

Observing Healthcare Leaders in Action After a Pathways to Leadership for Health Transformation Programme by World Health Organization Regional Office for Africa in Benin and Niger

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Purpose: This study aimed to assess the effect of the Pathways to Leadership for Health Transformation Programme (PLHTP) by World Health Organization Regional Office for Africa (WHO AFRO) on the leadership practices of its participants at their workplaces in Benin and Niger.

Participants and Methods: The study was conducted among leaders of healthcare facilities in Benin and Niger who had participated in the WHO PLHTP. Missions were deployed to Benin and Niger to observe changes in the leadership behaviors and healthcare outcomes at the workplaces of the PLHTP participants. Qualitative data were collected through observations, interviews, and document analysis. The data from the various methods were triangulated thematically to assess the effectiveness of PLHTP.

Results: PLHTP improved the leadership caliber and enhanced effective decision-making among the trained leaders in both Benin and Niger. The healthcare leaders in Niger applied the acquired leadership knowledge and skills better as evident in pragmatic resource management, innovation, and staff empowerment compared to Benin where excess resource wastage, suboptimal resource mobilization, poor external communication, and challenges in conflict management and team cohesion neutralized the program's positive effects. Niger has more participative cultures, accommodative health policies, and investments in healthcare compared to Benin, hence PLHTP had better outcomes in Niger than in Benin. Resistance to change by experienced colleagues of the trained healthcare leaders hindered the introduction of changes in the healthcare facilities in both Benin and Niger.

Conclusion: PLHTP improved the leadership capabilities of the participants in both Benin and Niger. Application of the leadership skills had better effect in Niger than Benin since its culture, policies and health systems are more accommodative. Integrating context-specific scenarios in the modules of PLHTP and leveraging digital technologies to make it freely accessible by all healthcare workers can enhance its effectiveness.

Keywords: observe, mission, leadership training, healthcare practice, effect, Africa, culture

Introduction

Global health issues prominently affect Africa due to the existing unique challenges and opportunities especially in West Coast nations like Benin and Niger. Geopolitical and sociocultural factors influence the experiencing of public health problems at all levels in Benin and Niger due to insufficient resources, changing political situations, rapidly evolving socioeconomic conditions, and diverse cultures.¹ The solution to Africa's health challenges lies in the decisions and actions of leaders.² Coping with population's diverse needs in such environments requires humanized health leadership



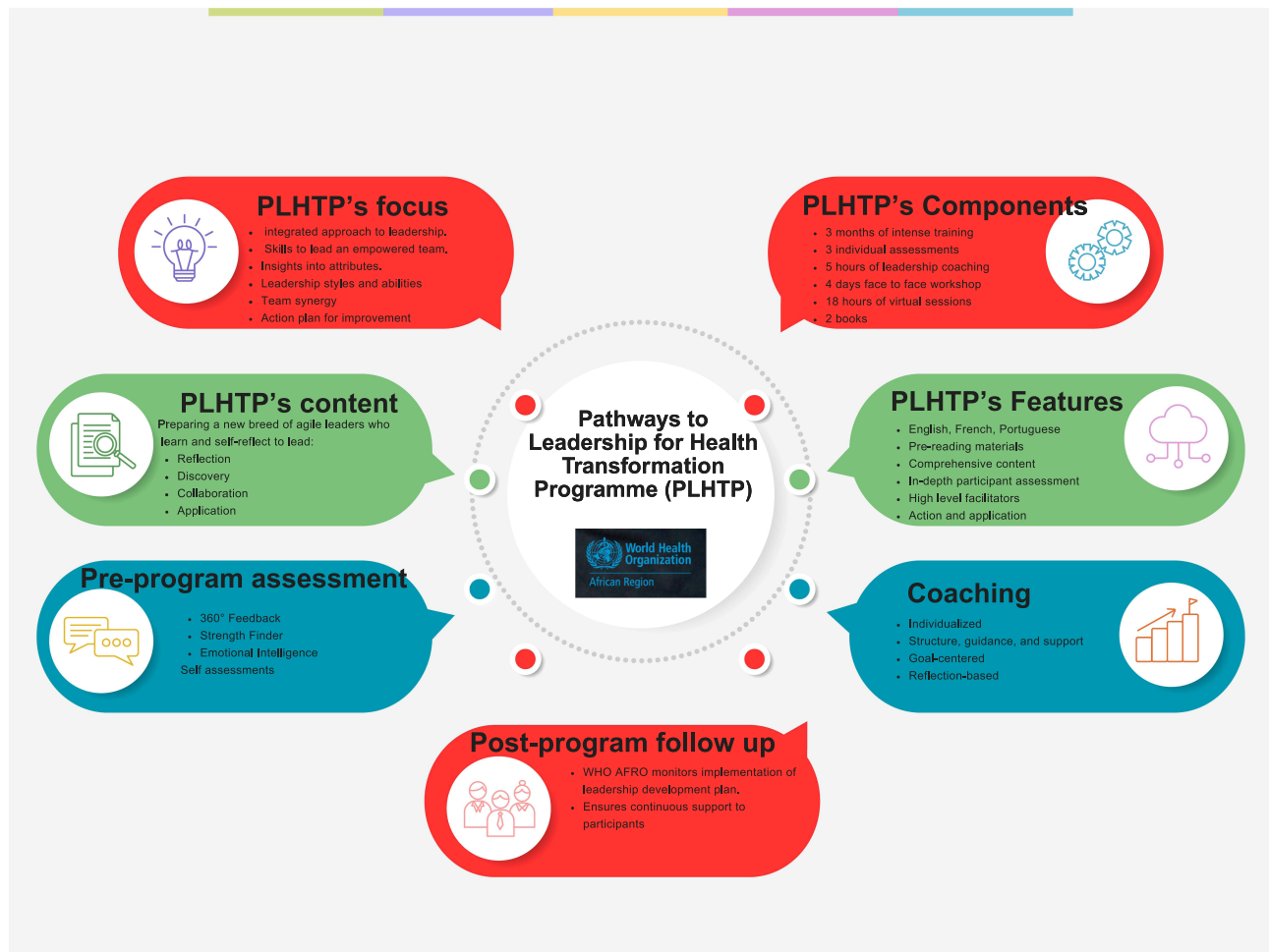


Figure 1 A mind map showing the main aspects of the Pathways to Leadership for Health Transformation Programme (PLHTP) by World Health Organization Regional Office for Africa.

and management, administrative expertise, a flexible spirit, sensitivity to the culture of society at large, and an approach conducive to innovation.³

Training is among the major approaches to improve the effectiveness of health leaders.⁴ The African Field Epidemiology Network (AFENET) responded to the health challenges in Africa by creating the Pathways to Leadership for Health Transformation Programme (PLHTP) (Figure 1). Its goal was to further enhance health systems by improving the leadership and operating skills of people in charge of healthcare by developing their strategy and leadership skills, and communication abilities. It also aimed to cultivate a climate of decision-making using scientific evidence and the efficient use of healthcare resources.

Evidence on the observed effectiveness of leadership and management training programs is scarce and mostly superficial.⁵ PLHTP has an evaluation component whereby the participants were followed in their work environments to observe their application of the leadership principles and skills imparted during the program. This paper reports the findings of the observation missions in Benin and Niger regarding the influence of the PLHTP on the decision-making and actions of the participants.

Materials and Methods

The Observation Mission

The observation mission targeted healthcare settings in Benin and Niger, two nations facing similar access challenges yet operating within distinct cultural and policy frameworks.^{6,7} The missions in Benin and Niger assessed participants' use of

skills gained during the PLHTP at their workplaces as they ran health facilities or dealt with the local communities. They also sought to explore best practices, obstacles, and outcomes of more effective leadership. PLHTP uses the observation missions to gather evidence for improving its training modules and supporting systems perpetually toward robust health systems and better health outcomes for the people of Benin, Niger, and all of Africa. The missions clarify the practical aspects of leadership training and define the direction of future improvements in health management throughout the region.

Duration and Locations of the Observation Missions

The mission carefully arranged for the observation visits to health centers, remote clinics, and hospitals in various rural and urban localities in Benin and Niger. A panel hands-on evaluation was conducted to determine the effect of skills obtained when leaders participated in the PLHTP. The breadth and depth of the geographical coverage provided a systematic, three-dimensional view of the healthcare leadership environment across the diverse settings, allowing participants to gain some understanding of different environments in their implementation of healthcare leadership skills.

Structure of the Observation Missions

The observation missions were carefully fashioned to allow comprehensive and systematic assessment of the leadership skills utilized by health professionals who had attended the PLHTP. Every visit was undertaken with strict adherence to a precisely drawn-up schedule, enabling the observer to devote sufficient time in each of the health centers. Data collection activities were similar in both Benin and Niger to enhance comparability of findings.⁸

Observations occurred in both formal and casual events for information about the performance of leaders across a wide range of situations. The hybrid approach enabled the observation of ups and downs of a leader throughout the day. Thus, it facilitated a comprehensive evaluation of the leader's application of the competencies and skills taught in the program.⁸

Data Collection Methods

The observer interviewed, directly observed, and reviewed related documentation for each participant. The triangulation of data collection improved the validity, comprehensiveness, perspective and depth of the data.⁹ The tools used for the data collection include observation grids, checklists, interview guides, feedback reports, secondary data including photos and videos, reflection and assessment tools, and follow-up visit documentations.

Observation Grid

An observation grid was designed to document health professionals' behavior when relating to each other in the workplace. Elements of leadership and management such as decision-making, team cooperation, coordination, conflict resolution, resource allocation, and communication were included in the observation grid. These grids provided for both qualitative narratives and quantitative grading, thus enabling a detailed assessment of each participant's performance.¹⁰

Checklists

Customized checklists for the healthcare management setting were used to record the observed leadership behavior and practices systematically. The checklists drew on best practices in healthcare leadership and the special skills that WHO AFRO intended to foster. They offered a relatively easy and effective way to assess the participants' adeptness in the practical application of lessons from the program.

Interviews and Feedback Sessions

Interviews and feedback were solicited from participants and subordinates in managerial chains of responsibility and senior managers. They collected data on the changes in leadership and management techniques of the trained leaders, challenges in the application of new knowledge and skills, and the influence of the training on the efficiency of operations at the healthcare facilities.

Review of Secondary Data

Reports and other documents with performance indicators of the healthcare facilities were reviewed to give meaning and context to the observed behaviors and practices, and set benchmarks for comparisons during follow-up visits.

Photographic and Video Documentation

Photos and videos were taken to record the practice of leadership and management in the work environment. The audio-visual documentation enhanced the precision of analysis and facilitated constructive criticism.

Reflection and Self-Assessment Tools

The participants were given tools to enable them reflect on their leadership behavior. The tools also spurred participants to learn and improve, which was consistent with the program's aim of developing reflective practitioners.

Follow-up Visits

Follow-up visits were made to see whether or not the effects of training continued over a period of time. They revealed the longevity of the effect observed in the first visit.

Ethical Considerations

Informed consent was sought from each participant. Frequent meetings were held to review matters and allay fears. Ethics were upheld through adherence to regulations, establishment of an environment of trust and respect, non-interference with health care and patients, and respect for people's dignity and rights. The study did not collect any identifiable personal data since it was an evaluation of a training program, hence it did not require ethical approval.

Results

Benin

Some participants were specially mentioned as performing exceptionally well as they had greater ability to lead and inspire others. They showed the qualities needed in a leader, including empathy and visionary direction of staff members. Most participants effectively practiced delegation to distribute tasks with balance and clarity. Apart from boosting efficiency, this allowed each member of the team to fully use their abilities for versatility at the workplace. Nevertheless, some participants lacked the necessary conflict management skills and team cohesion abilities. This shortcoming was continually linked with poor efficiency, misunderstanding, and loss of team spirit.

After training, most of the participants made clearer and more tactical judgments. Their grasp of coordination of resource allocations to match their facilities' exact needs is very important in places such as Benin and Niger, where resources are usually tight. Additionally, the participants were more strategic in their thinking, weighing long-range effects and the overall impact of what they did. Besides, some participants demonstrated data-driven decision-making while others showed great potential for improvement. In contrast, excessive wastage of resources or failure to fully mobilize existing resources was observed in some healthcare facilities, thus hampering efficient service delivery.

Internal communications were dramatically improved, with information flowing perfectly between different sections. For example, the management of one health center noted that internal communications improved markedly between departments, allegedly resulting in a 25% decline in the quantity of internal errors and misunderstandings over one year. The progress in communications enabled shared vision and cooperation among all team members, thereby improving coordinated care and streamlining operations. Also, work stations were more caring, which enhanced conduciveness of work environments and enhanced job satisfaction and staff retention. On the other hand, difficulties with external communication were observed.

PLHTP in Benin showed a trend toward increasingly competent health leadership or management as evident in the improved leaders' ability to motivate and lead their personnel. Furthermore, participants from Benin moved in the direction of more strategic planning, which is a trend toward greater active initiation by both healthcare providers and patients. For instance, a health center in Benin claimed to have decreased the average waiting time of patients by 40% through more effective staff scheduling.

Findings From Niger

Observations in Niger showed that participants were able to lead teams, make sound judgments, and manage resources effectively after the leadership training. Movement towards more democratic and participatory leadership was observed after the leadership program. The trained health professionals were more willing to allow their teams to contribute to care planning, which fostered a feeling of belonging and respect among members. More channels of communication emerged, with ideas coming easily back and forth for livelier healthcare.

Transformational leadership was evident in the activities of the trained leaders. They communicated the spirit behind a progressive health future, spurring their teams to contribute extraordinary performances in addressing pressing healthcare needs. They got their staff members thinking more actively and proactively, thus promoting a climate of constant learning and professional growth for adaptability. The leaders motivated their teams to accept new concepts and ways of thinking and moving healthcare toward a more innovative future that prioritized patients. For example, a health center adopted the use of telemedicine to improve the quality of care delivered to patients after its leader participated in the training.

The leaders explained policies and plans better, exemplifying natural clarity and breaking down barriers between management and staff, hence creating room for delineating job responsibilities. Additionally, the improved communication avoided misunderstandings and friction between department managers, which streamlined day-to-day work. The trained leaders established and strengthened responsive feedback mechanisms. They transitioned from a top-down information funnel to inclusive and shared decision-making. The better responsiveness enhanced the organization's flexibility to meet new demands as they arose. It also enhanced community engagement, which improve buy-in of healthcare services. For example, a community served by a local health center originally avoided its programs due to doubts about its capacity to offer effective care but upon the training of its leader, preemptive screening reportedly increased by 50%.

The trained leaders evaluated and utilized the strengths and competencies in their teams. They matched tasks to the individuals with the right skill mix for efficiency. They also expressed willingness to foster talent and seize opportunities. The leaders arranged training courses, guidance programs, and career tracks to encourage a spirit of constant improvement. Therefore, they raised morale, motivation, capability, and agility among the healthcare workers. Consequently, staff turnover rates decreased at health centers and employees became more satisfied with their jobs after the training of their leaders. Health workers in a health center said its staff turnover rate fell by about 30% a year after the training.

The trained leaders were more precise and systematic in their thinking, utilizing information from every corner to make decisions on how resources should be allocated. For example, one participant introduced systematic collection and analysis of patient outcomes, which resulted in more precise health practices and about 15% higher patient satisfaction rates. Furthermore, leaders became more conscious of the financial and logistical consequences of their moves, seeking to achieve cost-effectiveness without penny-pinching on patient care. Pragmatism was evident in procurement and maintenance, whereby leaders placed medical supplies and equipment where they were most needed at moments of greatest usefulness. The positive impact of this more effective management of resources extends beyond directly improving service delivery, which is vital in ensuring the long-term sustainability and robustness of healthcare efforts in Niger.

Comparison of the Effects of the Leadership Program in Niger and Benin Similarities

In both countries, the caliber of leadership in health management generally improved. The leaders made better decisions, communicated more effectively, and managed resources in a smarter way due to sound judgements and better coordination of resource allocation. Secondly, a shift toward inclusive leadership was observed among the trained leaders in both nations, with a conspicuous change from authoritative to more participative and transformational leadership styles. This has resulted in increased morale and greater team participation. Several health center managers in Benin and Niger demonstrated their skills in mobilizing and motivating teams.

Observation after the training showed that participants from both Benin and Niger became more effective decision-makers. They more competently used tools and methods to scrutinize situations. They smoothly shared information for strategic thinking and innovation. Thus, the healthcare facilities in both Benin and Niger reported earlier diagnoses and

more effective treatment plans that led to better overall outcomes under the management of the trained leaders. For example, a community health center in Benin indicated that readmission rate of patients dropped by 20% under the transformed leadership, suggesting higher quality initial care.

The trained leaders in both Benin and Niger struggled with resistance to change since the experienced colleagues in their healthcare organizations believed in the traditional leadership approaches such as authoritarian leadership. Nevertheless, leaders who were authoritative before the training exhibited a more inclusive leadership style and cooperative attitudes in the workplaces after the training. For example, in the Cotonou area of Benin, one manager confessed a move from rigidity to flexibility in decision-making. The leaders also faced the challenge of working with fewer resources than requested under volatile political environments amidst an impoverished economy.

Differences

The trained leaders in Benin and Niger implemented leadership principles differently due to variations in cultural contexts. For example, Niger's societal norms impact the ideas and attitudes toward participative leadership compared to Benin, thus making it easy for the leaders in Niger to apply principles of participatory leadership. Secondly, resource allocation strategies depended on the specific policies of the individual countries. Benin's and Niger's health needs and priorities differ, hence their policies on resource allocation are not similar.

Resource management differed between Benin's and Niger's leaders even after the leadership training. Niger's leaders applied precise and systematic thinking for pragmatic resource allocation and cost-effectiveness of interventions. For example, they applied skills matching and staff empowerment to optimally meet health needs while satisfying their staff members. On the other hand, excessive resource wastage and suboptimal resource mobilization were observed in a substantial number of the visited healthcare facilities in Benin.

Challenges in relationship-building were observed among leaders in Benin compared to Niger's leaders. Several Benin's leaders were poor in external communication, conflict management, and team cohesion. In contrast, leaders in Niger engaged communities, established responsive feedback systems, and practiced team cohesion and adaptability.

Discussion

The PLHTP has made a deep impression and changed the landscape of health management practices in both Benin and Niger. The trained leaders particularly in Niger initiated a trend of more active, open and proactive leadership bodes, which are soft skills vital for improvements in the quality of health care services.¹¹ Processes and results clearly vary between Benin and Niger. Nevertheless, the overall direction is still toward more successful, humane and streamlined health leadership characterized by more effective decisions. The improvements in the immediate access to health services will contribute to building a more resilient and patient-centered healthcare foundation for Niger.¹²

The differences noted between leaders in Benin and Niger could be due to cultural variations. Niger's cultures are generally more tolerant and participatory than Benin's.¹² Sociocultural factors substantially influence decision-making in Benin,¹³ hence the observed challenges in team cohesion, conflict management, external communication, and resource mobilization. Cultural sensitivity is key in successful implementation of programs in Benin due to strong cultural beliefs such as a strong faith in traditional medicine among her people.¹⁴ On the other hand, cultural beliefs only influence decision-making in a minority of Niger's residents.¹⁵

Differences in health policies and systems may have determined the extent of application of the leadership skills acquired from the training program between Niger's and Benin's participants. Benin has stricter requirements for healthcare workers such as the prohibition of community health volunteers from provision of integrated community case management, yet those in Niger are allowed.¹⁶ The restrictive policies may derail the implementation of acquired leadership skills, which emphasize flexibility. Benin is ranked among the top three countries with the lowest health financing globally. This may explain the lack of resource-consciousness seen in the excess resource wastage observed in Benin even after the leadership training.¹⁷ In contrast, Niger was recognized for good emergency preparedness, surveillance and detection during the COVID-19 pandemic,¹⁷ which points to stronger healthcare policies and systems compared to Benin.

The observed external communications gaps in Benin are worrisome because coordination with communities, local organizations, and other health partners is essential for the overall effectiveness of a healthcare system especially in public health emergencies.¹⁸ Good external communication is critical to attending to community demands, mustering support, and crowd-sourcing resources in the pursuit of better health. Filling the voids in external communication is not only a matter of information distribution but also about establishing mutual trust and relations for the healthcare network.¹⁹

The resistance to change among colleagues of the trained healthcare leaders as reported in both Benin and Niger shows that it is an important factor when designing and implementing health interventions. The workers' beliefs and attitudes about ongoing change influence uptake of the change and their work engagement as well as turnover engagements.²⁰ Resource-constrained work environments such as the healthcare facilities in Benin and Niger present their workers with the challenge of coping with job responsibilities,²¹ thus reducing their resilience when the need to cope with organizational change arises.

The main limitation of this study is that the evaluation did not account for the influence of confounders and other factors that may have affected the leadership practice of the participants besides the PLHTP. It was addressed through triangulation by collecting rich data from multiple sources using diverse approaches to distinguish the influence of the PLHTP on the leadership practices of the participants from spurious relationships. For example, an observed change in the communication approach explained by the leader as an outcome of the PLHTP is less likely to be due to other factors.

Conclusion

The long-term observation missions in Benin and Niger provided rich material for an understanding of the effect of PLHTP on local leadership and management of healthcare facilities. Strategic decision-making through sound judgments was generally the remarkable benefit of the leadership program. Resistance to change and limitations due to scarcity of resources were the main weaknesses of the implementation of the leadership program's lessons. Although communication competencies of the leaders improved remarkably in both Benin and Niger, external communication skills were barely transformed in Benin. The application of the leadership knowledge and skills was more effective in Niger than Benin due to Niger's better participative culture, accommodative health policies, and investments in health compared to Benin.

The training modules of PLHTP can be strengthened by incorporating context-specific scenarios to account for the hard realities of local healthcare due to unique cultures, policies, and priorities. The communication strategies of healthcare facilities should include interventions to improve the cultural sensitivity of both the leaders and staff members. The challenge of resistance to change can be addressed by increasing PLHTP's accessibility to all healthcare workers by employing digital tools including e-learning modules and virtual simulations and platforms to provide free access to training content.

Abbreviations

AFENET, African Field Epidemiology Network; COVID-19, Coronavirus disease 2019; PLHTP, Pathways to leadership for healthcare transformation programme; WHO AFRO, World Health Organization Regional Office for Africa.

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Disclosure

Patrice Inko and Dennis Kithinji conducted this study as independent consultants for the WHO Regional Office for Africa. Kizito Nsarhaza is a member of staff of the WHO Regional Office for Africa. The authors report no other conflicts of interest in this work.

References

- Gilson L. Everyday politics and the leadership of health policy implementation. *Heal Syst Reform*. 2016;2(3):187–193. doi:10.1080/23288604.2016.1217367
- Mbah CE. Leadership question and development crises: the 21st century challenges in Africa and quest for change. *J Sustain Dev Africa*. 2013;15(2):142–153.
- Gotsis G, Grimani A. Humanistic Leadership: a Global Roadmap Toward Inclusion. In: *Encyclopedia of Diversity, Equity, Inclusion and Spirituality*. Springer Nature; 2023:1–20. https://dlwqxts1xzle7.cloudfront.net/110276487/George_Gotsis_and_Aikaterini_Grimani_Humanistic_leadership_A_roadmap_toward_inclusion-libre.pdf?1704892951=&response-content-disposition=inline%3B+filename%3DGotsis_G_Grimani_A_2024_Humanistic_Leade.pdf&Expi.
- Reich MR, Javadi D, Ghaffar A. Introduction to the special issue on “effective leadership for health systems”. *Heal Syst Reform*. 2016;2(3):171–175. doi:10.1080/23288604.2016.1223978
- Tudor Car L, Kyaw BM, Atun R. The role of eLearning in health management and leadership capacity building in health system: a systematic review. *Hum Resour Health*. 2018;16:44. doi:10.1186/s12960-018-0305-9
- Zegeye B, El-Khatib Z, Ameyaw EK, et al. Breaking barriers to healthcare access: a multilevel analysis of individual- and community-level factors affecting women’s access to healthcare services in Benin. *Int J Environ Res Public Health*. 2021;18:750. doi:10.3390/ijerph18020750
- Oliphant NP, Ray N, Bensaid K, et al. Optimising geographical accessibility to primary health care: a geospatial analysis of community health posts and community health workers in Niger. *BMJ Glob Heal*. 2021;6:e005238. doi:10.1136/bmjgh-2021-005238
- Kosmützky A, Nokkala T, Diogo S. Between context and comparability: exploring new solutions for a familiar methodological challenge in qualitative comparative research. *High Educ Q*. 2020;74(2):176–192. doi:10.1111/hequ.12255
- Barr J, Dowding L. *Leadership in Healthcare*. 5th ed. Sage; 2022. <https://collegepublishing.sagepub.com/products/leadership-in-health-care-5-275047>.
- Reumont M, Simard M, Lapalme J. The unanticipated performativity of an observation grid through the evolution of its forms of agency. *Qual Res Organ Manag*. 2025. doi:10.1108/QROM-02-2024-2687
- Abraham TH, Stewart GL, Solimeo SL. The importance of soft skills development in a hard data world: learning from interviews with healthcare leaders. *BMC Med Educ*. 2021;21:147. doi:10.1186/s12909-021-02567-1
- Debie A, Nigusie A, Gedle D, Khatri RB, Assefa Y. Building a resilient health system for universal health coverage and health security: a systematic review. *Glob Heal Res Policy*. 2024;9:2. doi:10.1186/s41256-023-00340-z
- Icouthika KLM, Ahozonlin MC, Mitchikpe CES, Bouraima O, Aboh AB, Dossa LH. Socio-economic determinants of goat milk consumption by rural households in the Niger Valley of Benin and implications for the development of a smallholder dairy goat program. *Front Sustain Food Syst*. 2022;6:901293. doi:10.3389/fsufs.2022.901293
- Alaofè H, Yeo S, Okechukwu A, et al. Cultural considerations for the adaptation of a diabetes self-management education program in Cotonou, Benin: lessons learned from a qualitative study. *Int J Environ Res Public Health*. 2021;18:8376. doi:10.3390/ijerph18168376
- Issoufou Kapran M, Farris A, Wijayatunga NN, Valliant M, Mann G. Socio-cultural determinants of exclusive breastfeeding and infant feeding practices in Niger. *World Nutr*. 2023;14(4):41–55. doi:10.26596/wn.202314441-55
- Davis AL, Flomen L, Ahmed J, et al. Documenting community health worker compensation schemes and their perceived effectiveness in seven sub-Saharan African countries: a qualitative study. *Glob Heal Sci Pract*. 2024;12(3):1–11. doi:10.9745/GHSP-D-24-00008
- Zhao L, Jin Y, Zhou L, et al. Evaluation of health system resilience in 60 countries based on their responses to COVID-19. *Front Public Heal*. 2023;10:1081068. doi:10.3389/fpubh.2022.1081068
- Dick L, Moodie J, Greiner AL. Are we ready? Operationalising risk communication and community engagement programming for public health emergencies. *BMJ Glob Heal*. 2022;7:e008486. doi:10.1136/bmjgh-2022-008486
- Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. Assessing meaningful community engagement: a conceptual model to advance health equity through transformed systems for health. *NAM Perspect Expert Voices Heal Healthc*. 2022. doi:10.31478/202202c
- Khaw KW, Alnoor A, AL-Abrow H, Tiberius V, Ganesan Y, Atshan NA. Reactions towards organizational change: a systematic literature review. *Curr Psychol*. 2023;42(22):19137–19160. doi:10.1007/s12144-022-03070-6
- Kern M, Zapf D. Ready for change? A longitudinal examination of challenge stressors in the context of organizational change. *J Occup Health Psychol*. 2021;26(3):204–223. doi:10.1037/ocp0000214

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