Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital

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PLAGIARISM DECLARATION

I, Oupa Steven Motshweneng (MTSOUP002), hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university. I authorise the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

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ABSTRACT

Distributed leadership has been proposed to offer value for health systems – by enabling people to work towards collective goals within settings such as hospitals. Yet, there is still lack of clarity about what distributed leadership is and how to nurture its development. To address these knowledge gaps, this case study draws on conceptual work in empirically examining leadership in one district hospital in the Western Cape province, South Africa, seeking to identify evidence of distributed leadership and the factors influencing its emergence. Data were extracted from 28 academic theses, policies and strategic documents relating to health leadership, management and governance in the provincial health system (Phase 1) and 12 semi-structured, in-person interviews were conducted with hospital personnel (Phase 2). Phase 1 data provided the context of the case and guided the collection of data in Phase 2. All data were thematically analysed. The analysis reveals that there were pockets of distributed leadership within the hospital, as characterised by chains of multiple leaders working together to co-create shared meaning, take collective decisions and achieve common goals, enabled by relational leadership practices. These pockets supported both routine service delivery and bottom-up service improvement action. However, the unequal distribution of decision-making power, in the context of bureaucratic and professional hierarchies, limited the widespread emergence of distributed leadership. The case study suggests that distributed leadership can emerge in district hospitals with positive consequences for health service delivery, but that efforts to nurture its emergence should both bolster the leadership capabilities of individual leaders and address the bureaucratic and professional hierarchies that characterise the context within which hospital leadership unfolds. To aid the future practice of, and research about, distributed leadership the paper presents a comprehensive definition of the concept, synthesised from the wider literature and this study's empirical findings.

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I am eternally grateful to God, who has graciously opened a door of opportunity for me to undertake this learning journey. All that I have and all that I am, I owe it to Him. Indeed, 'I am what I am by God's grace' (1 Cor 15:10, CEB).

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To all of you I say: tanki hanngwe, tanki habedi, tanki hararo!

ACRONYMS AND ABBREVIATIONS

CEO	Chief Executive Officer
DHS	District Health System
e-HPSR	Embedded Health Policy and Systems Research
EQ	Emotional Quotient (also called Emotional Intelligence)
HOD	Head of Department
HPSR	Health Policy and Systems Research
LMICs	Low- and Middle-Income Countries
NDoH	National Department of Health
NHS	National Health Service
PHC	Primary Health Care
PI	Primary Investigator
RTA	Reflexive Thematic Analysis
UCT	University of Cape Town
UK	United Kingdom
WCDHW	Western Cape Department of Health and Wellness (also called Western Cape Government Health and Wellness)
WHO	World Health Organization

GLOSSARY OF TERMS

Bureaucracy	A system of an organization which is controlled by rules, regulations, and hierarchical structures.[1]
Health Policy and Systems Research	An interdisciplinary field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes.[2]
Health System	Consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.[3]
Leadership	A process that involves the creation of a vision and strategic direction for the organisation, communication of that vision to the people and customers of the organisation, and inspiring, motivating and aligning people and the organisation to achieve this vision.[4]
Relational Leadership	An interpersonal phenomenon associated with collaboration, empathy, trust and empowerment; non-hierarchical and distributed; and embedded within everyday interactions, conversations and relational processes.[5]

[1] Mai T. 2016. The power of bureaucracy. *Journal of US-China Public Administration* **13**: 244-255.
[2] Gilson L (Ed). 2012. *Health policy and system research: a methodology reader*. Alliance for Health Policy and Systems Research, World Health Organization.
[3] World Health Organization. 2007. *Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organization.
[4] Gilson L, Daire J. 2011. Leadership and governance within the South African health system. In: Paradath A, English R (Eds). *South African Health Review 2011*. Durban: Health Systems Trust, 69-80.
[5] Cleary S, Toit AD, Scott V, Gilson L. 2018. Enabling relational leadership in primary healthcare settings: Lessons from the DIALHS collaboration. *Health Policy and Planning* **33**: ii65-ii74.

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PART A: JOURNAL MANUSCRIPT

‘Distribution of responsibility without distribution of autonomy’: exploring the emergence of distributed leadership in a district hospital of the Western Cape province, South Africa.

Oupa Motshweneng[i]

Targeted Journal

Health Policy and Planning[ii]

Abstract

Distributed leadership has been proposed to offer value for health systems – by enabling people to work towards collective goals within settings such as hospitals. Yet, there is still lack of clarity about what distributed leadership is and how to nurture its development. To address these knowledge gaps, this case study draws on conceptual work in empirically examining leadership in one district hospital in the Western Cape province, South Africa, seeking to identify evidence of distributed leadership and the factors influencing its emergence. Data were extracted from 28 academic theses, policies and strategic documents relating to health leadership, management and governance in the provincial health system (Phase 1) and 12 semi-structured, in-person interviews were conducted with hospital personnel (Phase 2). Phase 1 data provided the context of the case and guided the collection of data in Phase 2. All data were thematically analysed. The analysis reveals that there were pockets of distributed leadership within the hospital, as characterised by chains of multiple leaders working together to co-create shared meaning, take collective decisions and achieve common goals, enabled by relational leadership practices. These pockets supported both routine service delivery and bottom-up service improvement action. However, the unequal distribution of decision-making power, in the context of bureaucratic and professional hierarchies, limited the widespread emergence of distributed leadership. The case study suggests that distributed leadership can emerge in district hospitals with positive consequences for health service delivery, but that efforts to nurture its emergence should both bolster the leadership capabilities of individual leaders and address the bureaucratic and professional hierarchies that characterise the context within which hospital leadership unfolds. To aid the future practice of, and research about, distributed leadership the paper presents a comprehensive definition of the concept, synthesised from the wider literature and this study’s empirical findings.

Keywords

Distributed leadership, district hospital, relational leadership, decision-making, district health system

Key messages

- Leading in health systems, including district hospitals, requires a shift from individualistic and hierarchical leadership styles.
- Relational leadership practices can enable the emergence of distributed leadership in district hospitals, to support routine health service delivery, crises response and service improvement.
- Unequal distribution of decision-making power, in the context of bureaucratic and professional hierarchies, constrain the widespread emergence of distributed leadership.
- Nurturing distributed leadership requires developing the leadership capabilities of individual leaders and establishing enabling policy frameworks that distribute decision-making power and autonomy.

Word count

6 998

INTRODUCTION

There is global recognition of leadership as a critical health system component. (Alliance for Health Policy and Systems Research, 2016; Chee et al., 2013; De Savigny and Adam, 2009; World Health Organization, 2007). Leadership is largely understood to be a social process that involves influencing, inspiring, mobilising and motivating people in building and achieving a common vision (Aberese-Ako et al., 2018; Gilson and Daire, 2011; Okello, 2021; Patel, 2022). It has been linked to staff satisfaction and motivation (Belrhiti et al., 2020; Musinguzi et al., 2018) and, broadly, to health systems performance (Bosongo et al., 2023). Yet the limited, but growing, body of literature about health system leadership in low and middle-income countries (LMICs) commonly reveals leadership weaknesses (Bosongo et al., 2023; Coovadia et al., 2009; Daire et al., 2014; Daire and Gilson, 2014; Edmonstone, 2018; Govender et al., 2018; Munezhi and Hammad, 2021; Mutale et al., 2017). Within hospitals, for example, leadership problems have been noted to contribute to low staff motivation (Gilson and Agyepong, 2018; Mathole et al., 2018), financial mismanagement (Bateman, 2013) and poor-quality services (Lembani et al., 2015).

District (or first referral) hospitals play an essential role in health systems in LMICs. For example, they provide clinical support to primary care facilities and coordinate care between these facilities and specialised hospitals (English et al., 2006). Despite their importance, there is insufficient research on district hospitals in LMICs. During a recent research landscape review, Jeffries-Mazhar et al. (2024) identified only seven academic papers 'which appear to position [district hospitals] … as the main subject of their research' (p.229). Little is also known about the nature of leadership in district hospitals, what influences it and how it supports hospital performance. Only a handful of empirical studies have examined district hospital leadership in LMICs, finding different forms and experiences of leadership, shaped by their context, both within and between hospitals (Aberese-Ako et al. 2018; Nzinga et al., 2018; Okello, 2021). These studies reveal how relational and supportive leadership, in contrast to that which is authoritarian and hierarchical, can overcome contextual barriers and improve health services (Mathole et al., 2018). Indeed, a recent international workshop concluded that transforming district hospitals in LMICs requires a shift from 'traditional hierarchical management models… [to developing leaders] with abilities to nurture staff and respond to and manage relationships with communities and multiple different stakeholders' (English et al., 2024: e367).

The leadership identified as needed in district hospitals reflects what has come to be termed distributed leadership in the wider leadership literature – that is, 'a group activity that works through and within relationships, rather than individual action' (Bolden, 2011: 252). Although the idea that leadership may have

a *distributed pattern* can be traced back to the 1950s (Gronn, 2002), the notion gained momentum in the 1980s through Brown and Hosking (1986)'s work. Since then, several similar leadership concepts have emerged – such as collective, distributive, dispersed, relational (Gronn, 2002), emergent, collaborative (Bolden, 2011), concurrent, co-ordinated (Fitzsimons et al., 2011), shared and co-leadership (Thorpe et al., 2011). While some scholars argue that these are distinct concepts (Fitzsimons et al., 2011), others see them as 'variants' of the same idea (Bolden, 2011: 254), and sometimes the terms are used interchangeably (Gronn, 2002; Thorpe et al., 2011). Concerns have, therefore, been raised about the lack of a clear and comprehensive definition of distributed leadership that can guide rigorous research and practice (Bolden, 2011; Currie and Lockett, 2011).

Against this backdrop, this study seeks to make two contributions. First, it aims to add to the limited body of knowledge on district hospital leadership in LMICs by exploring both the extent to which leadership in one district hospital in the Western Cape province of South Africa is *distributed*, and what factors influence its *distribution*. Second, it aims to tease out the key dimensions of distributed leadership by engaging conceptually and empirically, to guide future research and practice. Our research question was*: is there evidence of distributed leadership in Bophelo hospital (a pseudonym given for anonymity) and what has enabled or constrained its emergence?*

The Western Cape provided an appropriate context for this work. The provincial Department of Health and Wellness (WCDHW) recognises the critical role of leadership – including district health system and district hospital leadership – in supporting health system development (Gilson et al., 2017; 2024; Vallabhjee et al., 2021; WCDHW, 2014). In its current long-term strategy, 'dynamic and distributed leadership across the ranks of management, clinicians and administration' (WCDHW, 2014: 41) is identified as a key requirement for the realisation of its vision of 'access to person-centred quality care' (WCDHW, 2014: 33) and a shift from health to wellness (WCDHW, 2014). Similar to the United Kingdom (UK)'s National Health Service (Fitzgerald et al., 2013; Martin et al., 2015), the WCDHW has, therefore, explicitly sought to support distributed leadership by investing in leadership development across all levels of the provincial health system, through interventions such as formal training, coaching and tailored action learning projects (WCDHW, 2014). This study adds to the only other study (Okello, 2021) that explored the extent to which leadership is *distributed* in the provincial health system's district hospitals, by specifically drawing on the concept of distributed leadership in examining hospital leadership.

MATERIALS AND METHODS

This research was nested within a broader review of health system development in the Western Cape from 2014 to 2024, undertaken by the WCDHW and the Universities of Cape Town and the Western Cape. Ethics clearance was received from the University of Cape Town (HREC:207/2024) and institutional approval was granted by the WCDHW (WC_202404_012). The overall approach was a single, exploratory case study as depicted in Figure 1 and described below.

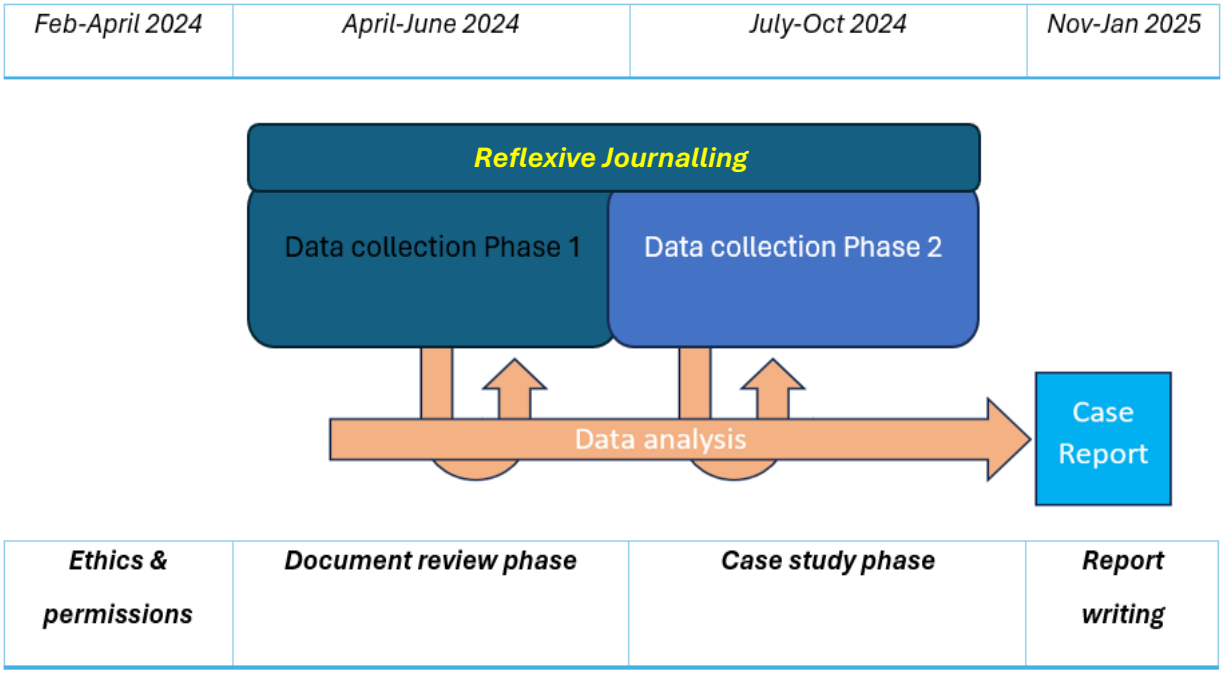

Figure 1. Study design and timelines

Conceptual framing

An initial synthesis of relevant literature was conducted to develop the conceptual framework. We first purposefully identified relevant conceptual literature and identified core concepts from these papers through thematic analysis. Then we purposefully identified and considered relevant empirical literature to understand how these concepts have been used empirically. The synthesis revealed four key characteristics of distributed leadership, as summarised in Box 1, which informed data collection and analysis. This use of theory in the collection and interpretation of data further strengthened the analytical rigour of this single case study (Gilson, 2012; Yin, 2004).

Box 1. A synthesis of common characteristics of distributed leadership

Distributed leadership is:

A. *More than just about individual leaders but rather a collective capacity of the system* (Bolden, 2011; Fitzsimons et al., 2011; Fitzgerald et al., 2013; Okello, 2021; Thorpe et al., 2011; WCDHW, 2014).
B. *Distributed across multiple system levels but connected and collaborative* (Doherty et al., 2018; Fitzsimons et al., 2011; Gronn, 2002; Günzel-Jensen et al., 2018; Martin et al., 2015; Nzinga et al., 2018; WCDHW, 2014)
C. *Relational - involving interpersonal relationships, mutual influence and interdependent actions* (Bolden, 2011; Cleary et al., 2018; Fitzgerald et al., 2013; Günzel-Jensen et al., 2018; Martin et al., 2015; Nzinga et al., 2018; Okello, 2021; Thorpe et al., 2011).
D. *Inclusive - going beyond people in official management positions to include both formal and informal leaders* (Bolden, 2011; Cleary et al., 2018; Doherty et al., 2018; Fitzgerald et al., 2013; Günzel-Jensen et al., 2018; Okello, 2021; WCDHW, 2014).

Study setting

Bophelo Hospital is one of 33 district hospitals in the Western Cape. It was selected as the 'case site' for purposive and pragmatic reasons. It is a typical (Yin, 2009) large district hospital in its district and the researchers were able, relatively easily, to secure permission to conduct this work in this hospital. Figure 2 provides contextual information about the hospital's organisational structure and processes, while Table 1 outlines the range of services provided. In this study, *senior leaders* refer to the hospital's executive management team, *mid-level leaders* denote middle managers and clinician-managers[iii], and *frontline workers* refer to those who do not hold formal management positions. However, most middle managers and clinician-managers do frontline (i.e. patient-facing) work.

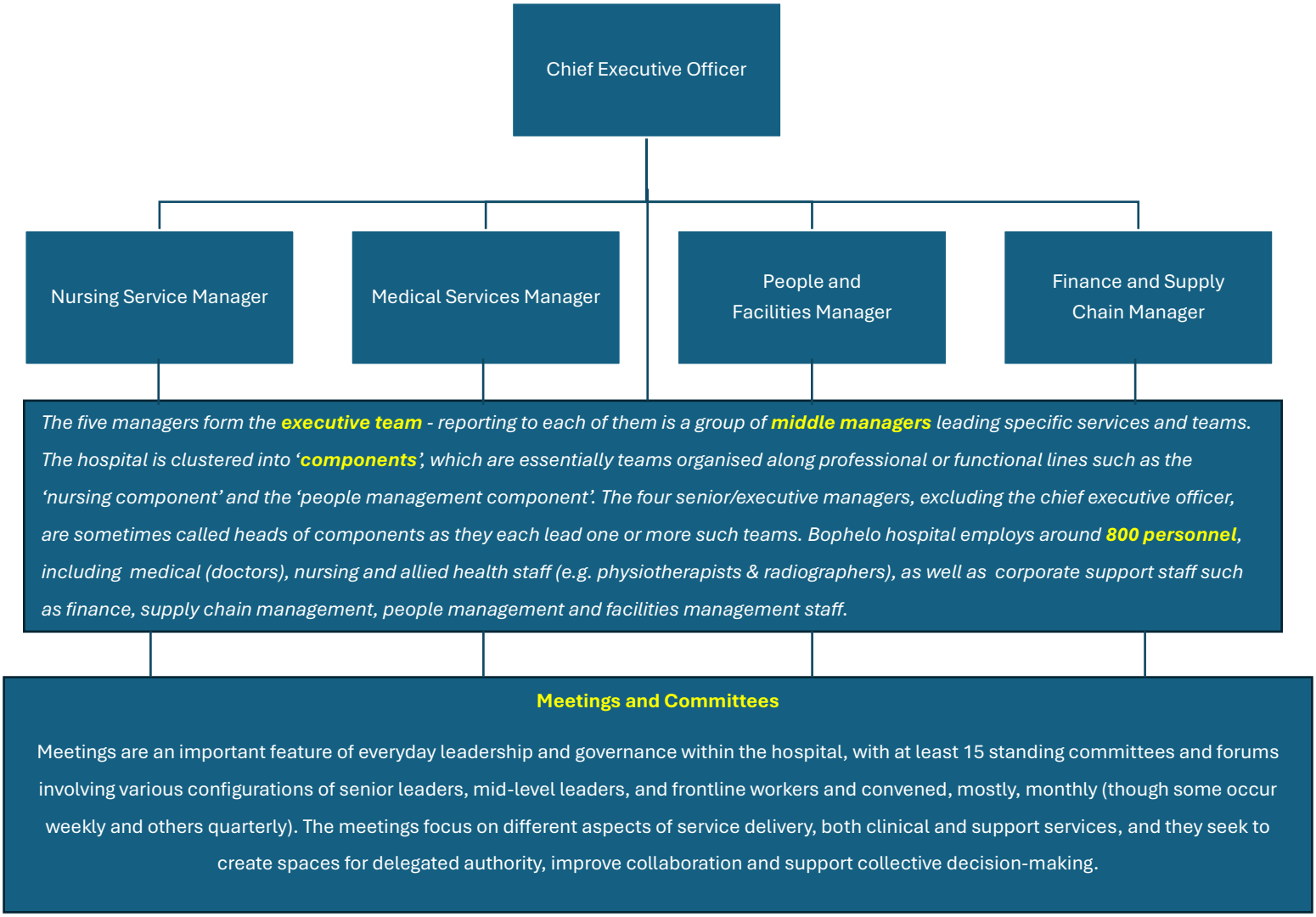

Figure 2. Hospital organisational structure and processes

Table 1. Hospital services

CLINICAL SERVICES: outpatient departments & about 300 inpatients beds						SUPPORT SERVICES	
Acute District Services	**Clinical Support**	**Allied Health Services**			**Nursing & Related**	**People & Facilities**	**Finance & Supply Chain**
		Radiography	*Therapeutic*	*Social Services*			
Emergency medicine; Clinical forensic; Internal medicine; Paediatric care; Psychiatry; Obstetrics & gynaecology; Surgical care; Anaesthetics.	*Pharmacy; Laboratory.*	*General X-rays; Sonography; Computerised tomography.*	*Dietetics; Occupational therapy; Physiotherapy; Psychology; Speech therapy.*	*Social services.*	*Palliative care; Infection control; Occupational health.*	*People management; Labour relations; Mortuary; Cleaning; Security; Transport; Porters.*	*Financial admin; Admissions; Case management; Medical records; Procurement; Asset management.*

Study design

The single, exploratory case study design was appropriate for this study as case studies enable researchers to use different sources of data to empirically study phenomena in their context (Yin, 2004) – which is important for understanding distributed leadership (Thorpe et al., 2011). They are also suited for exploring phenomena that are not well understood (Robson, 2002), such as distributed leadership. More specifically, single case studies allow researchers to study phenomena in great detail – generating insights into how and why something happens or does not happen (Thomas et al., 1998). In this study, 'the case' (Yin, 2009) is: *the emergence of distributed leadership in Bophelo Hospital*.

Data collection

Data collection involved two sequential but overlapping phases. Phase 1 consisted of a document review conducted by both researchers.[iv] Academic theses, policies and strategic documents relating to health leadership, management and governance in the WCDHW (n=20) and at Bophelo Hospital (n=8) were reviewed, focusing on the period from 2014 to 2024 (Table 2)[v]. Each document was read carefully to identify

issues relating to leadership, management, governance and decision-making. Furthermore, the ways in which leadership was framed in these documents – with specific reference to Box 1 – were identified. Data were extracted into a Microsoft® Word document and the extracts were grouped according to common issues. The review provided an initial understanding of the context of Bophelo Hospital, and guided Phase 2 of data collection by revealing relevant issues that helped inform the interview questions.

Table 2. Documents reviewed in Phase 1

WCDHW (n=20)	**Bophelo Hospital** (n=8)
Reports	***Reports***
WCDHW Annual Reports, 2015/2016 – 2021/2022 (n=7)	Bi-annual Staff Satisfaction Survey, 2013 – 2023 (n =5)
Indaba Reports, 2023 (n=2)	Key Indicators, 2013 – 2023 (n=1)
State of Department Adress Presentation, 2023 (n=1)	Staff Turnover, 2017 – 2023 (n=1)
Corporate Services Reform Presentation, 2023 (n=1)	
Policies and Strategic Plans	***Policies and Strategic Plans***
Healthcare2030 Strategy (n=1)	Annual Operational Plan, 2023/2024 (n=1)
5-year Strategic Plans, 2015-2019 & 2020-2025 (n=2)	
Governance and Accountability Framework, 2015 (n=1)	
Leadership Development Strategy, 2016 (n=1)	
Leadership Competency Framework, 2016 (n=1)	
Transformation Strategy, 2017 (n=1)	
Resurgence, Recovery and Reset Strategy, 2020 (n=1)	
Academic Theses	
Okello, 2021 (n=1)	

In Phase 2, 12 participants (Table 3) who were currently working or had worked at the hospital within the past 10 years were purposefully sampled, using leadership experience, access and snowballing as guiding principles. Participants were selected to ensure perspectives were gathered from all hospital components as well as from both senior and mid-level leaders, and frontline workers. Although a small sample size, as Guest et al. (2006) explain, in in-depth qualitative research data saturation – 'the point in data collection when no additional issues or insights are identified' (Hennink and Kaiser, 2022: 2) – can be reached as early as the sixth interview and can be expected by the twelfth interview. Saturation is, further, an important part of ensuring rigour in qualitative research (Morse, 2015).

Table 3. Participant characteristics (n=12)

Gender	
Females	4
Males	8
Staff 'category'	
Senior leaders	5
Mid-level leaders	5
Frontline workers	2
Professional background	
Allied health	3
Corporate support	3
Medicine (doctors)	4
Nursing	2
Time working/worked at the hospital	
0-5 years	4
6-10 years	4
11 + years	4

With written consent, the interviews were conducted in-person, by OM, using a semi-structured interview guide and ranged from 60 to 90 minutes in duration. Broadly, participants were asked to reflect on the key features of leadership in the hospital and the factors they judged to have shaped it over the last 10 years, with prompts that enabled exploration of characteristics in Box 1 and issues identified in Phase 1 above.11 of the interviews were audio-recorded; one participant declined recording but allowed the researcher to take notes during the interview. OM transcribed all interviews verbatim using Microsoft® Word. To ensure anonymity, participants' names were removed from the audio files and transcripts, and replaced with an alphanumeric code system – also used in reporting the findings in the results section. All codes start with the letter 'P' which stands for 'participant', followed by a number unique to each participant.

Data analysis and reflexive practice

The 11 interview transcripts and one set of notes were imported into NVivo® 14 for further analysis. OM read and coded each interview transcript/notes. All codes were then exported from NVivo and categorised into initial themes using tables in Microsoft® Word. LG reviewed the codes and initial themes, which were then further synthesised by grouping around common issues to develop the final themes. Both researchers agreed on the final themes. Thematic analysis was primarily inductive, although the distributed leadership characteristics outlined in Box 1 were applied in judging whether and where distributed leadership could be observed in the hospital.

Four steps were undertaken to ensure analytic rigour. First, OM maintained a reflexive journal (Olmos-Vega et al., 2022; Smith, 1999) throughout the study to help with regular reflections on his own positionality and subjectivities, and how these may influence the research process. Issues from the reflexive journal were further discussed during debriefing meetings. Second, during both Phase 1 and Phase 2 of data collection, the researchers regularly met to debrief (Gilson, 2012; Lincoln and Guba, 1985) and together consider emerging insights. Third, in analysis data were triangulated (Gilson, 2012; Lincoln and Guba, 1985) both between Phase 1 and Phase 2 data sets, and across participant interviews in Phase 2. For example, insights about leadership experiences were triangulated between the staff satisfaction survey reports (Phase 1) and interviews (Phase 2), and between participants from different staff categories and professional backgrounds. Fourth, as noted, theory was applied in analytic judgements of whether distributed leadership was observed or not, and where it was observed, by drawing on the characteristics in Box 1 to interpret data. Steps one, two and three were particularly important for this study as OM is an employee of the WCDHW – although not employed by the hospital – and has professional relationships with some participants. This embeddedness within the health system has, however, been noted to contribute to the rigour of health policy and systems research through, for example, better access to people and information, more in-depth knowledge of system and context, and opportunities to engage with difficult findings in safe and constructive ways (Olivier et al., 2018). The journal and regular de-briefing with LG, an outsider to the WCDHW, but one with good understanding of its functioning, helped limit OM's insider biases, whilst the use of theory supported appropriate analytic judgements.

RESULTS

In this section we present insights about the nature of leadership in the hospital, including evidence of distributed leadership, and the factors influencing its emergence. The sub-headings represent the key analytic themes identified.

Multiple leadership experiences within one hospital

Participants reported that different forms of leadership were found within different hospital components, as described below:

> *There's definitely different habitats almost in the same organization… there's definitely a group or there's a component or habitat… that is much more militaristic, autocratic. Where there is fear of… punitive approach or punishment [which] is definitely a driver behind people's motivation. So, you definitely find that stream of actions or leadership approach, I think. Then there's definitely in the facility [also]… more of a consultative approach.* (P07)

Leadership experience was also reported to vary within components, with individual leaders playing a role in shaping such differences. As one head of component explained:

> *So, all of us don't lead the same way and that is the reality. I have… managers that report [directly] to me. There's… managers that report to… those… managers. I have my leadership style, the… managers [who report to me] individually have their leadership style, the… managers [who report to them] individually have their leadership style. So, you can now see the dynamics and the complexity…* (P02)

Pockets of distributed leadership

Within the different experiences, we also observed pockets of distributed leadership as characterised by collective sense-making and decision-making among teams, and collaborative action towards common goals. Although observed both within and across components, distributed leadership appeared to be largely concentrated amongst mid-level leaders and frontline workers. For example, Participant 04 reported how staff within their component responded to the real-time situation of extreme weather conditions, which resulted in the closure of schools and staff absenteeism. Despite these conditions, these frontline staff exercised agency and collective action to ensure that service delivery was not disrupted.

> *I'm telling you; I've got [less members] today of my team… because of the situation with the children, people being sick and the rain… but I'm sitting here, I don't have a problem… I never have that problem that I don't know what is gonna work. My people will come up and say don't worry, we'll do it this way, we'll do it that way.* (P04)

This observation reflects wider provincial experience that distributed leadership in the frontlines has been instrumental in enabling the health system to respond to crises such as the COVID-19 pandemic (Resurgence, Recovery and Reset Strategy, 2020; State of Department Address, 2023).

A similar collaborative approach was also observed in how frontline multi-disciplinary clinical care teams coordinated patient care within the hospital (P05). Importantly, pockets of distributed leadership were observed across clinical care and corporate support teams. One participant described a process of collective sense-making, decision-making and action among a team of mid-level leaders and frontline workers from different clinical and corporate components in efforts to improve patients' experience of care:

> *We said like let's get together as a team and make this department work and use client experiences and commit ourselves to this project and we as a team decide what works for us… it was last year already based on our 2022's waiting time results. We said we need to make a change and we said…*

> *let's try and implement appointment slots. But then let's also look at the way we function, our flow. How do we do bookings? Let's do a broad review, and so the team got together and we made goals and we put out our vision and our mission…* (P03)

The experiences of distributed leadership observed in how mid-level leaders and frontline teams approached routine work, crises and service improvement were also noted by participants outside these teams. As one senior leader commented:

> *So, let's say for instance there is a task at hand or a new improvement project or issue or crisis, I found… [that] the teams naturally approach these in quite a multidisciplinary or interdisciplinary way. It was infrequent that there would be only one person that would make a decision… so I think there was an awareness about that interdependence.* (P07)

These observations of pockets of distributed leadership are supported by wider evidence from the hospital which suggests that mid-level leaders and frontline teams judged that they had some level of agency to make decisions *within* their teams. Specifically, in the 2023 staff satisfaction survey, aspects related to decision-making, action and goals amongst teams received the highest proportion of positive responses:

1. *'In my team we make decisions quickly when it is necessary'* = 74%
2. *'In my team actions are taken quickly when decisions have been made'* = 67%
3. *'In my team, we work towards clear goals'* = 67% (Staff Satisfaction Survey Report, 2023).

These aspects had also received similarly high proportions of positive responses in the previous staff satisfaction survey (Staff Satisfaction Survey Report, 2021).

Interpersonal relationships matter

Further analysis showed that leadership practices that recognise the importance of, and nurtured, trusting interpersonal relationships were a key enabler of the emergence of distributed leadership among teams in the hospital. Below is an example of such leadership practices, in the context of performance management:

> *I have now two people in the same role to compare… and if you just look at the different approaches in how they do our performance review. With [Manager X] we would sit, we would engage. You know, really connect. Try [to] connect on a one-to-one level. And really hear the employee out and try and address their concerns and see how they would want to be developed further. That sort of came from the leader… which I really enjoyed and then whereas now performance review is very much just a quick tick box exercise. Review yourself… and then I'll give you your score and we go on with our lives.* (P03)

These leadership practices were linked to all experiences of distributed leadership identified in the study and were framed by participants through concepts such as caring (P04, P05, P06, P07 and P08), empathy (P07 and P09) and connecting (P02, P03, P07 and P08). They also played a key role both in breaking down the barriers fragmenting groups and in creating inclusive spaces where team members felt they could contribute despite, for example, their disciplinary background and position in the hierarchy (P04, P05 and P07). Such practices also had a reciprocal effect: those who cared for others also experienced being cared for. For example, the manager described as caring and connecting in the preceding quote described how, in turn, employees cared for him:

> *I think my team also cared for me… because, especially under pressure, I become quite goal orientated and then I go into this hyper-action mode… and I think what my team reminded me about was taking time to still care for each other while there's pressure. So, either team was tremendously caring in that regard and wanted to make sure that I was also okay.* (P07)

This reciprocal effect created safe environments wherein team members cared for each other both in times of work-related pressures (P07) and personal life challenges (P08); and established loops of personal and honest feedback that itself supported leadership development (P03 and P07). The 'soft… people skills' (P04) or 'EQ [emotional intelligence]' (P05) that underpin these leadership practices were seen by some participants as 'the real essence of leadership' (P07).

Unequal distribution of decision-making power

Making decisions was highlighted by all participants as an integral part of the process of leadership. Further, as already noted, the ability of teams to make decisions and take action towards collective goals, based on shared meaning, was observed as an important feature and consequence of distributed leadership. Some participants also, themselves, described this as an important feature of distributed leadership – which they understood as being 'about empower[ing] people… so that they can be part of decision making.' (P02)

Participant 06 further expanded on this idea:

> *For distributed leadership to happen… people beyond the small core cluster of power owners have to be able to make decisions, take action and therefore get outcomes without the knowledge or permission…of [the senior leaders]… So, if I'm a… manager but I cannot make a decision about what services I am going to stop and what services I am going to continue in the light of our current financial crisis, if I have to ask someone else for permission to make those kind[s] of decisions, then that's not*

distributed leadership. All that it is, it is distribution of responsibility without distribution of autonomy which is an absolute nightmare. (P06)

More specifically, other participants understood decision-making power as something that, in principle, should be, and sometimes is, distributed:

You as a[n] executive manager…[should] support, give input at a point and distribute that leadership and the power to make decisions and support them [teams], rather than wanting to take it over and control the whole project. (P03)

Nonetheless, top-down decision-making emerged as a prominent feature of leadership in the hospital. While some senior leaders perceived decision-making as largely participatory, all mid-level leaders and frontline workers reported limited distribution of decision-making power beyond the hospital's senior management team, as described by these two participants:

You've got your top five, you've got your exec, they make decisions and then it just flows from top down… It comes across as [if] it is consultative, but the decisions… are made with the five. (P04)

There is a lot of management engagement meeting[s] we attend and all that kind of stuff, but the decision is made by four, five people and then it has to be implemented. There isn't a lot from, you know, at the bottom going up when decisions are made. (P09)

Explaining how a bottom-up multidisciplinary team initiative aimed at improving a particular care process ended, Participant 03 also highlights how top-down decision making sometimes limited frontline teams' ability to collaborate towards shared goals – an important dimension of distributed leadership:

We had a project… the team sat together and we came up with a plan and then the next week you had [Manager Y]… saying that this can't work, we can't make decisions by ourselves… end of story. And so… it's got to end there, there's no room for engagement further, saying well, okay… why is this a problem? Let's work around it… So, you as a team might decide something but you know that the next week the project can be squashed at any stage without consultation. (P03)

As the value of client care or 'client-centred[ness]' (P07) was one that strongly resonated with participants, such examples of the limited power of teams to take decisions and action towards improving client care, notwithstanding resource constraints, resulted in feelings of disempowerment:

…they [mid-level leaders] can't execute any of those decisions with any degree of autonomy and so now you have exactly what I said earlier. You have insight over much, power [over] nothing… because

> *when you can see what needs to be done, but you can't do it, you have the illusion of distributed leadership. And then you don't get the outcomes, which we don't get but you are still held accountable for it… and that makes you extremely unhappy.* (P06)

An increasing sense of limited decision-making power in the hospital was also reflected in documentary evidence where autonomy saw the greatest decline in rating between the 2021 and 2023 staff satisfaction surveys. In 2021, 81% of the survey respondents felt they could 'make… [their] own decisions concerning… [their] work' (Staff Satisfaction Survey Report, 2021: 6), compared to 49% in 2023 (Staff Satisfaction Survey Report, 2023).

A context of bureaucratic hierarchy

The distribution of decision-making power in the hospital is itself influenced by the wider context in which the hospital is embedded. Several participants (P02, P03, P06 and P12), across the three categories of staff, stated their belief that leadership is not about titles or position in the hierarchy. This belief aligns with the provincial perspective that every staff member in the WCDHW has a leadership role (Governance and Accountability Framework, 2015). Yet, the 'realities' (P08) of bureaucratic hierarchy form part of the context within which leadership (including decision-making) in the hospital unfolds. These realities were also mentioned by both senior and mid-level leaders (P02, P03, P08, P11 and P12), and were acknowledged as a barrier in the wider provincial health system (Indaba Commission Report, 2022). One participant further described how this context can influence who is seen as a leader and, consequently, can make decisions:

> *I think again in a system that is very structured according to hierarchy and position and titles… maybe this is my perception [but] people don't think of the [specific middle management position] as part of the leader[s], the core leadership team… I'm influenced by the way of thinking in the government that you have to be appointed to be a leader.* (P03)

Furthermore, within this context, the senior leaders of the hospital sometimes have little room to move as key decisions are made at the district and provincial levels and must be implemented by the hospital team. Participant 02 reflected on one such a situation:

> *…we were not ready, now we feel it and it's because it wasn't a collective decision that was made as a whole exec… but what is difficult for [Bophelo Hospital] and our system is [that] we work in a bureaucracy. So, when that [instruction] comes [from] there and we have to implement the instruction, we have to find the best ways to navigate implementing that instruction. So, we work in a very complex environment and I think for [Bophelo Hospital] most of that bureaucracy has also*

> *impacted on how we, and especially the leader that has the executive authority, try to navigate decision making. So, you can understand it's difficult for somebody in that position when [the] instruction come from the seniors and you must now implement it and sometimes your team members won't agree. You know the system cannot allow it, you know your team is not ready, you know it, but you have to follow an instruction*. (P02)

Such top-down decision-making sometimes led mid-level leaders and frontline staff to resist the implementation of decisions made at higher levels, especially where those decisions were not well communicated and understood (Staff Satisfaction Survey Report, 2023). As one senior leader reflected, a factor leading to resistance to some changes was that:

> *...people don't understand and the reason why they don't understand certain things it's because they're not in the same meetings where this information is given to us, maybe from the director... So, they [are] often resisting because they don't know where we're going. They only know what we [are] saying, they don't have that top part.* (P11)

Professional and functional silos

While we observed pockets of collaboration across different components, professional and functional silos remained a key contextual feature of the hospital identified by many participants (P01, P02, P03, P04, P06, P07, P08, P09 and P10). One participant, for example, shared this perspective on the relationship among hospital components:

> *From my perspective, I don't see a lot of cohesion... [We're] working in silos ... everyone is working on his little island.* (P01)

These silos were re-enforced by several factors, including past changes in the organisational structure of the hospital, driven by wider WCDHW decisions:

> *With the previous hospital secretary [a position now abolished], like I said, there was regular meetings, so you felt part of, you know, of everything that was going on. But now it's like there [are] different islands at the hospital... under the hospital secretary [there] would be like finance, you know, directly, supply chain, support services, food services and hospital fees. They would fall directly, and medical records, they would fall directly under the hospital secretary... I knew what was going on in the rest of the hospital components. [But with the organogram change, positions were divided] ... Half went that way, the finance and supply chain and medical records and the rest*

> *went under… the other manager… [That] created islands because everybody was working in their own silos and in their own direction.* (P09)

Further, there was a sense of disconnectedness and some relational tensions amongst senior leaders (P01, P02, P06 and P07), and between the senior and middle leadership levels (P04, P05, P08, P09 and P12). These were partly attributed to changes in the individuals occupying senior management positions (due to turnover and temporary secondments):

> *Also, part of what shapes it [hospital leadership] is the coming and the going. So, in my time we've lost [hospital superintendent – incumbent retired and position was reconfigured] and gained [medical manager – new position created]. We've lost [previous nursing manager] and we gained [current nursing manager]. We then lost [medical manager] and then we gained [new medical manager]. At each of those junctions there is a period where the water in the bucket is very agitated… The water in the ocean is very upset because it's change and it's new and it's, you know. [Manager A] was busy, as I said, [Manager A] had this vision and was busy with this project. And then along comes [Manager B] and he's like, no, but he's not interested in that stuff, he's now looking at this. And so suddenly everything that was being worked towards, there's something now different and it's not different wrong, it's just different. And that also contributes to the shape of this thing [hospital leadership] and whether it works or it doesn't work.* (P08)

Coupled with bureaucratic hierarchies, these tensions and silos between components constrained distributed leadership by making it difficult for cross-component teams to take collective decisions and work together. One senior manager explained this challenge:

> *Tension between different component heads filters down into different components. I think that made a difference… unfortunately when there is a strong hierarchical structure… lower-level managers would almost naturally take on the stance of the component head towards certain issues. And so, I think that is how it could filter down, especially if there was like a visible behavioural response or visible actions… so people would be reluctant to engage, people would be reluctant to have further conversations or make decisions. I think that also definitely disabled or made people…[to] feel [not] equipped any longer to make those decisions. I think that confidence in making decisions was lost when there was that friction.* (P07)

DISCUSSION

The study reported here sought to explore whether there is evidence of distributed leadership in Bophelo Hospital and what enabled or constrained its emergence. It also sought to develop and test an understanding of distributed leadership to guide future practice and research. Drawing from the currently available conceptual and empirical literature, we developed a synthesis of common characteristics of distributed leadership (Box 1) and apply this synthesis here in discussing the experiences of distributed leadership identified through this study.

As noted, both within and across hospital components, we found pockets of distributed leadership in how teams approached routine work, crises and service improvement – with positive consequences such as protection of service delivery during extreme weather conditions and absenteeism, initiatives aimed at improving linkage to care and patients' experience of care, and innovations intended to promote staff safety and wellbeing. Reflecting *Points A and B* (Box 1), these pockets were characterised by chains of multiple leaders working together to co-create a shared meaning, take collective decisions and achieve common goals. This finding adds to previous studies in South Africa (Okello, 2021), Morocco (Belrhiti et al., 2020), Kenya (Nzinga et al., 2018) and the UK (Fitzgerald et al., 2013) which have shown the potential benefits of distributed leadership in supporting health service improvement in the face of wider bureaucratic and resource constraints. However, the pockets of distributed leadership identified in Bophelo hospital were mostly concentrated among mid-level leaders and frontline workers. In contrast, there were few reported experiences of collaboration, between middle and senior leadership levels and within the senior leadership team. Yet there were a wide range of hospital meetings that sought to create spaces for delegated authority, improve collaboration and support collective decision-making across all levels. Certainly, in other hospitals in the province, meetings have been found to be spaces of collaboration and interprofessional problem-solving between middle and senior managers (Okello, 2021) and amongst senior managers (Patel, 2022).

In addition to exploring signs of distributed leadership in the hospital, an important contribution of this study are insights on what might support or constrain its emergence. Our initial literature synthesis suggested it is fundamentally a relational practice (*Point C*, Box 1). Insights from Bophelo Hospital confirm that relational leadership practices, which are concerned with interpersonal and relationship processes such as collaboration, empowerment, trust and empathy (Cummings et al., 2010; Johnson et al., 2021), are critical enablers of distributed leadership. In this hospital, these practices were expressed as notions of caring, connecting and empathy and were linked to all the pockets of distributed leadership observed in the study. Similarly, in a multiple case study that sought to determine the impact of distributed leadership on

health service improvement in the UK, Fitzgerald et al. (2013) found that distributed leadership supported service improvement and, critically, was enabled by good relationships.

Furthermore, this study found that the relational leadership practices that enable distributed leadership had a positive reciprocal effect through mutual influence and interdependent actions – themselves defining properties of distributed leadership (*Point C,* Box 1). As found in Bophelo Hospital, such reciprocity creates safe environments wherein leaders can give and receive honest feedback about how they lead and so contribute to continuous learning and development both for individuals and teams. Continuous reflection and learning have also been observed in other settings as critical in developing the dynamic and distributed leadership capabilities needed to lead in complex systems (Cleary et al. 2018; Doherty et al., 2018; Thorpe et al., 2011).

In contrast, as noted by Fitzgerald et al. (2013) and also found in this study, interpersonal conflicts and tensions constrain the emergence of distributed leadership. In Bophelo Hospital, tensions and weak interpersonal relations between the middle and senior leadership levels and within the senior leadership team contributed to low levels of collaboration and connectedness across levels (outside the observed pockets of distributed leadership) despite the multiple meetings aimed at fostering the same, as discussed earlier. These tensions were partly attributed to changes in individuals occupying senior management positions, highlighting the role of individuals in distributed leadership. Indeed, the exercise of individual agency in distributed leadership is often overlooked and, therefore, remains inadequately clarified (Currie and Lockett, 2011). This study shows that by exercising their agency, individual leaders, particularly those in formal management positions, play a crucial role in delegating and shaping hospital leadership – including the extent to which leadership is distributed. They do this through the leadership practices they adopt and enact, which can either support or inhibit the emergence of distributed leadership. The role of formal managers in enabling distributed forms of leadership is also highlighted by Belrhiti et al. (2020), who examined the leadership practices of four successive CEOs in a Moroccan public hospital – showing how hospital CEOs, through their leadership practices, can either support or constrain the emergence of distributed leadership in public hospitals. Studies of district hospital leadership in South Africa (Mathole et al., 2018; Okello, 2021) also underscore the role of senior managers' leadership practices in shaping experiences of leadership and health worker motivation. Therefore, whilst the notion of distributed leadership focuses on the collective, it is important not to ignore the role of individuals within distributed leadership. Indeed, distributed leadership is the 'constellation in which *individual members* play distinct roles and all members work together' (Nzinga et al., 2018: ii28, emphasis added).

Point D (Box 1) characterises distributed leadership as transcending hierarchies – meaning that leadership is not only reserved for certain individuals who are formally appointed to lead. Nevertheless, both in high-income (Currie and Lockett, 2011; Martin et al., 2015) and LMIC (Okello, 2021; Nzinga et al., 2018) settings, power imbalances along bureaucratic and professional hierarchies form a key feature of the context within which leadership unfolds. Such imbalances were observed in this study and were found to be nested within the wider South African health system history and context of hierarchies and silos. Bureaucratically, the South African health system context is often described as a 'pyramid sitting on its head' (Kawonga et al., 2016: 1275) due to the concentration of power at higher ranks, with limited delegations to lower levels (Choonara et al., 2017; Kawonga et al., 2016; Wolvaardt et al., 2013). Professionally, as argued by Gilson and Daire (2011: 74), it is 'underpinned by the particular configuration of power balances…: of consultant over junior doctor, of specialist over generalist, of doctor over nurse, and of provider over patient.'

In Bophelo Hospital, these hierarchies and silos, exacerbated by the growing size of the hospital, organisational re-arrangements and relational tensions between managers, resulted in feelings of disengagement and disconnectedness – a sense that people were working in silos. This undermined the emergence of distributed leadership which is fundamentally about 'connecting leaders across the system in productive ways', as noted by Doherty et al. (2018: ii52). Moreover, those who found themselves at the periphery of these hierarchies felt less empowered to lead. While enjoying legitimacy amongst their peers, informal leaders who emerged to lead teams in response to collectively identified needs found it difficult to navigate the strict bureaucratic protocols and autocratic leadership practices – consequently limiting the spread and impact of innovations and improvement efforts. Yet, as reflected in *Point D* (Box 1), such informal leadership is an important dimension of distributed leadership. In Okello's (2021) study of two district hospitals, informal leaders played a crucial role – acting as champions and bringing teams together. The value of informal leadership in increasing organisations' ability to produce goods and services is also recognised in high-income settings (Marion et al., 2016). Finally, and importantly, we also found that factors related to individual leaders (such as autocratic leadership practices and relational tensions) and factors related to the context (such as hierarchies and silos) interact with each other in complex ways to create features that either support or inhibit the emergence of distributed leadership. These complex interactions are also noted in Aberese-Ako et al. (2018)'s study of district hospital leadership in Ghana, which positioned decision-making as a product both of individual managers' leadership practices and of the context in which they work.

This study's findings have highlighted how the four characteristics of distributed leadership identified in Box 1 can assist in investigating such leadership empirically, although *Point A* should be adapted to

acknowledge the role of individuals in establishing distributed leadership. Ultimately, therefore, to guide future studies and action, we propose that distributed leadership can be defined as:

> *An emergent property of the health system, characterised by the collective endeavour of different individual leaders – both formal and informal – located in multiple parts of the system, but working together to make sense of their environment, develop shared goals and pursue those goals through collaborative and interdependent actions that are underpinned by good interpersonal relationships and autonomy.*

Overall, the study's findings demonstrate the value of distributed leadership in district hospitals, not only in service provision and in response to crises but also, and importantly, in supporting service improvement and innovation. They support the argument that distributed leadership is the 'the fulcrum of policy implementation and system change' (Gilson, 2016: 190), necessary for leading in increasingly complex systems (Cleary et al. 2018; Doherty et al., 2018; Nzinga et al., 2018; Thorpe et al., 2011) and for transforming district hospitals in LMICs (English et al., 2024; Okello, 2021). In addition, the study shows that efforts to nurture distributed leadership and support agency, bottom-up action and collaboration, should both focus on developing the capabilities of individual leaders and include the development of enabling policy frameworks that distribute decision-making power and autonomy more equally than it is currently found in bureaucratic hierarchies (Currie et al., 2009; Nzinga et al., 2021).

Limitations

Although the study focused on only one district hospital, the detailed description of context, comparison with similar studies and use of theory supports the relevance of the findings and the transferability of insights about distributed leadership to similar contexts. The study also had a small sample size of 12 participants, but all core components of the hospital and its three categories of staff were represented. In addition, the point of data saturation was reached after 10 interviews. The possible biases revealed by participants reporting their own leadership practices were limited by triangulating data across participants. Similarly, any biases in data collection and analysis arising from OM being an employee of the WCDHW and knowing some participants were mitigated through reflexive journalling and regular debriefing meetings with LG who is external to the WCDHW.

CONCLUSIONS

The limitations of hierarchical and individualistic leadership practice saw the concept of distributed leadership gain traction in leadership literature, and in LMIC research on public health systems. This study empirically explored distributed leadership in one South African district hospital. It identified pockets of distributed leadership which supported routine service delivery, response to crises and service improvement. It also demonstrated how distributed leadership, supported by enabling leadership practices – empowering, caring and empathetic – can create spaces of engagement and collaboration in the face of wider contextual constraints. Efforts to nurture distributed leadership in district hospitals should, therefore, consider the leadership practices of individual leaders, especially those in formal management positions, as well as the context – distributing decision-making power more equally and addressing bureaucratic and professional hierarchies. The further research needed to develop and test interventions to support distributed leadership development can draw from this study.

NOTES

[i] For the purposes of thesis examination, the student is the first and sole author of the article.

[ii] See Appendix B for journal manuscript guidelines.

[iii] Hybrid managers who lead/manage clinical departments but also do some clinical work. e.g. head of internal medicine (medical specialist) and radiography assistant director.

[iv] Student (OM) and supervisor (LG)

[v] Some of the documents (Phase 1 data) listed in the table and cited in the findings are not available in the public domain. Therefore, although cited, they are not formally referenced to protect anonymity and confidentiality.

REFERENCES

Aberese-Ako M, Agyepong IA, van Dijk H. 2018. Leadership styles in two Ghanaian hospitals in a challenging environment. *Health Policy and Planning* **33**: ii16-ii26.

Alliance for Health Policy and Systems Research. 2016. *Open mindsets: Participatory leadership for health*. Geneva: World Health Organization.

Bateman C. 2013. Health leadership training academy tackles worst first. *South African Medical Journal* **103**: 707-708.

Belrhiti Z, Van Damme W, Belalia A, Marchal B. 2020. Unravelling the role of leadership in motivation of health workers in a Moroccan public hospital: A realist evaluation. *BMJ Open* **10**: e031160.

Bolden R. 2011. Distributed leadership in organizations: A review of theory and research. *International Journal of Management Reviews* **13**: 251-269.

Bosongo S, Belrhiti Z, Ekofo J, Kabanga C, Chenge F, Criel B, Marchal B. 2023. How capacity building of district health managers has been designed, delivered and evaluated in sub-Saharan Africa: A scoping review and best fit framework analysis. *BMJ Open* **13**: e071344.

Brown MH, Hosking DM. 1986. Distributed leadership and skilled performance as successful organization in social movements. *Human Relations* **39**: 65-79.

Chee G, Pielemeier N, Lion A, Connor C. 2013. Why differentiating between health system support and health system strengthening is needed. *The International Journal of Health Planning and Management* **28**: 85-94.

Choonara S, Goudge J, Nxumalo N, Eyles J. 2017. Significance of informal (on-the-job) learning and leadership development in health systems: lessons from a district finance team in South Africa. *BMJ Global Health*, **2**: e000138.

Cleary S, Toit AD, Scott V, Gilson L. 2018. Enabling relational leadership in primary healthcare settings: Lessons from the DIALHS collaboration. *Health Policy and Planning* **33**: ii65-ii74.

Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. 2009. The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, **374**: 817-834.

Cummings GG, Spiers JA, Sharlow J, Germann P, Yurtseven O, Bhatti A. 2013. Worklife improvement and leadership development study: a learning experience in leadership development and 'planned' organizational change. Health Care Management *Review* **38**: 81–93.

Currie G, Lockett A, Suhomlinova O. 2009. Institutional limitations on distributed leadership in complex organizations: A 'catch 22'in English public services. *Human Relations* **60**: 341-370.

Currie G, Lockett A. 2011. Distributing leadership in health and social care: Concertive, conjoint or collective?. *International Journal of Management Reviews* **13**: 286-300.

Daire J, Gilson L, Cleary S. 2014. *Developing leadership and management competencies in low and middle-income country health systems: A review of the literature*. Cape Town: Resilient and Responsive Health Systems (RESYST).

Daire J, Gilson L. 2014. Does identity shape leadership and management practice? Experiences of PHC facility managers in Cape Town, South Africa. *Health Policy and Planning* **29**: ii82-ii97.

De Savigny D, Adam T (Eds). 2009. *Systems thinking for health systems strengthening*. Geneva: World Health Organization.

Doherty J, Gilson L, Shung-King M. 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**: ii50-ii64.

Edmonstone J. 2018. Leadership development in health care in low and middle-income countries: is there another way?. *The International Journal of Health Planning and Management* **33**: e1193-e1199.

English M, Lanata CF, Ngugi I, Smith PC. 2006. The district hospital. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, … Musgrove P (Eds). *Disease Control Priorities in Developing Countries*. 2nd edn. Washington (DC): The World Bank.

English M, Rispel L, Ssengooba F, Edwards N. 2024. Breaking the silence on first referral hospitals and universal health coverage. *The Lancet Global Health* **12**: e366-e367.

Fitzgerald L, Ferlie E, McGivern G, Buchanan D. 2013. Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly* **24**: 227-239.

Fitzsimons D, James KT, Denyer D. 2011. Alternative approaches for studying shared and distributed leadership. *International Journal of Management Reviews* **13**: 313-328.

Gilson L (Ed). 2012. *Health policy and system research: a methodology reader*. Alliance for Health Policy and Systems Research, World Health Organization.

Gilson L, Agyepong IA. 2018. Strengthening health system leadership for better governance: What does it take?. *Health Policy and Planning* **33**: ii1-ii4.

Gilson L, Daire J. 2011. Leadership and governance within the South African health system. In: Paradath A, English R (Eds). *South African Health Review 2011*. Durban: Health Systems Trust, 69-80.

Gilson L, Pienaar D, Brady L, Hawkridge A, Naledi T, Vallabhjee K, Schneider H. 2017. Development of the health system in the Western Cape: Experiences since 1994. In: Paradath A, Barron, P (Eds). *South African Health Review 2017.* Durban: Health Systems Trust, 59-69.

Gilson L, Vallabhjee K, Naledi T, Brady L, Hawkridge A, Pienaar D, Schneider H. 2024. Examining sustained sub-national health system development: experience from the Western Cape Province, South Africa, 1994–2016. *Health Policy and Planning* **39**: 1087-1098.

Gilson L. 2016. Everyday politics and the leadership of health policy implementation. *Health Systems & Reform* **2**: 187-193.

Govender S, Gerwel Proches CN, Kader A. 2018. Examining leadership as a strategy to enhance health care service delivery in regional hospitals in South Africa. *Journal of Multidisciplinary Healthcare* **11**: 157-166.

Gronn P. 2002. Distributed leadership as a unit of analysis. *The leadership Quarterly* **13**: 423-451.

Guest G, Bunce A, Johnson L. 2006. How many interviews are enough? An experiment with data saturation and variability. *Field methods* **18**: 59-82.

Günzel-Jensen F, Jain AK, Kjeldsen AM. 2018. Distributed leadership in health care: The role of formal leadership styles and organizational efficacy. *Leadership* **14**: 110-133.

Hennink M, Kaiser BN. 2022. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine* **292**: 114523.

Jeffries Mazhar R, Willows TM, Bhattarai S, Tinn CS, Misago N, English M. 2024. First referral hospitals in low-and middle-income countries: The need for a renewed focus. *Health Policy and Planning* **39**: 224-232.

Johnson O, Sahr F, Begg K, Sevdalis N, Kelly AH. 2021. To bend without breaking: a qualitative study on leadership by doctors in Sierra Leone. *Health Policy and Planning* **36**:1644-1658.

Kawonga M, Blaauw D, Fonn S. 2016. The influence of health system organizational structure and culture on integration of health services: the example of HIV service monitoring in South Africa. *Health Policy and Planning* **31**: 1270-1280.

Lembani M, de Pinho H, Delobelle P, Zarowsky C, Ager A. 2015. *Health systems resilience: A systems analysis*. Project report. https://www.academia.edu/download/87080718/health-systems-resilience_eastern-cape-case-study_final-report.pdf

Lincoln YS, Guba EG. 1985. *Naturalistic inquiry*. Newberry Park, CA: Sage Publications.

Marion R, Christiansen J, Klar HW, Schreiber C, Erdener MA. 2016. Informal leadership, interaction, cliques and productive capacity in organizations: A collectivist analysis. *The Leadership Quarterly* **27**: 242-260.

Martin G, Beech N, MacIntosh R, Bushfield S. 2015. Potential challenges facing distributed leadership in health care: Evidence from the UK National Health Service. *Sociology of Health & Illness* **37**: 14-29.

Mathole T, Lembani M, Jackson D, Zarowsky C, Bijlmakers L, Sanders D. 2018. Leadership and the functioning of maternal health services in two rural district hospitals in South Africa. *Health Policy and Planning* **33**: ii5-ii15.

Morse JM. 2015. Data were saturated… *Qualitative Health Research* **25**: 587-588.

Munezhi M, Hammad N. 2021. Ethical health leadership: Lessons from low-and middle-income countries during COVID-19. *Healthcare Management Forum* **34**: 62-67.

Musinguzi C, Namale L, Rutebemberwa E, Dahal A, Nahirya-Ntege P, Kekitiinwa A. 2018. The relationship between leadership style and health worker motivation, job satisfaction and teamwork in Uganda. *Journal of Healthcare Leadership* **10**: 21-32.

Mutale W, Vardoy-Mutale AT, Kachemba A, Mukendi R, Clarke K, Mulenga D. 2017. Leadership and management training as a catalyst to health system strengthening in low-income settings: Evidence from implementation of the Zambia Management and Leadership course for district health managers in Zambia. *PLoS One* **12**: e0174536.

Nzinga J, Boga M, Kagwanja N, Waithaka D, Barasa E, Tsofa, B, … Molyneux S. 2021. An innovative leadership development initiative to support building everyday resilience in health systems. *Health Policy and Planning* **36**: 1023-1035.

Nzinga J, McGivern G, English M. 2018. Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. *Health Policy and Planning* **33**: ii27-ii34.

Okello DRO. 2021. The leadership trinity: Examining the interplay between healthcare organisational context, collective leadership and leadership effectiveness in the health sector - a multiple case study of district hospitals in the Western Cape province, South Africa. PhD thesis. University of Cape Town.

Olivier J, Whyle E, Gilson L. 2018. *Embedded health policy and systems research: within the system, for the system, used by the system*. Technical brief for the Alliance for Health Policy and Systems Research. https://ahpsr.who.int/publications/i/item/embedded-health-policy-and-systems-research

Olmos-Vega FM, Stalmeijer RE, Varpio L, Kahlke R. 2022. A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher* **45**: 241–251.

Patel B. 2022. Exploring the contribution of a leadership development program on the implementation of improvement projects at a South African central hospital. PhD thesis. University of Cape Town.

Robson C. 2002. *Real world research: A resource for social scientists and practitioner-researchers*. 2nd edn. Oxford: Blackwell Publishers.

Smith BA. 1999. Ethical and methodologic benefits of using a reflexive journal in hermeneutic-phenomenologic research. *Image: The Journal of Nursing Scholarship*, **31**: 359-363.

Thomas A, Chataway J, Wuyts M (Eds). 1998. *Finding out fast: investigative skills for policy and development*. California: Sage Publications.

Thorpe R, Gold J, Lawler J. 2011. Locating distributed leadership. *International Journal of Management Reviews* **13**: 239-250.

Vallabhjee K, Gilson L, Davies MA, Boulle A, Pienaar D, Reagon G, … Cloete K. 2021. Reflections on the health system response to COVID-19 in the Western Cape Province. In: Govender K, George G, Padarath A, Moeti T (Eds). *South African Health Review 2021*. Durban: Health Systems Trust,173-187.

Western Cape Department of Health and Wellness. 2014. *Healthcare 2030: The road to wellness*. https://www.westerncape.gov.za/assets/departments/health/healthcare2030_0.pdf

Wolvaardt G, Johnson S, Cameron D, Botha B, Kornik S. 2013. Challenges and constraints at district management level. In: English R, Padarath A (Eds). *South African Health Review 2013*. Durban: Health Systems Trust, 81-92.

World Health Organization. 2007. *Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organisation

Yin RK (Ed). 2004. *The case study anthology*. California: Sage Publications.

Yin RK. 2009. How to do better case studies. In Bickman L, Rog DJ (Eds). *The SAGE Handbook of Applied Social Research Methods*. 2nd edn. California: Sage Publications, 254-282.

PART B: RESEARCH APPENDICES[6]

Appendix A: Research Protocol

INTRODUCTION

From the classic World Health Organisation (WHO) health system building blocks (WHO, 2007) to health systems strengthening (Alliance for Health Policy and Systems Research, 2016; Chee et al., 2013; De Savigny and Adam, 2009), leadership (and governance) has been widely recognised as a critical component of any health system and a necessary ingredient for well-functioning health systems. Scholars have established links between leadership and both specific and broader health system issues, such as health worker satisfaction and motivation (Belrhiti et al., 2019; Musinguzi et al., 2018; Okello, 2021) and health systems performance (Bosongo et al., 2023; Nzinga et al., 2018), respectively. Chee and colleagues (2013) argue that 'weak' leadership at multiple system levels is a common feature of 'weak' health systems. Underscoring the critical role of leadership in strengthening health systems, Frenk (2010: 2) suggests that 'the most complex challenge in health systems is to nurture persons who can develop the strategic vision, technical knowledge, political skills, and ethical orientation to lead the complex processes of policy formulation and implementation. Without leaders, even the best designed systems will fail.' Notwithstanding McDonald's (2014) warning against viewing leadership and leadership development as a silver bullet to every health system challenge, it is clearly important to think about leadership and ways to develop leadership in efforts to strengthen health systems and improve their performance.

As Gilson and Agyepong (2018) point out, there is a limited knowledge base on health leadership in LMICs. However, the limited available literature on health leadership in LMICs paints a picture of generally 'weak' leadership, including weaknesses at the district health system (DHS) level (Bosongo et al., 2023; Edmonstone, 2018; Munezhi and Hammad, 2021; Mutale et al., 2017; Nzinga et al., 2018), but with some positive leadership experiences (Daire and Gilson, 2014; Mathole et al., 2018; Okello, 2021; Patel, 2022). The DHS, which 'consists of a large variety of inter-related elements that contribute to health in homes, schools, workplaces and communities' (WHO, 1988: 9), is a critical part of national health systems. It has been argued, for example, to be central to achieving universal health coverage (Meessen and Malanda, 2014; Tangcharoensathien et al., 2018; Tumusiime et al., 2019). Given the importance of the DHS and existing leadership weaknesses, strengthening DHS leadership in LMICs is key for strengthening health systems in these settings.

[6] Parts of the research protocol and other appendices have been redacted to protect anonymity.

BACKGROUND

Leadership and management

Much work has been done to compare and contrast 'leadership' and 'management'. Although there are countless variations of definitions for either concept, there seems to be an agreement that leadership and management are complementary but not the same, and both are important for health systems (Bosongo et al., 2023; Gilson and Daire, 2011; Okello, 2021). Unlike management, which is seen to be more about managing resources, planning, control and consistency (Aberese-Ako et al., 2018; Okello, 2021) leadership is largely understood to be a social process that involves influencing, inspiring, mobilising and motivating people in building and achieving a common vision (Aberese-Ako et al., 2018; Okello, 2021; Patel, 2022). The understanding of health systems as socially constructed, complex and adaptive (Begun, 2003; Sturmberg and Bircher, 2019), with people at the centre (Sturmberg et al., 2010), makes leadership a critical component of any health system and, as already argued, a requirement for well-functioning health systems - something that is widely acknowledged (Agyepong et al., 2018; Alliance for Health Policy and Systems Research, 2016; Chee et al., 2013; De Savigny and Adam, 2009; Johnson et al., 2021; WHO, 2007).

The concept of distributed leadership

Within the leadership literature, there have been increasing efforts and calls to move away from individualistic notions of leadership - where leadership is seen as the function of certain individuals, usually located at the top of the organisation, to more systemic approaches to leadership (Gronn, 2002; Gilson, 2016; Nzinga et al., 2018; Thorpe et al., 2011). This move saw the concept of 'distributed leadership' gain traction in health leadership conversations, as it is seen to provide a more holistic and collective sense of leadership and a 'dynamic, non-linear frame on how people and events interact in organisations' (Nzinga et al., 2018: 28). The sections below discuss the concept of distributed leadership, considering its origins, theoretical underpinnings, practice and challenges.

The idea that leadership may have a 'distributed pattern' can be traced back to the 1950s (Gronn, 2002). However, it was in the 1980s that the notion of distributed leadership gained momentum, through the work of Brown and Hosking (1986). Since then, several similar concepts of leadership have emerged, such as collective, distributive, dispersed, relational (Gronn, 2002), emergent, collaborative (Bolden, 2011), concurrent, co-ordinated (Fitzsimons et al., 2011), shared and co-leadership (Thorpe et al., 2011). Some of these concepts are sometimes used interchangeably (Gronn, 2002; Thorpe et al., 2011). Although Fitzsimons et al., (2011) argue that they are different and using them interchangeably may obscure important theoretical differences, inconsistencies and contradictions, other authors see them as 'variants'

of distributed leadership rather than totally different concepts. Nonetheless, these authors acknowledge the nuances between them and the need to minimise confusions and conflations to maintain the conceptual rigour of distributed leadership and its usefulness as a framework for studying leadership (Bolden, 2011; Currie and Lockett, 2011). Notwithstanding these disagreements, all emerged as a result of the limitations of top-down and individualistic approaches to leadership and all seek to take a more systemic approach to the study and practice of leadership.

A closer look at the attempts made to define distributed leadership reveals common ways of thinking about the notion (see Box 1). Drawing from this synthesis, distributed leadership can be conceptualised as leadership that is collective, relational, collaborative and inclusive. This conceptualisation, which will be used in this study, is not a definitive definition of distributed leadership. As Bolden (2011) argues, any attempt to provide a definitive definition of distributed leadership would fall short of capturing the complexities and contestations in, and about, the concept.

Box 1. A synthesis of common characteristics of distributed leadership

Leadership through the distributed lens is seen as:

- *More than just about individual leaders but rather a collective capacity of the system* (Bolden, 2011; Fitzsimons et al., 2011; Fitzgerald et al., 2013; Okello, 2021; Thorpe et al., 2011; WCDHW, 2014).
- *Relational- involving interpersonal relationships, mutual influence and interdependent actions* (Bolden, 2011; Cleary et al., 2018; Fitzgerald et al., 2013; Günzel-Jensen et al., 2018; Martin et al., 2015; Nzinga et al., 2018; Okello, 2021; Thorpe et al., 2011).
- *Distributed across multiple system levels but connected and collaborative* (Doherty et al., 2018; Fitzsimons et al., 2011; Gronn, 2002; Günzel-Jensen et al., 2018; Martin et al., 2015; Nzinga et al., 2018; WCDHW, 2014)
- *Inclusive- going beyond people in official management positions to include both formal and informal leaders* (Bolden, 2011; Cleary et al., 2018; Doherty et al., 2018; Fitzgerald et al., 2013; Günzel-Jensen et al., 2018; Okello, 2021; WCDHW, 2014).

Importantly also, the context within which leadership unfolds is seen as integral to the practice of leadership (Bolden, 2011; Currie and Lockett, 2011; Fitzgerald et al., 2013; Thorpe et al., 2011). Fitzgerald et al. (2013: 228) conceptualise context as 'a set of interacting influences, which can be analysed at the macro, meso and micro levels'. Neuman (1997) defines the macro level as the national or sub-national context, the meso-level as the institutional context, and the micro level as individuals and interactions between them. The strength of Fitzgerald et al. (2013)'s conceptualisation of context lies in the inclusion of macro and meso levels, which have been often overlooked in the literature on distributed leadership (Martin el., 2015). Both Fitzgerald et al. (2013)'s conceptualisation of context and the conceptualisation of

distributed leadership derived from the literature presented earlier are used, in combination, as a conceptual framework to explore DHS leadership in this study.

Theoretical underpinnings of distributed leadership

The bulk of current empirical and theoretical work on distributed leadership is framed by Peter Gronn's early research on this topic. Gronn (2000) posits that the theoretical roots of distributed leadership lie in two key theories: distributed cognition and activity theory. According to Bolden et al. (2011: 253) distributed cognition 'represents human cognition and experience as integrally bound up with the physical, social and cultural context in which it occurs', while activity theory 'highlights the manner in which human activity is both enabled and constrained by individual, material, cultural and social factors'. Thorpe et al. (2011) build on Gronn's early work and the later ideas of Leithwood et al. (2007) and Iles and Feng (2011) to develop a theory-based framework for future research into distributed leadership (see Figure 1). In this framework, which was later adapted by Martin et al. (2015), Thorpe and colleagues propose two dimensions of thinking about distributed leadership with each dimension representing a continuum. The vertical axis (planned to emergent activities) represents a *continuum of leadership distribution* where on the 'planned' end the distribution of leadership responsibility is formally planned and structured- a minimalist version of distributed leadership according to Gronn (2002). The 'emergent' end of the vertical dimension, on the other hand, represents an emergent and more holistic distribution of leadership that stretches across different contexts and is enabled by tacit understanding, intuition and trust (Thorpe et al., 2011). The horizontal axis represents a *continuum of alignment* where at the 'aligned' end activities are 'seen as having some common aspects, provided in some cases by organizational structure and strategy' and at the 'misaligned' end 'people may be unaware of or unintentionally ignore the activities of others and the potential benefits of sharing aims and interests' (Thorpe et al., 2011:245). The intersection of these axes results in four quadrants as seen in Figure 1 below.

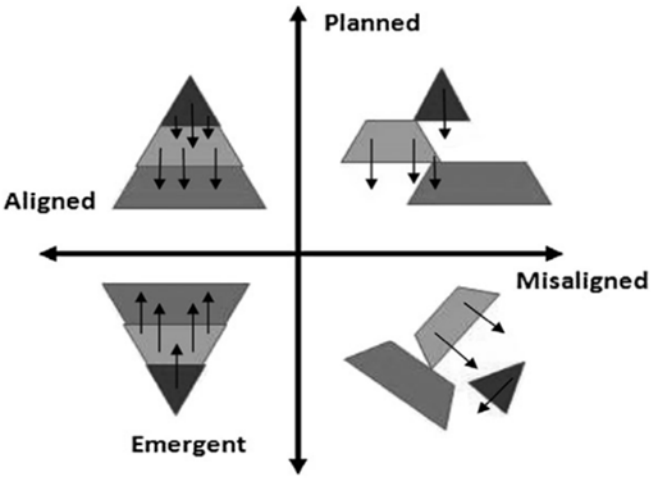

Figure 1. Dimensions of distributed leadership (Source: Thorpe et al., 2011)

The strength of this framework lies in that it enables researchers to explore not just whether there is evidence of distributed leadership in a given organisation but it also, and critically, aids the exploration of *how* leadership is distributed. This is an important consideration because, as Bolden (2011) argues, distributing leadership is not automatically beneficial but it is how leadership is distributed that is more important.

The practice and challenges of distributed leadership

A large portion of literature on distributed leadership emerged from the educational sector, with promising results (Thorpe et al., 2011). In the health sector, distributed leadership first gained traction in the United Kingdom where the National Health Service (NHS) adopted it as a part of its strategy and approach to leadership development (Fitzgerald et al., 2013; Martin el., 2015) and the bulk of the empirical work on distributed leadership in health is concentrated in this part of the world. Evidence from this work points to the potential benefits of distributed leadership in the health sector. For example, a multiple case study investigating the relationship between distributed leadership and service improvement in the English NHS found that distributed leadership facilitates co-ordination of improvement activities across the organisation and enables service improvement (Fitzgerald et al., 2013). In another study, strategic-level stakeholders indicated that distributed leadership is beneficial for improving quality and safety of care, while arguing that it should be complemented with hierarchically based leadership to avoid creating a 'vacuum of authority' (McKee et al., 2013: 3). The comment on the risk of a 'vacuum of authority' reflects wider concerns with distributed leadership in that it may create a situation where everyone is a leader (or there is no leader at all) resulting in challenges such as mixed messages, overlaps and ambiguities in roles,

conflicting messages and demands, and even lack of accountability (Chreim and MacNaughton, 2016; McKee et al., 2013).

Furthermore, evidence from the NHS reveals some barriers to the emergence of distributed leadership in the public health sector and these include national policies and legislation, organisational arrangements and issues of power, such as power imbalances between clinical/non-clinical and hospital/national leaders (Currie and Lockett, 2011; Martin et al., 2015). However, these barriers are not unique to high-income countries. Similar issues were found in studies that sought to examine district hospital leadership through a distributed leadership lens in Kenya (Nzinga et al., 2018) and South Africa (Okello, 2021).

Notwithstanding the concerns and barriers, the concept of distributed leadership highlights the importance of the chains of formal and informal leaders working across the system to achieve shared goals. For example, this sort of leadership is, as Gilson (2016:190) argues, 'the fulcrum of policy implementation and system change.'

The South African health system and health leadership

South Africa is a quasi-federal state with nine provinces. The national department of health (NDoH) is responsible for overall policy formulation and oversight while each of the nine provinces is responsible for implementing national policies, developing provincial health policies and delivering health services to their respective populations (National Health Act 61 of 2003). The health system in South Africa is pluralistic and consists of the public sector (serving the majority of the population) and the private sector that serves the minority of the population who can afford health insurance and those who can afford to pay for healthcare out of pocket (McKenzie et al., 2017).

Similar to other LMIC countries, decentralisation has been a key feature of health system reform efforts in South Africa, resulting in the establishment of the DHS. Conversations about the development of the DHS in the country can be traced back to as early as 1993 (African National Congress, 1994; Owen, 1995) and it has been a central platform of the ruling African National Congress' health policy since 1994 – to support primary health care (PHC) and counter the hospicentric and fragmented nature of the (pre)apartheid South African health system (African National Congress, 1994; Gilson et al., 2017a; Whyle and Olivier, 2023). A typical South African DHS would consist of a district management team, which links the DHS upwards to the provincial management team and downwards to sub-districts. The DHS service platform generally consists of a district hospital, primary care facilities and community-based care services, with down and up referral pathways between the three. The district hospital is a critical component of the DHS, not only clinically but also administratively as district hospitals provide managerial support (especially finance and

supply chain) to primary care facilities within the district and district hospital managers often form part of the sub-district management teams. This makes district hospitals an important entry point to understanding DHS leadership.

Health leadership trends in South Africa are similar to the broader LMIC picture in that there is generally 'weak' leadership, including weaknesses at the DHS level (Coovadia et al., 2009; Daire et al., 2014; Daire and Gilson, 2014; Govender et al., 2018) and pockets of strong leadership in some geographical areas (Mathole et al., 2018; Okello, 2021; Patel, 2022). National efforts to strengthen health leadership have been somewhat inconsistent. For example, in 2012 the NDoH launched the Academy for Leadership and Management in Health Care in efforts to 'overhaul dysfunctional and often inept leadership at public hospitals' (Bateman, 2013: 707). However, ten years later there is almost absolute silence about the Academy or its work. The need to strengthen health leadership in South Africa, especially at the DHS level, is as great today as it was ten years ago- if not greater, given the impact of the COVID-19 pandemic on the health system and the imminent health budget cuts resulting from government spending austerity measures. These health system shocks compound the existing chronic everyday stresses experienced by the South African DHS, such as staff shortages (Fusheini and Eyles, 2016; Mathole et al., 2018; Wolvaardt et al., 2013) and unresponsive supply chain processes (Gilson et al., 2017b; 2020), for example. Together, they reflect the complex, dynamic, challenging and unpredictable nature of health systems, which require not only strong leadership and management competencies (Daire et al., 2014) but also distributed leadership (Gilson, 2016). Given the centrality of the DHS in the South African health system and the existing leadership weaknesses, strengthening DHS leadership is key to strengthening the national health system, supporting policy implementation and achieving system goals.

The Western Cape Department of Health and Wellness (WCDHW)

The Western Cape Department of Health and Wellness (WCDHW) is one of the nine provincial health departments (systems) of South Africa and is thought to be one of the relatively well-performing provincial health systems in the country. For example, it has recently achieved a clean audit outcome for the fifth year in a row and is the only provincial health department in South Africa to achieve this. While acknowledging the influences of historical legacies and other contextual factors, the achievements of WCDHW have been partly attributed to its 'leadership stability and depth' (Gilson et al., 2017a: 63).

The WCDHW sees a 'dynamic and distributed leadership across the ranks of management, clinicians and administration' (WCDHW, 2014: 41) as a key requirement for the realisation of its vision of 'access to person-centred quality care' (WCDHW, 2014: 33) and the envisaged shift from health to wellness, which

underpins its 2030 strategy (WCDHW, 2014). Similar to the NHS (Fitzgerald et al., 2013; Martin el., 2015), the WCDHW has explicitly adopted, and sought to develop, distributed leadership to achieve set health system goals. In 2014, the WCDHW published its 2030 long term strategy document- *Healthcare 2030: The Road to Wellness*. The Healthcare 2030 document underscores the central role that distributed leadership is envisaged to play in enabling the provincial health system to realise both its vision and 2030 strategic goals.

Since the publication of Healthcare 2030, the WCDHW has invested both energy and resources in efforts to develop distributed leadership across all levels of the provincial health system, with a particular focus on frontline leadership. For example, a provincial health system leadership and management development strategy was developed in 2016. During the 2021/2022 financial year, a total of 676 WCDHW employees undertook leadership and management development interventions, ranging from two-year university postgraduate diplomas to short courses and conferences spanning a few days (WCDHW, 2023). Currently, the provincial health system has set-up a contract arrangement called the Leadership Panel of Services that enables its employees to access leadership and management development services such as 360-degree leadership assessments and change management training (WCDHW, n.d.).

Despite WCDHW's explicit intention to develop distributed leadership, and the subsequent resource investments, there is little evidence about the extent to which this intention has been realised. To date, only one study in the Western Cape, and South Africa, explored district hospital leadership through a distributed lens (using the concept of collective leadership), in 'examin[ing] the interplay between organisational context, leadership practices, and staff satisfaction and morale' (Okello, 2021: 7). The study offers some important insights about potential barriers and enablers to distributed leadership in a WCDHW district hospital. The proposed study, therefore, builds on Okello's and other's work by conducting a theory-driven exploration of the emergence of distributed leadership in a WCDHW district hospital. Given its important role in the DHS, and the WCDHW's focus on frontline leadership, the district hospital will be used as an entry point to explore the emergence of distributed leadership in WCDHW's DHS.

RESEARCH QUESTION

Against the above background, this study seeks to answer the following research question and sub-questions:

- What are the barriers and enablers to the emergence of distributed leadership in a district hospital of the Western Cape Government Health and Wellness (WCDHW)?

a) How is distributed leadership framed by actors at different levels of the Western Cape provincial health system?

b) Is there evidence of distributed leadership currently at the hospital, and if so, how is leadership distributed and what are the possible consequences?

c) What has supported or inhibited the emergence of distributed leadership in this district hospital in the last ten years?

The objective of the first sub-question (*a*) is to explore how different actors (e.g., policymakers, strategic and operational managers, healthcare practitioners) at the different system levels (provincial, district, hospital) frame distributed leadership. It is hypothesised that how distributed leadership is understood and framed by different actors will have some form of influence on its emergence. The second sub-question (*b*) firstly draws on the earlier conceptualisation of distributed leadership to search for evidence of distributed leadership. In the case that there is some evidence of distributed leadership at the hospital, then the sub-question moves on to explore how leadership is distributed, drawing mainly on the dimensions of distributed leadership framework, and possible consequences. Additionally, in the case where the study finds evidence of distributed leadership at the hospital, sub-question (*c)* will explore the factors that supported its emergence. However, the possibility that there might be no evidence of distributed leadership at the hospital is also recognised, and in this case sub-question (*c*) will explore factors that inhibited its emergence. Widening the focus of the last sub-question (*c*) from current to a ten-year period will allow the study to explore the period since the publication of the Healthcare 2030 strategy document, which marks the formal adoption of distributed leadership as a strategic lever to achieving WCDHW's vision and goals and the beginning of intentional efforts to develop such leadership. The three sub-questions are envisaged to contribute to answering the main research question and achieving the overall aim of the study which is to explore the barriers and enablers to the emergence of distributed leadership in a district hospital of the Western Cape Government Health and Wellness.

RESEARCH PURPOSE AND DESIGN

The purpose of this study is explorative. An explorative purpose has been adopted due to the limited body of work on the nature of health leadership in LMICs and the complexity of the concept of distributed leadership. Even fewer studies have specifically examined DHS leadership in LMICs. As a result, health leadership is still a little-understood phenomenon in LMIC health systems, especially at the DHS level. According to Robson (2002: 59), exploratory research is well-suited for 'find[ing] out what is happening, particularly in-little understood situations'. Furthermore, exploratory research aims to study 'phenomena

in new light' (Robson, 2002: 59). This aim aligns with this study as it seeks to explore health leadership through the distributed leadership lens - a relatively new approach to empirical inquiry into health leadership in LMICs. It is also envisaged that this initial exploratory study will provide a platform for more detailed future work.

A flexible research design will be used to achieve the research purpose and is appropriate given the dynamic nature of distributed leadership itself (changing and adapting in response to the environment) (Thorpe et al., 2011). The tight pre-specifications associated with fixed designs (Gilson, 2012) would make it difficult to sufficiently capture new and emerging insights anticipated with an exploration of such a dynamic and social process. The research methods that will be used in the study are described in detail below.

SUB-STUDY ARRANGEMENT

This study is nested within a broader collaborative project by the WCDHW and health policy and systems (HPSR) researchers from the Universities of Cape Town and the Western Cape. The project builds on a previous 20-year review (1994-2014) of the development of the provincial health system in the Western Cape (see Gilson et al., 2017a) and aims to evaluate the Healthcare 2030 strategy. The evaluation project will consist of a retrospective evaluation, focusing on the period from 2015 to 2023/2024, and a prospective evaluation that will focus on the period from 2024/2025 onwards. The lessons from the evaluation of Healthcare 2030 will guide the development of WCDHW's next long-term strategy (2045).

As part of the broader evaluation project, cases of key interventions outlined in Healthcare 2030 will be explored to understand the experiences of the implementation of the Healthcare 2030 strategy. This sub-study lands itself within the retrospective phase of the evaluation project and contributes to this project by exploring the emergence of distributed leadership, as a key strategic intent, to deepen the understanding of the implementation of the broader Healthcare 2030 strategy and guide both the development and implementation of the 2045 strategy.

METHODS

Overarching research strategy

This research will be a single case study. A case study was chosen as the overarching strategy for three main reasons. Firstly, context is critical to the understanding of distributed leadership (Thorpe et al., 2011) and forms part of the conceptual framework guiding this study. According to Yin (2004), a case study is essentially an empirical study of a phenomena in context, drawing from multiple sources of evidence. Thus, employing a case study strategy will enable the empirical inquiry of distributed leadership (the

phenomenon) as it unfolds within its context, while the multiple sources of evidence will enable the generation of contextually rich insights and allow for data triangulation. Second, the case study strategy has been found to be useful in explorative studies and flexible designs (Gilson, 2012; Robson, 2002). This creates an alignment between the purpose, design and strategy of this study. Thirdly, this strategy has been found to be helpful in answering the 'what' and 'how' questions that characterise this study (Okello, 2021; Schneider and Nxumalo, 2017). One of the criticisms against case studies is that they lack rigour (Rowley, 2002). However, there are several principles and processes that can be adopted and followed to ensure rigour for case study research, and these are discussed in detail in the rigour section.

One of the important decisions to make in designing case study research is to choose between a single-case and multiple-case strategies (or designs). According to Yin (2009), the two designs are a 'primary distinction in designing case studies'. For this research, a decision was made to conduct a single case study. Single case studies enable researchers to explore a phenomenon in great detail, focusing on interrelationships and interactions within the phenomenon to understand how and why something happens or does not happen (Thomas et al., 1998). Thus, a single case study is suitable for this research as we seek to understand, in detail, the emergence of distributed leadership in a WCDHW district hospital. Moreover, a single case study seems appropriate as this project is timebound (due to resources and academic requirements) which might make it difficult to conduct a multiple case study in sufficient detail and, therefore, risk losing the richness and detail that characterises good case study research. However, as mentioned earlier, it is envisaged that this study will serve as a platform for future research work on this topic.

The case

One of the critical steps in designing good case study research is the identification of 'the case'. A clearly defined case, together with well framed research questions, helps in defining the parameters of the research (Yin, 2009). This is important to ensure that the research is contained within the appropriate scope considering available resources, time and, in the instance of this study, academic requirements. According to Yin (2009), a case can be a single individual, a group of individuals or an event/entity such as decisions, programmes, organisational change or implementation process. This study will focus on the emergence of distributed leadership in a WCDHW district hospital as part of the wider organisational culture change journey of the provincial health system- seeking to understand whether and how distributed leadership has emerged and what has supported or inhibited its emergence. The identified case, therefore, is: *the emergence of distributed leadership in Bophelo Hospital*.

The context

Our understanding of leadership as a social process makes the context within which leadership unfolds integral to understanding and doing leadership (Thorpe et al., 2011). Additionally, context is a defining feature of case study research. As such, context is a critical part of both the phenomenon of interest in this study and the chosen strategy. This study has adopted Fitzgerald et al. (2013: 228)'s conceptualisation of context as 'a set of interacting influences, which can be analysed at the macro, meso and micro levels'. For the purposes of this study, the macro level refers to the provincial health system (WCDHW), the meso level refers to Bophelo Hospital and the micro level refers to the individual actors within the hospital. In other words, this is a meso level study, that also considers how macro and micro contextual factors influence the emergence of distributed leadership. Two types of influences will be considered: negative influence, which relates to factors that inhibit the emergence of distributed leadership and positive influence, which relates to factors that support(ed) the emergence of distributed leadership. These two types of influences align with the study's research question. Some of the contextual factors found to influence the emergence of distributed leadership in other settings, as identified in the literature, include professional hierarchies, national policies, organisational arrangements, power practices and relationships.

Theoretical and conceptual framing

The use of theoretical and conceptual frameworks can assist in designing and conducting a good case study. The use of theory is one of the strategies recommended to improve the rigour of a case study (Gilson, 2012), and the advantages of using conceptual frameworks include enabling better management of the scope/size of the research and strengthening analytical generalisability (Yin, 2004). This study will use both a theoretical framework and a conceptual framework to guide data collection and analysis.

Anfara and Mertz (2014: 15) define a theoretical framework as 'any empirical or quasi-empirical theory of social and/or psychological processes, at a variety of levels (e.g. grand, midrange, explanatory), that can be applied to the understanding of phenomena.' It provides a particular 'lens' through which a researcher can examine phenomena (Anfara and Mertz, 2014; Luft et al., 2022) and it influences the types of questions asked, the data collected and the interpretation of those data (Luft et al., 2022). Thorpe et al., (2011)'s dimensions of distributed leadership (Figure 1) is used as a theoretical framework (see above section on 'theoretical underpinnings of distributed leadership' for more details) in this study. This framework was chosen as it synthesises foundational theories (Gronn, 2002) and more recent thinking (Iles and Feng, 2011; Leithwood et al., 2007) to provide a lens through which researchers can study distributed leadership. Key to this framework is that it understands distributed leadership as a social process, with context integral to

its practice and understanding, and as an *emergent* property of various exercises of influence (Thorpe et al., 2011). This understanding is what drives the main research question in this study and further informs the researchers' understanding of distributed leadership and its relationship with context, which is captured in the conceptual framework.

Simply put, a conceptual framework is a description of the researcher's understanding of the factors involved in the study and how they relate to one another (Luft et al., 2022). It draws from relevant literature to explain key concepts in the study and the presumed relationships between them (Rocco and Plakhotnik, 2009). The conceptual framework that will be used in this study is drawn from the conceptualisation of distributed leadership, as synthesised from the literature (see Box 1.) and Fitzgerald et al. (2013)'s conceptualisation of context, and is further informed by the chosen theoretical framework. The resulting framework, referred to as the '*distributed leadership in situ*' framework (see Figure 2 below), posits that macro, meso and micro contextual factors are open to, and interact with, each other and combine to influence the hospital leadership (including whether or not it is distributed and how it is distributed). The conceptual framework is of direct relevance to all three sub-questions (*a*, *b* and *c*).

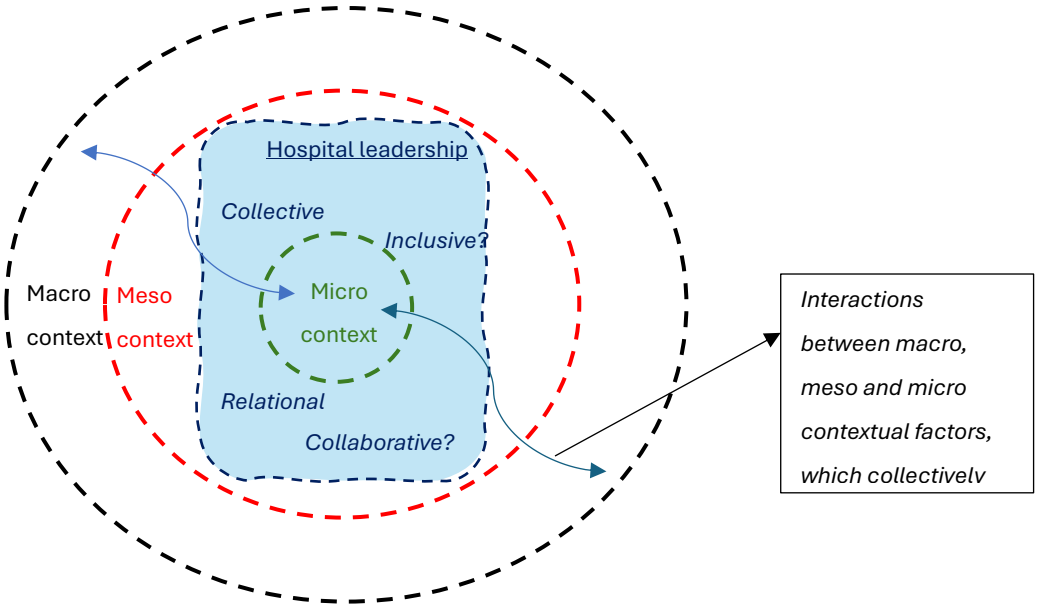

Figure 3. Distributed leadership in situ framework

Site selection and study setting

As mentioned, *the emergence of distributed leadership in Bophelo Hospital* is the case in this study. Bophelo Hospital was selected as the 'case site' for purposive and pragmatic reasons. Bophelo Hospital is located in the X district of the WCDHW, and it is the only district hospital in this geographic area. It presents

a useful site for studying the emergence of distributed leadership as it does not have particular 'outlier' characteristics, thus providing an opportunity for understanding distributed leadership in other similar district hospitals in the region. Yin (2009) refers to such cases as the representative or typical case. Further, Thomas et al. (1998) explains that in instances where there are no specific criteria for case [site] selection, a case may be selected for pragmatic reasons such as access. The researcher (OSM) is currently employed as quality manager in the WCDHW. Pragmatically, selecting Bophelo Hospital as the case site will enable improved research access (more on the embedded approach below), something that Thomas et al. (1998, pg.321) refers to as 'the one next door'.

Bophelo Hospital is a 300-bed large district hospital and it is geographically located in the X sub-district of the X DHS. The hospital's acute package of care includes emergency medicine, clinical forensic services, internal medicine, paediatric care, psychiatry, obstetrics and gynaecology, general surgery, orthopaedic surgery and anaesthetics. These services are supported by a range of diagnostic, therapeutic, social and nursing services. The above care services are further supported by a range of on-site cooperate support services such as finance, supply chain management, people management and facilities management.

In terms of its management structure, Bophelo Hospital has a hospital executive committee that comprises a nursing services manager, medical services manager and deputy directors for finance/supply chain management and people management/facility management. The four managers report to the hospital chief executive officer (CEO) who is the accounting officer for the hospital. Bophelo's CEO reports to the X DHS director, who is WCDHW's accounting officer for public healthcare services in the area and forms part of the WCDHW's senior management team. Importantly, Bophelo Hospital has identified embedding good governance and values-driven leadership as one of its strategic goals for the 2023/2024 financial year and has adopted distributed leadership as one of the strategies to achieve this goal (Bophelo Hospital, 2023). This further supports the suitability of Bophelo Hospital as the case site as they have explicitly adopted and sought to develop distributed leadership, in alignment with WCDHW's Healthcare 2030 strategy. Resultantly, the results of this study are expected to be of relevance to the hospital as they will provide feedback relevant to their strategic goals and efforts.

Data sources and data collection

As mentioned, one of the key characteristics of case studies is that they use multiple sources of evidence in assessing a phenomenon (Yin, 2004). This study will integrate multiple sources of evidence in seeking to understand both the *what* and *how* of leadership at Bophelo Hospital and the context within which the practice of leadership in this hospital unfolds. Data collection for this study will be in two sequential, but

overlapping, phases as depicted in Figure 3 below. The two phases of data collection will be further supported by reflexive journalling, which will, itself, form part of data collection.

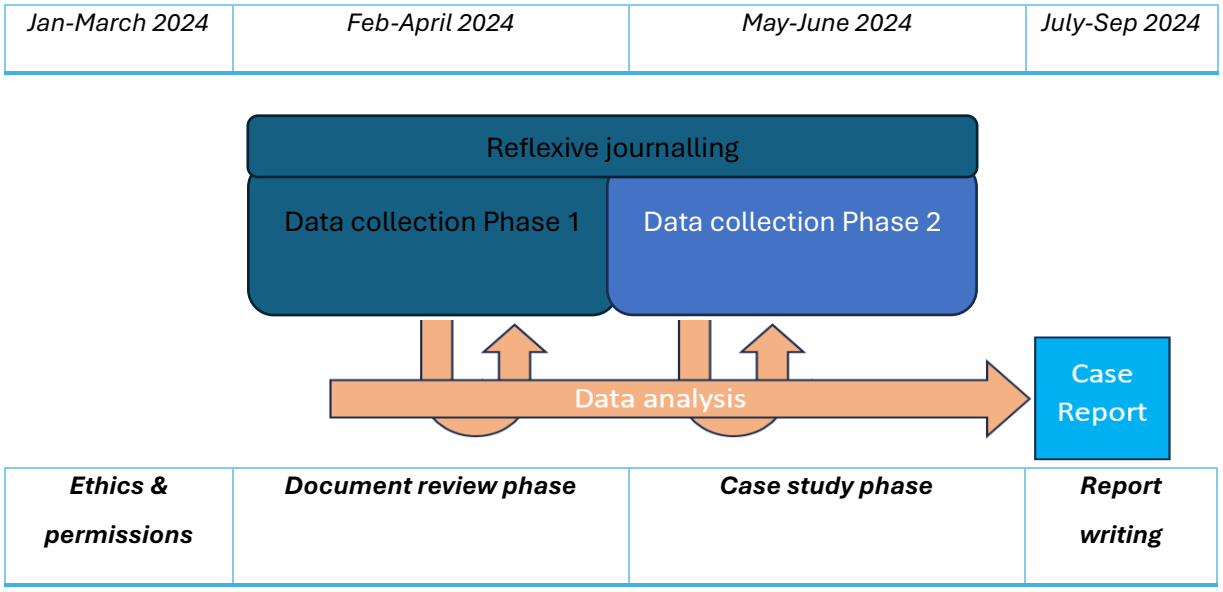

Figure 4. Overall research strategy with timelines

Phase 1: Document review

The first phase of data collection will consist of a document review. Policies and strategic documents related to health leadership, management and governance at the provincial, district/sub-district and hospital levels will be reviewed. The staff satisfaction and Barret Values surveys reports for the province, district/sub-district and hospital will also be reviewed. The review will focus on the past ten years. The aim of phase one is to gain initial understanding of the macro, meso and micro contextual factors that shape leadership at Bophelo Hospital and to guide phase two of data collection.

Phase 2: Participant and key informant interviews

The second phase will consist of face-to-face in-depth semi-structured interviews with hospital staff and key informants outside the hospital. In-depth interviews are a common data collection method in qualitative research, and case studies more specifically. We have chosen this method because of its ability to elicit subjective perspectives, experiences and conceptions (McGrath et al., 2019). This will enable us tease out participants' understanding, framing, experiences and practice of leadership to generate insights on whether, and how, leadership is distributed at Bophelo Hospital and the enabling/constraining factors (relevant to all three sub-questions). This phase will also be used to explore micro-contextual factors (relating to individual persons) in more depth, which may be difficult to do from a document review.

Purposeful sampling will be used to select participants for interviewing. Purposeful sampling is commonly used in qualitative research as it enables the 'identification and selection of information-rich cases related to the phenomenon of interest' (Palinkas et al., 2015: 1). The specific strategy that will be used is heterogeneous sampling. Heterogeneous sampling allows the researchers to explore and capture a wide range of perspectives and, therefore, understand the phenomenon of interest from different viewpoints (Robson, 2014). This is important for the objectives of this study, one of which is to understand how different actors at different systems levels understand and frame [distributed] leadership. The following principles, derived from the conceptual and theoretical frameworks and insights from the documents reviewed, will guide sampling of the initial participants and key informants for interviewing:

- *Hospital level data should reflect the experiences of participants in formal management positions and those who do not occupy management positions (frontline voices)*
- *Hospital level data should reflect different professional perspectives (e.g., not only doctors or nurses)*
- *Contextual considerations should reflect micro, meso and macro level perspectives.*
- *Perspectives from different demographic groups should be included (e.g., sex, age, years of experience, years working at Bophelo Hospital)*

Participants from Bophelo Hospital and key informants outside Bophelo will be interviewed (see Table 1). More participants may be needed or identified; in which case they will be approached for participation. The interviews will be anonymous, audio-recorded (with consent) and transcribed. In terms of duration, each interview is expected to take approximately 45 minutes to one hour. Hospital staff will be interviewed at the hospital and key informants will be interviewed at their respective offices. Interview guides (Appendix C for hospital participants and key informants who previously worked at the hospital, and Appendix D for other key informants) will be used to guide the interviews and will be piloted with or checked by at least two non-participating health workers before data collection. In line with the flexible study design, the interview guides may change slightly based on insights from phase one.

Table 1. Initial sources of data

Document review	Interviews
Provincial health policies and strategies relevant to leadership, governance and management	WCDHW HOD or senior manager responsible for strategy (Key informant)

WCDHW annual performance plans, reports and relevant strategic documents	Metro district manager (Key informant)
Metro district health plans and reports	X DHS manager (key informant)
X DHS annual operational plans and reports	Bophelo Hospital executive committee (5)
Bophelo Hospital annual operational plans and reports	Bophelo Hospital frontline staff (1 HOD, 1 ward manager, 1 doctor, 1 nurse, 1 allied health worker and 1 corporate admin support worker)
WCDHW Barret Values and Staff Satisfaction surveys reports	Bophelo Hospital former medical services manager (key informant)
Literature relevant health leadership, governance and management in the Western Cape province	Bophelo former medical specialist (Key informant)

Data analysis

Data analysis will begin during phase one of data collection and run concurrently with data collection, thereby allowing necessary adaptations to the data collection strategy based on insights emerging from analysis; and it will conclude after data collection phase two. The overarching data analysis approach proposed in this study is based on Braun and Clarke (2021) 's reflexive thematic analysis (RTA). This approach is chosen for three reasons. Firstly, it lands itself within the explorative qualitative research tradition (Morrow, 2007), which aligns with this study's overarching purpose and design. Secondly, RTA puts reflexivity, an important aspect of rigour, at the centre of data analysis by focusing the inquiry on the participants' experiences while promoting active awareness and recognition of the researcher's positionality and influence on the research process (Byrne, 2022; Clarke and Braun, 2013). Thirdly, RTA adopts a combination of both deductive and inductive analyses (Braun and Clarke, 2019, 2021; Clarke and Braun, 2013). This approach will allow the researcher to analyse the data deductively using the conceptual and theoretical frameworks presented earlier as analytic tools while also looking for, and allowing, any emerging themes (inductive analysis).

The overarching RTA analytic process will be used to analyse the interview data. RTA's six phase process will be followed (Braun and Clarke, 2019, 2021; Clarke and Braun, 2013) which entails data familiarisation (phase one), initial coding (phase two), generating initial themes (phase three), reviewing initial themes (phase four), defining and naming final themes (phase five), bringing the themes, data items, and literature together to contribute to the final report write up (phase six).

Embedded research approach

There has been increasing interest in embedded health policy and systems research (e-HPSR), especially in LMICs. Although there is no single definition of e-HPSR, it can be understood as research conducted 'within the system, for the system, [and] used by the system' (Olivier et al., 2018: 1). Furthermore, the 'embeddedness' can take different forms such as, for example, insider researchers where health workers working within the health system are doing HPSR relevant to the system they are working in or HPSR researchers from outside the health system who have immersed themselves in the system (Olivier et al., 2018). The increasing interest in e-HPSR is largely due to the reported benefits of the approach; chief of which is the increased likelihood of actionable and useable results resulting from the identification of substantively relevant health systems issues and questions, removal of barriers to research and creation of feedback loops of research results into the system (Olivier et al., 2017; 2018). Additionally, well-conducted e-HPSR is thought to strengthen the rigour of the research process (Olivier et al., 2018).

This study is considered to be embedded in the WCDHW health system for several reasons. First, the researcher (OSM) is an HPSR student researcher working in the WCDHW, where this research will be conducted. Secondly, the supervisor and primary investigator (LG) has been working, and conducting HPSR research in collaboration, with the WCDHW health system for over a decade. Thirdly, the study is a sub-study of a larger project commissioned by the highest decision-making body of the WCDHW to evaluate its long-term strategy, and the researchers are part of a steering committee appointed by the WCDHW to lead the larger evaluation project. Fourthly, the study derives its question from an issue that has been identified as critical by the WCDHW and that is a key thrust of its long-term strategy and so an element of the commissioned evaluation.

While e-HPSR has benefits, it also poses some methodological challenges that need to be considered and mitigated. Some of these challenges, relevant to this study, include difficulty in maintaining objectivity, tensions between using observations and experiential knowledge and feeling compelled to report more positively than negatively (Olivier et al., 2018). The researchers will apply strategies to mitigate against these challenges, namely member checking, reflexivity and peer debriefing. These strategies, and others, are discussed under the rigour section below.

Rigour

As mentioned earlier, case study research (Rowley, 2002) and health policy and systems research more generally (Gilson, 2012) have been criticised for lacking rigour. Table 2 details the strategies that will be used to ensure rigour in all stages of this research.

Table 4. Strategies to ensure rigour in the proposed research. *Drawn from Gilson (2012), Jootun et al. (2009), Lincoln and Guba (1985), Maher et al. (2018) and Olivier et al. (2018)*

Strategy	Application in this study	Contribution	Relevant stage(s) of research
Data triangulation	Data will be drawn and corroborated from different sources (hospital participants, key informants outside the hospital, literature etc.)	Credibility & confirmability	Data collection
Member checking	The initial findings of the study will be presented to the hospital participants to check whether their views are accurately represented before the research report is finalised.	Credibility	Interpretation of study findings
Thick description	A detailed description of both the case and context will be drawn from the data and provided in the final report.	Transferability & dependability	Sampling, data collection and data analysis
Methods triangulation	Different data collection methods will be used.	Dependability	Data collection and data analysis
Reflexivity	The primary researcher will keep a reflexive journal throughout all the stages of the research process to ensure reflexivity.	Confirmability & credibility	All stages of research
Peer debriefing	The research team will have regular debriefing meetings during data collection, data analysis and report writing to reflect on the research process, interpretations and their influence on the process, and share insights. During data analysis, the primary researcher will develop codes and themes and the rest of the team will check them.	Credibility	Data collection, data analysis and interpretation of study findings
Audit trail	The entire research process will be recorded, including any changes made and the rationale behind such changes. This is especially important because of the flexibility of this design.	Transferability & dependability	All stages of research
Use of theory	As discussed above, conceptual and theoretical frameworks will be used to guide data collection, data analysis and the presentation/interpretation of results.	Confirmability	Data collection, analysis and interpretation of findings
Representative Sampling	Heterogenous sampling will be used to ensure that perspectives of different sub-groups are	Credibility & confirmability	Data collection

	represented (e.g., different genders, professional groups, managers/workers, more/less experienced)		
Embedded research approach	The primary researcher has prior experience in the research setting/context. However, reflexivity, peer debriefing and member checking are critical to keep the researcher's influence 'in check'.	Credibility	All stages of research
Research alignment- 'golden thread'.	There is alignment between the research question, theory, purpose, design and strategy.	Credibility, dependability & confirmability.	All stages of research (including design)

PEOPLE AND TRACK RECORD

This study is a single case study set in one district hospital. The scope and size of the project does not require a large research team. However, the topic requires researchers with different disciplinary/professional backgrounds, and expertise in conducting qualitative research. For example, the social nature of leadership requires someone with a social science background or expertise in health systems leadership, while the setting of the study needs a person who has understanding and appreciation of health services and the complexities of healthcare delivery. Considering the above, the two-member research team (i.e., student-supervisor) is well positioned to conduct this study (see Table 3 below for more details on researchers' track record).

Additionally, the researcher will also draw from the steering committee of the wider evaluation project that this study is nested within. Members of this committee include two WCDHW senior managers responsible for strategy and service delivery, respectively, an experienced professor of health policy and systems research, and a public health medicine specialist.

Table 5. Research team description

Name and title	Role in Project	Disciplinary/professional background	Previous work relating to this topic
Lucy Gilson (LG), Prof	Primary investigator (PI) & supervisor	Social scientist and leading HPSR academic with extensive experience in doing HPSR work in LMICs. Current professor and head of health policy and systems division at UCT.	Published extensively on health leadership, management and governance in LMICs.
Oupa Motshweneng (OSM), Mr	Researcher & student	Trained radiation therapist with health service delivery experience as both a clinician and manager. Current public health student and manager in a DHS of the WCDHW.	Operational research on health leadership and quality of care in the DHS.

RESEARCH IMPACT

It is expected that this study will yield results usable for the immediate research setting and transferable to other similar contexts because the researchers have chosen a typical/representative case and rigour strategies will be used to ensure transferability (see Table 2). The key contributions envisaged from the study are as follows:

i) Provide feedback to Bophelo Hospital on their efforts to nurture distributed leadership as a strategy for embedding good governance and values-driven leadership. i.e., whether or not leadership in the hospital is distributed, if so, how it is distributed, and what has supported or inhibited the emergence of distributed leadership in the hospital.

ii) Contribute to the evaluation of WCDHW's Healthcare 2030 - specifically, the development of distributed leadership as a key lever to achieving the provincial health system's vision and strategic goals.

iii) Contribute to ongoing efforts to strengthening DHS leadership in South Africa by offering insights on the nature of leadership in a South African district hospital and the enabling/inhibiting factors.

iv) Add to the limited but growing evidence base of health system leadership in LMICs.

To achieve the first contribution, the results of the study will be presented at the annual district research day, which includes staff from Bophelo Hospital and surrounding primary care facilities. The second contribution will be supported by the embedded approach. The results of this study will form part of the report for the larger Healthcare 2030 strategy evaluation project which will be used to inform the next long-term strategy for the WCDHW provincial health system. Moreover, the senior manager responsible for strategy in the WCDHW co-chairs the steering committee responsible for the larger project with LG, and OSM also forms part of this committee. In terms of the third contribution, there has been a renewed focus on the DHS in South Africa. For example, there is a South African DHS learning initiative and the South African Medical Journal has recently (late 2023) launched a special series on the DHS. Further, the NDoH is currently reviewing its DHS and district management offices guidelines and strategies. For input in these conversations and efforts, the results of this study will be shared with the DHS learning initiative, which includes actors from the NDoH and other provinces. Finally, for the last contribution, the results of the study will be submitted for publication in a peer-reviewed journal. By feeding back to the different levels of the health system, we hope to prompt thinking and action on the supporting/inhibiting contextual factors at the

different system levels and, thereby, supporting leadership development at Bophelo Hospital and other similar contexts.

ETHICS

Risks and benefits

There are potential risks associated with participation in this study. Firstly, the interviews are expected to last approximately one hour each, and this imposes an opportunity cost in that this time could have spent working, in leisure or with friends/family. Secondly, there is a potential that the interviews may uncover sensitive information that might cause emotional upset or that participants might not wish to share. Thirdly, some participants may feel the need to give more positive responses in order for them not to jeopardise their work/careers. To mitigate against the second and third risks, the researchers will maintain confidentiality and the interviews will be anonymous. As part of the informed consent process, participants will be informed that participation is voluntary and that they may withdraw at any stage of the study. Also, no identifying information will be shared. However, these mitigation strategies do not address the issue of opportunity cost, which cannot be averted. Nevertheless, some participants may find value in the opportunity to pause and reflect on their work, which the interview provides, and this may potentially offset the initial opportunity cost.

Another layer of risk lies in the results of the study, and their potential impact on the hospital. The researchers recognise that examining the nature of leadership at a hospital might potentially and unintentionally create narratives about the hospital management team which might be negative, depending on the results. Furthermore, although the results will be anonymised, the possibility of some of the audience tracing the results back to the specific hospital cannot be ruled out. With this in mind, the initial results of the study will be presented to the Bophelo Hospital management team first before wider publication. The researchers will discuss with the hospital management about which aspects of the results, if not all, could be published/shared and how.

Other than the above, there are no known physical, emotional or economic risks associated with this study. Based on presented risks and the mitigation strategies, it can be concluded that this is a low-risk study. There are no direct benefits to the participants other than the envisaged contributions of the study to Bophelo Hospital and the WCDHW as discussed under the research impact section.

Ethical mindfulness

In addition to the health system issue identified above, embedded research such as this one presents additional ethical considerations in that: i) the positionality of researchers might become blurred overtime, ii) the long-term nature of the relationship between researchers and the health system requires nurturing and being mindful of issues of power and trust and iii) some of ethical challenges often emerge after the research has started (Molyneux et al., 2017; Olivier et al., 2018). This requires 'ethical mindfulness'- the researcher's ability to manage routine and unanticipated ethical challenges that emerge during the research process (Molyneux et al., 2017; Olivier et al., 2018). The researchers will use the regular peer debriefing sessions as spaces for building and practising ethical mindfulness.

Voluntary participant and informed consent

Participation in this study is voluntary and participants may withdraw at any stage with no implications for them. This information, including the nature and purpose of the research and potential risks and benefits will be clearly communicated to study participants before taking part in the project. In terms of the semi-structured interviews, the study information will be provided to the participants by providing participant information sheets (Appendix E), followed by a verbal explanation and an opportunity for participants to ask questions. Finally, interview participants will, voluntarily and willingly, sign a consent form (Appendix F), which will then be signed by the researcher as well. Participants will retain copies of the information sheet, while signed consent forms will be collected and stored safely in locked cabinet.

Privacy and confidentiality

The interviews with hospital participants will take place in the hospital boardroom or a private meeting room/office with only the researcher and the participants present. And interviews with key informants will take place at their respective offices, with similar privacy considerations. Interviews will be audio-recorded (and later transcribed) and consent for this will be sought from each participant. However, participants' identifying information will be removed from all files (recordings) and transcripts and replaced with untraceable numerical identity numbers, to protect their privacy, confidentiality and anonymity. Further, data will be stored on a password-locked computer, while the signed consent forms will be stored in a locked cabinet, accessible only to the researchers.

Re-imbursement for participation in the study

Participants will not be re-imbursed for participating in this study.

Clearance and permissions

Ethical clearance for the study will be sought from the University of Cape Town's Human Research Ethics Committee, while permission to interview WCDHW staff and access institutional reports that may otherwise not be in the public domain will be obtained from the WCDHW's Health Intelligence Directorate.

BUDGET

Transcription costs are the main costs associated with this study and are estimated as follows:

R 15.00 per audio minute X 60 minutes = R 900.00 X 20 interviews = R 18 000.00

REFERENCES

Aberese-Ako M, Agyepong IA, van Dijk H. 2018. Leadership styles in two Ghanaian hospitals in a challenging environment. *Health Policy and Planning* **33**: ii16-ii26.

African National Congress. 1994. *A National Health Plan For South Africa*. Johannesburg: Baar Mapping and Printing.

Agyepong IA, Lehmann U, Rutembemberwa E, Babich SM, Frimpong E, Kwamie A, ... and Gilson L. 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**: ii35-ii49.

Alliance for Health Policy and Systems Research. 2016. *Open mindsets: Participatory leadership for health*. Geneva: World Health Organization.

Bateman C. 2013. Health leadership training academy tackles worst first. *South African Medical Journal* **103**: 707-708.

Begun JW, Zimmerman B, Dooley K. 2003. Health care organizations as complex adaptive systems. *Advances in Health Care Organization Theory* **253**: 288.

Belrhiti Z, Van Damme W, Belalia A, Marchal B. 2020. Unravelling the role of leadership in motivation of health workers in a Moroccan public hospital: A realist evaluation. *BMJ Open* **10**: e031160.

Bolden R. 2011. Distributed leadership in organizations: A review of theory and research. *International Journal of Management Reviews* **13**: 251-269.

Bophelo Hospital. 2023. *Annual operational plan: Financial year 2023/2024*. Western Cape Department of Health and Wellness.

Bosongo S, Belrhiti Z, Ekofo J, Kabanga C, Chenge F, Criel B, Marchal B. 2023. How capacity building of district health managers has been designed, delivered and evaluated in sub-Saharan Africa: A scoping review and best fit framework analysis. *BMJ Open* **13**: e071344.

Braun V, Clarke V. 2019. Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health* **11**: 589-597.

Braun V, Clarke V. 2021. Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*: 1-11.

Brown MH, Hosking DM. 1986. Distributed leadership and skilled performance as successful organization in social movements. *Human Relations* **39**: 65-79.

Byrne D. 2022. A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity* **56**: 1391-1412.

Chee G, Pielemeier N, Lion A, Connor C. 2013. Why differentiating between health system support and health system strengthening is needed. *The International Journal of Health Planning and Management* **28**: 85-94.

Chreim S, MacNaughton K. 2016). Distributed leadership in health care teams. *Health Care Management Review* **41**: 200-212.

Clarke V, Braun V. 2013. Successful qualitative research: A practical guide for beginners. *Successful Qualitative Research*: 1-400.

Cleary S, Toit AD, Scott V, Gilson L. 2018. Enabling relational leadership in primary healthcare settings: Lessons from the DIALHS collaboration. *Health Policy and Planning* **33**: ii65-ii74.

Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. 2009. The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, **374**: 817-834.

Currie G, Lockett A. 2011. Distributing leadership in health and social care: Concertive, conjoint or collective?. *International Journal of Management Reviews* **13**: 286-300.

Daire J, Gilson L, Cleary S. 2014. *Developing leadership and management competencies in low and middle-income country health systems: A review of the literature*. Cape Town: Resilient and Responsive Health Systems (RESYST).

Daire J, Gilson L. 2014. Does identity shape leadership and management practice? Experiences of PHC facility managers in Cape Town, South Africa. *Health Policy and Planning* **29**: ii82-ii97.

De Savigny D, Adam T (Eds). 2009. *Systems thinking for health systems strengthening*. Geneva: World Health Organization.

Doherty J, Gilson L, Shung-King M. 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**: ii50-ii64.

Fitzgerald L, Ferlie E, McGivern G, Buchanan D. 2013. Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly* **24**: 227-239.

Fitzsimons D, James KT, Denyer D. 2011. Alternative approaches for studying shared and distributed leadership. *International Journal of Management Reviews* **13**: 313-328.

Frenk J. 2010. The global health system: Strengthening national health systems as the next step for global progress. *PLoS Medicine* **7**: e1000089.

Fusheini A, Eyles J. 2016. Achieving universal health coverage in South Africa through a district health system approach: Conflicting ideologies of health care provision. *BMC Health Services Research* **16**: 1-11.

Gilson L (Ed). 2012. *Health policy and system research: a methodology reader*. Alliance for Health Policy and Systems Research, World Health Organization.

Gilson L, Agyepong IA. 2018. Strengthening health system leadership for better governance: What does it take?. *Health Policy and Planning* **33**: ii1-ii4.

Gilson L, Barasa E, Nxumalo N, Cleary S, Goudge J, Molyneux S, ... Lehmann U. 2017. Everyday resilience in district health systems: Emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health* **2**.

Gilson L, Daire J. 2011. Leadership and governance within the South African health system. In: Paradath A, English R (Eds). *South African Health Review 2011*. Durban: Health Systems Trust, 69-80.

Gilson L, Ellokor S, Lehmann U, Brady L. 2020. Organizational change and everyday health system resilience: Lessons from Cape Town, South Africa. *Social Science & Medicine* **266**: 113407.

Gilson L, Pienaar D, Brady L, Hawkridge A, Naledi T, Vallabhjee K, Schneider H. 2017. Development of the health system in the Western Cape: Experiences since 1994. *South African Health Review*: 59-69.

Gilson L, Pienaar D, Brady L, Hawkridge A, Naledi T, Vallabhjee K, Schneider H. 2017. Development of the health system in the Western Cape: Experiences since 1994. In Paradath A, Barron, P (Eds). *South African Health Review 2017*. Durban: Health Systems Trust, 59-69.

Gilson L. 2016. Everyday politics and the leadership of health policy implementation. *Health Systems & Reform* **2**: 187-193.

Govender S, Gerwel Proches CN, Kader A. 2018. Examining leadership as a strategy to enhance health care service delivery in regional hospitals in South Africa. *Journal of Multidisciplinary Healthcare* **11**: 157-166.

Gronn P. 2002. Distributed leadership as a unit of analysis. *The leadership Quarterly* **13**: 423-451.

Gronn P. 2000. Distributed properties: A new architecture for leadership. *Educational Management & Administration* **28**: 317-338.

Günzel-Jensen F, Jain AK, Kjeldsen AM. 2018. Distributed leadership in health care: The role of formal leadership styles and organizational efficacy. *Leadership* **14**: 110-133.

Iles P, Feng Y. 2011. Distributed leadership, knowledge and information management and team performance in Chinese and Western groups. *Journal of Technology Management in China* **6**: 26-42.

Johnson O, Begg K, Kelly AH, Sevdalis N. 2021. Interventions to strengthen the leadership capabilities of health professionals in Sub-Saharan Africa: A scoping review. *Health Policy and Planning* **36**: 117-133.

Jootun D, McGhee G, Marland GR. 2009. Reflexivity: promoting rigour in qualitative research. *Nursing Standard* **23**: 42-47.

Leithwood K, Day C, Sammons P, Harris A, Hopkins D. 2007. *Leadership and student learning outcomes*. London: DCSF.

Luft JA, Jeong S, Idsardi R, Gardner G. 2022. Literature reviews, theoretical frameworks, and conceptual frameworks: An introduction for new biology education researchers. *CBE—Life Sciences Education* **21**: rm33.

Maher C, Hadfield M, Hutchings M, De Eyto A. 2018. Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. *International Journal of Qualitative Methods* **17**: 1609406918786362.

Martin G, Beech N, MacIntosh R, Bushfield S. 2015. Potential challenges facing distributed leadership in health care: Evidence from the UK National Health Service. *Sociology Of Health & Illness* **37**: 14-29.

Mathole T, Lembani M, Jackson D, Zarowsky C, Bijlmakers L, Sanders D. 2018. Leadership and the functioning of maternal health services in two rural district hospitals in South Africa. *Health Policy and Planning* **33**: ii5-ii15.

McDonald R. 2014. Leadership and leadership development in healthcare settings–a simplistic solution to complex problems?. *International Journal of Health Policy and Management* **5**: 227.

McGrath C, Palmgren PJ, Liljedahl M. 2019. Twelve tips for conducting qualitative research interviews. *Medical Teacher* **41**: 1002-1006.

McKee L, Charles K, Dixon-Woods M, Willars J, Martin G. 2013. 'New'and distributed leadership in quality and safety in health care, or 'old'and hierarchical? An interview study with strategic stakeholders. *Journal Of Health Services Research & Policy* **18**: 11-19.

McKenzie A, Schneider H, Schaay N, Scott V, Sanders D. 2017. *Primary health care systems (PRIMASYS): A case study from South Africa*. Geneva: World Health Organization.

Meessen B, Malanda B. 2014. No universal health coverage without strong local health systems. *Bulletin of the World Health Organization* **92**: 78-78A.

Molyneux S, Tsofa B, Barasa E, Nyikuri M, Waweru EW... Gilson L. 2017. *Ethical challenges in conducting embedded, long-term research*. Policy brief. https://resyst.lshtm.ac.uk/resources/ethical-challenges-in-conducting-embedded-long-term-research

Morrow S. 2007. Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist* **35**: 209–235

Munezhi M, Hammad N. 2021. Ethical health leadership: Lessons from low-and middle-income countries during COVID-19. *Healthcare Management Forum* **34**: 62-67.

Musinguzi C, Namale L, Rutebemberwa E, Dahal A, Nahirya-Ntege P, Kekitiinwa A. 2018. The relationship between leadership style and health worker motivation, job satisfaction and teamwork in Uganda. *Journal of Healthcare Leadership*: 21-32.

Mutale W, Vardoy-Mutale AT, Kachemba A, Mukendi R, Clarke K, Mulenga D. 2017. Leadership and management training as a catalyst to health system strengthening in low-income settings: Evidence from implementation of the Zambia Management and Leadership course for district health managers in Zambia. *PLoS One* **12**: e0174536.

Neuman WL. 1997. *Social research methods: Qualitative and quantitative approaches*. London: Allyn & Bacon.

Nzinga J, McGivern G, English M. 2018. Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. *Health Policy and Planning* **33**: ii27-ii34.

Okello DRO. 2021. The leadership trinity: Examining the interplay between healthcare organisational context, collective leadership and leadership effectiveness in the health sector - a multiple case study of district hospitals in the Western Cape province, South Africa. PhD thesis. University of Cape Town.

Olivier J, Scott V, Molosiwa D, Gilson L. 2017. Systems approaches in health systems research: approaches for embedding research. In: de Savigny D, Blanchet K, Adam T (Eds). *Applied systems thinking for health systems research: A methodological handbook*. New York: McGraw-Hill Education, 9-37.

Olivier J, Whyle E, Gilson L. 2018. *Embedded health policy and systems research: within the system, for the system, used by the system*. Technical brief for the Alliance for Health Policy and Systems Research. https://ahpsr.who.int/publications/i/item/embedded-health-policy-and-systems-research

Owen P. 1995. District health system development. In: Harrison D, Nielson M (Eds). *South African Health Review.* Durban: Health Systems Trust.

Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. 2015. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research* **42**: 533-544.

Patel B. 2022. Exploring the contribution of a leadership development program on the implementation of improvement projects at a South African central hospital. PhD thesis. University of Cape Town.

Republic of South Africa. 2003. *National Health Act 61 of 2003*. https://www.gov.za/documents/national-health-act

Robinson OC. 2014. Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology* **11**: 25-41.

Robson C. 2002. *Real world research: A resource for social scientists and practitioner-researchers*. 2nd edn. Oxford: Blackwell Publishers.

Rocco TS, Plakhotnik MS. 2009. Literature reviews, conceptual frameworks, and theoretical frameworks: Terms, functions, and distinctions. *Human Resource Development Review* **8**: 120–130.

Rowley J. 2002. Using case studies in research. *Management Research News* **25**: 16-27.

Schneider H, Nxumalo N. 2017. Leadership and governance of community health worker programmes at scale: A cross case analysis of provincial implementation in South Africa. *International Journal for Equity in Health* **16**: 1-12.

Sturmberg JP, Bircher J. 2019. Better and fulfilling healthcare at lower costs: The need to manage health systems as complex adaptive systems. *F1000Research* **8**.

Sturmberg JP, O'Halloran DM, Martin CM. 2010. People at the centre of complex adaptive health systems reform. *Medical Journal of Australia* **193**: 474-478.

Tangcharoensathien V, Witthayapipopsakul W, Panichkriangkrai W, Patcharanarumol W, Mills A. 2018. Health systems development in Thailand: A solid platform for successful implementation of universal health coverage. *The Lancet* **391**: 1205-1223.

Thomas A, Chataway J, Wuyts M (Eds). 1998. *Finding out fast: investigative skills for policy and development*. California: Sage Publications.

Thorpe R, Gold J, Lawler J. 2011. Locating distributed leadership. *International Journal of Management Reviews* **13**: 239-250.

Tumusiime P, Kwamie A, Akogun OB, Elongo T, Nabyonga-Orem J. 2019. Towards universal health coverage: reforming the neglected district health system in Africa. *BMJ Global Health* **4**: e001498.

Western Cape Department of Health and Wellness (n.d.). *Leadership training*. https://mygov.westerncape.gov.za/myhealth/health-update/leadership-training (Retrieved 2023, September 28).

Western Cape Department of Health and Wellness. 2014. *Healthcare 2030: The road to wellness*. https://www.westerncape.gov.za/assets/departments/health/healthcare2030_0.pdf

Western Cape Department of Health and Wellness. 2023. *2021/2022 Annual report*. https://mygov.westerncape.gov.za/myhealth/files/atoms/files/Annual%20Report%202021-2022.pdf

Whyle EB, Olivier J. 2023. A socio-political history of the South African National Health Insurance. *International Journal for Equity in Health* **22**: 1-26.

Wolvaardt G, Johnson S, Cameron D, Botha B, Kornik S. 2013. Challenges and constraints at district management level. *South African Health Review* **1**: 81-92.

World Health Organization. 1988. *The challenge of implementation: district health systems for primary care*. Geneva: World Health Organisation

World Health Organization. 2007. *Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organisation

Yin RK (Ed). 2004. *The case study anthology*. California: Sage Publications.

Yin RK. 2009. How to do better case studies. In Bickman L, Rog DJ (Eds). *The SAGE Handbook of Applied Social Research Methods*. 2nd edn. California: Sage Publications, 254-282.

Zaidi SA, Bigdeli M, Langlois EV, Riaz A, Orr DW, Idrees N, Bump JB. 2019. Health systems changes after decentralisation: Progress, challenges and dynamics in Pakistan. *BMJ Global Health* **4**: e001013.

Appendix B: Health Policy and Planning author guidelines

Scope

Health Policy and Planning is an open access journal, publishing health policy and systems research focusing on low- and middle-income countries. It provides an international forum for publishing original and high-quality research that addresses questions pertinent to policymakers, public health researchers and practitioners.

Manuscript format and style for all articles

Only articles in English are considered for publication.

The journal follows Oxford SCIMED style. Please refer to these requirements when preparing your manuscript. More information on preparing your manuscript is available. Oxford English spelling style should be used consistently throughout your manuscript. (-ize/-ization), except in quotations and in references. Prepare your manuscript, including tables, using a word processing program and save it as a .doc, .rtf or .ps file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

Title Page

The Title Page should be uploaded as a separate file type 'Title Page' and contain the following information:

- Title
- Corresponding authors name, address, country, e-mail address, ORCID details
- Each authors affiliation and qualification (BSc, MA, PhD…)
- Keywords
- Reflexivity Statement
- A word count of the full article: Word Limits do not include Abstract, References, Figure/Table legends.
- Ethical Approval
- if no ethical approval was required for the research, please note the reason:
- Example A: Ethical approval for this type of study is not required by our institute.
- Example B: Ethical approval for this research was waived by the authors institute/s IRB.
- Ethical Approval Received-Please note the institute/s which approved the research with reference number.
- Funding/Acknowledgements/Conflicts of interest/Ethical approval should be noted on the title page.

In the acknowledgements, all contributors who do not meet the criteria for authorship should be listed. Sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. The requirements for online submission and for reproduction in the journal are different: (i) for

online submission and peer review, upload your figures separately as low-resolution images (.jpg, .tif, .gif or. eps); (ii) for reproduction in the journal, you will be required, after acceptance, to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour images or 600 d.p.i for tone images, and 1200 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

Figures will not be re-lettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication. When creating figures, please make sure any embedded text is large enough to read. Many figures contain miniscule characters such as numbers on a chart or graph. If these characters are not easily readable, they will most likely be illegible in the final version. Certain image formats such as .jpg and .gif do not have high resolutions, so you may need to save your figures and insert them as .tif instead.

Figure accessibility and alt text

Incorporating alt text (alternative text) when submitting your paper helps to foster inclusivity and accessibility. Good alt text ensures that individuals with visual impairments or those using screen readers can comprehend the content and context of your figures. The aim of alt text is to provide concise and informative descriptions of your figure so that all readers have access to the same level of information and understanding, and that all can engage with and benefit from the visual elements integral to scholarly content. Including alt text demonstrates a commitment to accessibility and enhances the overall impact and reach of your work. Alt text is applicable to all images, figures, illustrations, and photographs. Alt text is only accessible via e-reader and so it won't appear as part of the typeset article.

Manuscript Preparation

Page 1: Title Page – as above.

Page 2: Abstract. To be prepared in one paragraph, no headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

Page 3: Key Messages. Include 3-4 key focusing on the main points in the paper, explaining the rationale for the research/paper, key finding(s), and implication(s) and lessons for health systems and health policy. Text should not be taken verbatim from the abstract. Please see this article as an example.

Page 4: Introduction. This should state the purpose of the investigation and give a short review of the pertinent literature and be followed by:

Materials and methods. This section should follow the Introduction and should provide enough information to allow repetition of the experimental work. For chemicals or equipment, the name and location of the supplier should be given in parentheses.

Results. This section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

Discussion. This should be an interpretation of the results and their significance with reference to work by other authors.

Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

References. References must follow the Harvard system and must be cited as follows:

Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics Volume number in bold: page numbers.

Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). Book title in italics. 2nd edn. Place of publication: Publisher's name, page numbers.

Tables. All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct. Tables should be provided as Word or Excel files.

Availability of Data and Materials

Where ethically feasible, Health Policy and Planning strongly encourages authors to make all data and software code on which the conclusions of the paper rely available to readers. Authors are required to include a Data Availability Statement in their article. Data should be presented in the main manuscript or additional supporting files or deposited in a public repository whenever possible. For information on general repositories for all data types, and a list of recommended repositories by subject area, please see Choosing where to archive your data.

Data Availability Statement

The inclusion of a Data Availability Statement is a requirement for all articles published in Health Policy and Planning. Data Availability Statements provide a standardised format for readers to understand the availability of data underlying the research results described in the article. The statement may refer to original data generated in the course of the study or to third-party data analysed in the article. The statement should describe and provide means of

access, where possible, by linking to the data or providing the required unique identifier. The Data Availability Statement should be included in the end matter of your article under the heading 'Data availability'.

Types of papers

Health Policy and Planning welcomes submissions of the following article types:

- Original research
- Review articles
- Methodological musings
- Innovation and practice reports
- Commentaries
- 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

Original Research

Manuscripts reporting quantitative or fixed design studies should be a maximum of 6,000 words, excluding tables and figures/diagrams and references. Manuscripts reporting qualitative, mixed method or flexible design studies should be a maximum of 7,000 words, excluding tables and figures/diagrams and references.

The manuscript will generally follow through sections: Title page, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, Acknowledgements, References. It may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (e.g., do not say 'beta' or 'regression coefficient', but 'mean change in Y per unit of X'). Provide 95% confidence intervals for estimates.
- Report the proportions as N (%), not just %.
- Report P values with 2 digits after the decimal, 3 if <0.01 or near 0.05 (e.g., 0.54, 0.03, 0.007, <0.001, 0.048). Do not report P values greater than 0.05 as 'NS'.
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc.).'

For acknowledgements, figures and measures see above.

Disclosure of Potential Conflict of Interest

Authors must declare any conflicts of interest during the online submissions process. The lead author is responsible for confirming with the co-authors whether they also have any conflicts to declare.

Ethical Research

A requirement of publication is that research involving human subjects was conducted with the ethical approval of the appropriate bodies in the country where the research was conducted and of the ethical approval committees of affiliated research institutions elsewhere. Furthermore, subjects' consent must have been obtained according to the Declaration of Helsinki. A clear statement addressing all these points must be made in any submitted manuscript presenting such research. In original articles, this information must also be included in the methods section of the submitted manuscript. Please note that it is the responsibility of the corresponding author to ensure that the relevant ethical approval described above is provided. The Editors-in-Chief reserve the right to refuse publication where the required ethical approval/patient consent is lacking, or where the approval/consent provided is deemed incomplete or ambiguous.

Appendix C: Hospital participants interview guide

Healthcare 2030 Review: Hospital participants interview guide

Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital

***Main research question*:** What are the barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital?

Sub-questions:

a. How is distributed leadership framed by actors at different levels of the Western Cape provincial health system?
b. Is there evidence of distributed leadership currently at the hospital, if so, how is leadership distributed?
c. What has supported or inhibited the emergence of distributed leadership in this district hospital in the last ten years?

Introductions (5-10 minutes)

- Introduce myself and my role in both the Western Cape Government Health and Wellness (WCDHW) and the University of Cape Town
- Go through the study information again, as in the participant information sheet
- Open for clarity-seeking questions
- Build rapport by asking participants some questions about themselves and their interests, while collecting key demographic information- specifically: sex, age, educational/professional background, years of experience, years working in WCDHW, current role/position and years in that position (does the current position include line management of district hospitals, if so, how many?

Core questions (30-45 minutes)

1. What is your understanding of leadership?

   Probing questions

   - *In your opinion, what does leadership mean, what does it look like?*
   - *The Department's strategic documents often speak about developing **distributed leadership**, and this hospital's recent annual operational plan also speaks about 'Distributed management and leadership capacity enhancement'. **What is your understanding of this kind of leadership [distributed leadership]?***

2. Now coming to Bophelo Hospital, how would you describe leadership in this hospital?

   Probing questions

- *When we talk about leadership in this hospital, who comes to your mind and why?*
- *Do you consider yourself part of the hospital leadership, why/why not? And if not, what is your relationship with the hospital leadership?*
- *What would you say are the **qualities, features or characteristics of leadership** in this hospital?*
  - *Examples?*
- *In what ways would you say some of these qualities/characteristics impact on you and your work? Can you think of any examples?*
- *When it comes to your specific team/department/unit, how would you **describe leadership in your team/department/unit?** Is it different from the hospital leadership you described earlier, in terms of qualities, features or characteristics? If so, how?*

3. Thinking over the last ten years, what would you say has shaped the hospital leadership as you have experienced it, and just described it?
   - *Do you think education and training has had any influence?*
   - *Are there any other factors within or outside the hospital that you can think of?*
   - *What do you think has been the impact of national and provincial policies on the hospital leadership?*

Closing questions/comments (5-10 minutes)

- As a parting point, how can leadership in this hospital be strengthened, in your opinion?
- Is there anything else you feel you would like to share or ask?
- Thank the participant for the participation and reassure them of the confidentiality of their responses.

Appendix D: Key informants interview guide

Healthcare 2030 Review: Key informants interview guide

Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital

***Main research question*:** What are the barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital?

Sub-questions:

a. How is distributed leadership framed by actors at different levels of the Western Cape provincial health system?
b. Is there evidence of distributed leadership currently at the hospital, if so, how is leadership distributed?
c. What has supported or inhibited the emergence of distributed leadership in this district hospital in the last ten years?

Introductions (5-10 minutes)

- Introduce myself and my role in both the Western Cape Government Health and Wellness (WCDHW) and the University of Cape Town
- Go through the study information again, as in the participant information sheet
- Open for clarity-seeking questions
- Build rapport by asking participants some questions about themselves and their interests, while collecting key demographic information- specifically: sex, age, educational/professional background, years of experience, years working in WCDHW, current role/position and years in that position (does the current position include line management of district hospitals, if so, how many?

Core questions (30-45 minutes)

1. What is your understanding of leadership?
   Probing questions
   - *In your opinion, what does leadership mean, what does it look like?*
   - *The Department's strategic documents often speak about developing distributed leadership, what is your understanding of this kind of leadership [distributed leadership]?*
2. Based on your experience, how would you describe district hospital leadership in WCDHW?
   Probing questions

- *What would you say are the qualities, features or characteristics of leadership in WCDHW's district hospitals? What are the strengths and weaknesses?*
- *In what ways would you say some of these qualities/characteristics impact on service delivery? Can you think of any examples?*

3. Thinking over the last ten years, what would you say has shaped hospital leadership in WCDHW's district hospitals?
    a. *What do you think has been the impact of national and provincial policies on district hospital leadership?*
    b. *What about education and training, has it had any influence?*
    c. *Are there any other factors within or outside the hospitals that you can think of?*

Closing questions/comments (5-10 minutes)

- As a parting point, how can leadership in WCDHW's district hospitals be strengthened, in your opinion?
- Is there anything else you feel you would like to share or ask?
- Thank the participant for the participation and reassure them of the confidentiality of their responses.

Appendix E: Participant information sheet

Healthcare 2030 Review: Participant Information sheet

Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital

Dear Prospective Participant,

We would like to invite you to take part in our research study, titled: ***Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital***. Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please take time to read this information and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask us.

What is the purpose of the study?

Leadership has been widely recognised as a critical component of any health system and a necessary ingredient for well-functioning health systems. More so, there has been increasing efforts and calls to move away from individualistic notions of leadership where leadership is seen as the exclusive function of certain individuals, usually located at the top of the organisation, to more systematic approaches to leadership. The Western Cape Government Health and Wellness (WCDHW) sees a 'dynamic and distributed leadership across the ranks of management, clinicians and administration' as a key requirement for the realisation of its vision of 'access to person-centred quality care' and the envisaged shift from health to wellness, which underpins its Healthcare 2030 strategy. To this end, the WCDHW has explicitly adopted, and sought to develop, distributed leadership to achieve set health system goals- with a particular focus on the frontline.

Despite WCDHW's explicit intention to develop distributed leadership, and the subsequent resource investments, there is little evidence to make judgements about the extent to which this intention has been realised. To try and close this gap, we seek to conduct a theory-driven exploration of the emergence of distributed leadership in a WCDHW district hospital, to understand whether there is evidence of distributed leadership or not, if so, how is it distributed and what has supported or constrained its emergence. Our main research is: *What are the barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital?*

Why have I been invited?

You have been invited to take part in this study because you are either a current or past employee at Bophelo Hospital, or you are a WCDHW senior manager working in or supporting the district health system.

Do I have to take part?

As much as we would like you to take part, it's important for you to know that participation in this study is entirely voluntary. In addition to this, you are allowed to withdraw from participating if you change your mind and you don't need to give a reason for this. Withdrawal from participating in the study will not affect your standing as an employee of WCDHW.

What will happen to me if I decide to take part?

If you decide to take part, we will ask you to sign an informed consent and participate in a 45-60 minutes one-on-one interview with the researcher. The interview will happen at your place of work, or where most convenient for you. With permission from the Chief Executive Officer of Bophelo Hospital and meeting attendants, the researcher will also observe some meetings in the hospital but will not interact with meeting participants.

Are there any possible disadvantages or risks from taking part?

There are no known risks to this study apart from the cost of time needed participate in the interview. While going through the interview, you may skip any questions you do not want to answer and you may end the interview at any time if answering any of the questions makes you feel uncomfortable. Open ended questions in interviews can lead to unexpected emotions, please share only what you are comfortable sharing with us.

What are the possible benefits of taking part?

There are no direct personal benefits for taking part in this study. However, we envisage that the study will make the following key contributions, at the hospital, provincial and national levels:

i) Provide feedback to Bophelo Hospital on efforts to nurture distributed leadership as a strategy for embedding good governance and values-driven leadership, as outlined in their annual operational plan. i.e., whether or not leadership in the hospital is distributed, if so, how it is distributed, and what has supported or inhibited the emergence of distributed leadership in the hospital.

ii) Contribute to the ongoing evaluation of WCDHW's Healthcare 2030- specifically, the development of distributed leadership as a key lever to achieving the provincial health system's vision and strategic goals.

iii) Contribute to ongoing efforts to strengthen district health system leadership in South Africa by offering insights on the nature of leadership in a South African district hospital and the enabling/inhibiting factors.

Will my taking part in the study be kept confidential?

We will keep all the information you share with us confidential. We may share the results of the study through reports, posters, conferences, presentations, and journals. In any of these cases, data will be anonymised.

Will I be reimbursed for taking part?

Participants will not be reimbursed for taking part in this study.

What will happen at the end of the study?

This study is linked to a bigger project commissioned by the WCDHW that aims to evaluate the Healthcare 2030 strategy. The insights generated from this study will feed into the bigger project, which also aims to guide WCDHW's

next long-term strategy. I am also undertaking this research project as part of my master's in public health degree studies at the University of Cape Town. So, the results of the study will be written up and submitted for examination towards the degree.

Further information and contact details:

For further information please contact:

Researcher

Oupa S. Motshweneng at Oupa.Motshweneng@westerncape.gov.za or 021 815 8875

Principal Investigator

Professor Lucy Gison at lucy.gilson@uct.ac.za

Ethics Committee

If you have any ethical concerns about this project, you may contact the University of Cape Town's Human Research Ethics Committee at hrec-enquiries@uct.ac.za

Should you decide to take part in the study, please sign the attached consent form. A copy of this information sheet will be given for you to keep.

Thank you for considering taking part in this work.

Appendix F: Consent form

Healthcare 2030 Review: Consent form

Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital

I, _____ (name & surname), consent to voluntarily participate in a research study conducted by Oupa Motshweneng from the Western Cape Government Health and Wellness and the University of Cape Town. I understand that the study aims to conduct a theory-driven exploration of the emergence of distributed leadership in a WCDHW district hospital, to understand whether there is evidence of distributed leadership or not, if so, how is it distributed and what has supported or constrained its emergence.

As a current/past employee at Bophelo Hospital, or a WCDHW senior manager working in/supporting the district health system (circle whichever is relevant), I understand that I am being invited to take part in a one-on-one in-person interview. In agreeing to participate, I understand that:

- My participation is voluntary.
- I will not be paid for my participation.
- The interview will last approximately 45-60 minutes, during which the researcher may take notes.
- The interview will be audio-recorded.
- If I feel uncomfortable in any way during the interview I have the right to decline to answer any question or to leave the session.
- The researcher will not identify me by name in any reports using the information obtained from the interview. My confidentiality as a participant will remain secure.
- Other staff members from the University of Cape Town and the Western Cape Department of Health and Wellness will not be present during the interview.
- I have read and understood the participant information sheet provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I hereby **agree / disagree** (circle the applicable option) to participate in the interview.

I hereby **agree / disagree** (circle the applicable option) to the audio recording of the interview.

Participant

Name: _____

Signed: _____

Date: _____

Researcher

Name: *Oupa S. Motshweneng*_____

Signed: _____

Date: _____

Appendix G: Ethics approval letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

E-52 – Room46, E-Floor, Old Main Building
Groote Schuur Hospital
Observatory 7925
Email: hrec-submissions@uct.ac.za
Website: https://health.uct.ac.za/home/human-research-ethics

09 April 2024

HREC REF: 207/2024

Prof L Gilson
Health Policy and Systems Division
Email: lucy.gilson@uct.ac.za

Dear Prof Gilson

PROJECT TITLE: BARRIERS AND ENABLERS TO THE EMERGENCE OF DISTRIBUTED LEADERSHIP IN A WESTERN CAPE GOVERNMENT HEALTH AND WELLNESS DISTRICT HOSPITAL (SUB-STUDY 071/2016) (MASTERS IN PUBLIC HEALTH: HEALTH SYSTEMS – MR OUPA S MOTSHWENENG)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is only granted for one year until the 30 April 2025.

The researcher is the QA Manager whose functions include [redacted] Hospital – this potential bias must be recorded in the protocol and document as the researcher may have a working relationship with some of the participants.

The HREC acknowledges that the following Master In Public Health: Health Systems Candidate– Mr Oupa S Motshweneng is also involved in this study.

Please submit a progress report, using the standardised Annual Progress Report Forms (FHS016) **or** (FHS 017) if the study continues beyond the approval period. Please submit a Standard Closure form (FHS 010) when the study has been completed, this includes after publication or thesis submission and final completion.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF 207/2024 in all your correspondence.

Yours sincerely

PROFESSOR MARC BLOCKMAN
CHAIRPERSON, FACULTY OF HEALTH SCIENCES HUMAN RESEARCH ETHICS COMMITTEE

HREC REF NO. 207/2024 approval letter

Appendix H: Institutional approval letter

Western Cape Government

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
24th Floor, 4 Dorp Street
Cape Town, 8001

REFERENCE: WC_202404_012
ENQUIRIES: Dr Glynis Denicker

[redacted]
For attention: Prof Lucy Gibson

Re: Approval of research at [redacted] Hospital
Study Reference: **WC_202404_012**
Study Description: **Barriers and enablers to the emergence of distributed leadership in a Western Cape Government Health and Wellness district hospital**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries:

[redacted] Hospital

Facility contact person: [redacted]
Contact Details: [redacted]
Number: [redacted]

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, provided that normal activities at requested facilities are not interrupted and staff are not put under pressure to comply with the research activities.
2. Researchers must provide the department with an electronic copy of a Final Report using the Annexure 9 template within six months of completion of research. This can be submitted to Health.Research@westerncape.gov.za. Future research will not be allowed on the health platform if a Final Report is not submitted.
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, or the final date of the ethics clearance letter, researchers are expected to complete and submit a progress report (**Annexure 8**) and an updated ethics clearance letter to Health.Research@westerncape.gov.za. Failure to do so will render this approval letter void.
4. Please note that if you are conducting a folder audit, and you do not have consent from individual study participants/subjects, you may not capture **identifiable patient information** in your database, as per the Protection of Personal Information Act 4 of 2013 (POPIA).
5. If you do have consent from individual participants in this study, and you are collecting identifiable patient data through your chosen research methodology, you should not keep the data for any longer than is required to complete this research, as per POPIA.
6. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY
DIRECTOR: HEALTH INTELLIGENCE
DATE: 18 June 2024
CC