the respondents also spoke about how the patriarchal nature of most African societies and family structures can make it challenging for women to participate effectively in leadership. To the women leaders, gender biases became more apparent as they rose up the ranks of leadership where gender parity is much more skewed, with fewer women in senior leadership positions. Some of the struggles one-woman leader mentioned included male colleagues making inappropriate comments and gestures.

> I think once you get into the workplace and moving to senior positions in health care, public health, science related type of fields, you see fewer and fewer women at the top. Even in the US, never mind in more traditional patriarchal societies, like Ghana or Nigeria or whatever. So, showing up showing up as the head of a team or as the director, sometimes your 'title' as a woman sometimes can throw people off. I think where it's felt bizarre is when I've had incidents of men making passes or not just men- colleagues. So, let's be specific. You're in a meeting room or conference and people you know, professionally, are just behaving a little bit inappropriately with you. You know that if you are male, this not happen by commenting or your clothing or inappropriate touching. That's just annoying and I would brush it off. I think if these were colleagues that I worked with day to day in my office space, it would become a barrier to work.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

In sub-Saharan Africa, however, and at all levels of the society-family and society participants spoke about how gender biases can create barriers for women's endeavors towards leadership development and progression. Family upbringing can greatly influence gender

stereotypes. Starting from a very early age young girls, especially those in rural areas, are often not encouraged or given the opportunity to pursue ambitious leadership or educational endeavors. In this case, however, most of the women participants recognized their unique privilege or pathway and how their particular situations could not necessarily be generalized to the majority of other African women and girls. Most of the women leaders stated that they felt fortunate either to have grown up with strong female role models—mum, aunties, sisters—or were brought up in families were boys and girls were seen as equals. In addition, some mentioned the importance of having a supportive spouse. So, having family support and role models greatly helped them overcome some of the barriers a lot of other African women and girls face. Many young women and girls, unfortunately, end up internalizing the gender biases and are 'unable to see themselves as leaders', as the former Health Minister of Senegal notes.

> And because I am a woman, I would like to focus more on the situation of woman to be a leader. So, for women, for me in my country and I know a lot of other countries in Africa are not pushed to be a leader. Because often, if you are a woman, maybe it's not important for you to go to school or it is not important to you for you to continue your training. Why not stopping to be a midwife? You know, when you are a doctor or whatever- why you want to be specialized? Just go and work. Or you have to start to look at being a wife or having children. All these, situations can be difficult for a woman who often don't know that she can be a leader. But with time you become a leader. But all these are obstacles on your way you need to overcome to be a leader.
>
> -Dr.Awa-Marie Coll-Seck_former Minister of Health Senegal

Not only do some of the young women and girls in Africa not see themselves as leaders but, sometimes, society as well as those in the workplace do not give women leaders the respect and authority they deserve as leaders either.

> The funniest example would be when my wife and I went to work in a district, she's a doctor, as well and when we got there, you will not believe that for the entire three years we worked in the district who they would never call her doctor. They would always call her Mrs. Mrs became her name. And no matter how often I explained to them, that she is also a doctor, we sat in the same class, whatever I did, she did. She even beat me in some of the subjects. They would never call her Dr. They called her Mrs. So that gives you a sense of how people have viewed these things. In the way that I've approached things is to try not to press my advantage as male. I have tried to distinguish myself through the results of whatever it is that I'm doing, whilst being my mindful that of course, there are certain roles that people will assign to you just because you're a male. And then also as a leader, being conscious to create the space for women to actually advance through the ladder.
>
> -Dr. Sodzi Sodzi-Tettey_Head of Africa Region IHI

Due to these biased social constructs of gender and leadership, women leaders sometimes face a harder time to build their legitimacy as leaders or just professionals.

> Then, of course, then I have a team that's fully female, young African females. You know, historically technical assistance in Africa has been tall, white males, right. And so, going to a government and saying we are the ones who are going to be advising you on how to set up the system and finance it. You are seen as not as the professional, but as this young girl and how would you know what to do about a government? And oh, by the way, you also look really nice, you know and is there a way that we can have .... you know, and it's there's a lot of nonsense that we face that unfortunately is because of the societal construct.
>
> -Dr. Angela Gichaga_CEO Financing Alliance for Health

Even when women do get to leadership roles, they often face huge burdens to effectively balance their professional roles with their roles as wives or mothers in their personal lives. Compared to the West, however, the communal nature of societies in Africa affords most women leaders in Africa the ability to get support in rearing their families through family

members or nannies. But, the lack of a supportive spouse can be a huge impediment towards pursuing leadership roles. And those that get there sometimes get there alone, not by choice.

> So, I've had children…. There's a physical and biological need to be able to go and have children, right. So, that takes a bit of time and then you don't stop being a mother. Which is why, for example, it's been so much easier for me to be a good professional, given any final global remit from Africa where I have so much help than to try to do that from Europe where there is no support right. So, I think there is an element of just the biological need and the support and the caretaking opportunities that are required. But there's also everything else around the taboo societies and the expectations that are required around what a woman should be, should do, in Africa. And the kind of responsibilities that come with being a wife. If you are married to an African, and you know that kind of hinders and can make it hard for you, right? Because then you're not only in competition with the outside world, you're also in competition within your couple, within your home. You may not to be getting the support- why do you think you are the boss outside, not here…. There's too many African women or black women that get there, but they get there alone. They don't get there supported. Either, they have to sacrifice having children, or they have to sacrifice having a man. I think that's really hard and that means that you need to educate men to be able to accompany women more and more along this journey, because I think that's the key.
>
> -Dr. Myriam Sidibe Director Social Mission Unilever

Compared to male participants, women leaders were more self-conscious of how their 'gender', 'physical appearance' as well as 'age', influences how they were being perceived as leaders by others in the workplace. A few of the women mentioned how their 'small frame' or looking 'young' made it harder to garner 'respect' or 'power' as leaders. The women participants' comments suggest that more informal authority is probably attributed to men and people who are older, taller, and with a more imposing physique.

> But I know for sure that when you are a woman in the workplace and you only five feet two inches, and you know, you weigh 54 kilos, you really need a certain confidence. Even now that I weigh 70, something I still need to stand firm and say you're not putting me

> down……. And like I said, my awareness of gender issues has come to me a bit later in life because of my later life experiences rather than my early life experience. But I realized maybe just from observing, it depends really on people and people can be so different. But I think if I'd been a big tall man, he probably wouldn't have tried to do many of the things he tried to do.
>
> -Dr.Irene Agyepong_Public Health Physician Ghana Health Services

This self-awareness of their looks and age gives women the extra burden of having to constantly mull over how they are being perceived in a way that male colleagues don't generally face.

> And as a woman, you think very carefully about what you choose to wear because you don't want the men in the room to be distracted by your clothing, your neckline, your earrings. Whatever it is, you just want them to focus on what it is you're saying. And what's frustrating is that I know that my male colleagues in a similar position who are trying to make a presentation are not worried about their clothing, or whether they're wearing lipstick or not or whether their hair is up or down or what neckline did they choose, so it's frustrating for women we have to use up extra brain space to worry about the thing in the air called sexism or gender stereotypes in addition to being very good at your work and being good with the visuals on your screen and being a good oral orator during your presentation. You are also worried about how you're being perceived.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

Sometimes women's participation in decision-making and opportunities for career development is limited because they are not privy to 'behind-the-scenes' or 'backchannel' conversations that happen amongst the male-leaders at the top. This can happen in professional circles anywhere in the world not just in Africa, that sometimes decisions are made during informal socializing or during work travels that women may not be privy to because of the conscious or unconscious 'boundaries' between men and women in professional settings. Dr. Basinga gives an example below about a scenario where, after a meeting, another male colleague

comments that he will follow-up with him on at the 'Sunday volleyball game' when they usually meet. He quickly realizes how this suggestion is alienating to his female Deputy Director, particularly since both men and women may choose not to engage much with colleagues of the opposite gender to protect their professional boundaries. However, if senior leadership is male-dominated and important conversations are happening in these backchannels then women are automatically at a disadvantage.

> The other thing I would say is that I pay attention very, very much on that is that there are you know places that we can meet as male, for example, we'll go to play soccer will. Like today I was, you know, discussing with the Head of XXX [organization] here. And, and then something happened, and I needed to follow up with my deputy director here who's female for example. So, we finished the meeting, and then he [Head of said organization] had some calls to do and then he said okay, so we will catch up on Sunday, right? Because we meet on Sunday to play volleyball together. He said we will follow up on Sunday. And then my deputy director asked what is happening on Sunday. I'm like, oh, we play volleyball together. So, automatically in my head, I was like, ohoh I ought to be very careful so that during the volleyball game I don't discuss anything which will jeopardize the person who should make the decision because she is not going to be there. Because she doesn't play volleyball, or she doesn't hangout with men. It is those kinds of access that as men you can meet in different places or you can travel easily. And you will see that you know you're doing even your PhD etc., and, and you know your supervisor is male. So, the male students may have more opportunity to meet with the Supervisor during sports or work, etc, because sometimes the male may say, look I'm not going to ask a female student to join me here or to spend more time.
>
> -Dr.Paulin Basinga_Gates Nigeria Country Director Gates Foundation

Women in patriarchal societies in Africa may also feel a greater need for self-protection to ensure these boundaries with those of the opposite sex because of less accountability afforded to men and lack of systems of reporting bad behavior.

> I am extremely cautious in engaging with men after office hours. One of my mentors for example, at the Bank who is woman said to me, at the time I was young and leading a regional health project, if your boss wants to meet you, meet the lobby, don't go to his room. There was a time when I joined most of the bosses were men. And what she said to me, do not put yourself in a potential compromised situation. If something happens people may come and say, how come you ended up in that bedroom for example? Maybe you went to submit a report, but if he touches you, and you scream, then people may ask, why did you end up there? So, I learned from very early on in my career, it's okay to go for reception, it's okay to have drinks. But I would make sure especially after office hours, there is more than two people, especially if it involves your male. Or you sit in a public place so there are no perceptions.
>
> -Joyce Msuya_Deputy Director UNEP

In many countries in sub-Saharan Africa, health is very politicized. For example, the position of Minister of Health is filled through an appointment by the President, but the candidate also has to be a parliamentarian voted in by constituents. In addition, the nature of politics in Africa can sometimes limit women's willingness to participate. As one writer states, women in Africa possess the managerial abilities to improve the political practice in Africa, but the archaic and dangerous mode of politicking makes women vulnerable in the African political arena (Ekwealor 1999).

> One thing I tell female colleagues is that if you decide to take a political position, you have to be determined. Your mind has to be made up. You have to accept all the insults. Normally females don't want to be bullied. And men know that, so they will use that against you. Men will not withdraw because of that, but females will quickly withdraw. So, if you decide to go for a political position, your mind has to be made up for that.
>
> -Dr.Bernice Dahn_former Minister of Health Liberia

Other times women's access to leadership opportunities in the system is limited, unfortunately, due to women's needs and expectations for childbirth and childrearing. For example, Dr.Basinga admits to being offered a leadership position at the University of Rwanda

with no competition after he graduated earlier from his doctoral studies than his female counterpart who had to take time off for maternity leave. This example points out to poor consideration of policies in health systems in sub-Saharan Africa that can safeguard gender equality.

> So, I went to school, with a colleague of mine. We went to the medical school together. She is female, extremely hardworking, very intelligent, and super smart and we finished medical school, and we were both recruited in schools of public health. And then we went to Tulane University together to do our MPH's, but we were doing it in different departments. We finished almost at the same time then I remember I finished my PhD a little bit before her, because she had babies, so she had to stop for a little bit. And then when I went back to Rwanda, I was the first to finish my PhD, not because I was the smartest but because, she was taking care of her family etc. And then I was offered the position without competition of the Deputy Director, because the University was waiting for the first one who will finish. And it just gave me that advantage …when I compare with her, you know, I see that difference.
>
> -Dr.Paulin Basinga_Gates Nigeria Country Director Gates Foundation

However, because of the way both women and men are socialized, society—including people in the workplace—has come to expect a 'nurturing' leadership style from women leaders. This can be a challenge when some women leaders adopt a different leadership style that is more direct or more associated with 'acceptable' male behavior. This is limiting for women leaders because they are rewarded differently from men and it can be difficult for them to navigate these gender politics.

> And I think some of it is the way we are socialized and what it is that women are rewarded for. So, one of the things that I think is a challenge for young women or girls, especially just starting out your career and being in leadership roles is that leadership behaviors that are accepted by society in men are not always the same ones that when women display are seen as positive. So, something like assertiveness for example, which you need in a

> leader. Like I mean, especially coming out of medicine, if you have a patient who is declining right in front of you and you have about five or six minutes to make a decision, assertiveness is key! clarity is key! If you don't do any of that you're going to lose the patient, you are going to create confusion in the team and you're going to be a terrible leader when you do you debrief afterwards. Your team is going to be mad at you. So, assertiveness is key but, in the workplace, sometimes when women are assertive, decisive, it throws people off. And not just men, it sometimes throws women off because the women in the workplace are also used to that style in men. Women have this extra burden of being expected to be like nice and friendly…Women are as varied as the men are, so we can't expect women to fall into a particular leadership nurturing style. Not all women are going to be in that nurturing kind of motherly role as a leader. Some women maybe more about getting the work done technically, tactically, but they're not trying to be nurturing and that's okay. If a man leader isn't trying to be this kind of fatherly figure, they don't get criticized for that. They are just doing the work.
>
> -Dr. Nana A. Y. Twum-Danso_Managing Director Rockefeller Foundation

Some men respondents stated that 'gender' was a non-issue for them, inferring that they were 'gender-blind' and that they attributed some of the gender biases and dynamics to individual personality or difference in leadership style rather than gender. This self-proclaimed oversight on gender dynamics can impede these men leaders from having the ability to be true allies to their female counterparts.

> I think when I was minister, I did not look at these issues of gender. No. For me, gender was really immaterial. Gender for me-men, female, we are all equal. I think, for me is an issue of more personality than gender as an issue. I don't see issues in gender. When I worked my deputy was a female, as I said, and we worked on very well. By the way, my Deputy was the secretary for XXX party women's counsel. You can see she was a leader in her own. But she was my Deputy, she was a nurse by profession. When I addressed my team, I addressed on issues that were at hand that point in time. I did not address them showing my muscles as a man, but rather, it is the capacity that spoke than who I was.
>
> -Dr.Richard Nchabi Kamwi_former Ministerof Health Namibia

**Coping Mechanisms**

Women and men leaders took various approaches to dealing with the social constructs of gender and the biases that can negatively affect women's leadership potential and progression.

For women leaders it was key to have confidence and the agency to know when to leverage their unique sensibilities as women in their leadership roles.

> And yes, I understand that societal constructs may slow potential progress and what I'm trying to do, but I'm also very aware that it will not stop me. And so, to that extent, I would say that being a female leader has not been the easiest journey, but it has been a worthwhile journey. I would not have it any other way. And how I've been able to survive is to ensure that that societal construct, I am aware how it impacts what happens and I'm also aware on how to leverage it. So, I will have my hair colorful, I will wear my colorful clothes or put my red lipstick. I wouldn't let society to let me I need to look a certain way to be a leader. But I'm also aware that the is a political savvy way of navigating the treacherous societal expectations of a leader.
>
> -Dr. Angela Gichaga_CEO Financing Alliance for Health

Many female leaders, when faced with undertones of sexism or gender bias's particularly related to interpersonal conflict, would choose to ignore or try not to internalize them by focusing on the 'bigger picture' as they put it. A few women leaders mentioned having to either change their leadership styles from consultative or informal to more command and control to deal with these matters. Women leaders felt that, in many ways, to build their legitimacy as leaders they had to persist, negotiate and occasionally compromise in ways that men don't have to.

> I feel that as a woman there were times when I had to choose my battles and focus very much on the main objective that we had to achieve both in-terms leading with whatever teams I was working with and actually achieve cohesion. I did happen in one of my one of my positions to work with a couple of male colleagues which requires having to really assert myself but in ways that gave them space, in ways that make it very clear that you know the natural style of asserting yourself to what you might see as a little girl who has to justify herself is not going to work. It involved having to sit down with a colleague and

> really get into detailed discussions basically about mutual respect because my style is very much informal and open, but we need at the end to be clear where we are going and what our different roles and responsibilities not to come doing. It is work in the end but there was one colleague who came from very traditional background with whom this has some effort and in general I mean as a woman leader in different positions like you have had to explain yourself insist, persist, negotiate, occasionally compromise keeping an eye on the big picture in ways that I felt a man wouldn't be doing this honestly.
>
> -Dr.Matshidiso Moeti_Regional Director WHO Africa

Women participants asserted the need to always over-prepare or work much harder to avoid being discredited because of their gender, and to ensure that their male colleagues don't have any opportunity to undermine them.

> And making sure very quickly we can show results so that you can be trusted because unfortunately, especially as a black African woman, or black woman in general, you constantly have to justify your place at the table. So that's another reasons why it's about results all the time.
>
> -Dr. Myriam Sidibe Director Social Mission Unilever

Learning how to respond and address implicit gender bias was also identified as an important skill for women leaders. Former Senegal Minister of Health mentions learning to respond without being "destroyed"- a reflection of the stigma women face for being perceived as weak or too emotive in the workplace.

> It's an issue of sometimes when you say something which is logic and very strong, somebody can tell you, oh no you are a woman, it's why you are saying that for example. To minimize you. In your training, you need to be able to have also the capacity of responding and also putting your voice without being shocked of being destroyed because somebody asked told you something. It seems that in leadership training, some part can be more gender focused.
>
> -Dr.Awa-Marie Coll-Seck_former Minister of Health Senegal

When interpersonal measures of dealing with gender prejudices didn't work—for example having a meeting with a male colleague who is an aggressor—it was interesting that none of the female leaders spoke about trying to escalate these issues to the organizational level. There was the impression and a personal recognition from women participants that they needed to deal with things within their 'locus of control'. A few women leaders mentioned trying to devise 'systems' within their mandate to work around issues of gender biases. For example, the former Minister of Liberia spoke about a male deputy who was not being cooperative because he was not okay getting directives from a woman leader. The Minister decided to introduce a management tool to encourage him to do the work despite their differences but also as a means to document his incompetence. She also worked around him by creating another sub-team, a delivery unit, and handed his work to them to ensure the work still got done.

> I have one deputy that was a male and I when I became minister, and the whole while he did not really grasp that he is a male, and he will just have to do the work. Because most of the programs fell under him and I realized that if we continue to work this way we were not going to deliver. That's why so I established delivery units. So, I worked around him. But also, with him specifically, because of him I developed a management tool for all my deputies. So, they could actually write down. I knew what they were doing. So, what I did was when the civil service agency already had that management tool. So, what I did was to take everybody's job that they were doing that I knew and populated the tool. And I gave it back to the deputies and asked them to finalize it so I could use that to monitor them. I was there for two and a half years and he never did it. The others did but he never did. So those kinds of things do exist. So, as a female you just need to know how to work way around it and get your work done.
>
> -Dr.Bernice Dahn_former Minister of Health Liber

Having other female mentors was quite important for the female leaders. For example, Joyce Msuya mentioned the value of having female mentors who gave her guidance on balancing

personal and professional life. This included taking the courageous decision early in her career to choose a job that did not involve travel so she could breastfeed her children.

> I've had a bunch of, I would say, five closest mentors, but for different things. For example, because I'm a mother I'm a wife, and I'm a working mother, I've had mentors, very senior executive women, who did or did not do the right thing in terms of balancing motherhood. And so, I've had people advising me, how do you align and balance all the responsibilities, particularly when it comes to kids, husband and working. But also, some of these female mentors have also been my strategic mentors in terms of them encouraging me to do the difficult things because from their experience they have learned by doing difficult things and taking difficult assignments. That's where you get the maximum growth or stretch growth as a leader…….For example, when my children were born and they were young, I chose to take a job that did not involve traveling because I was adamant that I needed to breastfeed all of them for one year. And therefore, I needed to be home rather than travel. So those are the choices that I made because of the guidance and mentorship that I received from others.
>
> -Joyce Msuya_Deputy Director UNEP

Male mentors also play a role in terms of acting as allies and also strategically navigating gender politics.

> But I've also had, for example, some Caucasian men who have been my mentors in terms of doing things differently, for example I was at the World Bank Group very happy working on health sector. One of my former bosses, who is Dutch, encouraged me to leave the health sector and to go and work in the chief economist's office. And his rationale was you're going to learn a different skill set and knowledge to complement what you have done in health because it's good to do health projects, but it's better to do health projects in a strategic manner. And by working with the chief economist directly, I was exposed to the strategic thinking, how does the World Bank Group at the highest level actually strategize on engaging with China on health sector….He told me, for example, yes it's great that you can work in Africa when I was at the World Bank Group but he said you should get out of Africa region and go to other regions, because if you perform in those regions, the way you've performed in Africa, people will respect you more. And he gave me his own example that he was Dutch, but he spent a lot of his career in Africa and that's what distinguished him from other competitors. And true enough now if I look back what I did in China and in Korea. In China I was the first African woman to be based there. Korea, I was the first World Bank Group staff to open the office. Those skill sets now make me much more marketable as an African woman leader, then if I did not pursue them.
>
> -Joyce Msuya_Deputy Director UNEP

For male leaders, being a true ally to their women counterparts meant recognizing their own privilege and not acting upon it. It also included being sensitive to or aware of gender dynamics in the workplace including the kinds of balancing acts women have to juggle between the workplace and the home. When women feel supported by their male colleagues it allows them to be their best in the workplace.

> I pay attention, big time because, when I start my one on one, I start by basic questions. So, how is your family? What is top of mind? What are you doing? Let me give you a very concrete example. I was having a meeting with one of my female colleagues, who leads our communication here. And, I know that she lives here without her husband and she has two kids, they go to school, etc. And the meeting was at four pm and I know that's the time to pick the kids She only got time on my calendar during that time. You know, when she just walked in, I saw that she wanted to run through things quickly, and I realized oh you know, this is the time to probably need to < pick her kids>. So, I just said you know what, I'm here next week what about you going to pick the kids? This meeting is not urgent. She was like, Oh, really? Do you think so? I'm like, Yes. Go. She was like, how do you know that? I'm like, No, no, I know, I pay attention to that. And she just said, oh, thank you so much because, you know, even my head was not here. You know, when you pay attention, those kinds of things you get people at their best. And sometimes they would say, look, you know, I need to go and put kids to bed and then, between 9pm to 10pm, I'm at my best, I'll respond to that email.
>
> -Dr.Paulin Basinga_Gates Nigeria Country Director Gates Foundation

**Case Study: What Lessons in Leadership Crisis from the Ebola Outbreak in Liberia can be applied to the COVID19 Pandemic?**

**Case Study**

**Leadership in a Crisis:**

**What Lessons in Leadership Crisis from the Ebola Outbreak in Liberia can be applied to the COVID19 Pandemic?**

In 2014, an unprecedented outbreak of Ebola hit West Africa becoming the largest and most complex Ebola outbreak since the virus was first discovered in 1976 (WHO 2015). The epidemic claimed more than 11,315 deaths, predominantly in the three West-African Nations of Guinea (2,536), Sierra Leone (3,955), and Liberia (4,809), but with deaths also recorded in Nigeria, Mali and the U.S. (BBC, 2016). From the first reported case on March 23rd, 2014, to the last case recorded on January 13th, 2016, a total of 28,637 Ebola cases had been reported. President Ellen Johnson Sirleaf exclaims that managing the Ebola Crisis was undoubtedly her greatest leadership challenge in her 12-year tenure as President of Liberia (2006-2017). Liberia was a fragile state that was just rising from the ashes of a 14-year civil war, and Ebola lay bare the weakened health system. In Madam Sirleaf's account, until this day, piercing sounds of sirens bring back haunting flashbacks of non-stop ambulances racing up and down to pick up lifeless bodies of Ebola victims from the streets <personal interview>.

Today the world finds itself in a global pandemic, Covid-19, that has infected more than 20 million people worldwide and claimed at least 750,000 deaths (New York Times 2020). The Coronavirus has affected nearly every country in the world, and national leaders have taken different approaches to managing the pandemic. Many countries like the United States have been highly criticized for a slow and poor response, while in New Zealand, Jacinda Ardern, the country's Prime Minister, has been lauded for her show of effective leadership during this crisis.

Currently, Africa has about 1 million confirmed Covid-19 infections, with about 24,256 deaths as of August 13th, 2020 (Al Jazeera 2020). Almost half of the cases on the continent are from one country alone, South Africa. Though the numbers of COVID-19 patients are increasing steadily throughout the continent, the cases have been much less than predicted. At the

beginning of the pandemic, there were dire warnings of how badly African nations will succumb to COVID-19, with the U.N. estimating up to 3.3 million deaths in the continent alone if no interventions are put in place (NPR 2020). Respected epidemiologists had also predicted that the death rates in Africa would mostly likely surplus those in China and Europe, but thus far, Africa has had fewer cases than almost any other region in the world (NPR 2020). Many founded and unfounded speculations have been put forward to understand this Africa conundrum -maybe it's the youthful population in Africa? Or the climate or just good genes? But many others are still pessimistic and worried that in the case Africa is hit by a second, stronger wave of the pandemic, the weak health systems characterizing many sub-Saharan countries will lead to catastrophic outcomes.

However, it is my opinion that Africa has not been given the credit it deserves for the prompt response and innovative measures several countries have taken to curb the pandemic. In Senegal, researchers developed home-grown diagnostic tests for Covid-19 that are affordably available for $ 1 each (Travaly and Mare 2020). Top engineering students in Senegal have also developed a medical robot to ease the burden on health workers by helping to test patient's blood pressure and temperature. Kenya, repurposed certain textile factories to produce in bulk Covid-19 protection masks (Washington Post 2020). Ghana, on the other hand, has been using Zipline to transport Covid19 samples for testing. The United States is slowly recognizing that they can learn from some of these global health innovations that have been successively piloted in Africa and have recently started using Zipline for the pandemic relief (Travaly and Mare 2020).

In early February 2020, when the COVID Pandemic had hit China and was quickly spreading through Europe, I was in Monrovia, Liberia. At that time, no case had been reported in

any African nation, but Liberia, having learned from the Ebola crisis, had already introduced strict measured for infection prevention and control. There were buckets of chlorinated water with soap outside every supermarket, hotel, office, and even church, requiring everyone to wash their hands before entering. Conversations with one of the doctors, Jerry Brown, a recognized hero for his leadership in the Ebola response in Liberia mentioned that at the time he was already working with the Ministry in the preparations for Standard Operating Procedures (SOP's) in the case that country gets any suspected case of Corona-virus. Therefore, Liberia offers an interesting case study on lessons in leadership from the Ebola response that can be applied to the COVID-19 pandemic.

**Background**

Liberia was considered a middle-income country in the 1970s, but the economy started declining in the 1980s due to the civil war (Wolmarans and Akwataghibe 2017). Liberia endured two bouts of a brutal civil war in 1989-1996 and 1999-2003 (BBC 2018). The Liberian civil wars were one of the goriest, in the post-independence era, killing more than two hundred (200,000) people in a small country that was just 2.1 million people (Momodu 2016). Many people were also displaced and living in schools, stadiums, and others becoming refugees in neighboring countries.

After the fourteen years of large-scale armed conflict by 2003, the health system was severely weakened due to broken infrastructure. As a result of this, over 90% of Liberia's health care services were delivered by external agencies and NGOs. A rapid assessment of the health situation conducted in 2006 showed that human resource for health was composed of approximately 4,000 full-time and 1,000 part-time staff (Wolmarans and Akwataghibe 2017). The

management systems were dysfunctional or non-existent, and a majority of the workforce didn't have the right qualifications.

When President Ellen Johnson Sirleaf came to power in 2006, she worked aggressively on rebuilding the health system. In the pre-Ebola phase (2007- 2011), the national health policy introduced a number of health sector reforms for the achievement of effective delivery of quality health that focused on decentralization(Wolmarans and Akwataghibe 2017). The focus was on a primary health care approach that would allow the country (and community) to drive decision making on resource management and service delivery. These changes led to an improvement in health outcomes, average life expectancy at birth estimated by WHO (2006) at 42 years had increased to 59 years (2010) (Wolmarans and Akwataghibe 2017).

When Ebola hit in 2014, Liberia had made marked milestones in several key areas of health service delivery. However, the epidemic outbreak eroded many of the health gains because a majority of health facilities and training institutions were closed, and many of the health workers had died in the beginning of the epidemic because of poor protective measures (Wolmarans and Akwataghibe 2017). During the outbreak, health workers were 21–32 times more likely to be infected with Ebola than the general adult population (Brolin et a.l, 2016).

Liberia makes a good case study for this assessment because even though its health system has been under-resourced with profound lack of health workers, and poor physical infrastructure, it had established a universal package of health services less than a decade after the civil war (Curry, Taylor, Chen, et al. 2012).

**Ebola Outbreak in Liberia**

Ebola is a highly contagious, deadly, viral disease that spreads from human to human through contact with blood or other bodily fluids. The deadly disease first broke out in the rural rainforest of Guinea on December 26th, 2013, when an 18-month-old toddler suddenly fell ill possibly from touching an infected wild fruit bat - and died (WHO, 2015). Not long after, several family members passed away with the same symptoms (Parshley, 2016). Ebola spread to Liberia when a Guinean patient went for treatment at Borma Hospital in Lofa-county, which borders Guinea. When the Ebola started in Liberia, there was an elusive calm start to the storm that was about to take over. The first two cases in Lofa county were confirmed on March 30th, 2014. A few days later, on April 2nd, Ebola had reached Monrovia, Liberia's capital, through a suspected infected traveler who had passed through Lofa county, though no new infections were confirmed in the city. A week later, on April 9th, there were was a total of about 22 cases of either confirmed or suspected infections in the country and a total of 12 deaths, including health workers (Schreiber 2017b).

The Ministry of Health was able to temporarily manage the response through effective organization of specialized committees focused on the medical, social, and logistical programming for the response (Schreiber, 2017). The outbreak was slightly abated for a few weeks, and the government thought they had things under control until about mid-June when it came back with a vengeance. By mid-July, new cases of Ebola had steadily risen to about 80 per week (Schreiber, 2017). The high fatality of victims from a disease that they had no prior knowledge of or understood how easily it was transmitted, frightened everyone in the country.

Things continued to worsen, and around November 2nd, Liberia had reported the largest number of cases (6,525) and deaths (2,697) compared to the two other affected West African countries of Guinea and Sierra Leone (Nyenswah et al., 2014). By around December 2014, the

fatality rate, meaning the percentage of deaths among those infected, was about 58% (WHO, 2014). Being diagnosed with Ebola was an immediate death sentence, and this frightened people.

Through a series of interventions including community mobilization, a strong communication campaign, a global mobilization of resources, and President Sirleaf's decision to take personal control of the response, Liberia was able to manage the epidemic. On September 3rd, 2015, Liberia was declared Ebola-free by the WHO (Schreiber 2017b). Just a year earlier, in September 2014, the CDC had made some gloomy predictions that as many as 1.4 million people would succumb to Ebola in the region. President Sirleaf had refused to accept this grim forecast and worked hard to reverse the trend. By the end of the epidemic, total confirmed cases in Liberia were limited to 10,657, which was a notable accomplishment (Schreiber 2017b).

**Methodology**

A literature review that included news articles and journal articles documenting the Ebola and Covid-19 response were used. Interviews were conducted with President Ellen Johnson Sirleaf along with two other leaders who were part of Sirleaf's administration and worked in the Ebola Response- Dr.Jerry Brown and Tobert Nyenswah. The interviews were conducted in-person, in Liberia, before the Covid-19 pandemic had been confirmed in the country. The interviews had an informal format with no predesigned questionnaire. The discussions centered on understanding the leadership decisions, processes, and actions taken by these respondents during the Ebola response. I then evaluated what lessons learned will be most relevant for leadership in a health crisis like the current Covid-19 pandemic.

It is important to highlight why these three leaders were selected for this case study:

- **President Ellen Johnson Sirleaf:** Since the outbreak of the Covid-19, President Sirleaf has been interviewed by various media channels, including CNN by Christiane Amanpour and France 24 to get her reflections on lessons learned from the Ebola experience that can be applied for the current Covid-19 pandemic. She has also been invited to a plethora of webinars to reflect on what's happening in the world. On March 19th, 2020, she published an article on Time with Raj Punjabi titled "Five key lessons from Ebola that can help us win against Coronavirus, everywhere "(Sirleaf and Panjabi 2020). In 2019, WHO director-general, Tedros Adhanom Ghebreyesus nominated President Sirleaf as the WHO Goodwill Ambassador for Health Workforce. In July 2020, Dr.Tedros also nominated Sirleaf to lead an independent review of the international response to the Covid-19 pandemic along with Helen Clark, former prime minister of New Zealand (WHO 2020).
- **Dr. Jerry Brown:** Dr. Brown was then the medical director and general surgeon at the Eternal Love Winning Africa Hospital (ELWA) in Monrovia, Liberia, a nondenominational Christian mission, comprising a school, a radio station, and a hospital. Dr. Brown was one of the few people who, from the early onset of Ebola in Liberia, had acted urgently to prepare his team for the outbreak by setting up a location of quarantining suspected patients. In 2014 Dr.Brown was nominated at the Time Person of the Year, for the incredible foresight and courage he had shown during the Ebola Epidemic (Drehle and Baker 2014) and has written on Time of lessons from Ebola that can be applied to this pandemic (Brown 2020).
- **Tolbert Nyenswah:** Mr.Nyenswah was a young assistant Minister who President Sirleaf nominated during the Ebola response to be the Incident Manager, leading the operational

aspects of the response and reporting directly to the President. He has documented his experience of leading Liberia through the Ebola crisis (Nyenswah, Engineer, and Peters 2016). After Ebola, he facilitated the establishment of Liberia's first National Public Health Institute. He became the first Director-General (2017-2019), and he is now a Research Scientists at John Hopkins School of Public Health.

**Key Lessons in Leadership from the Ebola Pandemic that can be applied to the Covid-19 pandemic**

**Address Fear and Channel into Hope and Action:**

When Ebola invaded Liberia, people were dying mercilessly due to a lack of proper infection prevention measures along with the high fatality rate of the disease. Liberia had never in its history gotten a case of Ebola. So many people did not have any knowledge of Ebola, how it transmits, and what's the best way to protect themselves. A deep fear overwhelmed Liberian people. Mr. Nyenswah cites that Liberians would exclaim that Ebola was worse than the civil war because at least with the war, they could anticipate when the enemy was about to attack, but Ebola was like an unknown enemy. The experience is very much similar to the Covid-19 pandemic, where the world did not have a lot of information on this SARs-related infectious disease. Is it airborne or not? How does it affect the body, and why do different people and demographics have different survival rates?

Many times, when a disease outbreak occurs, there is a lot of uncertainty and ambiguity, which often leads to fear. A leader's responsibility is to recognize this fear and address it empathetically. Intense fear can be paralyzing, causing a failure to act, and so effective leaders

can influence people to channel their fear into hope and action in times of crisis. As President Sirleaf asserts, -she addressed the fear of Liberian's by showing compassion and taking charge of the response. She traveled throughout the country and met with frontline workers and community members. She not only provided them with resources such as protective gears and necessary medications but spoke to them and acknowledged the collective grief that Ebola had caused. In the Covid19 Pandemic, New Zealand's Prime Minister is one of the leaders has been called exemplary for her ability to communicate empathy. In Jacinda Ardern's March 21st explanation of New Zealand's four-level alert system, she craftily acknowledges the growing pains of the pandemic and its effects. From how quickly this new normal has shifted people's day to day lives to effects of not being able to attend loved one's funerals (Wilson 2020).

> I realized that the fear that existed in people requires someone to address their fears and to help them to overcome their fears. And the only way to do it was for them to see that I was not afraid. And so, I went into clinics, I went into rural areas, into hospitals and when I went, I took the suits <protective gear> and the medications and all the things that were required I took it with me. But also, I went and met with them, the nurses. Just sitting with them and talking, look this is something we all have to fight together it's not going to go away. Some of your people have died, but that should be a challenge to us that nobody else should die-not you, nor the citizens! And so that gave them encouragement. I went all over the country, here, other places. And I think that that changed the whole fear, it enabled him to know that they were part of the resolution of the problem.
>
> -President Ellen Johnson Sirleaf

As one Mckinsey article on crisis leadership notes, "When people believe that a leader cares about their well-being, commitment, and success, it helps them move from that room called fear to that room called hope" (Rao and Sutton 2020). President Sirleaf was able to inspire health workers that, even as a national leader, she was physically and emotionally present for them as frontline workers and also affected communities.

Madame Sirleaf was able to encourage them without giving them false hope- "*this is something we all have to fight together it's not going to go away."* In immense ambiguity, basic human instincts can incite leaders to downplay the threat -and paint a false reality out of their own fear of either unnecessarily making people anxious or being the bearer of bad news (Kerrissey and Edmondson 2020). We saw elements of this in the United States when at the beginning of the Pandemic the President in Office called the Covid-19 a hoax and in many of his addresses has repeated that it "will go away like things go away" despite cases continuing to surge in America (Parker and Wingrove 2020).

President Sirleaf tried to create urgency to act for the collective good by helping health workers see that they were "part of the resolution of the problem." It has been documented that when people believe that their actions can change the world around them for the better, they are fueled with hope, and can show more resiliency and are more empowered to act (Rao and Sutton 2020). So, the implication for leaders is that though they cannot control what happens to their followers, people are likely to suffer less if they are given control over how they experience the stress and what to happens to them as a result of it (Rao and Sutton 2020).

**T-shaped Approach to Information Gathering and Sense-Making:**

The T-shaped approach is often used to describe the skill set of having 'breadth' and 'depth' of knowledge and experience. In this context, it is used to emphasize the importance of leaders applying a broad perspective to information gathering in a crisis but then to be able to hone in what works for this context and what does the science say. In other words, due to the lack of information and present of misinformation's leaders need to make sure they are hearing from

diverse perspectives or schools of thought and at the same time be able filter and hone in on the legitimate sources or the science of things. However, it is not only about collecting data but also being able to make sense of it urgently and framing the narrative in a way that can instill confidence in people.

During the Ebola crisis, President Sirleaf closely monitored the progress of the outbreak daily. She allowed the relevant key people to report directly to her. Every evening she would ask for the numbers of those who had died of Ebola on that day.

> That was another thing the President did. When the crisis was escalating further, she took charge and became almost like the head of the whole management team and allowed people to report to her daily on what was happening. So that's what the incident management team was all about, to report and update daily on the crisis. Because when that is happening, you as the leader can make a sound decision because your voice or your say will mean much more than any other person in the government, you can veto anything any other person says."
>
> -Dr.Jerry Brown

A leader cannot be everywhere at any point in time; that is why it is very important to have the right team and the right people in place. When Ebola struck in West Africa, Madame Sirleaf had to make sure she had a strong team of people to manage the response. For example, she had selected Mr. Tolbert Nyenswah, an assistant Minister, to lead the Incident Management Team, whose primary mandate was to manage the response. Mr. Nyenswah, who had just graduated from his Master of Public Health degree from John's Hopkins University was surprised Sirleaf appointed him because not only was he quite junior but also, he didn't have a medical degree. In sub-Saharan Africa a medical background is often highly regarded and signals legitimacy in the medical and public health space. But when Madame Sirleaf was asked what she saw in Mr.Tolbert and also when hiring people, she mentions:

> The ability to demonstrate concern and passion for the area or the mandate of their work. They're willingness to take risks. To forge ahead and to be assertive, if not aggressive. And these people stand out then yes, it's good if in the area of their mandate if they have the knowledge and the experience in it that always is a value factor. But that's down the list. What you're looking for is somebody who can achieve the results and can demonstrate the kind of commitment toward that. And clearly, in the meetings Tolbert sat in, the manner in which he responded he interacted, showed that this is a leader, and this is somebody who can take charge of this.
>
> -President_Ellen Johnson Sirleaf

In a crisis, a leader must be getting truthful data about what's happening on the ground. Sometimes those closest to the leader may be nervous about painting the true reality on the ground or maybe nervous to be constantly delivering bad news as a crisis is unfolding. For this reason, that is why it is not the only key to make sure the right people are on the table and that there is a diversity of perspectives. However, to caveat, this is a leader's responsibility is to also speedily swift through the information coming to them. Usually, at the table, there are politicians, scientists, the media, and all these different stakeholders can have very divergent interests, so one has to also really listen to the science and 'understand the disease' as Dr. Jerry Brown emphasizes.

> People tend to wait until it's late before they act, but a leader would delay if they don't understand what they are talking about. But if the leader took his time to understand the disease, and also learn about what's happening in other countries, you don't want to sit there. You watch the news, understand what is happening in other countries. Having understood that, the next thing the leader ought to do is to understand what you have. You call your health leaders together; Corona is elsewhere come, come, -Where are we in terms of preparedness? Let them talk to you. You have already read something about it. You already know a few things. So, if you're going to put the question to them, this where we are, tell me, where are we? What are your plans, be interested in management plan? Don't just sit and allow people to do it, and you just sit there. That's why during Madam Sirleaf's time, I was happy. She once called all of us to the mansion on a round table to ask us what happened? Hey gentlemen, what's going on? The one thing I've realized, many of the people don't say the truth to their leaders. If madam Sirleaf can remember me, well. One of the things I said to her when she asked me a question, I said Madam Sirleaf if we must contain this disease, the first thing is we must be sincere to one another because if we are not sincere to one another in giving our President the truth

about what's unfolding, she won't make the right decision. The person in leadership won't make the right decision.

-Dr.Jerry Brown

The other key aspect that is interrelated to 'information gathering' is 'sense-making,' which is particularly important in conditions of crisis where there is a lot of ambiguity and uncertainty. In crises, people rely more on their leaders to make sense of things and provide some form level of directionality. Some leaders either out of fear of out of not knowing what do or fear of failure can sometimes choose to be 'absent' or appear 'elusive'. This is a dangerous strategy, and in most democratic states, the media and press have a strong influence in shaping the narrative. Whether or not the narrative that the media choose to portray is true or 'fake news,' it can have a stronghold of people's belief system and either increase tensions or make people lose trust in the government. For example, in the wake of the Ebola outbreak in Liberia, when the country was still largely unprepared to deal with the epidemic, mistrust of the government escalated when one political leader started propaganda on the radio. The leader was a legislator, a senator, and he went on the national radio and told the Liberians to "Pay no mind" because Ebola is not real, that It was just a scheme by the Ministry of Health to secure more funding. These words became the sub-narrative of the initial response, and it heightened people's distrust of the government. Once this happened it became harder for President Sirleaf and her government to mobilize the mass.

Leadership literature states that 'sense-making' captures the idea that people (individuals or groups) make sense of confusing or ambiguous events by constructing plausible (rather than necessarily accurate) interpretations of events through action and the reinterpretation of past events (Hartley and Benington 2010). Therefore, the role of the leader becomes less about

having a 'clear' vision but rather offering plausible narratives to help citizens or people comprehend what's happening and empower them to act. In the process of 'sense-making,' a leader often offers 'explanations,' 'rationalizations' or 'legitimations' of their decisions and actions (Hartley and Benington 2010).

A good example from an Africa, a leader who has tried to do a good job in sense-making the situation of the Covid-19 Pandemic is the president of Uganda, H.E. Yoweri Kaguta Museveni In his address to the nation on March 18th, 2020, concerning the country's guidelines on preventative measures (Africa Tembelea 2020). Below is an excerpt of the introduction of his speech and his message on the importance of safe burials:

> Today, I have come to address you on the issue of the Coronavirus, abbreviated as Covid-19. They call it corona because, under the micro-scope, it looks like a crown (ekiruunga, engure). This is a new virus, but it belongs to the family of the common-cold (Senyinga, Rubyamira) group of viruses. It makes some people very sick because, being a new virus, all of us do not have immunity against it because we had never been exposed to it…… The other occasion that gathers a lot of people is a funeral. Again, relatives, friends, associates, neighbors, etc., turn up in big numbers. Again, with this virus, this is a danger point. Many people could be infected there. We cannot ban or postpone burials for 32 days. It would not be rational. We, therefore, recommend that the burial is done by the relatives who are nearby. They should be the ones to Kuziika (to bury). Then the mourning (the kukungubaga – ekyosi) could be later when the rituals could be done. This may combine both science and culture. Most importantly, it would be safe for the participants. If the deceased is, however, suspected of dying from the Coronavirus, the State will take over and bury the person in the scientific way without the involvement of the family as we did for the Ebola victims. We should not replicate the lack of enlightenment that was exhibited in West Africa where the ritual of washing dead bodies was maintained even when people were dying from Ebola. The consequence was that the "bathers of the dead bodies" ended up dying themselves in service of a non-scientific cultural practice. By confronting this disease with enlightened, scientifically based actions, we shall defeat it as we did with Ebola three times, with Marburg and with AIDS.
>
> -President Yoweri Museveni

His language throughout the speech is very simple and he uses a mix of both English and some Swahili and vernacular words used in the country. He is not only able to translate the

science in very simple terms, but he offers reasoning and rationalizations to the decisions and explains how he has considered both science and also culture in his recommendation. He gives examples of Ebola in West Africa to make justification for state conducting burials for suspected victims.

**Admitting Failure and Quickly Correctly for it:**

In a crisis, it is key for leaders to act urgently but not be reactive because mistakes are bound to happen with knee jerk reactions. However, regardless of how well leaders are able to manage their reactions, due to little information and the novelty and complexity of health crisis mistakes are inevitable (Kerrissey and Edmondson 2020). Therefore, how leaders respond to the mistakes and failure is equally important to how they first address the crisis.

> In the initial stages because we didn't know what to do, we had a knee jerk reaction, stop these people from moving, you know, get them to stay in their areas. If things were to happen now, I will do things differently. But then it was like I say it was just a quick reaction to an unknown enemy. Could we have done it differently? I don't know. Because we didn't know this and the first thing, we could think of is that it we come in and we handle it with force, to force things to happen.
>
> - President Ellen Johnson Sirleaf

Ebola spreads fast through human to human contact and fluids. To contain the erratic movement of people, the government's first reaction was to call the military and to quarantine communities where there were victims of Ebola or any suspicion of infection. The intention was to reduce the chaotic movement of people. And so, soldiers were operating the main entry points of these areas with barricades. However, people were upset and rebellious about this perceived military 'invasion'. President Sirleaf, quickly noticed that using military force was not the correct

response and that she had not effectively communicated to the public her reasons for instituting quarantine. At that time, she felt she had failed to calm people down and make them cooperative amicably. People's confidence in her and her government over the response went down.

While she and other high-level officials were developing a plan of action to correct for the quarantine, they had implemented worse challenges surfaced. People were unhappy being quarantined and began rioting. During one particular struggle of rioters trying to flee a quarantined area in West Point, one of Monrovia's poorest slums, a 15-year old boy was shot and killed by the military. The army also shot two other residents, although they survived. This deeply escalated the tensions between the government and the people. The quarantine was a failure, and she had to acknowledge that and take responsibility without blaming and pointing fingers. People were able to find open entry points to escape the quarantined areas, and they would move in more significant numbers, which was harder to control. After the quarantine and disorder subsided, Madam Sirleaf went into the communities and met with the family that had lost the young boy and owned up to her failure and explained the actions her government had taken quickly correct for the mistake.

> Once some of the chaos had subsided, I went in and actually sat with the affected families- for example, the family that had lost a child in the quarantine. I wanted to meet them in their own environment, their own homes, and reach out to them. When I went into the communities, I didn't go with any protection or army, though there was potential that the youth and some angry citizens who have rioted or harmed me. But I wanted to reach out to them, to bring in a sort of calmness and explain to them why we felt we had to do what we did at that time and how we quickly corrected it and admitted to the failure.
>
> - President Ellen Johnson Sirleaf

As people are observing different global leaders taking drastically different leadership approaches to manage this pandemic, many have already failed. At the beginning of the pandemic, it was rumored that the British government was planning on applying the "herd

immunity" theory that discourages lockdowns from allowing the virus to spread naturally to build up the population's herd immunity. After death rates were increasing under this strategy and the new sciences were showing otherwise, the British Prime Minister, Boris Johnson, admitted that the strategy has failed and "drastic measures" were being put to correct for it.

Many other countries also have made mistakes and had to reverse their strategies. For example, at the beginning of the Corona Pandemic, there was a huge debate on whether or not Covid-19 is airborne. The strategy and campaign in many places around the world, including the U.S. and Europe, were that masks are not necessary, and using a mask and touching your face can put you at higher risk. Later as more knowledge on the science of the disease became unknown and learning from China, the strategy in many parts of the turned to make wearing masks mandatory.

**Making Hard Decisions but Implement Humanely:**

Leadership in a crisis is about learning to make hard decisions, because outbreaks like Ebola and Covid-19 are critical and adaptive challenges with no straightforward solutions, especially in the time when there is no vaccine or cure.

In Liberian culture and traditions, 'death is an extension of life' (NPR, 2014). Especially in the Muslim communities, when someone dies, loved one attend to the body. They bathe the body and dress it up with the best attire. Funeral celebrations run for days or even weeks, where people come together to celebrate and mourn the life of the departed. Ebola came and changed many of these cherished traditions. For instance, people were becoming infected at funerals either from the handling of dead bodies or through the intermingling of large crowds. The

precautions for safety did not allow people to care for loved ones who were already infected, and it also did not allow them to mourn them properly when they were gone. As death tolls increased, people were gripped with fear of infection, and communities were refusing Ebola victims from being buried in their land. One evening, Tolbert Nyenswah, the head of the Ebola Incident Management team, needed to find a place to bury 78 Ebola victims in the capital, Monrovia. However, there were no burial sites. Madam Sirleaf had given permission to bury more than one person in one grave, but even this was not sufficient. They found a place in a rural district called Johnsonville, and that same evening they went and buried all 78 people. However, the area was quite swampy.

In the morning, people from those communities awoke to find dead bodies floating on the wetland. They started taking pictures of the bodies and blaming the government for dumping the bodies in their community. Media as well made a folly of this and wrote about it and put videos of the horrid scene online. That deeply frustrated President Sirleaf, and she immediately called Mr. Tolbert and made the hard decision that from then on, dead bodies of Ebola victims in Monrovia must be cremated. For health workers, cremation quickly solved the problem of finding places to bury people. However, cremation was a taboo in Liberia. So, people were resisting, and even faked death certificates and others stopped bringing their loved ones to the Ebola treatment units or faking the death certificates.

> In Liberia, cremation is not a tradition. So, what I think what made her make that decision was that evening, I had gone to bury like 78 dead bodies in a rural district called Johnsonville. And that night the President kept on a telephone with me and she and Marie Broh, that where are we burying these people because there was no burial site? Everywhere no one wanted to accept Ebola bodies in their county. So that night, I remember the President said- Tolbert you people should bury these people, don't give

> them individual grave. The escalator which we took down to do the deepening of the ground broke down. There was a swampy area, and we put some of the bodies in there. Soon that morning, the bodies started to float on the water. In the newspapers, every news and press people went in there and started to get pictures of dead people Ebola bodies that were buried in a wetland. So, when Madam saw those pictures, Oh, I remember the phone call she gave me that morning. Tolbert, what did you guys do? You know, from today, we will cremate the people. When we started to cremate people, the burial issue was solved automatically, but we have to change the strategy, and this is why the Ebola response we always had to strategize and do adaptive strategic response. As things go bad, you adapt. So when burial cremation was started, people got afraid of cremation, so they were not bringing their sick people to the Ebola treatment units. So right there, we designed a strategy called the safe and dignified barrier where people will follow up to the gravesite.
>
> -Mr. Tolbert_Nyenswah

When leaders make hard decisions that people are resistant to, they are more likely to accept them and comply even if they don't agree when they believe that their leaders care about them and are working to do something for the greater good (Rao and Sutton 2020). Additionally, according to Rao and Sutton (2020), leaders who care about their people do more than listen, and express empathy, or display symbolic actions, 'they know how to implement tough and distressing decisions in a humane manner'. Madam Sirleaf and Mr. Nyenswah redesigned a new process of the cremation and called it the safe and dignified burial. After the bodies of victims were cremated, the ashes were transported to a burial site called Disco-Hill, where black barrels that were enveloped in white with red ribbons circling them were used to preserve the ashes in vaults (New York Times, 2015). Muslim families would place the ashes in vaults with a clay mound facing North, and Christians would come and pay respect to sample graves marked with white wooden crucifixes. This was a means to try to bridge the standard burial tradition and cremation.

Similarly, many leaders in this Covid19 pandemic, have had to make tough decisions, including mandating lengthy lockdowns, where people have rebelled aggressively. Closing of

borders, as well as the separation of families, have led to increased distress and including mental health. Leaders have had a hard time to explain and convince people that some of these measures are for the collective good. For example, President of Ghana, Nana Addo Dankwa Akufo-Addo, in addressing the nation concerning the strict measures he was placing due to the pandemic, he said, "We know how to bring the economy back to life. What we do not know is how to bring people back to life". He not only communicated with empathy, but he also put in measures to support citizens with the lockdown. Many African countries, including Ghana, have had to take into account the local contexts and priorities before applying the strict lockdown measures that have been used in the West. In many parts of the world where the majority of people are living in less than $3 a day with no savings or social safety net, strict lockdowns can lead to starvation or even more sickness and death (Jamison 2020). A recent finding showed that in 20 African countries, more than two-thirds of people exclaim that they would starve if they had to stay home for 14 days (BBC 2020b).

So along with a lockdown, the President of Ghana also put in several provisions for the people, including absorbing the electricity and water bill of the poorest of families (BBC 2020a). President Akufo's government also 'embarked on a US$40 million effort to distribute dry food packages and hot meals to more than 400,000 vulnerable individuals in areas that have been affected by the lockdown. Another US$40 million was allocated to the Ghana National Buffer Stock Co., an agency under the Ministry of Agriculture that buys food and releases it into the system when there are shortages and price hikes' (Gakpo 2020). Other nations such as Uganda, Kenya, and Nigeria have also distributed maize flour or similar grains, a staple in most African communities, to people who are unable to earn daily wages during the lockdown.

**Community Activation through Personal Involvement:**

There was a plethora of interventions implemented in the Ebola response-including massive awareness campaigns, partnerships, and resources from around the world that Madam Sirleaf was able to garner through incredible stance and relationships in the international community. So, it is hard to attribute success to just one intervention. However, community mobilization is documented by many others, including madam Sirleaf as a turnkey solution that turned the tide of the response (Schreiber 2017a). After many of the top-down measures failed, there were massive campaigns that were done to mobilize communities to take charge of their prevention and protection against Ebola. From her perspective as a national leader, Madam Sirleaf believes she was only able to mobilize people once she regained their confidence in her and her government. From years of civil war and bad leadership, Liberians have always had a considerable mistrust for those who are in power. So that historical context coupled with the failed approach of using the military to quarantine whole communities and the smear campaigns that had propagated by various groups or leaders, made it very difficult for her to connect to the people. When asked how she was able to bring back the confidence in her leadership, she says it came back by itself once she was able to demonstrate her leadership and involvement in the response and addressing the areas of low confidence:

> It came back up itself! My demonstration of concern and my reaction. So, when confidence is at stake, demonstration of reacting to the confidence, in the areas that bring about the loss of confidence, is not to retreat, you know, or isolate yourself from it or disregard it, but to accept it and then move towards addressing it. And that's what I do with protests. You know, I don't retreat and call security- I go and handle it myself and that just breaks down the hostility. If you confront it, doesn't mean you have to appease them. What you do to show concern and to also say to them you care, BUT you have to abide by the law, you can't do this. But you are there you're not sending a message. You're not sending somebody else to control that you're controlling it yourself. Personal

> involvement, personal direction, personal concern in leadership, I think, helped to keep us at peace for twelve consecutive years.
>
> - President Ellen Johnson Sirleaf

Once people recognized her compassion and personal involvement in leading the response, they were also mobilized to take charge of their health and protect themselves and their communities. Community leaders took charge of educating their people and self-governing and monitoring the movement of people in and out of their areas. For Madam Sirleaf, the personal Involvement she demonstrated included some of the travels she did to meet with frontline workers and affected communities throughout Liberia.

> But when I ultimately put the community in charge, and also took personal control of it by going into hospitals and clinics to give confidence to nurses and doctors who were on the front lines of service delivery. I traveled in trucks into rural places where nurses were doing their best to maintain their calm, to be able to render service to people. I had to go and sit with them, carry supplies. I carry supplies and medication all around the country to different places. So, in the end, of course, I became a hero to them because of the action I took. Only then I was able to move from one position of very low confidence and questioning my ability of doing anything. Taking on the responsibility and being personally in charge of it at the point of care was crucial to building people's trust.
>
> - President Ellen Johnson Sirleaf

As the COVID19 pandemic is unfolding we are seeing how the crisis has brought the best and worst in some leaders. There have been many leaders who have shown personal involvement and resilience, while others have been criticized for their disregard of the pandemic and not acting quickly enough. For example, the U.K. Prime Minister, Boris Johnson, was under fire for poor handling of the pandemic in the initial stages. There is evidence admitting that he missed five key emergency meetings when the crisis first hit. He also chose to pre-recorded his lockdown announcement from March 24th, 2020, not giving media the opportunity to ask questions and he

framed his message as a form of command or instruction (The Guardian 2020; Wilson 2020). In Tanzania as well, at the beginning of the pandemic, the President, went to stay in his home village for an extended period when citizens were looking up to the leadership for direction. Many opposition leaders took to social media like twitter to criticize his absenteeism in times of great confusion. In Nigeria as well, in the beginning of the pandemic, President Muhammadu Buhari had not addressed the nation concerning the pandemic even after deaths had been reported in the country and his spokesperson defended him on 'twitter' saying that addressing the country is a matter of personal leadership style (The Cable 2020). That President Buhari has put people like the Minister of Health and the leader of a special Covid-19 task force who can address the nation. However, especially in a crisis, there is no replacement for the political leadership of the highest.

## Section IV: Discussion

The debate on whether leaders are born or made has been ongoing for decades. However, modern leadership research leans more towards the latter (Hartley and Benington 2010). When considering how leadership can be developed and all the different elements of leadership—conceptualization, context, nature of challenges, etc.—this section highlights the implications for leadership development of health leaders in sub-Saharan Africa. Although there is no right or universal approach to leadership development, it is vital to consider the alignment between leadership development in Africa and the 'needs,' or 'purpose' and 'values' as well as the context of the leaders as well as other beneficiaries of such investments.

On the conceptualization of leadership, study participants had a very similar understanding and definition of leadership as in the Western literature. The leaders interviewed

in this research were highly educated and well-exposed and it can be assumed almost all of them, at some point, had either participated in a formal or informal training where Western leadership concepts were discussed. In the interview process, leaders were asked to share their leadership definitions based on their personal experience and journeys as leaders, and not necessarily a scholarly one. Nonetheless, given that at least five of the leaders, for example, participated in the Harvard Ministerial Leadership program, it is hard to parse out the roots or the influence of their understanding of leadership.

When it comes to values associated with leadership, 'humbleness' or 'humility' as a valued attribute amongst African leaders was a revealing element of authentic leadership in the Africa context. This idea is also connected to the notion of 'collective good' because humble leaders recognize that organizational success stems from people working together. In the West, teams are recognized as necessary in many industries, including technology and health; however, when it comes to rising competitive corporate ladders, there is an influential culture of the individualistic 'I' than the 'we.' It is essential, though, to recognize that since Africa is a vast continent with many subcultures, it is not possible to generalize that humility is viewed positively in all African nations. Anecdotally, for example, Nigerians in West Africa and Kenyans in East Africa are known to be more direct, aggressive, and driven than their counterparts in neighboring Ghana and Tanzania. So, leadership humility may be perceived very differently in these contexts. More research is needed to understand what leadership humility is and isn't in different parts of Africa, mainly because humility is not a virtue that is discussed explicitly in many leadership models that I have come across. However, since relationship-building is a substantial part of doing the work in health systems in sub-Saharan Africa, more exploration should be done to

understand how humility can be effectively used as a skill to build legitimacy while building awareness on how this attribute is perceived either positively or negatively in different contexts.

Findings from this research show that leaders need to have relevant technical competence, which is documented in other studies on the continent (Doherty, Gilson, and Shung-King 2018). Some essential technical abilities that were highlighted given the context of the work were communication and writing skills. The need for communications skills was highlighted mainly by the leader from francophone Africa. Writing skills are crucial to public health systems in Africa because the health systems are very heavily dependent on financing from donors and being able to write grants and reports is critical both in Anglophone and Francophone African nations. This is a positive characteristic, however, one issue that often arises, primarily in the public sector of health systems in Africa, is that because the methods of recruiting are heavily focused on technical competence, relevant 'soft' skills in leaders are not given enough attention or priority when hiring for leadership positions. For example, people with a medical background are often automatically perceived as leaders and given leadership positions in the health sector because of their medical knowledge; however, many may not have the leadership and management skills and experience to lead.

To be able to develop a critical mass of people who can lead, leadership training, which is often missing at the bachelor's level, needs to start earlier in the educational system. Leadership development can be incorporated into medical education and other public health and bachelor programs that often mint leaders into the health system. This is important because, as Curry et al. (2012) emphasize, leadership skills are difficult to teach primarily in externally developed training; also, unlike management development programs, they require time and a more

profound level of engagement. One option that Curry et al. suggest is that designing leadership programs in true collaboration with governments and partners on the ground is more likely to be successful at this.

Effective leadership capacity-building initiatives assist participants in coping and thriving in a complex adaptive system (Hartley and Benington 2010). Recognizing 'context' within leadership development programs can help develop leaders who can better read and make sense of context, and this, in turn, influences more informed and appropriate leadership strategy and decision-making. For example, recognizing the difference between direct and indirect leaders is useful in leadership development programs because different strategic and leadership approaches may be used for various roles. Most research on leadership is done amongst managers and their subordinates, and so focuses only on direct leadership contexts (Hartley and Benington 2010). Leaders who work in institutions like WHO and have more indirect leadership roles, working through governments or positional authority to influence, as Dr.Moeti described, may focus on leading change through mass communication, policies, and procedures rather than interpersonal connections. Indirect leadership means leaders are removed from direct engagement with those who want to influence, and so it is vital for them to invest in formulating a compelling vision and clear goals so as to shape organizational climate (Hartley and Benington 2010) and perceived outlook to those they work with. 'Symbolic acts' are also an essential tool for indirect leadership; for example, when President Sirleaf talks about going to the frontlines working alongside health providers during the Ebola crisis, these are means to communicate symbolically to the health workers their value and importance as part of the response.

Understanding social systems and contextual elements in sub-Saharan Africa is vital, given the way communities are organized. For example, in my own experience, while working as a Program Manager doing family planning research in rural communities in Tanzania, it was imperative, when going into communities, to acknowledge and formally greet all the elders and formal and informal leaders in the villages. Building legitimacy with different stakeholders and within all levels of the health system by being aware of cultural norms is a critical topic to include in leadership development programs. Also, leaders must deal with or avoid cultural biases such as tribalism that can occur when working in countries where these dynamics are more pronounced, for example, in Kenya or Ethiopia, as mentioned by one of the leaders. The first step for African leaders is just an awareness of these tribalistic undertones and how to identify them, especially when working in another African context that is different from their own. Tribalism in the African context can sometimes be hard to identify, and leaders felt that these tribal undercurrents are inherent in many organizations or have become structural issues that one may not be sure how to tackle. I believe the same principles that are applied for teaching on racial diversity in Western organizations can be adapted to deal with tribalism challenges in a manner that is inclusive and leads to self- and organizational reflections. It can be more productive to ignite these conversations at the leadership and management level, so policies of accountability and governance in terms of hiring and promotions can safeguard from such problems.

The challenge of African senior leaders balancing high social burdens with their work is comparable to the problem's senior leaders in the West also face, although the context is different. For example, in Africa, social responsibility is often centered around partaking in social community activities that are important in building trust and legitimacy, as well as in managing

spousal expectations in the home. In the West, the social burden is often quite personal around child-rearing in an environment where there isn't the social support system that is present in many sub-Saharan communities for such responsibilities. In developing countries that have many more impoverished communities, there are few shock absorbers to take care of people's challenges. The west has better developed government social protection programs that act as a safety net for people, but in sub-Saharan Africa, people often depend on their leaders, particularly recognized government leaders, to act as their shock absorbers. If people are sick, or they are fundraising for a wedding, they go to their leaders. In Western society, it is almost unheard of for people to go to their leaders on a Saturday morning, for example, to ask for support for a wedding or bereavement.

Dr. Karima Ladhani, the Assistant Director of the Harvard Ministerial program (HMLP), also confirmed these findings of the high social burden for African leaders and highlighted that it appears to be a more significant challenge for women leaders. Dr.Ladhani mentioned that women leaders often have a massive fear of failure around managing expectations of social burdens because they are more involved than men in such activities. She said that as part of HMLP leadership development programs, they ask the participants a question on what keeps them up at night and many, most especially women leaders mention high societal demands.

> Women, in particular, express the social burden not just of general society, but also the social commitment within their families, their homes, in their close circles in terms of what's expected of women within socializing with other women, around community events and things like that. I feel like women, their involvement is higher than men. So, by not being able to participate in those, the loss seems greater. And that's, I think those things definitely come up more so for women with the family burden as well as the community burden.
>
> Dr.Karima Ladhani_Assistant Director _HMLP

Leadership development programs such as the Oliver Tambo leadership training in South Africa (Doherty, Gilson, and Shung-King 2018) often mention how participants of such capacity-building initiatives find it challenging to exercise leadership once they go back to their jobs due to lack of a supportive enabling environment in the professional settings, but few discuss this added layer of the social burden. It is quite crucial for leadership development programs catering to African leaders to provide the tools and means for managing these additional social burdens and expectations in society, especially for women leaders. Practices that encourage mindful leadership and activities for self-care and meditation can be useful in the African context. Incorporation of such training in leadership development may likewise be helpful for leaders in times of crisis and critical situations.

Both in terms of the economy and political context, providing training in 'political awareness' that includes competence in persuasion, negotiations, and communication skills and being able to scan the environment is essential for leadership development. As shown in these findings and also in a large WHO study on leadership (2016), diverse actors participate in health systems, and managing these relationships to affect change is vital. In the United Kingdom, the National Health Services (NHS) framework defines political awareness or astuteness as "showing commitment and ability to understand diverse interest groups and power bases within organizations and the wider community, and the dynamic between them, to lead health services more effectively." There aren't too many leadership developments programs that explicitly teach political awareness skills, and most leaders gain these skills through experience (Hartley and Benington 2010). One research study in the UK showed that most leaders, including those in healthcare, gain their political awareness ability mainly through experience; for instance, 88%

mentioned learning through failure (Hartley et al. 2007) . Although raw experience is quite valuable, it is not sufficient for leadership learning. So leadership development models need to assist participants in reflecting and analyzing the failures to develop conceptual models that they can apply and adapt to varying contexts (Hartley and Benington 2010). In the context of imbalances of power that occur due to neo-colonialist dynamics between developed nations (or 'donors') and African states, leadership development programs have to equip African leaders to negotiate and persuade even from positions of weakness.

According to Hartley and Benington (2010), problem identification and not only problem solving is developing traction as an essential skill for leaders. Given similar findings from this research, leadership development programs need to provide models for interpretation of the type challenges African health system leaders are faced, and conceptual models for responding to such problems. Challenges such as providing strategic vision can be seen as technical challenges needing a functional response. However, as some senior leaders indicated, the ability to do vital work effectively in health systems in sub-Saharan Africa is hampered by factors including high social burdens, not having enough skilled people in the system and also by countless events in the system that feel like 'mini' crises because the institutions are weaker and less resilient. As an anecdotal example of this, a close relative had worked at a high-level position in the Ministry of Health in Tanzania, and one of her daily frustrations was having to spend a considerable amount of time to review simple documents from her subordinates such as emails and reports for grammatical errors because of lack of such skills in her team. In addition, because of the politics involved in working in the public sector, she always had to respond to situations that may not have been real emergencies but were framed as 'crisis' or 'critical' due to pressures

from media or the opposition side of the government. Given that the MOH in many countries is an extension of the government, a leader's ability to manage legitimacy and reputation is a crucial skill.

The nature of challenges for African health system leaders is heavily centered around managing relationships with different actors in the process of 'building legitimacy,' 'managing external influences,' and 'task accomplishment.' These can be both technical as well as adaptive challenges, depending on the context. However, given the varying degrees of authority and power as well as a difference in interests, values, and cultural expectations amongst the actors and their organizations, these quickly become complex adaptive challenges to manage. There are many models for leadership development that have been proposed to tackle these challenges, including participatory leadership (WHO 2016), distributive leadership (Nyenswah, Engineer, and Peters 2016), and Heifetz's (1994) adaptive leadership framework. For example, the HMLP uses the Heifetz adaptive model for its training, which is a less prescriptive and more emergent approach of teaching that center around the leader's own experiences as tools for learning. Prescriptive approaches to leadership development are focused on redesigning the inputs (e.g., skills and competence), as well as the outcomes of leadership. Emergent approaches on the other hand "view leadership as a dynamic process, with a set of interactions between leaders, followers, context and so on, and therefore that leadership has properties that arise from these interactions, and that cannot be predicted in advance (Hartley and Benington 2010)." Emergent approaches often require more time investment because participants need to be provided with support for reflection on their experiences. Programs like the HMLP run for about four 12-hour

days in Boston, which is relatively short though they do have access to a virtual implementation program, which is an online training module that they can share with others in their team.

The majority of leadership development programs focus on building key competencies that are deemed 'good' or 'effective' through literature or experience. However, as the findings of this research shows, there are significant missteps to this approach if there is little consideration of the context and nature of challenges of leadership. Therefore leadership development models need to build in more theory and evidence about what works in what kinds of roles and in what types of situations (Hartley and Benington 2010).

Gender distinctions on who makes a better or a worse leader are not fruitful discussions, nor is the debate around effective leadership styles of one gender. For example, women being perceived as 'nurturers' can have both positive and negative consequences depending on the situation. It has been documented that this expectation placed on women leaders can compel them to focus more on relationship-building. This a useful attribute, but leadership consists of other facets like being strategic or results-oriented, which may be deemed more effective in a particular setting. Understanding how leadership is socially constructed and how these perspectives may put one gender at a disadvantage is critical for leaders and leadership development. When it comes to leadership development models for gender challenges in leadership, it is again important to consider the context. Western feminist models may not be very applicable given the patriarchal nature of most communities in Africa. Models that help to build more informed male allies who have a sensitivity to gender issues may work better in the African context. This research found men in leadership positions can be valued allies in helping to support organizational and political cultures and climates that advance women's leadership.

Also, there is little evidence to support the notion that, because of their gender, women leaders are more devoted or skilled at promoting women's agendas (Poltera 2019). As some of the leaders in this research sometimes exclaimed, women themselves can be perpetrators of gender bias given how they, too, have internalized socially construed gender biases on leadership.

Similar to Nyenswah, Engineer, and Peter's (2016) conclusion on their case study of the Ebola crisis, a single case examined retrospectively makes it challenging to test specific hypotheses about leadership in a crisis. However, this study does help to highlight some leadership approaches from the 2014 Liberia Ebola outbreak that can be applied to the ongoing Covid-19 pandemic and to draw some comparisons and contribute to the analysis of what leadership behaviors and actions are more likely to be useful in a health crisis. Given weaker institutions and limited resources, the health crisis in Africa is expected to have graver effects, making a case for much-needed leadership in crisis training for health leaders in the region.

Overall, this research has primarily focused on formal leadership development training. However, as noted by many of the participants, mentorship and on-the-job training have also been invaluable in their leadership journeys. Many leadership development programs, including the Oliver Tambo Fellowship (Doherty, Gilson, and Shung-King 2018) and the HMLP, have found it difficult to operationalize mentorship activities once participants complete the programs. Some of the reasons for this difficulty given by the Oliver Tambo program are alumni of the program being too busy and overwhelmed with work and lacking the commitment and motivation to continue. There is also a lack of appropriate expectations between the mentor and mentee, mainly when one party has not attended the training. For these interactions to work, there is a need for mutual effort, a focus to their discussions, and proximity for regular engagement.

However, lack of strong mentorship models is a huge missed opportunity for current leadership development programs because, as leaders in this research, expressed mentors, coaches, and peer networks are an excellent resource for leadership growth. Also, current leadership development programs can be strengthened through incorporating job-based learnings, including, for instance, flexible and contextualized job-assignments or secondments (Hartley and Benington 2010). However, most leadership training programs shy away from such modules because of the time commitment and also unpredictability of the system and not being able to account for the outcomes of such designs.

There are several strengths to this study. First, the study used a purposeful sampling of very high-ranking senior health system leaders with many years of experience and a wealth of knowledge working on a variety of health challenges and leading different kinds of organizations. There was a diversity in national and international experience, gender, leadership roles, types of organizations, and also geography. This allowed me to get a comprehensive perspective of the competence of senior African health system leaders. Secondly, rigor was built into the study by using a recommended strategy for accessing and interviewing 'elites' or senior leaders. This included, for example, having an intent list for essential interview questions, which helped me as the interviewer to prioritize the questions in the case of time limitations but also to frame the targeted questions appropriately. Thirdly, though time was anticipated as a constraint, many of the leaders were willing and excited to speak much longer than the time allotted, which suggests that this is a topic that is of relevance for leaders in these settings. Some of the leaders even asked for summaries of their interviews so they could continue to reflect on their thinking on leadership and share their thoughts with their teams.

Despite the strengths of this study, some limitations are essential to consider in the interpretations of the findings. First, similar to Curry et al. (2012) research study that used qualitative methods to analyze participants' complex experiences on health leadership and leadership development, the results of the study cannot necessarily be generalized to other leaders in sub-Saharan Africa. Secondly, this study had a diversity of perspectives both in terms of the country of origin of the participants and also the locality of the organizations represented. However, Africa is not a monolith where the challenges or context of one country can apply to many others. So, it is challenging to hypothesize leadership approaches that can work for all health systems leaders within the region. Thirdly, the fact I interviewed very high-level leaders is both a strength of the study, but also a limitation in terms of the generalizability of the findings. Leaders are needed at all levels of the health system, but the focus of this research is on leadership at the strategic levels and leadership development at the individual level. Fourthly, social desirability may have influenced the findings. Given the high visibility of the leaders and also conscious of the fact some of the leaders are alumnae of the HMLP, interlinked with my identity as a Harvard student and a research fellow with the HMLP, may have motivated the participants to provide socially desirable responses. Fifthly, my identity as an African woman with experience working in a few African countries may influence my perspective as a researcher and the choice of what findings were highlighted or not and contribute to confirmation bias.

## Section V: Key recommendations

The four main recommendations for this research include:

1. To build leadership that is authentic to the African context it is essential to leverage leadership qualities (i.e. humility, collectivist ), that are valued by leaders and people in

this region. However, leadership programs need to help African leaders reflect on how these values translate both positively and negatively in different contexts and also varying levels of leadership.

2. My findings largely confirm that societal perceptions of leadership influence women's ability to access leadership positions rather than their individual abilities as leaders. Additionally, there is heighted lack of accountability measures for men leaders in sub-Saharan Africa due to the strong patriarchal nature of African societies. Therefore, leadership programs that promote male allyship in-terms of gender disparities for leadership positions may be more suitable and effectual in the African context. Additionally, leaderships programs can help women leaders to create more awareness of gender biases and how to leverage gender dynamics as well as strategies to push for organizational level accountability measures for gender equality.
3. Leadership development programs need to help African leaders first recognize social, political, economic and organizational contextual elements that influence leadership. And then educate them on how to leverage the softer side of context (e.g. gatekeepers, social ties) and ways to navigate challenging context.
4. Leadership development models for health leadership in Africa need to consider context as an analytical dimension and not only a descriptor. In the proposed model for African health leadership, contextual elements that influence leader's ability to cope with the nature of challenges they face are analyzed and then key capabilities, values and mindset that are more beneficial in that context are identified.

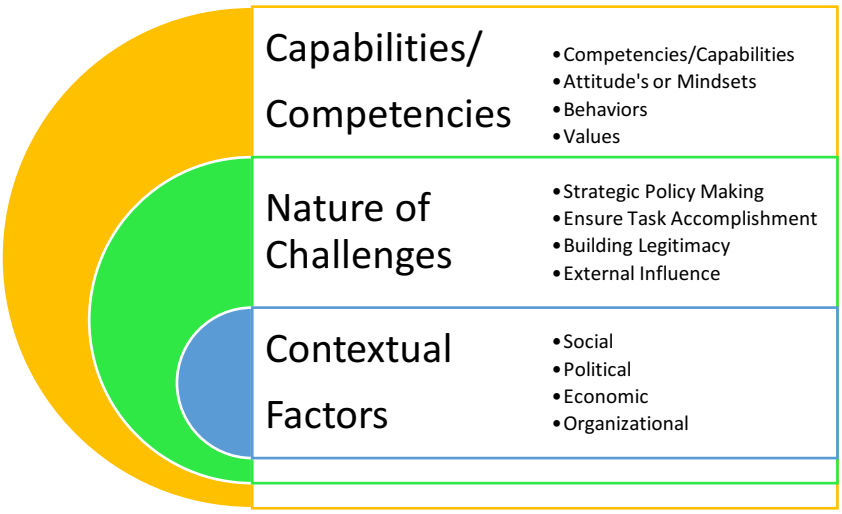


*Figure 3: Leadership Competency Model for African Health Leadership*

## Section VI: Bibliography

Adair, John. 2010. *Strategic Leadership: How to Think and Plan Strategically and Provide Direction*. Illustrated. Kogan Page Publishers. http://books.google.com/books?id=MYAmVOicVx8C&pgis=1.

Adewale, Adeyinka. 2020. "A Model of Virtuous Leadership in Africa: Case Study of a Nigerian Firm." *Journal of Business Ethics* 161 (4): 749–62. https://doi.org/10.1007/s10551-019-04340-3.

Africa Tembelea. 2020. "Verbertim: President Museveni's Address on Coronavirus." March 18, 2020. https://www.africatembelea.com/verbertim-president-musevenis-address-on-coronavirus/.

Agyepong, Irene Akua, Uta Lehmann, Elizeus Rutembemberwa, Suzanne M Babich, Edith Frimpong, Aku Kwamie, Jill Olivier, Gina Teddy, Boroto Hwabamungu, and Lucy Gilson. 2018. "Strategic Leadership Capacity Building for Sub-Saharan African Health Systems and Public Health Governance: A Multi-Country Assessment of Essential Competencies and Optimal Design for a Pan African DrPH." *Health Policy And Planning* 33 (suppl_2): ii35–49. https://doi.org/10.1093/heapol/czx162.

Bastian, Hilda. 2020. "What the Data Really Says About Women Leaders and the Pandemic | WIRED." Wired. July 1, 2020. https://www.wired.com/story/what-the-data-really-says-about-women-leaders-and-the-pandemic/.

BBC. 2016. "Ebola: Mapping the Outbreak ." January 14, 2016. https://www.bbc.com/news/world-africa-28755033.

———. 2018. "Liberia Profile - Timeline - BBC News." 2018. https://www.bbc.com/news/world-

africa-13732188.

———. 2020a. “Coronavirus: Ghana Govment Absorb Electricity Bills of Consumers, Extend Covid-19 Lockdown.” BBC Pidgin. April 10, 2020. https://www.bbc.com/pidgin/tori-52241302.

———. 2020b. “Coronavirus: Most Africans ‘will Go Hungry in 14-Day Lockdown’ .” May 6, 2020. https://www.bbc.com/news/world-africa-52557464.

Braun, Virginia, and Victoria Clarke. 2006. “Using Thematic Analysis in Psychology.” *Qualitative Research in Psychology* 3 (2): 77–101. https://doi.org/10.1191/1478088706qp063oa.

Brolin Ribacke, Kim J, Dell D Saulnier, Anneli Eriksson, and Johan von Schreeb. 2016. “Effects of the West Africa Ebola Virus Disease on Health-Care Utilization - A Systematic Review.” *Frontiers in Public Health* 4: 222. https://doi.org/10.3389/fpubh.2016.00222.

Brown, Jerry. 2020. “Doctor: I Fought Ebola. Here’s How We Conquer Coronavirus .” Time. April 14, 2020. https://time.com/5820615/ebola-lessons-coronavirus/.

Chamorro-Premuzic, Tomas, and Avivah Wittenberg-Cox. 2020. “Will the Pandemic Reshape Notions of Female Leadership?” Harvard Business Review. June 26, 2020. https://hbr.org/2020/06/will-the-pandemic-reshape-notions-of-female-leadership.

Chunharas, Somsak, and Dame Sally C. Davies. 2016. “Leadership in Health Systems: A New Agenda for Interactive Leadership.” *Health Systems and Reform*. Taylor and Francis Inc. https://doi.org/10.1080/23288604.2016.1222794.

Collins, Jim. 2001. *Good to Great: Why Some Companies Make the Leap... and Others Don’t* . Harper Business. https://www.goodreads.com/book/show/76865.Good_to_Great.

Curry, Leslie, Lauren Taylor, Peggy G. Chen, and Elizabeth Bradley. 2012. “Experiences of

Leadership in Health Care in Sub-Saharan Africa." *Human Resources for Health* 10 (September). https://doi.org/10.1186/1478-4491-10-33.

Curry, Leslie, Lauren Taylor, Peggy Guey, Chi Chen, and Elizabeth Bradley. 2012. "Experiences of Leadership in Health Care in Sub-Saharan Africa." https://doi.org/10.1186/1478-4491-10-33.

Dhatt, R., S. Theobald, S. Buzuzi, B. Ros, S. Vong, K. Muraya, S. Molyneux, et al. 2017. "The Role of Women's Leadership and Gender Equity in Leadership and Health System Strengthening." *Global Health, Epidemiology and Genomics* 2 (E8). https://doi.org/10.1017/gheg.2016.22.

Doherty, Jane, Lucy Gilson, and Maylene Shung-King. 2018. "Achievements and Challenges in Developing Health Leadership in South Africa: The Experience of the Oliver Tambo Fellowship Programme 2008-2014." *Health Policy and Planning* 33 (suppl_2): ii50–64. https://doi.org/10.1093/heapol/czx155.

Downs, Jennifer A., Lindsey K. Reif, Adolfine Hokororo, and Daniel W. Fitzgerald. 2014. "Increasing Women in Leadership in Global Health." *Academic Medicine*. Lippincott Williams and Wilkins. https://doi.org/10.1097/ACM.0000000000000369.

Drehle, David von, and Aryn Baker. 2014. "TIME Person of the Year 2014: Ebola Fighters." Time. December 10, 2014. https://time.com/time-person-of-the-year-ebola-fighters/.

Ekwealor, Chigbo. 1999. "Women and Democratic Leadership in Africa: An Appraisal - ProQuest." *Journal of Cultural Studies* 1 (1): 139–44. https://search-proquest-com.ezp-prod1.hul.harvard.edu/docview/847122129?pq-origsite=summon.

Figueroa, Carah Alyssa, Reema Harrison, Ashfaq Chauhan, and Lois Meyer. 2019. "Priorities and

Challenges for Health Leadership and Workforce Management Globally: A Rapid Review." *BMC Health Services Research*. BioMed Central Ltd. https://doi.org/10.1186/s12913-019-4080-7.

Frenk, Julio. 2010. "The Global Health System: Strengthening National Health Systems as the next Step for Global Progress." *PLoS Medicine*. https://doi.org/10.1371/journal.pmed.1000089.

Gakpo, Joseph Opoku. 2020. "African Governments Mobilize to Keep People Fed during COVID-19 Lockdowns - Alliance for Science." Cornell Alliance for Science. April 9, 2020. https://allianceforscience.cornell.edu/blog/2020/04/african-governments-mobilize-to-keep-people-fed-during-covid-19-lockdowns/.

Galer, Joan Bragar, Sylvia Vriesendorp, and Alison Ellis. 2005. "Managers Who Lead: A Handbook for Improving Health Services." www.msh.org.

Gill, T. 2006. *Theory and Practice of Leadership*. *Sage Publications*. Sage Publications. https://psycnet.apa.org/record/2006-03535-000.

Gilson, Lucy, and Irene Akua Agyepong. 2018. "Strengthening Health System Leadership for Better Governance: What Does It Take?" *Health Policy and Planning* 33 (suppl_2): ii1–4. https://doi.org/10.1093/heapol/czy052.

Global Health 50/50. 2018. "The Global Health 50/50 Report 2018."

———. 2020. "Power, Privilege and Priorities," 115. https://globalhealth5050.org/wp-content/uploads/2020/03/Power-Privilege-and-Priorities-2020-Global-Health-5050-Report.pdf.

Gomes Sambo, Luis, and Joses Muthuri Kirigia. 2014. "Investing in Health Systems for Universal

Health Coverage in Africa." *BMC International Health and Human Rights* 14 (28). https://doi.org/10.1186/s12914-014-0028-5.

Grint, Keith. 2005. "Problems, Problems, Problems:The Social Construction of 'Leadership.'" *Human Relations* 58 (11): 1467–94. https://doi.org/10.1177/0018726705061314.

Hartley, Jean, and John Benington. 2010. *Leadership for Healthcare*. Bristol, UK; Portland, OR, USA: Bristol University Press. https://doi.org/10.2307/j.ctt9qgmjk.

Hartley, Jean, Clive Fletcher, Petra Wilton, Patrick Woodman, and Christoph Ungemach. 2007. "Leading with Political Awareness." *Chartered Management Institute*. London.

Heifetz, Ronald A. (Ronald Abadian). 1994. *Leadership without Easy Answers*. *Belknap Press of Harvard University Press*. Cambridge, Mass: Belknap Press of Harvard University Press.

Jamison, Julian. 2020. "Coronavirus Lockdowns Will Starve People in Low-Income Countries ." The Washington Post. April 20, 2020. https://www.washingtonpost.com/outlook/2020/04/20/lockdown-developing-world-coronavirus-poverty/.

Jazeera, Al. 2020. "Tracking Africa's Coronavirus Cases ." August 13, 2020. https://www.aljazeera.com/news/2020/04/tracking-africa-coronavirus-cases-200401081427251.html.

Kerrissey, Michaela J., and Amy C Edmondson. 2020. "What Good Leadership Looks Like During This Pandemic." Harvard Business Review. April 13, 2020. https://hbr.org/2020/04/what-good-leadership-looks-like-during-this-pandemic.

Kotterman, James. 2006. "Leadership Versus Management: What's the Difference? - ProQuest." *The Journal for Quality and Participation* 29 (2): 13–17.

https://search.proquest.com/openview/9e519b2df53655fd0f5f39c35480c1ac/1?pq-origsite=gscholar&cbl=37083.

Leach, Steve. 2000. *Local Political Leadership*. *Policy*. Bristol, UK.

Leach, Steve, and David Wilson. 2002. "Rethinking Local Political Leadership." *Public Administration* 80 (4): 665–89. https://doi.org/10.1111/1467-9299.00323.

Liu, Ewen, Juliet Iwelunmor, G. Gabagaya, H. Anyasi, Alejandra Leyton, Karen A. Goraleski, Shufang Wei, et al. 2019. "Women's Global Health Leadership in LMICs." *The Lancet Global Health*. Elsevier Ltd. https://doi.org/10.1016/S2214-109X(19)30308-0.

Liu, Xu. 2018. "Interviewing Elites: Methodological Issues Confronting a Novice." *International Journal of Qualitative Methods* 17 (April): 1–9. https://doi.org/10.1177/1609406918770323.

Makuta, Innocent, and Bernadette O'Hare. 2015. "Quality of Governance, Public Spending on Health and Health Status in Sub Saharan Africa: A Panel Data Regression Analysis." *BMC Public Health* 15 (1). https://doi.org/10.1186/s12889-015-2287-z.

Momodu, Samuel. 2016. "First Liberian Civil War (1989-1996) • BlackPast." 2016. https://www.blackpast.org/global-african-history/first-liberian-civil-war-1989-1996/.

Murray, Christopher J L, and Julio Frenk. 2000. "Theme Papers A Framework for Assessing the Performance of Health Systems." *Bulletin of the World Health Organization : The International Journal of Public Health* 78 (6): 717–31.

New York Times. 2020. "Coronavirus Map: Tracking the Global Outbreak." 2020. August 13, 2020. https://www.nytimes.com/interactive/2020/world/coronavirus-maps.html.

NPR. 2020. "Africa And The Coronavirus: Forecasters Have Different Scenarios ." June 10, 2020.

https://www.npr.org/sections/goatsandsoda/2020/06/10/872789379/why-forecasters-cant-make-up-their-mind-about-africa-and-the-coronavirus.

Nudzor, Hope Pius. 2013. “Interviewing Ghanaian Educational Elites: Strategies for Access, Commitment, and Engagement.” *International Journal of Qualitative Methods* 12 (1): 606–23. https://doi.org/10.1177/160940691301200132.

Nyenswah, Tolbert, Cyrus Y. Engineer, and David H. Peters. 2016. “Leadership in Times of Crisis: The Example of Ebola Virus Disease in Liberia.” *Health Systems & Reform* 2 (3): 194–207. https://doi.org/10.1080/23288604.2016.1222793.

Oc, Burak, Michael R. Bashshur, Michael A. Daniels, Gary J. Greguras, and James M. Diefendorff. 2015. “Leader Humility in Singapore.” *Leadership Quarterly* 26 (1): 68–80. https://doi.org/10.1016/j.leaqua.2014.11.005.

Office of the Special Adviser on Gender Issues and the Advancement of Women (OSAGI). 2001. “OSAGI Gender Mainstreaming - Concepts and Definitions.” August 2001. https://www.un.org/womenwatch/osagi/conceptsandefinitions.htm.

Oleribe, Obinna O., Jenny Momoh, Benjamin S.C. Uzochukwu, Francisco Mbofana, Akin Adebiyi, Thomas Barbera, Roger Williams, and Simon D. Taylor-Robinson. 2019. “Identifying Key Challenges Facing Healthcare Systems in Africa and Potential Solutions.” *International Journal of General Medicine* 12: 395–403. https://doi.org/10.2147/IJGM.S223882.

Omaswa, Francis, and Nigel Crisp. 2014. *African Health Leaders : Making Change and Claiming the Future*. Oxford University Press.

Pan African DrPH Consortium 2014. 2014. “Strategic Leadership Training Needs Assessment Protocol.” http://purl.org/dc/terms/.

Parker, Mario, and Josh Wingrove. 2020. “Trump Says Surging Virus ‘Will Go Away Like Things Go Away’ - Bloomberg.” Bloomberg. August 5, 2020. https://www.bloomberg.com/news/articles/2020-08-05/trump-says-surging-virus-will-go-away-like-things-go-away.

Poltera, Jacqui. 2019. “Exploring Examples of Women’s Leadership in African Contexts.” *Agenda* 33 (1): 3–8. https://doi.org/10.1080/10130950.2019.1602977.

Rao, Hayagreeva, and Robert Sutton. 2020. “Crisis Leadership: An Agenda for Troubled Times | McKinsey.” Mckinsey & Company. July 9, 2020. https://www.mckinsey.com/featured-insights/leadership/from-a-room-called-fear-to-a-room-called-hope-a-leadership-agenda-for-troubled-times.

Riordan, C. 1994. “A Central Question in Cross-Cultural Research: Do Employees of Different Cultures Interpret Work-Related Measures in an Equivalent Manner?” *Journal of Management* 20 (3): 643–71. https://doi.org/10.1016/0149-2063(94)90007-8.

Roncarolo, Federico, Antoine Boivin, Jean-Louis Denis, Rejean Hébert, and Pascale Lehoux. 2017. “What Do We Know about the Needs and Challenges of Health Systems? A Scoping Review of the International Literature.” *BMC Health Services Research* 17 (636). https://doi.org/10.1186/s12913-017-2585-5.

Schreiber, Leon. 2017a. “"Everybody’s Business": Mobilizing Citizens During Liberia’s Ebola Outbreak, 2014–2015.” *"Everybody’s Business": Mobilizing Citizens During Liberia’s Ebola Outbreak, 2014–2015*, April. https://successfulsocieties.princeton.edu/publications/ebola-outbreak-mobilizing-citizens-liberia.

———. 2017b. “Chasing an Epidemic: Coordinating Liberia’s Response to Ebola, 2014–2015.” *Chasing an Epidemic: Coordinating Liberia’s Response to Ebola, 2014–2015*, April. https://successfulsocieties.princeton.edu/publications/ebola-chasing-epidemic-coordinating-liberia-response.

Seale, Clive. 2018. *Researching Society and Culture*. *Sage*. 4th ed. Los Angeles ; London: Sage.

Shannon, Geordan, Melanie Jansen, Kate Williams, Carlos Cáceres, Angelica Motta, Aloyce Odhiambo, Alie Eleveld, and Jenevieve Mannell. 2019. “Gender Equality in Science, Medicine, and Global Health: Where Are We at and Why Does It Matter?” *The Lancet*. Lancet Publishing Group. https://doi.org/10.1016/S0140-6736(18)33135-0.

Sinclair, Amanda. 2005. *Doing Leadership Differently : Gender, Power, and Sexuality in a Changing Business Culture / - Harvard University*. 2nd ed. Victoria, Australia: Melbourne University Press. https://hollis-harvard-edu.ezp-prod1.hul.harvard.edu/primo-explore/openurl?sid=oup:oso&genre=book&aulast=Sinclair&aufirst=A.&title=Doing leadership differently: Gender, power and sexuality in a changing business culture&date=2005&vid=HVD_URL&institution=01HVD&url_ctx_val=&url_ctx_fmt=null&isSerivcesPage=true.

Sirleaf, Ellen Johnson, and Raj Panjabi. 2020. “Key Lessons From Ebola That Can Help Us Defeat Coronavirus .” Time. March 19, 2020. https://time.com/5806459/five-key-lessons-from-ebola-that-can-help-us-win-against-coronavirus-everywhere/?utm_source=twitter&utm_medium=social&utm_campaign=editorial&utm_term=ideas_&linkId=84637782.

Sridhar, Devi. 2009. “Post-Accra: Is There Space for Country Ownership in Global Health?” *Third*

*World Quarterly* 30 (7): 1363–77. https://doi.org/10.1080/01436590903134981.

Stogdill, Ralph M. 1950. "Leadership, Membership and Organization." *Psychological Bulletin* 47 (1): 1–14. https://doi.org/10.1037/h0053857.

Taub, Amanda. 2020. "Why Are Women-Led Nations Doing Better With Covid-19? - The New York Times." New York Times. May 15, 2020. https://www.nytimes.com/2020/05/15/world/coronavirus-women-leaders.html.

The Cable. 2020. "'Not Addressing Nigerians on Coronavirus Is a Matter of Style' — Femi Adesina Defends Buhari ." March 26, 2020. https://www.thecable.ng/not-addressing-nigerians-on-coronavirus-is-a-matter-of-style-femi-adesina-defends-buhari.

The guardian. 2018. "Nobel Peace Prize 2018 Won by Denis Mukwege and Nadia Murad - as It Happened | World News | The Guardian," 2018. https://www.theguardian.com/world/live/2018/oct/05/nobel-peace-prize-2018-live-updates.

The Guardian. 2020. "Tories on Defensive as Criticism Grows of Early Handling of Coronavirus." April 19, 2020. https://www.theguardian.com/world/2020/apr/19/pm-was-missing-in-action-during-early-phase-of-pandemic-claims-labour.

The Washington Post. 2017. "WHO Picks Tedros Adhanom Ghebreyesu of Ethiopia to Lead the Global Health Agency - The Washington Post." 2017. https://www.washingtonpost.com/news/to-your-health/wp/2017/05/23/who-chooses-a-new-leader-to-head-the-global-health-agency/?utm_term=.6fbea8c0b88d.

Travaly, Youssef, and Aretha Mare. 2020. "Learning from the Best: Evaluating Africa's COVID-19 Responses." Brookings. July 8, 2020. https://www.brookings.edu/blog/africa-in-

focus/2020/07/08/learning-from-the-best-evaluating-africas-covid-19-responses/.

Vasileiou, Konstantina, Julie Barnett, Susan Thorpe, and Terry Young. 2018. “Characterising and Justifying Sample Size Sufficiency in Interview-Based Studies: Systematic Analysis of Qualitative Health Research over a 15-Year Period.” *BMC Medical Research Methodology* 18 (1): 148. https://doi.org/10.1186/s12874-018-0594-7.

Wanasika, Isaac, Jon P Howell, Romie Littrell, and Peter Dorfman. 2011. “Managerial Leadership and Culture in Sub-Saharan Africa.” *Journal of World Business* 46 (2): 234–41. https://doi.org/10.1016/j.jwb.2010.11.004.

Washington Post. 2020. “Kenya Coronavirus: The Factory That Transformed into a Surgical Mask Assembly Line Overnight - The Washington Post.” April 8, 2020. https://www.washingtonpost.com/world/africa/the-kenyan-factory-that-transformed-into-a-surgical-mask-assembly-line-overnight/2020/04/08/fac04912-783e-11ea-a311-adb1344719a9_story.html.

WHO. 2000. “The World Health Report 2000: Health Systems Improving Performance.” *The World Health Report*.

———. 2013. “State Of Health Financing In the African Region.”

———. 2015. “Liberia: A Country – and Its Capital – Are Overwhelmed with Ebola Cases.” 2015. https://www.who.int/csr/disease/ebola/one-year-report/liberia/en/.

———. 2016. “Open Mindsets: Participatory Leadership for Health.” *WHO*. Geneva: World Health Organization.

———. 2017. “What Needs to Be Done to Solve the Shortage of Health Workers in the African Region | WHO | Regional Office for Africa.” August 24, 2017.

https://www.afro.who.int/news/what-needs-be-done-solve-shortage-health-workers-african-region.

———. 2020. “Independent Evaluation of Global COVID-19 Response Announced.” July 9, 2020. https://www.who.int/news-room/detail/09-07-2020-independent-evaluation-of-global-covid-19-response-announced.

Wilson, Suze. 2020. “Three Reasons Why Jacinda Ardern’s Coronavirus Response Has Been a Masterclass in Crisis Leadership.” The Conversation. April 5, 2020. https://theconversation.com/three-reasons-why-jacinda-arderns-coronavirus-response-has-been-a-masterclass-in-crisis-leadership-135541.

Wittenberg-Cox, Avivah. 2020. “What Do Countries With The Best Coronavirus Responses Have In Common? Women Leaders.” Forbes. April 13, 2020. https://www.forbes.com/sites/avivahwittenbergcox/2020/04/13/what-do-countries-with-the-best-coronavirus-reponses-have-in-common-women-leaders/#31bfd58c3dec.

Wolmarans, Liezel, and Ngozi Akwataghibe. 2017. “Liberian Health Sector Performance Evaluation (2006-2017).” http://moh.gov.lr/wp-content/uploads/2017/12/1-Wesseh_Health-Sector-Evaluation-Presentation_Dec_2017.pdf.

World Health Organization. 2007. “Everybody Business : Strengthening Health Systems to Improve Health Outcomes : WHO’s Framework for Action.”

## Section VII: Appendix

**Semi-Structured Questionnaire for Study:**

**Building Public Health Leadership in Africa: Competencies for Strategic Leadership needed to Transform Health Systems in Africa**

The primary interest of this DELTA project will be to explore leadership competencies needed to drive strategic leadership for African health systems. Specifically, we are interested in how you, as a leader, have dealt with a particular opportunity or challenge in current or past work. I am interested in learning what leadership strategies were essential in either overcoming the problem or seizing the opportunity. You are being asked to participate in this research because you are a respected leader that has worked to improve healthcare systems in Africa.

**Leadership questions:**

**I. Concept of Leadership:**

a. How do you define leadership?
b. In the past when hiring someone in your team, for work in a position in the health sector, what things did you primarily look for?
c. How would you describe your own style of leadership?

**II. Context of health leadership in Africa**

a. Briefly, what are the major or critical challenges of leadership in Africa (i.e, what is the nature of challenges for leaders in Africa working to improve health systems?) How are these challenges different from other global contexts, such as working in a multinational organization?
b. In what ways is how you are handling this challenge or opportunity in that context of working in Africa, same or different from how you would do things in a more global context such as working in an international organization? From your perspective is there a layer of complexity that is added from the two contexts?

**III. Competencies for Leadership and Forms of Leadership Support or Training**

a. I am interested to learn more about leadership competencies needed to bring about transformation in healthcare systems in Africa. Think about a challenge or an opportunity in your current or former roles, where you had to apply your leadership skills. Would like to know in great detail what the challenge/opportunity was and what leadership steps you took to handle it. (List

challenges in resolving strong competing interests or in launching major new initiatives as well as challenges in addressing difficult issues of public perception and support or opportunity getting a grant/funding to scale up a program)

i. What was the main scenario or context to the situation?
ii. What was the challenge or opportunity?
iii. How did that challenge/opportunity described above arise? *(probe: what stakeholders were involved and what were their views)*
iv. How did you first approach the opportunity/challenge?
v. Which solution (turn key solution) or leadership was most salient?
vi. What kinds of setbacks did you experience? What sort of resistant did you face?
vii. Did you feel prepared to deal/take-up with the challenge/opportunity or what were your concerns?
viii. Were there other team members involved? How did the dynamics affect how you solved the challenge/seized the opportunity?
ix. Did your relationship with any individual change as a result of working through the challenge/opportunity?
x. What was the outcome?

b. What factors do you think finally drove success or failure or slow progress in solving the challenge/seizing the opportunity?
    i. Was there a turning point where you felt like the right pieces into place in order for the problem to be successful?
c. Tell me about a training/education/or work-place experience that you felt most useful in preparing you to deal with challenges or seize opportunities in such contexts? In what ways was it useful? Any mentors or advisers that helped?
d. What do you attribute your success to? (personal or professional background?)
e. What kinds of unintended consequences (either positive or negative occurred)? Any surprises.
f. Looking back is there anything that you might have done differently?

**IV. Gender Lense**

a. To what extent or in what ways do you feel gender was relevant in the situation you described?
b. Can you describe to me in this situation or in a past experience how you felt that either gender hindered or helped in your professional trajectory or leadership growth?
c. If you were different gender would you have tackled the challenge differently?
d. Do you think gender affects the kind of training or support needed to develop leadership skills?