Key for classifying research inference

- Descriptive
- Exploratory
- Explanatory
- Emancipatory
- Influence
- Predictive
Chapter 6.

Leadership, management and organizational cultures

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6.1 Defining the chapter

Leadership, management and organizational cultures are key concepts and practices in human resources for health (HRH), with very substantial bodies of literature not only in the field of health policy and systems research (HPSR) but also in organizational and management sciences, public management sciences, sociology, and neighbouring fields such as education. The objective of this chapter is to explore the concepts of leadership, management and organizational cultures relevant for HRH, and how these have been innovatively researched. Specifically, this chapter attends to the topics of organizational and managerial cultures, including manager and frontline staff relations, change management, and leadership and management development and capacity-strengthening, from the perspective of HPSR.

This chapter acknowledges the influence of leadership, management and organizational cultures on health worker performance, motivation, training and supervision, but these themes are covered more deeply elsewhere in the reader. This chapter does not address change management issues of task-shifting or organizational conflict issues, such as industrial action and the dynamics of unions in health-care settings as they relate to leadership, management and organizational cultures, because these are beyond its scope.

6.2 Background on leadership, management and organizational cultures

While there are variations in the definitions of leadership and management and the similarities and differences between them, most sources agree that there is substantial overlap and that both are central for the functioning of organizations. The World Health Organization (WHO, 2007b, p. 1) suggests that “while leaders set the strategic vision and mobilize the efforts towards its realization, good managers ensure effective organization and utilization of resources to achieve results and meet the aims”. This means that a key distinction between leadership and management is the former’s stronger focus on developing, nurturing and achieving organizational vision, whereas the latter is oriented more towards operationalizing organizational function. The definition of organizational culture is largely agreed to be about the pattern of values, beliefs, traditions and assumptions that organizational members share (Mansour et al., 2005).

Current academic debates about leadership and management in (primarily public) health systems have many antecedents. Of note in low- and middle-income countries are bodies of literature focusing on human resource management in the context of health sector reforms of the late 1990s (represented prominently in the early volumes of the journal Human Resources for Health; see, for example, work by Buchan (2004), who draws lessons on human resource management from other, mainly private-sector literature; Kohlemainen-Aitken (2004), who
focuses on the mechanisms and impacts of decentralization on human resource management; and Bossert (1998), who describes the decision space of managers in decentralized health systems. Leadership and management have also been considered in the context of complex adaptive systems; for example, see Plsek and Wilson (2001), who point to the importance of viewing organizations as complex adaptive systems in order to bring about more innovative management styles in health. Leadership and management, then, both have a role in shaping organizational cultures and in turn are shaped by them.

In 2007 WHO issued a series of working papers on strengthening leadership and management in low- and middle-income countries as a way of supporting overall health system strengthening (WHO, 2007a, 2007b), resulting in a framework to answer the question “What conditions are necessary for good leadership and management?” (WHO, 2007b, p. 2). The framework points to the interaction of four main organizational factors (adequate numbers of managers; adequate competencies; functional support systems; enabling working environments) as necessary for good leadership and management to emerge, which in turn can lead to improved health services and health goals (Figure 6.1).

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Figure 6.1 Leadership and management in health systems


Since then, as the appreciation for the complexity and interconnectivity of health systems has deepened, so too has our understanding of leadership, management and organizational cultures. Gilson and Daire (2011), for example, highlight the importance of leadership as the enabler to allow actors within organizations to face challenges and yet still achieve results despite complex contexts. This involves creating vision and strategic direction for the organization, and then communicating, inspiring and maintaining the attainment of that vision. Key is the notion that leadership is not found only in particular positions or at the organizational apex but is distributed throughout the organization. Bradley et al. (2015) focus on a definition of management that brings human, financial and technical resources to bear on achieving predetermined objectives, supported by a suite of core competencies. Kwamie (2015) stresses the need to view leadership and management as interactive and emergent,
and argues that weaknesses in leadership and management are linked to organizational challenges beyond individual competencies alone. Taken together, these three papers point to (i) the capacity for leadership and management reforms to challenge traditionally hierarchical organizational structures and cultures that characterize most health-care settings in low- and middle-income countries; (ii) the dual nature of leadership and management being both an individual and systemic capacity, which has implications for the transformative power of capacity-strengthening interventions; and (iii) the need for more policy and practice research on leadership, management and organizational cultures.

The 2016 flagship report of the Alliance for Health Policy and Systems Research on participatory leadership for health echoes these notions and further presents “the role of context, the reciprocal influence actors have upon one another’s interests and priorities, and the enabling environment within the health eco-system [as] important considerations in understanding, supporting and creating leadership that addresses the needs of the population in future-thinking health systems” (WHO, 2016, p. 8). This suggests a need for greater research to understand the effects of these dimensions on leadership, management and organizational cultures.

6.2.1 Research approaches for investigating leadership, management and organizational cultures

Diverse methodological approaches have been used to investigate the domains of leadership, management and organizational cultures. Some critical examples are presented here, mainly conducted within districts and hospitals, the operational “grounds” of much leadership and management practice, and where organizational cultures and structures are experienced by managers and staff.

Employing the use of theory has been important in deepening understandings of leadership, management and organizational cultures. Lipsky's (1980) “street-level bureaucracy” theory has shed much light on how frontline public servants use discretion in enforcing their mandates in light of organizational contexts (and particularly when the lack of resources can cause them to shorten decision-making routines, which can affect policy intent). As another theory on discretion, Bossert's decision-space theory has been applied (e.g. Kwamie et al., 2015a) and combined with complex leadership theory (Uhl-Bien et al., 2007), which conceptualizes organizations as complex contexts with unknowable futures that leaders cannot control. Instead, those in leadership and management draw on, and are part of, the interactions within organizational structures, giving rise to adaptive leadership and management patterns that seek to enable the future. The authors’ findings from Ghana demonstrate that top-down policy implementation constrained local managerial decision space, thereby giving rise to a local leadership type that was less responsive to local-level challenges and more geared towards serving the health system bureaucracy.

Theories of organizational trust have also been applied to health-care and hospital settings to effectively unwind complexities of the discrete elements at play within the organization (Gilson, 2006; Kramer, 1999). Trust, operating at individual and institutional levels, exists as an organizational mechanism of coordination and cooperation and is bound by perceptions of risk, uncertainty and vulnerability, and individual motivation, expectation and responsibility. The degree of organizational credibility will depend on how much the visible structures of the organization (vision, mission, operating policies) align with the invisible structures of the organization (individual needs, interpersonal and power relations). For example, Cogin et al. (2016) investigate hospital management in Australia through the use of a commitment-versus-control theoretical framework and in-depth interviews. They find that management controls designed to regulate staff behaviours (including standardized jobs, rules and close staff monitoring) are used more to manage nurses, allied health professionals and junior doctors, while more commitment-based approaches (such as goal-setting, socializing staff to organizational values and greater staff discretion) are used to manage senior physicians. Such
transactional forms of leadership focused on supervision, performance, role differentiation between staff cadres, and compliance through reward and punishment lead to negative job attitudes, staff frustration and operational inefficiencies. This is in contrast to theories on more transformational forms of leadership, which focus on motivating staff to perform beyond expected levels by helping them identify with organizational goals and interests, and engaging with individual staff values to encourage innovation and shape organizational context (Sarros et al., 2008).

Many qualitative research methods have been used in low- and middle-income countries to probe the human interactions that underpin these dynamics. For example, Aitken (1994) uses ethnography and organizational theory to study district health managers in Nepal. She finds the coexistence of two value systems underpinning the district health system – one official (based on the quality and number of health services delivered) and one actual (based on receiving and accounting for funds through progress reporting and providing staff with an income). These value systems have divergent aims and expectations and yet thrive together owing to a lack of organizational clarity; their existence explains managerial decision-making that may appear outwardly irrational but follows an internal logic. George (2009) also uses an ethnographic approach to explore issues of supervision and disciplinary action as they relate to managerial accountability in a district in India. The findings demonstrate the ongoing negotiation processes of accountability mediated by social relationships to the benefit and detriment of the health system at various times.

In highlighting the role of key actors that are often underrepresented, O’Meara et al. (2011) assess community participation and accountability as part of local budgeting and planning processes in Kenya. They find that lacking established community-planning units created challenges to realizing comprehensive community representation, and furthermore caused mismatch between evidence-based and demand-based planning.

The application of realist approaches is also useful in explicitly seeking causal explanations by linking the observed outcomes of interventions to the contexts in which they are deployed. From a realist perspective, especially with regard to interventions (whether policies or programmes), intended and unintended outcomes arise not only because of intervention design but also as a result of the interactions between the people engaging with the intervention and the overarching context into which the intervention is introduced. Marchal et al. (2010) use realist case studies to demonstrate how high-commitment practices (that is, bundles of balanced management practices, sound administration and participatory decision-making) work in two hospitals in Ghana. Dieleman et al. (2009) use realist synthesis and find that globally, combining interventions that consist of participatory training and health system strengthening successfully lead to improving health worker performance through increasing health worker knowledge and skill, improving motivation, and encouraging health worker obligations to change.

Action learning – that is, the application of cycles of reflection and action to solve real problems – has proven a particularly suitable methodological approach to examining leadership, management and organizational cultures. An exemplar in this regard is the long-term District Innovation and Action Learning for Health Systems Development (DIALHS) project in South Africa, which partnered researchers and managers in cycles of action learning and systematic reflection to examine leadership typologies within district health systems. In particular, the project team was interested in understanding the challenges of centrally initiated interventions that aim to strengthen local-level leadership and management. Gilson et al. (2014) argue that new forms of leadership are needed to support systemic organizational change, and that managerial sense-making is important in mediating health worker discretion; Scott et al.’s (2014) findings determine that dissonance in organizational cultures at central levels can affect local-level leadership, governance and organizational relationships.
Several efforts have been made to measure leadership, management and organizational culture using quantitative techniques. These methods have been applied for testing different theoretical propositions and typically include creating composite indices for these latent constructs with reliable and validated psychometric properties. For example, Cummings et al. (2010) conducted a multidisciplinary literature review to collate several measurements of leadership styles and their association with various performance measures in nursing job satisfaction. They found that relational leadership styles were associated with higher nursing job satisfaction, whereas leadership styles focused on tasks alone do not achieve optimum satisfaction outcomes. Similarly, Scott et al. (2003) carried out a systematic review of quantitative questionnaires designed to measure organizational culture and change; they found 13 such instruments, varying in their underlying theory, scope, length and scientific properties. A low- and middle-income country example is found in the work of Jayasuriya et al. (2014), who examine the impact of organizational culture and climate on staff attitudes towards behaviours that build organizational citizenship (treating colleagues respectfully, and being helpful, efficient and effective). Using a self-administered questionnaire of a national sample of rural health workers in Papua New Guinea and multilevel regression analysis, their key finding is that an enhanced work climate results in higher levels of organizational citizenship (this article is highlighted in Chapter 4 on health worker performance).

Research on leadership, management and organizational cultures has usefully incorporated the use of theory, and spanned diverse research methods, both qualitative and quantitative. There do exist evidence gaps in both research topics and methodology, however; for example, there are few empirical articles on leadership and gender in low- and middle-income countries and community-level leadership (see section 6.4).

6.3 Illustrative primary research articles

Seven state-of-the-art primary research articles are included in this section. These articles reflect innovation, rigour and illuminating findings across the breadth of the above-noted methods and diverse geographical regions. These articles were selected from a pool collated from a doctoral seminar at the Johns Hopkins School of Public Health, a crowdsourcing exercise supported by Health Systems Global and subsequent searches using the bibliography of key articles and on relevant databases and search engines (PubMed and Google Scholar). The main criteria used to select the articles included diversity in region, cadre and methods, as well as the quality of the studies based on standard guidelines.

The inherent hierarchical and authoritative nature of public services in many countries, and how this filters into health leadership and management, is a theme that emerges in the work of Rocha et al. (2014) and Kwamie et al. (2015b). Rocha et al. (2014) and Choi et al. (2016) reflect on broader social and historical trends in Brazilian and Malaysian society, respectively, and how the embeddedness of organizational cultures within broader societal values in turn affects the health workforce. The ongoing implications of decentralization processes, particularly as they relate to power, resources and governance, and how these affect district- and facility-level leadership and management, are themes that emerge from the work of Nyikuri et al. (2015) and Kwamie et al. (2015b). Both papers demonstrate the complexities of decentralization as a critical health system reform that directly affects leadership and management, although its implementation may be varied. The social relations and negotiations involved in accountability emerge through Aberese-Ako et al.’s (2014) work on frontline staff perceptions of organizational fairness. Lehmann and Gilson’s (2015) methodological reflections and Prashanth et al.’s (2014) research strongly present how new and different approaches to capacity-strengthening can support sustainable organizational change. The balance and duality of organizational versus individual capacities for leadership and management is an overarching theme that emerges from all the articles, signalling the interplay of actors and their behaviours and decisions within organizations, and how the structures and procedures of organizations shape actors’ choices.
These seven articles have been defined broadly under the following three headings: understanding and measuring management, leadership and organizational cultures; effects of management and organizational cultures on health workers; and initiatives to improve leadership and organizational cultures.

6.3.1 Understanding and measuring management, leadership and organizational cultures


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<tr>
<th>Health workers</th>
<th>Hospital-based nurses and auxiliary staff</th>
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<tr>
<td>Geographical area</td>
<td>Brazil</td>
</tr>
<tr>
<td>Research methods</td>
<td>Quantitative: provider survey</td>
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<tr>
<td>Research inference</td>
<td>Descriptive</td>
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Rocha et al. (2014) in Brazil use a cross-sectional study design to survey nurses and auxiliary staff in a public hospital to describe its organizational culture. The article uses a conceptual framework of the embeddedness of organizational cultures within broader social and historical contexts, and seeks to describe organizational culture in terms of the shared beliefs and values, collective identity and process of construction, and how these in turn influence workplace functioning. The findings point to the presence of hierarchical rigidity and power centralization, and insufficient recognition of staff well-being, satisfaction and motivation, although there is cooperation between staff. The authors argue that such process- and work-oriented organizational cultures reflect the broader Brazilian authoritative administrative cultures seen across several public organizations and that are historical in nature. This analysis usefully pushes understandings of HRH forward from the health policy and systems view that health systems are social and historical constructions, and thus the knowledge, standards and behaviours that give rise to organizational cultures are learned and transmitted through the prevailing values and beliefs.


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<tr>
<th>Health workers</th>
<th>Public sector primary health care managers</th>
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<tbody>
<tr>
<td>Geographical area</td>
<td>Kenya</td>
</tr>
<tr>
<td>Research methods</td>
<td>Qualitative: Learning site collaborative research based on in-depth interviews and observation</td>
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<tr>
<td>Research inference</td>
<td>Explanatory/Emancipatory</td>
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In Kenya, Nyikuri et al. (2015) collected data from a “learning site” – a long-term collaborative research process between health managers and researchers in a set geographical location. Through cycles of action learning, which included formal and informal interviews and observation of managers’ daily routines over a 12-month period, and the analytical use of a framework examining the “hardware” (infrastructural, technological and financial inputs) and “software” (values, norms and behaviours), the authors address issues of primary health-care managers and their multiple accountabilities, daily routines and coping strategies amidst changing contexts of devolution. These changing contexts include the transfer of health facility ownership from national to county levels, and the simultaneous removal of user fees from public primary-level facilities and maternity services from public hospitals. The authors highlight the resilience and
adaptability needed by primary health-care managers to cope with resource scarcity and change; and they comment on the importance of relationships and governance as “micro-processes” – the ongoing, daily negotiation of power and decisions between local actors.


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<th>Health workers</th>
<th>Public sector district managers</th>
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<tr>
<td>Geographical area</td>
<td>Ghana</td>
</tr>
<tr>
<td>Research methods</td>
<td>Qualitative: historical analysis based on literature review and key informant interviews</td>
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<tr>
<td>Research inference</td>
<td>Explanatory</td>
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Using a theory-driven historical case study, Kwamie et al. (2015b) examine the historical processes and critical junctures between the development of the district health system and broader democratic governance developments as a way of explaining current configurations of district manager decision space in Ghana. In particular, the authors discuss the importance of the sequencing of decentralization processes (administrative, fiscal and political) in the actual shift in power to local levels, and the self-reinforcing centralizing tendencies of government decision-making over time that affect local leadership and management. Similar to Rocha et al.’s (2014) findings on the influence of social and historical forces on organizational cultures, this article forefronts historical patterns at both the macro- and micro-level on leadership and management capacities to perform their mandated functions. Additionally, this article highlights the complexities of decentralization for local managers and the challenges in translating the rhetoric of power transfers into practice. From a methodological perspective, this article uses an explicitly historical analysis, which remains an underused methodology in both HRH studies and HPSR.

6.3.2 Effects of management and organizational cultures on health workers


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<tr>
<th>Health workers</th>
<th>Multiple public sector hospital based health workers</th>
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<tbody>
<tr>
<td>Geographical area</td>
<td>Ghana</td>
</tr>
<tr>
<td>Research methods</td>
<td>Qualitative: Ethnography; participant observation, conversation and in depth interviews over 16 months in two public hospitals</td>
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<tr>
<td>Research inference</td>
<td>Exploratory</td>
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Aberese-Ako et al. (2014) use hospital ethnography in two public facilities in Ghana to examine how frontline health workers perceive the fairness of the organizational support they receive, and how this in turn influences their motivation to be responsive to clients’ health-care needs. The authors find that frontline staff perceptions of unfairness and mistreatment by the management of their facilities hamper their own ability to deliver good-quality, people-centred care to clients; in essence, there exists a discontinuity of organizational values between what is expected to be delivered to external clients and what is being received by internal clients (that is, staff). Intrinsic motivation among some frontline staff, however, does appear to be a factor
to support responsive care despite the organizational culture. This article importantly makes the case for organizational credibility as a means of supporting health workers in meeting their prescribed duties. As with the other articles in this section, the interplay of various elements of the organizational context on health worker decision-making and behaviour is detected.


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<tr>
<th>Health workers</th>
<th>Public and private sector nurses</th>
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<tbody>
<tr>
<td>Geographical area</td>
<td>Malaysia</td>
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<tr>
<td>Research methods</td>
<td>Quantitative: provider Likert survey and regression analysis</td>
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<tr>
<td>Research inference</td>
<td>Exploratory</td>
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Choi et al. (2016) in Malaysia conduct a quantitative survey with a five-point Likert scale investigating the constructs of transformational leadership, empowerment and job satisfaction with nursing students in private and public facilities. The authors discuss hierarchical structures within hospitals that position nurses beneath physicians, commonplace across clinical settings, and suggest the need for new forms of leadership and empowerment to increase nursing job satisfaction. This study adds a key finding that employee empowerment mediates the relationship between transformational leadership and job satisfaction. The role of employee empowerment has been little explored previously, and the authors convincingly argue for transformational leadership and employee empowerment as effective human resource practices to improve management and enhance job satisfaction among staff.

6.3.3 Initiatives to improve leadership and organizational cultures


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<th>Health workers</th>
<th>Public sector primary health care facility managers</th>
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<tr>
<td>Geographical area</td>
<td>India</td>
</tr>
<tr>
<td>Research methods</td>
<td>Mixed: realist evaluation using qualitative data (interviews and observation notes) and quantitative measures of commitment, self-efficacy and supervision style</td>
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<td>Research inference</td>
<td>Explanatory</td>
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In two districts in India, Prashanth et al. (2014) conducted a realist case study with both qualitative and quantitative methods to explain the observed outcomes of a district manager capacity-strengthening programme over time. The authors examine the individual, institutional and contextual influences for arriving at the outcomes of interest based on exposure to the programme (for example, manager intention to make positive change, seeking opportunities to make positive organizational change, and improved annual action planning), and find that responses to the same intervention differ by subdistrict. Variations in manager commitment, self-efficacy and supervision style are highlighted as mechanisms that affect the programme outcomes. Alignment of existing relationships between individual managers and their
organizations and the broader policy and sociopolitical environment are equally important. The authors demonstrate how the individuality of health managers, organizational factors in which they are embedded, and guiding contexts interact and influence the ability of a training programme to bring about change. (This article is also highlighted in Chapter 3 on health worker training and supervision.)


<table>
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<tr>
<th>Health workers</th>
<th>Public sector district managers</th>
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<tbody>
<tr>
<td>Geographical area</td>
<td>South Africa</td>
</tr>
<tr>
<td>Research methods</td>
<td>Qualitative: action learning on routine district health operations through document review, in-depth interviews, observation, review of notes from field researchers, presentation and workshops notes, and meetings</td>
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<td>Research inference</td>
<td>Emancipatory</td>
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From the DIALHS project, Lehmann and Gilson (2015) write up a methodological reflection on the utility of long-term action learning and co-production – that is, the collective and collaborative development of research questions and articulation of evidence between researchers and practitioners (in this case, health managers). Specifically, their article highlights the central focus of HPSR on people and their relationships within the health system, the challenges of interdisciplinary work as a way of studying these interactions and the embedded nature of HPSR research. They discuss the themes of working with diversity and managing the complexity of researchers and practitioners in co-production; theorizing relationships of co-production; and characterizing co-production evidence. For example, both practitioners and researchers in this learning site had to grapple with the complexities of transcending distinctions and hierarchies of the researcher–practitioner divide (along with its differing knowledge bases and power dynamics), had to work at forming mutual learning (instead of assuming that it would occur naturally), and had to agree on the nature of evidence. These insights point to the value of new (shared) forms of seeing and understanding leadership and co-creating interventions for leadership development.

6.4 Research challenges, gaps and future directions

While the literature reviewed was rich in management capacity-strengthening, organizational change, organizational cultures and workforce planning (drawing from the classic HRH literature as well as from studies that locate themselves explicitly in the HPSR literature), there exist some challenges in this topic area. These relate mainly to methodology gaps and research topic gaps.

6.4.1 Methodology gaps

While most of the literature on leadership, management and organizational cultures in the context of low- and middle-income countries uses qualitative methods, in high-income country contexts and in non-health sectors such constructs are also measured using quantitative techniques. The insufficient degree of quantitative research in this domain presents a challenge because it potentially limits the understandings of leadership, management and organizational
cultures in low- and middle-income countries. There may be a gap in the low- and middle-income country evidence base because existing theoretical and measurement frameworks either are not valid (hence the need to develop them) or are not applicable (that is, the political economy of primary health care services in low- and middle-income countries differs from that in tertiary hospitals in high-income countries or other profit-making sectors). There is a need for more innovation and adaptation for quantitative research techniques to measure leadership, management and organizational cultures and their influence on HRH performance more suited to the context of low- and middle-income countries.

6.4.2 Research topic gaps

A limitation in the current literature is a leanness of empirical articles on gender and leadership, especially in low- and middle-income countries. This is in stark contrast to the “feminized” nature of health-care work and the fact that the literature on gender and HRH tends to focus on frontline nursing or community health work, while issues of gendered leadership and management remain an area of further research. Exceptions are a study from Lebanon that describes the macro-, meso- and micro-level barriers and enablers to women advancing into managerial health-care roles (Tlaiss, 2013), and research that undertakes an exploratory cross-country case study investigating four large-scale European academic health centres to understand institutional support to advancing gender equality at mid- and top-level leadership (Kuhlmann et al., 2017). Clearly, further research on gender and leadership, management and organizational cultures, particularly in the context of low- and middle-income countries, is required.

There also appears to be a gap in evidence on community-level leadership – that is, leadership and management at the community outreach level. Research to date on community governance has focused on the role of community health workers, community voice and participation, and the functioning of health facility committees (see, for example, the body of work developed on accountability, trust and health service performance by the Consortium for Research on Equitable Health Systems, e.g. Macha et al., 2011; Uzochukwu et al., 2011). While this work has discussed the challenges of unclear member roles, questions around true representativeness and power dynamics, and linkages to formal governing structures, this literature has not to date delineated meanings of community leadership and management, and thus raises questions about the forms community leadership takes: how does it manifest, how is it recognized, how is it fostered, and how can it be measured and assessed? This represents a rich gap worthy of further research.

Acknowledgements

We wish to thank Asha George, Kerry Scott and Veloshnee Govender for their careful reading and insightful comments on iterative drafts of this chapter.
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